NHS
Health Education England

Bart's Health NHS Trust

Neonatology, Maternity and Midwifery

Multi-professional Review (on-site visit)

Quality Review report

20 June 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Area for review	Neonatology, maternity and midwifery
Number of learners met with	The review team met with six postgraduate medical trainees in neonatal medicine, seven postgraduate medical trainees in obstetrics and gynaecology (O&G) and six student healthcare learners across neonatology, maternity and midwifery.
Number of educators met with	The review team met with clinical and educational supervisors from neonatal medicine and obstetrics and gynaecology, two senior nurses in neonatology and the following Trust representatives: • Medical Director Andrew Kelso • Director of Nursing / Head of Therapies, Louise Crosby • Director of Medical Education, Emma Young • Director for Midwifery Services, Gloria Rowland • Simulation Leads, Rachel Gill and Jemma Joseph • Associate Director of Quality for Medical and Dental Education, Nate Hill • College Tutors (Neonatal) Alam Mohammed • College Tutor (O&G), Farah Saeed

Background to review	A multi-professional review was planned as a result of a number of long standing issues in relation to the neonatal and maternity services being delivered at Newham University Hospital. Health Education England (HEE) also had concerns around the culture and inter-professional working relationships between the departments and professional groups. HEE had previously undertaken a number of Quality Reviews to the neonatal and maternity services at Newham University Hospital over the previous two years: • Paediatrics (19 April 2017) • Obstetrics and Gynaecology (13 March 2018) • Neonatal medicine (02 July 2018) • Neonatal medicine (14 January 2019) The most recent quality review on 14 January 2019 identified a number of areas which had improved since 02 July 2018 and which the Trust were congratulated for: • The support and mentorship provided by the consultants within the Neonatology department. • The favourable working relationship with the nursing staff in the Neonatology department. The review team also noted that the attrition rate for the nursing workforce was low. • That the intervention of the Neonatal Matron and Clinical Lead had led to an improvement with regards to the Neonatal resuscitation equipment. However, there remained the following areas identified as of concern or in need of improvement: • There were missed opportunities for the whole team to learn from serious incidents / near misses.

	• The extremely high workload and service demands was contributing to workplace stress and, potentially, deteriorating team behaviours. • There was potential for new trainees, without previous neonatal experience, to feel unsafe when using resuscitaires and when completing baby checks if sufficient training was not provided at the departmental induction. • The neonatal medical trainees felt that the historical culture around bullying and undermining amongst staff still prevailed, primarily related to interactions with a number of Trust grade doctors in neonatal medicine but which had also been experienced / witnessed by staff (both medical and nursing) within maternity services (Labour ward, theatres and inpatient areas). The full reports and findings from the previous quality reviews which the HEE review team took in to consideration can be accessed at: https://www.lpmde.ac.uk/var/plqru/medical-quality-management/qif/focus-areas/quality-reviews/quality-reviews-reports In addition to intelligence obtained through HEE led quality reviews, HEE were also made aware of the Care Quality Commission (CQC) inspection of the maternity service in September 2018 which highlighted concerns resulting in a CQC Section 29a Warning Notice (Health and Social Care Act 2018). The findings from previous HEE quality reviews and the CQC inspection in September 2018, prompted HEE to organise a multi professional review to assess the clinical learning environment as a whole. The rationale for incorporating other healthcare professional learners was to provide the HEE review panel with a holistic view of the learning environment with a view to providing increased clarity over the information previously obtained during the recent quality reviews with medical specialty trainees.
HEE intelligence sources	In advance of the quality review on 20 June 2019, the HEE London Quality, Reviews and Intelligence (QRI) team reviewed the following intelligence sources in order to inform the pre-review meetings and to further advise the quality review team: • General Medical Council National Trainee Survey (GMC NTS) 2018 and 2019 • National Education Training Survey (NETS) • Escalation of concerns • CQC inspection report on maternity services 2019 • Feedback from City University
Supporting evidence provided by the Trust	In advance of the quality review on 20 June 2019, Bart's Health NHS Trust submitted the following evidence to the HEE QRI team. This evidence was reviewed by the quality review team as part of the pre-review processes. • Updated Trust action plan • Culture and Leadership programme • Charter for Standards of Behaviour 2019 • Big Reveal of Culture and Behaviour Programme • Recruitment and retention data for nursing and midwives • 2018 Annual Staff Survey • Exception Report • Teaching and simulation feedback • Quality and Safety Reports (November 2018, January 2019, February 2019 and March 2019) • Incident Report for gynaecology (February to April 2019) • Monthly site CQRM Report (April 2019 and May 2019) • Violence and Aggression report

	• Site governance reports • Datix reports for neonatology (July 2018 to March 2019) • Undergraduate student nurse feedback • Undergraduate medical student feedback • Feedback and attendance registers from teaching sessions • Local Faculty Group minutes for Paediatrics and O&G • Learning from excellence report • Q4 Friends and family test
How HEE carried out this review	The multi-professional review was arranged for 20 June 2019 and the Trust were invited to submit supporting evidence to illustrate the clinical learning environment for all learners. The review team thanked the Trust for the time taken to prepare, collate and return the substantial amount of evidence received in advance of the actual review date. In addition to the evidence submitted by the Trust, the QRI team undertook a detailed analysis of other intelligence sources available to HEE. This included a review of the General Medical Council National Trainee Survey 2018 results, the National Education Training Survey (NETS) results from November 2018 and the Higher Education Institute escalation of concerns returns. Notification was also sent to the Higher Education Institutes that placed nursing and midwifery learners at Newham University Hospital. The Higher Education Institutes were invited to contact the HEE QRI team with any additional intelligence or feedback from their learners and to confirm numbers of learners who were currently on placement in relation to the departments being visited The purpose of requesting evidence from the Trust and for the internal HEE analysis was to ensure that the review team were fully prepared in advance of meeting the Trust and its learners on 20 June 2019. The evidence was discussed at two internal pre-review meetings held at HEE and which the review team and Higher Education Institutes were invited to attend and contribute to. The review on 20 June 2019 commenced with a meeting with Trust management, followed by a confidential session with the Freedom to Speak Up Guardian. This session was included to further understand whether learners had access to support should they have concerns around unprofessional behaviours and, in particular, whether any concerns had been raised around maternity and midwifery. The review team also held separate sessions with the neonatology trainees, O&G trainees, and the nursing and midwifery learners. The same sessions were then held with the education and clinical supervisors for neonatology and O&G. However there were no Clinical Practice Facilitators or Nurse Educators / Mentors available on the day of the review so the review team were unable to complete a full triangulation of the information obtained from the nursing and midwifery learners.
Summary of findings	The review team thanked the Trust and the Education Academy team for facilitating the multi-professional review. Full details of the findings have been detailed within the findings section of this report. However, in summary, the review team was pleased to note that a number of areas were working well with significant improvements reported by the learner groups and the Trust should be congratulated for their work within these clinical areas. **<u>Maternity and Midwifery</u>** • A new Head of Midwifery had been appointed to be responsible for the implementation of the culture change and organisational development diagnostic work initiated by the new Trust Director of Midwifery Services. • New charter of behaviour and strategy for excellence in care and kindness amongst staff.

- A mutually respectful and supportive relationship across O&G trainees and Trust grade doctors.
- A dedicated obstetric theatre had been established and an additional theatre was also available (if required) from November 2018.

Neonatology

- Regular, time-tabled consultant led educational activities embedded.
- An enhanced induction programme for preparing new trainees.
- The establishment of a local faculty group and junior-to-junior meeting for any emerging issues to be openly discussed and acted upon.
- A safe learning culture was developing with learners encouraged to report any issues via the Trust incident reporting systems with weekly feedback
- All learners felt supported by their consultants and Clinical Practice Facilitators.
- The working environment was heard to be supportive and enjoyable.
- The first in-situ multi-professional simulation session had been undertaken.
- The department had reviewed its workload and workforce and new rotas planned for September would provide a more manageable frequency of on-calls for trainees.
- Regular audits had been put in place to address the resuscitation equipment risks highlighted by the CQC.

The following areas were identified as of concern or in need of improvement:

Maternity and Midwifery

- Unprofessional behaviours, including instances of bullying and undermining, had been observed amongst members of the multi-professional teams working in obstetric theatres and in labour rooms.
- Midwifery learners affected by the unprofessional behaviours were able to access pastoral support from their Clinical Practice Facilitators. However, the review team was concerned that these learners were accepting these behaviours as the norm and had learnt to cope rather than to challenge.
- There appeared to be a lack of consistent compliance with the World Health Organisation (WHO) (NatSSIPs) safety checklist in obstetric theatres.
- The apparent lack of robust coordination of patient flow and oversight in obstetric wards posed a high risk and unsafe environment for trainees, staff and patients.
- There appeared to be a lack of a well-led, multi-professional handover system.
- The lack of structure, coordination and guidance around escalation protocols for deteriorating patients posed a risk to trainee and patient safety.
- The debriefing afforded to trainees following clinical incidents or maternal/neonatal death, was described as being ineffective.
- There was room for improvement with the teaching programme, particularly around cardiotocographic interpretation, and there should be increased consultant participation and leadership to ensure a high quality teaching programme.

	Neonatology • The review team remained concerned about the lack of a robust training programme and assessment process for Trust appointed doctors to support their professional development. • There were concerns about the level of competency and experience in the safe resuscitation of neonates within the labour room.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean HEE (London)	**School of Paediatrics Representative**	Dr Ruth Shephard Consultant Neonatologist Deputy Head of School for Paediatrics and Child Health
School of Obstetrics and Gynaecology Representative	Mr Greg Ward Head of London school for Obstetrics and Gynaecology	**HEE Healthcare Professionals Representative**	Julie Combes, Head of Clinical Education Transformation
External Nursing Representative	Alex Phillips Neonatology Matron St Thomas' Hospital	**HEE Representative**	Lynda Frost Head of Quality, Patient Safety & Commissioning Manager HEE (London
Lay Member	Jane Gregory Lay Representative	**Observer (HEE)**	Andrea Dewhurst Quality, Patient Safety & Commissioning Manager HEE (London)
HEE Representative	Tolu Oni Learning Environment Quality Coordinator HEE (London)		

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, serv ice users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement Reference Number
NMM 1.1	**Department Culture** The Trust submitted several pieces of evidence in advance of the quality review to demonstrate the steps that had been taken to address the culture across maternity and midwifery. This included details of the Culture and Leadership programme, the Charter for Standards of Behaviour 2019 and the Culture and Behaviour Programme. Overall the review team was pleased to note that the culture within the neonatology department had improved considerably as a result of these steps taken by the Trust. However, the review team remained concerned about the culture amongst members of the multi-professional teams working in obstetric theatres and in labour rooms. The review team remained optimistic about the Trust's commitments and acknowledged the developments within the neonatology and O&G departments as a welcome improvement. • **Neonatology** As part of the organisational development plan the review team heard of the work being undertaken to address the cultural issues within the Neonatology unit and heard about the department "Away Day" in October 2018 that focused on team building and improving working relationships between training and trust-appointed junior doctors. • **Maternity and Midwifery** The review team explored the steps taken by the Trust to address the on-going cultural issues, particularly with regard to inter-professional interaction amongst the obstetrics teams and the Director of Midwifery provided an update on interventions made to date. It was reported that a diagnostic test and root	NMM1.1a

	cause analysis had been undertaken; the findings of which were accompanied with recommendations and subsequently presented to the Trust Executive Committee (TEC) and the Director of Nursing. The review team was informed that a new Head of Midwifery had been appointed and part of their remit would be to manage the implementation of the culture change and organisational development work. The review team was also pleased to note that the new charter of behaviour and strategy for excellence in care and kindness amongst staff had been initiated. The review team heard reports from all learners that, at times, there had been a culture of poor inter-professional behaviours between members of the multi-professional teams working within the obstetric theatres and labour rooms. However, the review team noted the evidence submitted by the Trust and remained hopeful that the diagnostic tests undertaken by the Director of Midwifery would improve inter-professional relationships. • **Midwifery Learners** The review team heard that midwifery learners would take steps to ensure that the patient was not affected by any negative inter-professional relationships. The review team also heard that the learners were able to access pastoral support from their Clinical Practice Facilitators (CPF). The review team was concerned that there was an increasing tendency to accept such behaviour as the 'norm' rather than to challenge this behaviour and thus embed this negative culture in the unit. • **O&G** Although the trainees reported that the breadth of clinical experience available was adequate, there was a reluctance to recommend the placement to peers due to concerns around the culture within the department.	
NMM 1.2	**Patient Safety** • **Maternity and Midwifery** The review team was advised that there was a lack of robustness in the identification and escalation of high risk and deteriorating patients within the maternity unit. • **O&G** The review team heard that compliance with the World Health Organisation (WHO) (NatSSIPs) checklist had been variable and that there had been the potential for patient and trainee safety to be impacted. However, the review team noted that the Trust was in the process of recruiting a midwife who would have responsibility for ensuring compliance with WHO check list.	NMM1.2a NMM1.2b
NMM 1.3	**Rota Arrangement** • **Neonatology** The review team heard from the neonatal trainees that workload had been an ongoing concern, with trainees working a one in six rota. The neonatal Matron advised that rota gaps were proactively identified through discussion at	

	consultant and nursing meetings. The Clinical Director confirmed that the unit was kept safe at all times and that consultants often stepped down to provide support when rota gaps were identified. The review team further heard that a new clinical fellow with a focus on teaching was appointed in October 2018 and that recruitment plans were underway to appoint locum consultants to support the neonatal unit. In addition, it was noted that a monitoring system for staffing had been established and all staff had access to the trigger list. The review team heard from the trainees that the rota was currently managed by a higher specialty trainee with support and guidance provided by one of the neonatal consultants. • **O&G** With regards to staffing for O&G, the College Tutor confirmed that the Trust had a plan in place to address the issues related to staff shortages.	
NMM 1.4	**Handover & Escalation** • **Neonatology** The review team heard that the trainees found the handover meetings to be disorganised and examples were cited of a lack of clarity in the escalation of patients from nurses to doctors. The review team heard no evidence of regular multi-disciplinary handover meetings. • **O&G** The review team heard of a lack of structure, coordination and guidance around the escalation protocols for deteriorating patients. This had led to trainees receiving unfiltered or ungraded calls from junior midwives which had added to their workload. The trainees commented that the lack of robust escalation protocols could lead to deteriorating patients being missed. The O&G trainees reported that they attended handover at 08:00 but that there were no set handovers at other times of the day. The trainee also described the morning handover as poorly organised and lacking structure or leadership. The review team heard that the department held regular monthly risk management meetings where issues raised from the wider Multi-Disciplinary Team were discussed and where trainees were encouraged to participate.	NMM1.4a
NMM 1.5	**Induction** • **Neonatology** The review team heard that the neonatal medicine induction was robust and appropriate for preparing new arrivals in delivering safe care in a demanding environment.	
NMM 1.6	**Protected time for learning and organised educational sessions** • **Neonatology** The trainees confirmed that they were able to attend local and regional teaching programmes but advised that these were not bleep free.	

	• **O&G** The review team heard that the departmental teaching sessions lacked leadership or oversight from consultants and were often challenging for trainees to attend due to service pressures.	NMM1.6a
NMM 1.7	**Adequate time and resources to complete assessments required by the curriculum** • **Neonatology** It was understood that the department had a procedure in place for facilitating the documentation and competencies required for trainees preparing for their Annual Review of Competence Progression (ARCP). • **Maternity and Midwifery** The review team heard that the Trust had received a warning notice following a recent inspection from the Care Quality Commission (CQC) and that this had initially detracted from the effort placed on training and teaching. As a measure of mitigation, the Director of Medical Education (DME) commented that there was now ongoing teaching with a stronger emphasis on education, for example discussion of lessons-learned. • **O&G** The O&G trainees reported that they had experienced difficulties achieving the competencies and supervised learning events (SLE) required for their ARCP. The review team was concerned to hear reports from trainees of inadequate induction, ineffective cardio-tocographic interpretation teaching and poor participation and leadership from consultants in delivering the programme. This had notably affected the specialty training levels one to three (ST1-3) who, at times, felt unprepared and unsafe in clinical practice. The review team also heard that this had affected the ST4-7 trainees when organising their advanced training specialty modules (ATSMs).	
NMM 1.8	**Access to simulation-based training opportunities** • **Neonatology** The trainees indicated that they found the simulation sessions to be a beneficial experience. The review team acknowledged this as a marked improvement and welcomed this change. The review team was pleased to hear that the first in-situ multi-professional simulation learning event had been undertaken in the neonatal department and a regular schedule had been planned. It was also noted that there were plans to extend simulation to O&G. • **Maternity and Midwifery** The review team also heard of the steps taken by the Trust to develop multi-disciplinary training across the maternity unit and labour ward. It was reported that the unit held monthly in-situ and multi-professional simulation training and that plans were underway to streamline simulation training to engage the wider multidisciplinary team. The review team remained assured of the Trust's commitments and acknowledged the developments within maternity and midwifery as a welcome improvement.	

	• **O&G** The College Tutor for O&G reported that all trainees received simulation-based training and education.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

NMM 2.1	**Appropriate system for raising concerns about education and training within the organisation** • **Neonatology** The review team heard that the trainees were familiar with the process of raising concerns using Datix and the review team had seen the Trust Datix reports for neonatology as part of the evidence submitted prior to the quality review. • **Maternity and Midwifery** The review team had reviewed the governance evidence submitted by the Trust in advance of the quality review and further heard from the DME that the Trust recognised that there were a disproportionately low number of Datix reports following serious incidents (Sis). However, the DME advised that the unit optimised learning from trainee feedback through the Local Faculty Groups. The review team heard that the Trust had implemented a safety huddle meeting which included representation from gynaecology consultants. The neonatal Matron confirmed that the safety huddle meeting afforded learning opportunities through the discussion of Datix and SI reports. In addition, the review team was informed that the department held regular handover meetings where issues raised from the wider multi-disciplinary team were discussed. The review team heard that the Trust had addressed equipment safety concerns related to resuscitaires; of note was the embedding of a robust checking system that ensured that all emergency equipment, particularly the resuscitation trolleys, were regularly checked The review team also recognised that the Trust had implemented a Greatix system which enabled learning from positive clinical scenarios and best practice. • **O&G** The O&G trainees reported the absence of a structured risk management meeting which focused on learning from serious incidents. However, the	

	College Tutor for O&G reported that trainees had access to regular Mortality & Morbidity meetings. It was understood by the review team that efforts were made by the department to share lessons learned or curriculum relevant opportunities for trainees.	
NMM 2.2	**Appropriate system for raising concerns about education and training within the organisation** • **Neonatology** The trainees confirmed that there was a monthly Local Faculty Group as well as a junior to junior meeting where any emerging issues were discussed and acted upon. • **Maternity and Midwifery** The review team heard that trainees did not perceive raising an exception reports as effective and were therefore reluctant to do so. However, the review team recognised that all trainees were aware of both the Guardian of Safe Working Hours (GoSWHs) and of the process for highlighting issues through the appropriate pathway. It was also reported that steps had been taken to foster a safe environment which allowed open discussions around patient safety issues as well as escalation of related concerns. To supplement this, the review team heard of the newly implemented Schwartz rounds aimed at raising concerns and discussing lessons learned following clinical incidents.	NMM2.2a
3. Supporting and empowering learners		
HEE Quality Standards **3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.** **3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.**		
NMM 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The review team heard that an independent Freedom to Speak Up Guardian had been appointed and that the service had been accessed by staff seeking assistance. The Freedom to Speak Up Guardian informed the review team of the governance in place for patient safety related concerns. The review team heard that all patient safety concerns raised would be dealt with in a timely manner and that the Freedom to Speak Up Guardian worked in close partnership with staff and/or learner groups to reflect on the issues raised. The review team noted that there had been no new requests or issues raised in recent months. The review team was advised that all members of staff were informed of the actions taken following concerns raised about education or patient safety. It was also reported that all learners were encouraged to participate in shared learning exercises. • **Maternity and Midwifery** The review team acknowledged the potential psychological impact of neonatal death on trainees and explored the structures in place to support them. The College Tutor for O&G reported that a debrief proforma had been implemented	

	for the current intake of trainees. It was also reported that trainees were debriefed following significant events, but it was unclear to the review team whether the education supervisors (ES') and clinical supervisors (CS') working in the O&G unit, had been adequately equipped and empowered to undertake these responsibilities. The review team was disappointed to hear that the debriefing afforded to trainees following clinical incidents was described by the trainees as being ineffective and, on occasion, this had a negative impact on their mental wellbeing.	NMM3.1a
NMM 3.2	**Access to study leave** • **Neonatology** The neonatal medicine trainees reported that access to study leave was good but commented that they had experienced some difficulty with the reimbursement processes. • **O&G** In contrast, the O&G trainees indicated that access to study leave was restricted due to rota gaps and the need to prioritise service demands.	
NMM 3.3	**Organisation to ensure access to a named educational supervisor** • **Maternity and Midwifery** The review team noted that all learners had an allocated educational supervisor and were satisfied with the level of clinical supervision provided during clinical duties. The learners also confirmed that the consultants and Practice Educators were supportive and available when needed.	
NMM 3.5	**Organisation to ensure access to a named clinical supervisor** • **Maternity and Midwifery** The review team heard that trainees were able to access their clinical supervisors when needed both within and out-of-hours to escalate concerns with deteriorating patients.	

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

NMM 4.1	**Sufficient time in educators' job plans to meet educational responsibilities** • **O&G** The Clinical Director and Medical Director advised the review team that all O&G education supervisors had been allocated two Supporting Professional Activities (SPAs) and that included time for teaching.	NMM4.1a

	However, it was also acknowledged that the time dedicated within the consultant job plans was insufficient to achieve the requisite educational and clinical supervision for supporting trainees. This lack of dedicated educational supervision was reported to be adversely affecting junior trainees or trainees needing additional support and this had been reflected in adverse outcomes at ARCP. The review team was also advised that the Trust was looking at succession planning for education supervisors.	
NMM 4.2	**Organisation to ensure time in trainers' job plans** • **Maternity and Midwifery** The review team heard that the Trust would be undertaking a review of job planning.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

NMM 5.1	N/A	

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

NMM 6.1	**Organisation to support and develop the local workforce** The review team heard that a number of developmental initiatives had been implemented to support the training and development of locally appointed Trust grade doctors and that the Trust was exploring opportunities for this cohort to be co-opted into the electronic	NMM6.1a

	training portfolio. However, the review team remained concerned about the lack of a robust training program and assessment regime to support professional development and to manage any reported lack of professionalism or clinical competency.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
• The review team was pleased to see that a safe and transparent learning culture was developing within the neonatal department with a new weekly safety huddle established to review emerging concerns. • The review team was pleased to see that the first in-situ multi-professional simulation learning event had been undertaken in the neonatal department and a regular schedule planned. • The review team was reassured to hear that an independent 'Freedom to Speak up Guardian' had been established and that this service had been previously accessed by staff seeking assistance			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
NMM1.2 b	The Trust is required to clearly define and demonstrate compliance with the WHO checklist and safety culture in the Obstetric theatres to reassure HEE around trainee and patient safety.	The Trust is to provide evidence (audit & LFG minutes) by 01 December 2019.	R1.1
NMM1.4 a	The Trust is required to describe the structure, leadership and governance of a multi-professional handover at the start and end of every shift.	The Trust is to provide evidence (audit) by 01 December 2019 that daily consultant-led handovers with involvement from the wider multi-disciplinary medical team in maternity and neonatal unit at shift changes.	R1.14
NMM1.2 a	Trust to describe clear thresholds and escalation pathway for deteriorating patients in maternity and neonatal department	Trust to provide audit data from NEWS compliance by 01 December 2019.	R1.1

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
NMM3.1 a	The Trust to ensure that education supervisors (ES') and clinical supervisors (CS') working in the O&G unit have been adequately equipped and empowered to undertake debriefing sessions following serious clinical incidents.	The Trust to provide evidence by 01 December 2019 that demonstrates that trainees have access to appropriate support systems following serious clinical incidents and that ES' and CS' have been sufficiently trained to deliver debriefings of this kind.	R3.2
NMM4.1 a	The Trust must ensure that the Educational supervisors (ESs) have a minimum of 0.25PA time per trainee visible and accounted for in job plans for training and educational supervision of trainees	The Trust to provide evidence by 01 December 2019 that ES' have a minimum of 0.25PA time per trainee allocated within their job plan.	R2.10

NMM1.1 a	The Trust to ensure that a co-developed charter of excellence in day-to-day interactions, respectful communication, supportive team-working and a high standard of professionalism mapped to the General Medical Council (GMC) Good Medical Practice should be implemented and that a Team Behaviour assessment tool should be utilized at regular intervals and monitored by the Trust's education academy.	The Trust to provide evidence by 01 December 2019 that demonstrates the continued implementation and benefits of the charter of excellence across neonatology, maternity and midwifery.	R1.17
NMM1.6 a	The O&G department to ensure that teaching sessions are consultant-led, arranged at times that most trainees can attend, and bleep free except for emergencies.	The Trust to provide evidence by 01 December 2019 that demonstrates teaching sessions are consultant-led, being attended by trainees and are bleep-free.	R1.16
NMM2.2 a	The department to facilitate and encourage trainees to understand the benefits of exception reporting on working conditions, safety and wellbeing, from the Guardian of Safe Working Hour (GoSWHs).	The Trust to provide evidence by 01 December 2019 that demonstrates trainees are aware of, and understand, the process for exception reporting.	R1.3
NMM6.1 a	The Trust is required to appoint a Consultant lead for Trust appointed doctors in O&G (as in Neonatal department) who is responsible for the professional development, supervision, career support and access to a portfolio demonstrating acquisition of relevant clinical and professional competencies as per the requirements of their role and specialty.	The Trust is required to demonstrate the engagement and professional progression for all Trust appointed doctors across neonatology and O&G by 01 December 2019.	R4.1

Recommendations		
Rec. Ref No.	**Recommendation**	**GMC Req. No.**
	The Trust are encouraged to share the document detailing latest internal audit report on the neonatal resuscitation equipment.	
NMM1.1 a	The Trust are encouraged to share with HEE further details of how the new charter of behaviour and strategy for excellence in care and kindness has been initiated.	

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**

The Trust is required to facilitate a follow up focus group meeting in September 2019 between representatives from HEE and the Trust management team to allow a review of the issues and risks pertinent to foundation year trainees working the Obstetrics and Gynaecology unit.	HEE London and Bart's Health
HEE would be happy to recommend Professional Support Unit support for developing these sessions and their assessment. Progress on this action should be part of the monthly reports to HEE.	HEE London and Bart's Health

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty, Deputy Post Graduate Dean (North East London)
Date:	09 September 2019

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.