NHS
Health Education England

St George's University Hospital NHS Foundation Trust

Cardiology

Risk-based Review (on-site visit)

Quality Review report

4 December 2018

Final report

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Quality Review details

Background to review	Health Education England (HEE) felt that with the release of the 2018 General Medical Council's (GMC) National Training Survey (NTS) results and an Educational Leads Conversation (ELC) which took place in September 2018, that a conversation with the higher trainees in Cardiology was required.
Training programme / learner group reviewed	Cardiology
Number of learners and educators from each training programme	The review team met with a number of higher trainees in cardiology. - Specialty Trainee Level 5 (ST5) - Speciality Trainee Level 7 (ST7) As well as meeting with the trainees, the review team also met with a number of the senior management within the department including: - Director of Medical Education - Medical Education Manager - Clinical Lead - Educational Lead - Deputy General Manager of Cardiology
Review summary and outcomes	The quality review team would like to thank the Trust for accommodating the on-site visit and for ensuring that all sessions were well-attended. The quality review team was pleased to note the following areas that were working well: - The higher trainees all agreed that consultants were supportive and encouraging and that there were formal and informal mechanisms in place for feedback. - The cover issues for the Magnetic Resonance Imaging (MRI) process had been resolved through the appointment of a new fellow. - The two existing Physicians Associates (PAs) on the wards had a positive impact on the higher trainee's workload. - The removal of cardio thoracic trainees had increased workload, however, it was recgonised by consultants and trainees that the re-organisation of the morning MDTs where patients are discussed individually had been educationally beneficial for trainees. However, the quality review team also noted a number of areas for improvement: - The review team noted from the higher trainees that there had been an increase in workload due to the difficulty of not being able to recruit national training numbers or Trust grade doctors to fill rota gaps and partly due to the removal of cardio thoracic trainees. - The review team heard of some concerns from the higher trainees about the Trans-oesophageal echo cover (TOE) for the Transcatheter Aortic Valve Implantation (TAVI) service and felt that there was no educational benefit for the frequency of cover required for the service. - The review team was disappointed to hear that the higher trainees reported to have heavy clinic templates seeing up to 15 patients per clinic. The review team felt that the higher trainee clinics should be limited to 12 patients.

Quality Review Team			
Head of London School of Medicine	Andrew Deaner, Head of London School of Medicine and Medical Specialties, Health Education England	**External Clinician**	Brian Clapp Consultant Interventional Cardiologist
Deputy Postgraduate Dean	Anand Mehta, Deputy Postgraduate Dean for South London, Health Education England	**Lay Representative**	Jane Chapman Lay Representative
HEE Representative	Bindiya Dhanak, Learning Environment Quality Coordinator, Health Education England London and Kent, Surrey and Sussex	**Observer**	Kheelna Bavalia Deputy Postgraduate Dean for South London Health Education England
Observer	Kenika Osborne Learning Environment Quality Coordinator, Health Education England London and Kent, Surrey and Sussex		

Educational overview and progress since last visit – summary of Trust presentation

The Trust gave the review team an overview of the directorate and changes made in the training environment in the cardiology department since the previous Educational Leads Conversation (ELC) that took place in September 2018.

The Deputy General Manager (DGM) informed the review team that cardiology was its own Clinical Academic Group (CAG) in the division of medicine and cardio thoracic and chaired by the Divisional Directors of Operations where education was a standing item. The DGM informed the review team that this meeting fed through to the Chief Operating Officer but reported that the DGM does not sit on the Trust board. The Director of Medical Education (DME) informed the review team that the new Medical Director (MD) who was on the Trust board was one week into the post. The DME stated that the workforce and education committee was chaired by a member of the board and this fed into the board itself. The DME indicated to the review team that Medical Education Committee (MEC) meetings were attended by the Associate Medical Education Director (ADME) where cardiology was represented as well as other specialities. It was noted by the review team that there was no trainee representation at the MEC meetings but the Educational Lead (EL) for cardiology informed the review team that there was good trainee representation at Local Faculty Group (LFG) meetings.

The DME indicated to the review team that because of changes in the region, increasing clinical activity and a focus on safety and quality, there had been a change in service delivery across the Trust. This had led to issues with aspects such as consultant supervision and at times a lack of educational benefit for trainees working on the wards. The trust felt that these were the primary reasons behind the adverse GMC signals.

The EL recognised that the Trust had historically performed well in the General Medical Council (GMC) National Training Survey (NTS) results and felt the red outliners were not a surprise due to the impact that the above factors and rota gaps had on training. The EL indicated to the review team that initially when they were

appointed as EL, there had been a conflict of interest in managing clinical services. As a result of this, two separate consultants had been appointed in October 2017 to assist with direct conversations with the trainees. The EL informed the review team that this had worked well and felt that as a result of this there had been more engagement with the trainees on a daily/weekly basis.

It was heard by the review team that the higher trainee led clinics had been cancelled to enable them to attend mandatory training at the Royal Society of Medicine (RSM) which required a 70% attendance rate. The EL confirmed that the teaching programme from the RSM had been embedded into the rota in order for all trainees to be released for teaching. The EL informed the review team that the local weekly teaching programme had been re-introduced with higher trainee and consultant led teaching which had received positive feedback from the higher trainees.

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The review team heard from the Clinical Lead (CL) that there had been an expansion of four cardiology consultants within the last three years. The EL informed the review team that imaging consultants had been appointed to manage the Magnetic Resonance Imaging (MRI) sessions. The EL recognised that higher trainees felt that the MRI sessions had no educational value. The review team was pleased to hear that the Trust had appointed a MRI fellow to manage the MRI sessions which enabled higher trainees to focus on other educational interests.

The DME informed the review team that they had held workforce intervention meetings for cardiology and had looked at new working models of how ward work could be improved. The DME indicated to the review team that they had looked into having prescribing pharmacists, increasing the number of Physician Associates and senior nurses to help manage the cardiology services The DME indicated that the Trust had been unsuccessful in recruiting Trust grade doctors to completely fill rota gaps.

The Speciality Trainees Level 7 (ST7s) noted to the review team that there had been a significant improvement to the culture in cardiology. It was noted by the review team that the ST7s felt the culture was supportive and that following the appointment of new consultants there had been a rebalance of workload.

The review team was pleased to hear that all higher trainees would recommend their post to others and would be happy for friends and family to receive care at the Trust.

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service 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
C1.1	**Patient safety** The review team was happy that no trainees spoken to on the day indicated that they had issues that related to patient safety being directly compromised.	
C1.2	**Appropriate level of clinical supervision** The review team was pleased to hear that the higher trainees all agreed that they had no concerns about consultant support and felt supported and encouraged. The ST7s informed the review team that there was no expectation to discuss every patient in clinics with consultants but if a discussion was needed, they felt comfortable approaching the named consultant to discuss. The ST5s noted to the review team that there were some clinics where consultants would discuss patients with them prior to clinics but this practice was not consistently embedded across the department. The ST5s were all in agreement that having the support from the ST7s was an advantage.	Yes, please see 1.3b
C1.3	**Rotas** The ST7s informed the review team that on average they undertake two to three clinics a week. The review team was concerned that the higher trainees reported that clinical workload could often be problematic with heavy clinic templates seeing up to 15 to17 patients per clinic. The ST7 noted to the review team that Service Managers were looking into booking issues. The review team noted from the higher trainees that there had been an increase in workload due to the difficulty of not being able to recruit national training numbers or Trust grade doctors to fill rota gaps and partly due to the removal of cardio thoracic trainees. The DME informed the review team that they had held Workforce Intervention meetings for cardiology and had discussed new working models of how ward work could be improved. The higher trainees informed the review team that weekend cover was busy. It was noted by the review team that there was one Trust grade doctor for on calls and one Trust grade doctor for the wards and occasionally a Trust grade doctor for half the day over the weekend for extra support. The higher trainees felt this appointment should be made permanent as there was a need for this level of staffing support long term. The review team heard from the ST5s that cover for the blood pressure unit had been poor as it was logistically difficult to travel to the clinic and this had prevented them from accessing other learning opportunities. The EL informed the review team that the higher trainees would no longer be covering the blood pressure unit and that two fellows had been appointed to cover offsite clinics. The review team also heard of some concerns from the higher trainees about the Trans-oesophageal echo cover (TOE) for the Transcatheter Aortic Valve Implantation (TAVI) service and it was felt that there was no educational benefit for the frequency of cover required for the service. The ST5s informed the review team that when consultants were on leave, clinics would usually be cancelled however this was not routine practice. If cover was required by the higher trainees, they all confirmed they would know which consultants to approach if support or advice was needed. The Educational Supervisors (ESs) also informed the review team there would be a consultant available for support if the named consultant was on leave and that if needed the consultant would go through patients prior to clinics. The ST5s noted that Physician Associates (PAs) had a good relationship with consultants and could be contacted on their mobile number if needed.	Yes, please see C1.3a Yes, please see C1.3b Yes, please see C1.3c

C1.4	**Induction** All trainees confirmed to the review team that they received a corporate induction as well as a departmental induction.	
C1.5	**Handover** The higher trainees informed the review team that patient documents and information were uploaded electronically on the Electronic Patient Record (EPR) and felt that this had improved handover. The ST5s informed the review team that there was a face to face handover meeting with the higher trainees. The ST5s indicated to the review team that a morning board round took place every day and was an opportunity to highlight any concerns.	

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.

C2.1	**Impact of service design on learners** The review team heard that the higher trainees had a 'link' week which provided free time for other clinical interests. The ST5s noted that consultants encouraged sub speciality exposure for developing interests and were actively informed of sub speciality leads to approach during their induction week. The review team heard that the removal of cardio thoracic trainees had increased workload, however, it was recgonised by the Educational Supervisors (ESs) and trainees that the re-organisation of the morning cardiology and cardio thoracic MDT where patients are discussed individually had been of educational value for trainees.	
C2.2	**Appropriate system for raising concerns about education and training within the organisation** The DME indicated to the review team that Medical Education Committee (MEC) meetings were attended by the Associate Medical Education Director (ADME) for MedCard where cardiology was represented as well as other specialities. It was noted that trainees did not attend this meeting as it was a business planning meeting. The ST5s felt that if they needed to raise concerns they would feel comfortable to do so either to the ADME, Educational lead or their own supervisors. It was noted by the ST5s that there was good support from the ST7s and that the consultants who were actively involved in the rota were supportive. It was noted by the review team that the ST7s felt it was a supportive culture and that the cardiology consultant body were approachable.	

C2.5	**Organisation to ensure access to a named educational supervisor** All higher trainees confirmed to the review team that they had been allocated an educational supervisor (ES) within their sub speciality which was beneficial.	

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.

C3.1	**Regular, constructive and meaningful feedback** The review team noted that there were formal and informal mechanisms for feedback. The EL informed the review team that there was a 'WhatsApp' group created with the trainees as an additional channel of communication and feedback. The EL informed the review team that LFG meetings took place every three months with good trainee representation. It was noted by the review team that a number of higher trainees had attended LFG meetings but were unsure of future dates.	

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.

C4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The CL informed the review team that all ESs and ELs had time in their job plans to meet educational responsibilities.	

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.

C5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The EL informed the review team that the higher trainee led clinics had been cancelled to enable them to attend mandatory training at the Royal Society of Medicine (RSM) which required a 70% attendance rate. The EL indicated to the review team that they had received the teaching programme from RSM for the year and had embedded this into the rota to ensure all trainees were released for teaching. All higher trainees confirmed that the service provisions enabled them to be released for mandatory training. The EL informed the review team that the local weekly teaching programme had been re-introduced with higher trainee and consultant led teaching which had received positive feedback from the higher trainees.	

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.

C6.1	**Appropriate recruitment processes** It was reported that rota gaps at junior trainee level had impacted on higher trainees' experience in the past year. The Trust had attempted to mitigate this by increasing the level of consultant support and bringing in National Training Numbers (NTNs) and Trust grade doctors to help manage the workload at junior level. Recruitment to the posts had been unsuccessful. The EL informed the review team that the Trust has regular workforce planning meetings to which cardiology was represented monthly. It was noted that new models on how ward work could be constructed are explored during the meetings including the recruitment of additional PAs, prescribing pharmacists and senior nurses to help manage cardiology services. The review team was encouraged by the work undertaken on the role of PAs but felt that additional support was required.	Yes, please see C6.1

Good Practice and Requirements

Good Practice
The review team was pleased that higher trainees all agreed that consultants were supportive and encouraging and that there were formal and informal mechanisms in place for feedback.
The review team felt that cover issues for the Magnetic Resonance Imaging (MRI) process had been resolved through the appointment of a new fellow.

The review team felt that the presence Physicians Associates (PAs) on the wards has had a positive impact on the higher trainees workload.
The review team understood that the removal of cardio thoracic trainees had increased workload, however, it was recgonised by consultants and trainees that the re-organisation of the morning MDTs where patients are discussed individually had been educationally beneficial for trainees.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
C1.3a	The Trust should ensure that clinics are limited to 12 patients to make this manageable for higher trainees.	The Trust is to provide evidence of clinic templates to show a limit to 12 patients per clinic. The documentation should be provided within three months.	R1.12
C1.3c	The Trust to ensure appropriate levels of supervision in clinics for trainees when named consultants are not present.	The Trust is to provide evidence of supervision arrangements for trainees in clinics. Please provide an update in three months.	R1.8

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
C1.3b	The Trust should ensure that Trans-oesophageal echo cover for the Transcatheter Aortic Valve Implantation service is not covered frequently by the imaging trainees due to lack of educational value.	The Trust should explore other ways in which the service could be covered on a frequent basis. Please provide an updated within three months.	R1.7
C6.1	The Trust is to progress its business case for Prescribing Pharmacists, PAs and ANP to provide appropriate ward cover which would release trainees from educationally unproductive tasks and improve training experience	The Trust should provide an update on the progress of the business case within three months.	R1.12

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Andrew Deaner
Date:	11 January 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.