QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Royal Brompton & Harefield NHS Foundation Trust (Royal Brompton Hospital)

Risk-based Review (Education Lead Conversation)

Anaesthetics, Cardiology and Clinical Radiology

Quality Review report

30 November 2017

Final

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Quality Review details

Training programme	Anaesthetics, cardiology and clinical radiology
Background to review	The Educational Lead conversation was proposed in response to specific negative outlier results received in the 2017 General Medical Council National Training Survey (GMC NTS). In clinical radiology, Royal Brompton Hospital received six red outliers in the following areas: overall satisfaction, reporting systems, teamwork, induction, adequate experience and curriculum coverage. Additionally, three pink outliers were received in: supportive environment, educational governance and educational supervision. In cardiology, Royal Brompton Hospital received four red outliers in the following areas: overall satisfaction, supportive environment, adequate experience and curriculum coverage. Additionally, ten pink outliers were received in: clinical supervision, clinical supervision out of hours, teamwork, handover, induction, educational supervision, feedback, local teaching, regional teaching and study leave. Anaesthetics at Royal Brompton Hospital received four red outliers in the following areas: overall satisfaction, teamwork, supportive environment and adequate experience. Additionally, four pink outliers were received in: reporting systems, handover, curriculum coverage and feedback. Therefore, HEE felt it was necessary to undertake an educational lead conversation, in order to meet with departmental leads and create a bespoke action plan for the Trust to undertake, that would address the issues highlighted in the GMC NTS.
HEE quality review team	Dr Jane Young, Head of the London / KSS Specialty School of Radiology Dr Karen Le Ball, Head of the London School of Medicine and Medical Specialties Dr Claire Shannon, Head of the London Academy of Anaesthesia Dr Orla Lacey, Deputy Postgraduate Dean, Health Education England North West London Ed Praeger Learning Environment Quality Coordinator, Health Education England London and the South East
Trust attendees	**Clinical Radiology** Head of London School of Radiology Radiology Training Lead/Training Programme Director (TPD) and Radiology Trainers Director of Medical Education **Cardiology** Divisional General Manager CMT Lead Clinical Lead for Electrophysiology

	Clinical Lead for Heart Failure Clinical Lead for Pulmonary Hypertension Clinical Lead for ACHD/Intervention Clinical Lead for Cardiology Director of Medical Education **Anaesthetics** College Tutor for Anaesthetics Clinical Director for Anaesthetics Deputy College Tutor Director of Medical Education

Conversation details

GMC Theme	Summary of discussions	Action to be taken? Y/N
CR 1	**Clinical Radiology** The Clinical Radiology Training Lead/TPD informed the review team that regarding the training posts that they had at the Trust, there were four core trainees within year two to year 3 (ST2-3), from a number of Trusts (Chelsea and Westminster Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust and St George's University Hospitals NHS Foundation Trust) and two additional sub-specialty trainees (ST4/5). The Training Lead for Clinical Radiology also highlighted to the review team that they had up to two visiting trainees at a time, generally organised through the Training Programme Director (TPD). The TPD for Clinical Radiology informed the review team that the workload in the department could be divided into X-ray reporting and cross section (chest and Cardiac) with some screening and interventional opportunities present. The service component included the on call commitment and plain film reporting with approximately 30-40 ultrasounds a month. The TPD for Radiology informed the review team that each of the sessions were covered by a named consultant, with trainees aware of who they could call for a senior opinion. The Radiology TPD informed the review team that the regular paediatric workload within the department made up approximately 10-15% of the total workload. When asked about the out of hours (OOH) rota structure within the department, the Clinical Radiology TPD informed the review team that the department ran a one in six on call rota with six trainees. The review team were informed that the changes had been made to the rota following the junior doctors' contact, which resulted in an (extra) day off given if a weekend was worked. The Clinical Radiology TPD highlighted that the trainees were happy with the rota and workload, which was less onerous when compared with the trainee's base hospitals.	

	The Clinical Radiology TPD highlighted that the department had recently introduced a daily consultant session in the weekend rota to allow for reviews of scans from the Friday night onward which was also a great teaching opportunity. When asked about the General Medical Council National Training Survey (GMC NTS), the Radiology TPD highlighted to the review team that this was completed by the only four trainees present in the department and the results showed that two were satisfied and two less satisfied. Through an internal investigation, the department felt that rota issues were the main cause of concern within the trainees at the time of the NTS. The Clinical Radiology TPD highlighted to the review team that since the NTS results, a new cohort of trainees was in post, who were surprised regarding the previous results that the department received through the NTS. Additionally, all trainees since the NTS had been asked to complete an anonymous online survey, identical to the NTS, and the feedback to date had been excellent from all trainees. The Clinical Radiology TPD informed the review team that through internal investigations prompted by the NTS results received, the department learned that trainees wanted opportunities to be able to report on chest CT at an earlier stage in their training. The TPD for Clinical Radiology informed the review team that this had now been actioned and the radiology trainees had given them positive feedback. The TPD for Clinical Radiology highlighted to the review team that the department had a shortage of reporting workstations available for use by trainees in the reporting offices. The TPD for Clinical Radiology informed the review team that the Information and Technology (IT) department within the Trust had repaired a broken workstation, but the TPD for Clinical Radiology felt that either a new workstation or an upgrade to the current PACS workstation in place would greatly benefit the trainees. The TPD for Clinical Radiology indicated to the review team that they offered evening tutorials prior to the Fellowship of Royal College of Radiologist 2B Examination (FRCR), which were open to trainees from the associated hospitals as well as all current trainees. The TPD for Clinical Radiology highlighted to the review team that the department recorded the pathology seen in every CT list, so that they were able to pull archived cases to teach on. Registrars could also access archived cases, and were also able to review final reports on cases that they had provisionally reported, providing good feedback. The TPD for Clinical Radiology informed the review team that the case mix-offered a balance of cases from common to the rarer cases and that they covered the curriculum. The TPD for Clinical Radiology also highlighted to the review team that the trainees would get five CT sessions a week and one session a week on plain films, directly supervised by a consultant. The department was actively encouraging trainees and all reporters to report on 20 plain films a day. The department was introducing a structure with the trainees where the trainees would report on 30 chest x-rays within a short time of starting in post, and then the trainees would re-report on the same 30 x-rays after a four-month period to be able to demonstrate the increase in their knowledge. The TPD in Clinical Radiology informed the review team that trainees could attend multidisciplinary team (MDT) meetings and present cases with consultant support. The	Yes, please see CR 1.1 below

	trainees were also able to attend lung cancer meetings and daily intensive therapy unit (ITU) meetings. The Radiology TPD reported that ultrasound work included thoracic and general cases and ITU ultrasounds. There was also recognition that the paediatric ITU work involved young children and babies (but not infant head ultrasounds) There was plans for a new consultant appointment, which would include paediatric sessions to support this area. There was scope for clarifying trainee's responsibilities in this area at induction. The Director of Medical Education (DME) highlighted to the review team that the department had had trainees sent on rotation from two other Trusts that were less than full time into full time slots, resulting in a rota pressure. As these trainees were on secondment, and the LTFT status was communicated at a late stage, it was not possible to recruit a locum (due to lack of financial support from the LDA and the unanticipated gap) this affected service delivery and training of other trainees, and was reflected in the survey results changing so dramatically. The DME felt that this was a consequence of the historical contracts in place regarding trainee placements. She asked that the causal factors be raised within HEE during the reconfiguration of radiology training and that the following measures were discussed and responded to: firstly, to ensure that LTFTs were staggered through the department from across programmes, and secondly that sufficient notice and financial support was provided to the Trust through LDA funding to recruit to post gaps. The issue of the LDA not being transferred to the Trust also raised the issue of the funding of clinical and educational supervision, library services and other educational placement support normally funded via the LDA – the current arrangement meant that the Trust is in deficit. The DME informed the review team that the postgraduate medical education team would like further clarification on the roles and responsibilities of the administrative support role (band 4) within the department as this was very important to supporting training.	Yes, please see CR 1.2 below
CA 1	**Cardiology** The appointed educational lead for higher specialty trainees (HSTs, overseeing the provision of training for this cohort) informed the review team that a level of dissatisfaction was present amongst the registrars, owing to the fact that they were unable to attend the training opportunities, particularly procedural sessions, open to them due to outpatient and ward responsibilities, meaning that they would have to stay and cover. The educational lead for HSTs informed the review team that a registrar had had discussions directly with the TPD and that changes made to meet his training requirements had then resulted in the other trainees being further disadvantaged and had been viewed as favouritism by the other trainees. The educational lead indicated to the review team that since the survey the department was working harder with the trainees to make sure that their training requirements were met. The educational lead indicated that a new interventional cardiologist (who was present at the meeting) had recently been appointed which would result in more sessions in the laboratory being available for trainees. The educational lead informed the review team that the rota design had been changed, with a rolling rota introduced for the registrars instead of two parallel rotas, meaning that all registrars would take turns in doing a residential and non-residential on-call. The Trust had invested in night practitioners (NP) present but unfortunately	Yes, please see CA 1.1 below

	there were gaps in the NP rota, which resulted in the registrars having to undertake fairly menial tasks. The DME indicated to the review team that a lot of work was being done in regards to the rota, and recruitment, with the rota back up to 16 persons by January 2018. The DME explained to the review team that the department had two new consultants appointed to the intervention team (also supported by nurse practitioners), and that a new senior "staff grade" appointment was being made to support the ward work in the EP service. The DME informed the review team that she had met with the trainees and asked them to meet with their educational supervisors to agree their procedural/training sessions in the laboratories and not covering clinics at the times that training lists were available; she had met with the rota manager to facilitate these changes and would continue to meet with the trainees to ensure that they were meeting their requirements. The DME also emphasised that the current lack of NPs remained a problem, and that the trust had been meeting in a workforce group to try to address these issues. It was also indicated to the review team that the department had been meeting with the registrars to discuss their training goals, with a balance in service needs and training needs discussed. The review team were informed that members of the cardiology department met with the trainees to discuss the trainees training needs, and fed this information back to the trainee's clinical supervisor to ensure that trainees were able to meet their Annual Review of Competence Progression (ARCP) targets. It was also pointed out that there was an expectation that the trainees also had the responsibility to raise issues where they felt they had specific training needs with the training leads and educational supervisors so that these could be addressed. When the review team inquired about the Core Medical Training trainees within the department, the DME informed the review team that there were currently eight trainees and that the department had scheduled weekly Wednesday cardiology teaching sessions as well as weekly teaching on a Tuesday that covered a variety of topics. This additional session allowed the trainees an opportunity to present and thus sign off module teaching observation on the curriculum. The DME informed the review team that the decision was taken in December 2016 to take CMT trainees out of the intervention firm due to the high level of routine work and minimal education and training the trainees were exposed to was not considered to be sufficient balanced between service and training The DME informed the review team that the CMT trainees were rostered in to clinic to meet their curricular requirements and that they had an hours teaching with a consultant each week. The educational lead for Electrophysiology informed the review team that the department was highlighting the ward round teaching element, with hands on teaching and also laboratory work. The educational lead for Electrophysiology indicated that a low number of CMT trainees were attending organised teaching sessions, with the DME highlighting that this underlined the fact that the trainees had to cover the ward. The visiting team were assured that the CMT trainees were released to attend the regional and local training events. The higher specialty trainees were able to attend the regional cardiology training days had an attendance of approximately 70%, with the attendance list monitored by the TPD and covered at the ARCPs. The training lead informed the review team that the trainees were able to attend Computed Tomography	Yes, please see CA 1.2 below

	(CT) and other imaging courses, as well as a one-day session covering all aspects of echocardiogram imaging. The HST educational lead indicated to the review team that external funding to help set up case conferences would be greatly beneficial to the trainees learning. It was suggested that this could start locally and expand, and would have to be out of working hours. The review team heard that the department has access to an excellent morphology unit which could be regularly accessed for teaching purposes. The HST educational lead informed the review team that faculty meetings consisted of a group of consultants sitting down, along with a trainee representative. Within these meetings, the trainee representative was encouraged to give feedback. The DME indicated to the review team that the department had managed to hold three of these meetings within the last year, but will organise meetings at short notice (as part of monthly consultant meetings) if an issue that needs to be urgently discussed arises. Recent changes in training distribution had resulted in the electrophysiology trainees getting more access to the laboratory. The review team heard that National Training Number (NTN) doctors often had access to more training opportunities, but the department was working towards all NTN and Locally Employed Doctors (LEDs) having equity of access. At a Trust level, all trainees are required to have a named educational supervisor, induction meetings and a record of end of attachment sign off with appraisal portfolio access (as required for revalidation) made available to them. The HST educational lead informed the review team that the trainees were told at induction that all Trust staff were expected to contribute to the care of private patients in the hospital and that there should be no difference in the care provided between NHS and private patients, in line with the HEE guidance on the care of private patients. It was highlighted that both offer great teaching and learning opportunities. The DME highlighted to the review team that the Resident Medical Officer (RMO posts (The doctors with day to day responsibility for the private patient area) had proved difficult to recruit so the educational leads for CMT and DME had reworked the advert, job description and person specification to provide additional career opportunities and the cardiology CMT lead had taken over their educational supervision. Two posts were filled now with a plan for a third post to be advertised in 2018. The clinical lead for Electrophysiology highlighted to the review team that there was an endovascular simulator at the Harefield site, which she would be keen to use to run courses with this excellent piece of equipment to develop the skills of the trainees. The DME emphasised that there was no reason why this equipment could not be moved between sites and would ensure the appropriate staff were aware of this request.	Yes, please see CA 1.3 below Yes, please see CA1.4 below
AN 1	**Anaesthetics** The College Tutor for Anaesthetics informed the review team that the department currently had eleven trainees, ranging from ST5 to ST7. The College Tutor for Anaesthetics indicated to the review team that the trainees had often gained their cardiac skills at the Hammersmith Hospital where many did intermediate cardiac training. The visit team reminded the trainers that these trainees may only have completed 2-3 months of cardiac training before working at the Brompton so may be	

	quite inexperienced. The College Tutor in Anaesthetics informed the review team that regarding the trainees' individual training, all trainees are supervised by a small group of consultants so that they have more consistency in their short 3 month placements. The consultants would have the first couple of days to ascertain the skill level of the trainees before proceeding with their individual training. This allowed trainees in difficulty to be flagged early on in their training programme. The group discussed the difficulties that trainees and trainers experienced as a result of short placements The local feedback to the DME suggested that trainees at the Brompton for 6 months had a better experience overall. The College Tutor for Anaesthetics indicated to the review team that due to the complex workload at the Brompton, the department would not allow pre- CCT trainees to work without direct supervision until the consultants were confident that the doctor's skill level aligned with the department's expectations. There was an awareness that some trainees with more cardiac experience doing advanced training found this difficult. The College Tutor for Anaesthetics indicated to the review team that trainees could see a large number of thoracic and cardiac cases at the Trust, and that if the trainee was working toward being a general anaesthetist, then the department could tailor the training need of the trainee to the curriculum. The College Tutor for Anaesthetics informed the review team that the trainees received protected theatre time and were never pulled off a planned list. The group discussed the negative outlier in the GMC survey 2017 and the trainers felt that this was unduly influenced by one particularly unhappy trainee who felt over supervised. The College Tutor for Anaesthetics informed the review team that the department felt that the NTS results were heavily influenced by this trainee and that it left the cohort of trainees present at the Trust over the survey dates polarised. In fact, several of the other trainees complained about this particular trainee to the college tutor as they felt she was having a negative impact on them and their training. The department felt that they had done everything they could to accommodate this trainee including organizing some training at Harefield Hospital at her request. The College Tutor for Anaesthetics informed the review team that a number of trainees had complained of unsupportive behaviour towards them whilst in post, from various sources such as ODPs, nursing staff, other doctors (trainees and consultants). Having spoken to the trainees, the College Tutor for Anaesthetics indicated that the trainees felt that a number of consultants and surgeons at times behaved in a manner that appeared dismissive towards the trainees, which was in part due to the short placements in a complex environment making trainees effectively supernumerary in many aspects of clinical care, for example one trainee reported that they were not able to introduce themselves at team briefs; the Tutor had investigated this and found it to be an isolated incident. The DME indicated to the review team that Human Resources (HR) were actively monitoring attendance at anti-bullying sessions set up by the Trust. The College Tutor for Anaesthetics highlighted to the review team that they encouraged trainees to highlight with the trainers what they would like to get out of each list in terms of training. There was a discussion about the difficulties trainees may have in approaching consultants who were expert in their specialist field and that this may be an unreasonable expectation for trainees to do this. The visit team suggested it should be the consultants who took ownership of this process and actively discussed training needs with the trainee. The Trust leads explained that they	Yes, please see AN 1.1 below Yes, please see AN 1.2 below

	were working with colleagues to introduce an 'educational time out' to facilitate this process. The College Tutor for Anaesthetics indicated that they could both highlight with the consultants the need to discuss the trainee's learning, relative to their training requirements from each case, and emphasise at departmental induction that trainees should approach consultants as soon as possible after the brief occurs in theatre to outline the training they would like from the case. The College Tutor for Anaesthetics informed the review team that the department was looking into raising awareness amongst consultants of what the more junior trainees wanted from the job and approaches suitable for this generation of younger doctors. The College Tutor for Anaesthetics indicated that trainees felt that they did not receive enough feedback from consultants, without always recognising feedback when it was given, which was highlighted by the DME as a "generational" shift in trainer-trainee relationships across all specialties. The Tutor had already launched an intervention for list-specific feedback to incorporate more frequent information from consultant supervisors, given more immediately. Regarding the multi-disciplinary teaching and training present at the Trust, the College Tutor for Anaesthetics informed the review team that there was a theatre education team and a simulation expert forum, as well as the medical education committee and focussed group meetings quarterly with the DME, where trainees were able to talk directly to the DME regarding the teaching and training programme. The DME highlighted that LFGs were pre-booked a number of months before the date and that the discussions with trainees were increasingly well attended. The College Tutor for Anaesthetics highlighted the work that the department was trying to do in terms of making trainees more confident around consultants. The Clinical Director for Anaesthetics highlighted that often allowing the trainee to feel more in control when dealing with cases proved beneficial to the confidence and empowerment of the trainees.	

Requirements / Recommendations

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
CR 1.1	Clinical Radiology The Trust are required to review the existing PACS workstations with a view to providing an extra workstation or an upgrade to the existing PACS workstation in the reporting offices of clinical radiology.	The PACS workstations in the reporting offices of clinical radiology meet the number and training needs of the radiology trainees.	R2.3
CR 1.2	Clinical Radiology		R1.13

	The Trust to implement a structured review of the supervision and induction requirements to support the clinical radiology trainees in paediatric and neonatal ultrasounds.	The Trust is required to provide evidence that the clinical radiology trainees have an induction and appropriate supervision for paediatric and neonatal ultrasounds.	
CA 1.1	Cardiology The Trust is to review the routine and basic tasks performed by the cardiology trainees out of hours as a result of the gaps in the night practitioner rota.	The Trust to provide a strategy to manage the night practitioner rota gaps to minimise the impact of the cardiology trainees out of hours duties.	R1.12
AN 1.1	Anaesthetics The Trust are required to highlight the importance of the morning briefing with all senior staff prior to each surgical list, including introducing all staff members present in line with the WHO surgical safety guidelines.	The Trust to provide evidence that the anaesthetic trainees and all theatre staff are engaged with and involved in the morning briefings prior to starting the surgical list.	R1.14

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
CA 1.2	Cardiology In cardiology there should be a meeting within three weeks of trainees starting their placement to ensure that training needs and opportunities have been agreed.	DME to provide a list of the cardiology trainees and their designated educational supervisor with confirmation of the training needs meeting within three weeks of starting their placement.	R1.10
CA 1.3	Cardiology The Trust needs to maintain regular faculty meetings in cardiology where trainees meet with consultants to discuss departmental issues. These should be at least 3 times a year minutes and action points be recorded.	Minutes for said meetings to be shared with HEE	R2.7
CA 1.4	Cardiology The Trust to look into utilising the endovascular simulator currently at the Harefield site to provide further training opportunities to cardiology trainees.	Evidence of planned courses and sessions utilising the endovascular simulator at the Harefield or Brompton site.	R1.17
AN 1.2	Anaesthetics Anaesthetic consultants and trainees are recommended to discuss the potential training aims at the start of the day, using for example their suggestion of the ‘educational time out’.	Feedback on the suggested concept of an ‘educational time out’ and whether this helps maximise training opportunities.	R1.18

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

Requirement	Responsibility
Clinical Radiology The DME to receive further clarification on the roles and responsibilities of the administrative support role (band 4) within the department from Health Education England. The review team heard that the Trust felt that the historical contracts in place regarding the placement of core radiology trainees at the Trust had caused issues with last minute rota gaps. HEE was asked to review these arrangements to see if there were any changes that could be made, in particular to the funding arrangements with LDA placement support, study leave and salary.	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Orla Lacey
Date:	18/01/2018

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.