Health Education England

Royal Brompton & Harefield NHS Foundation Trust

Cardiology

Risk-based review (on-site visit)

Quality Review report

13 December 2018

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	Health Education England (HEE) planned the review following the release of the General Medical Council National Training Survey (GMC NTS) 2018 results. Cardiology at Royal Brompton Hospital received six red outliers in the GMC NTS 2018 survey. These were in overall satisfaction, handover, supportive environment, curriculum coverage, local teaching and rota design. Cardiology at Harefield Hospital received red one outlier for workload. There were additional concerns raised via the specialty school which primarily related to supervision and whether trainees had adequate opportunities to gain procedural experience.
Training programme / learner group reviewed	Cardiology
Number of learners and educators from each training programme	The review team met with four specialty trainees at levels four to seven (ST4-7s) at Harefield Hospital and seven ST3-7s at the Royal Brompton Hospital. The review team also met with educational and clinical supervisors at both sites and Trust representatives including: • Director of Medical Education • Deputy Directors of Medical Education (both sites) • Educational Leads for Cardiology • Divisional Director (Harefield Hospital, Heart) • College Tutors (both sites) • Guardian of Safe Working Hours • Divisional General Manager (Harefield Hospital).
Review summary and outcomes	The review team heard about several areas of good practice including the local teaching programmes, the range of subspecialty experience available and the support provided by the postgraduate medical education team for supervisors (please see Good Practice section). The review team advised that a follow-up review would be carried out in spring 2019 at the Royal Brompton Hospital. This related to a serious concern around the difficulties reported by trainees working in the electrophysiology and interventional cardiology subspecialties in obtaining sufficient procedural experience. It was reported that the cardiac catheter laboratory team ethos was that services should be consultant-delivered. The trainees advised that they had been told that the majority of patient cases were too complex for them, even at specialty training levels six and seven (ST6-7). The review team also identified the following areas for improvement: • The night on-call cardiology rota included two higher trainees but trainees advised that the workload did not justify this and that the resulting zero days impacted on access to training opportunities during the day. Many of the tasks given to the trainees overnight could be done by non-medical colleagues such as nurses, nurse practitioners or physician associates.

	• Trainees had difficulty accessing cardiac catheter laboratory lists and clinics relevant to their subspecialty training. • The review team heard that some cardiology clinics did not have consistent consultant supervision. • Consultant input in inpatient areas was described as variable and trainees were often not aware of when the consultant would attend the ward or conduct ward rounds. This made it difficult for trainees to plan and prioritise their work. • The exception reporting rate was extremely low. Trainees advised that they did work additional hours but perceived exception reporting as complaining and thought it reflected badly on the department.

Quality Review Team			
HEE Review Lead	Andrew Deaner Head of London School of Medicine and Medical Specialties Health Education England	**External Clinician**	Darrel Francis Professor of Cardiology, Imperial College London Training Programme Director for Cardiology, north west London
Trust Liaison Dean/County Dean	Geoff Smith Deputy Postgraduate Dean, North West London Health Education England	**Lay Member**	Robert Hawker Lay Representative
HEE Representative	Louise Brooker Learning Environment Quality Coordinator Quality, Patient Safety & Commissioning Team, London Health Education England		

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

The review team was informed that the two Trust sites ran separately in terms of training and education. The Director of Medical Education (DME) and Guardian of Safe Working Hours (GoSWH) worked across both sites but there were separate Educational Leads (ELs) and Deputy DMEs (DDMEs) for each site.

Harefield Hospital

It was noted that in the 2018 General Medical Council National Training Survey (GMC NTS) cardiology department had received a red outlier result for workload. The Clinical Tutor indicated that the department had introduced a second middle-grade junior doctor on the weekday morning cardiology rota to hold the bleep, allowing ward rounds to proceed without interruption when this slot was filled. Due to gaps in the higher trainee rota, the Trust had recruited middle-grade locally employed doctors (LEDs) to ensure adequate cover. The on-call cardiology rota included one resident trainee or LED for general cardiology and one non-resident trainee or LED to cover cardiac and respiratory transplant patients. There was also a resident core medical trainee or junior clinical fellow on-call during the day and overnight.

The Divisional Director (DD) advised that outpatient services remained a challenge and that clinic arrangements were being restructured to allow more time for patients and for training as well as reducing unnecessary follow-

up appointments. The review team was informed that clinics were not routinely cancelled if the consultant was on leave but that only follow-up clinics run by specialty trainees at level five (ST5) and above would usually continue in this situation.

Royal Brompton Hospital

The review team was informed that there were ongoing difficulties for trainees in the electrophysiology (EP) and interventional cardiology subspecialties around gaining procedural experience and getting sufficient time in clinics and the cardiac catheter laboratory. Several reasons for this were suggested, including trainee workloads on the inpatient wards, a culture of consultant-delivered procedures and the number of zero days following on-call shifts. It was reported that the intervention laboratory team took the view that cases were too complex to be carried out by trainees even if they had significant experience and that the assisting team actively prevented trainee involvement. The review team heard that the EP team was working to recruit a senior clinical fellow to cover some of the service provision and allow trainees to be released for training more often.

The Royal Brompton site ran a two-tier on-call rota for higher trainees, with a resident trainee who took on higher level and urgent tasks and a second trainee who took on more basic tasks when needed or took the bleep from the first on-call in the case of an emergency procedure. The second on-call was mostly non-resident but would come in for weekend ward rounds or if workload required. The DME advised that workload overnight was variable but a bleep audit had revealed that a significant proportion of the queries and tasks could have been dealt with by a nurse site practitioner (SP). There were SPs on-call on some nights, but the rota had gaps and the skill level of these staff was not consistent, for example some SPs could not prescribe medications. It was suggested that having just one trainee on-call overnight would positively impact training as trainees would work fewer nights and need fewer zero days.

Trainees had given feedback to the department that some consultants did not carry out regular ward rounds. The EL noted that there were five higher trainees or middle-grade LEDs on the ward rota each weekday which meant that colleagues could always access advice from a member of each subspecialty team during these shifts. However, if consultants did not conduct daily ward rounds or consistently attend the wards, this prevented higher trainees from leaving the wards and accessing other learning opportunities.

Trust-wide

The Trust information technology (IT) systems were acknowledged as an issue, as there were multiple, separate systems relating to patient care, medications and investigation results. This impacted on all clinical staff, who had to access multiple systems to gather or record information about patients and their treatment and spend time transcribing details between systems. The DME advised that a new Chief Information Officer was due to start work in January 2019.

The GoSWH described an extremely low rate of exception reporting. The Trust had run a trainee survey to determine why trainees did not exception report and the results showed that they feared exception reports would reflect badly on the department and their supervisors, or that reports would be perceived as complaining.

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** Harefield Hospital The trainees advised that patients received good care from the cardiology team but that, due to the specialist nature of the hospital, it took longer for patients with comorbidities to be referred to specialty teams at other Trusts such as endoscopy. The trainees did not describe any cases where patient safety had been compromised due to these delays. Royal Brompton Hospital All trainees said that they would be happy for friends and family to be treated at the hospital and felt that patients received high quality care.	
C1.2	**Appropriate level of clinical supervision** Harefield Hospital The review team heard that consultants in the cardiac transplant team held board rounds every morning with the trainees and did ward rounds of all transplant patients on two fixed days each week. Trainees felt that this was safe and ensured that patients had clear treatment plans, while allowing the trainees some autonomy. The cardiac disease inpatient ward rounds were not on a set schedule and trainees reported that the frequency of rounds depended on which consultant was on duty. The trainees were confident that they could call consultants for advice or urgent reviews when needed but they did not always know when the consultant would attend the ward. Royal Brompton Hospital The trainees reported that there was variation between the consultants in terms of the amount of time spent on the ward and the frequency and timing of ward rounds. The review team heard that some consultants would review their own patients but not do full rounds. This made it difficult for trainees to plan their work. The trainees also described some inconsistency in consultant supervision in clinics. When consultants were not in clinic they were available by phone so trainees felt able to seek support and advice. The review team was informed that clinics run by trainees were typically for follow-up appointments and that new outpatients would be booked into consultant clinics.	Yes, please see C1.2a Yes, please see C1.2b
C1.3	**Rotas**	

	Harefield Hospital The supervisors reported that the middle-grade rota included 11 junior doctors, eight of whom were trainees. The other slots were filled by locally employed doctors (LEDs). The trainees advised that there had been rota gaps when LEDs left which were not filled in a timely way and resulted in some lost training opportunities due to the increased workload. The trainees did not think that there were sufficient junior doctors on the rota to allow for cover in case of sick leave or study leave. Despite this, trainees were reluctant to submit exception reports. Royal Brompton Hospital The review team heard that the weekday rota included one junior doctor for each subspecialty to ensure that each ward was covered. There were two trainees on-call at any time, one to act as first on-call for the daytime, a first on-call overnight and a second to cover the full 24-hours. At night the second on-call could choose whether to remain on-site or go home. The trainees suggested that the high number of junior doctors on the wards was necessary due to the lack of consistent consultant attendance. At weekends the first and second on-call trainees did the ward rounds together. The trainees felt that the two-tier rota overnight was often not necessary and that approximately a third of their time was spent doing tasks such as cannulation and prescribing basic medications which could be done by nurse practitioners, nurses or physician associates. The department employed site practitioners (SPs) at night but the trainees reported that there were frequent gaps in the SP rota. If there was an emergency procedure such as a primary coronary angioplasty required overnight, the trainees explained that the on-call consultant would be called in and would perform the procedure, the first on-call would assist and the second on-call would take the bleep. During their on-call weeks the trainees found that their subspecialty training suffered due to the number of zero days. The supervisors were aware of trainees' concerns around on-call shifts and reported that the department was working to recruit more SPs. It was agreed that if there was consistent SP cover at night then it might not be necessary to have a second trainee on-call. Supervisors were sympathetic to the trainees' frustration at the amount of time spent on basic tasks and the impact of more regular on-calls on the subspecialty rotas. The review team noted that there were rare occasions where the first on-call was called to see a patient at the Royal Marsden Hospital and the second on-call was required to assist the consultant in the cardiac catheter laboratory at the same time. The review team heard that there had been some issues with trainees being scheduled to cover clinics which were not on the rota, some of which clashed with planned learning opportunities or other clinical duties. The trainees advised that the postgraduate medical education (PGME) team was working with the rota coordinator to address this.	Yes, please see C1.3
C1.4	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** Harefield Hospital The trainees commended the range of learning opportunities available and reported that they were encouraged to gain experience of procedures relevant to their subspecialties. Trainees participated in the general cardiology on-call rota but advised that this was still valuable for training. The review team heard that trainees were able to act as first operator on elective lists in the cardiac catheter laboratory and second	

	operator during on-calls, that the transplant consultants were keen to ensure trainees met their learning needs and that trainees in all subspecialties were able to access lists. The trainees advised that they were responsible for updating the Myocardial Ischaemia National Audit Project (MINAP) database with details of patient cases after patients had been discharged. Some trainees reported that they and other colleagues were sent lists of patient cases which they had not been involved with, making the task purely administrative and not valuable for training. The supervisors felt that the main challenge in ensuring breadth of experience was the lack of time for training in busy outpatient clinics. The Divisional Director (DD) advised that clinic services were being restructured and that this should allow more time for consultants to train during clinics and discuss cases with trainees at the end of the list. The review team heard that devices and electrophysiology (EP) services were run separately so it was sometimes difficult for trainees to gain combined experience. The supervisors reported that trainees typically focussed on ablation procedures initially and then moved on to devices, but that if trainees required it, the department could arrange for them to work on both. <u>Royal Brompton Hospital</u> The trainees commended the range of clinical experience available in the department and felt that the variety and complexity of patient cases was good for learning. Despite this, trainees found it difficult to obtain sufficient procedural experience as first operator in the cardiac catheter laboratory. It was reported that the cardiac catheter laboratory team ethos was that services should be consultant-delivered and that trainees had been told that the majority of patient cases were too complex for them, even at specialty training levels six and seven (ST6-7). The review team heard that some consultants were keen to support trainees to carry out procedures but other members of the laboratory team could be obstructive. In addition, trainees in interventional cardiology were not rostered for cardiac catheter laboratory lists and found it difficult to fit in lists around their rotas, with some advising that they had come in on zero days to access lists. The review team heard that on occasion trainees had had to go to the cardiac catheter laboratory at the Harefield site to obtain the procedural competencies required by the curriculum. Trainees across several subspecialties reported that access to lists and clinics were a challenge. When asked what could improve the situation, the trainees suggested that the department should ensure that trainees were rostered to work a sufficient number of relevant clinics and lists in the cardiac catheter laboratory and that the department management should communicate to all laboratory staff that training was a priority. The supervisors were aware of the need to develop the training culture within the department and noted that lessons could be learned from colleagues at the Harefield site. The Educational Leads (ELs) acknowledged that the on-call rota impacted on trainees' access to clinics and lists due to the number of resulting zero days and that more work was needed to align clinic allocations to training needs. The ELs advised that the consultants in the department were skilled trainers but that the culture of consultant-delivered procedures prevented some of them from maximising the training opportunities available. The supervisors were also aware that some trainees missed clinics and lists due to workloads, which included administrative tasks that could be done by other staff. The review team heard that some consultants gave trainees their letters and blood results for follow-up.	Yes, please see C1.4a Yes, please see C1.4b Yes, please see C1.4c
C1.5	**Protected time for learning and organised educational sessions**	

	Harefield Hospital When training days were scheduled six weeks or more in advance, the trainees reported that they were able to book these with the rota coordinator and attend the training. There had been difficulties when training days had been moved. Clinics were not automatically cancelled if the trainee had booked to attend training and the Divisional Director expressed concerns that if this was done it would impact negatively on service provision. The review lead pointed out that it was usually better to cancel clinics in advance than at short notice, but that if cover was arranged and clinics were reinstated at short notice, the appointments would usually be filled. Both sites Following trainee feedback, the Trust had introduced three to four sessions per month of subspecialty teaching which was accessible via video link across Trust sites. The trainees were complimentary of the local teaching programme.	
C1.6	**Access to simulation-based training opportunities** Harefield Hospital The review team heard that the Trust planned to introduce more simulation training in addition to the combined infection training and echo pericardiocentesis courses which were already running.	

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** Harefield Hospital The trainees described a steep learning curve when starting work in the unit but with good support from consultants and other trainees. The trainees reported that the department provided a good range of experience and that there were strong working relationships between the subspecialty teams. The trainees were asked about exception reports and advised that they knew how to report but did not do so. The trainees felt that exception reporting reflected badly on the department and might be interpreted as complaining. The low rates of exception reporting were discussed with the supervisors. Some suggested that trainees stayed late to access learning opportunities and chose not to exception report. The review	

	lead urged the supervisors to encourage the trainees to view exception reporting as an important way to provide information to the Trust, in the same way as Datix reporting. The DD suggested that exception reporting data should be discussed at the monthly local faculty group (LFG) or safety meetings which were attended by trainee representatives. Royal Brompton Hospital The review team heard that trainees in clinic were sometimes put under pressure to make decisions outside their remit by non-medical staff. Trainees advised that clinics were busy and this often resulted in them staying late. However, very few trainees had submitted exception reports. The supervisors felt that there was not a culture of exception reporting, but trainees were told during their induction how and when to submit exception reports.	Yes, please see C2.1
C2.2	**Organisation to ensure access to a named educational supervisor** Harefield Hospital The supervisors reported that they met with each trainee at the start of their rotations to determine their individual training needs and write a training contract which was checked at formal meetings at the mid-point of the rotation and prior to the annual reviews of competency progression (ARCPs). As the department was small, the supervisors indicated that they often met trainees informally in practice or as clinical supervisors.	

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	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** Harefield Hospital The review team was informed of a number of support mechanisms offered for trainees and staff. These included Schwartz rounds, which the supervisors reported were well-attended and had received good feedback. There were also crisis training sessions for all staff which included simulation and which were included in the teaching programme for trainees. The cardiac catheter laboratory team had introduced reflection sessions which were open to all staff. The DD remarked that the consultants in the department worked well together and that working in a small, well-functioning unit helped to create a sense of belonging.	

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	**Access to appropriately funded professional development, training and an appraisal for educators** Harefield Hospital The supervisors stated that their job plans included 0.25PA (programmed activities) per trainee for supervision time and that they received good support from the PGME team and management to undertake supervision training and attend ARCPs. The DD indicated that the Trust had worked to update and improve job plans in recent years to meet supervisors' needs.	

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.

	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.

C6.1	**Learner retention** Harefield Hospital	

	The trainees advised that they would recommend their training posts to colleagues. Royal Brompton Hospital The trainees reported that the hospital was a good place for more senior trainees and for certain subspecialties depending on the level of procedural experience available.	

Good Practice and Requirements

Good Practice
Trainees all described the consultants as approachable and supportive and reported that most consultants were engaged with training.
The trainees reported that cardiac catheter laboratory-based cardiology training at Harefield Hospital was high quality and well-supervised.
The Trust provided trainees with a good range of subspecialty training experience.
All trainees felt that patients received good care and would recommend the Trust to friends and family members requiring treatment.
All supervisors had time allocated in their job plans for supervision and were well supported by the department and the postgraduate medical education team to access continuing professional development, educator appraisals and additional experience such as attending annual reviews of competency progression (ARCPs).
Trainees complimented the local teaching programmes at both sites.

Immediate Mandatory Requirements			
Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
	None		

Mandatory Requirements			
Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
C1.2a	**Royal Brompton Hospital** The Trust is required to ensure that there are regular consultant rounds of inpatients in each subspecialty area. The ward round schedule should be displayed in the relevant inpatient area so that trainees and other staff are aware when consultants will attend the ward.	Please provide copies of the ward round schedules for each inpatient area by the end of January 2019.	R1.12
C1.2b	**Royal Brompton Hospital** The Trust is required to assign a consultant to attend and supervise all outpatient clinics. Consultants should be physically present in their allocated clinics for trainees	Please provide copies of the clinic schedules including the names of the consultants assigned to supervise each clinic and copies of thet LFG meeting minutes for quarter one and quarter two.	R1.12

	to access direct supervision. This item should be added to the LFG agenda for the next two meetings to monitor trainee feedback and ensure that trainees are appropriately supervised in clinic.		
C1.4a	**Harefield Hospital** The Trust should not make trainees undertake administrative tasks unrelated to training or to the care of their own patients. The Trust should inform the staff administering the MINAP database that trainees should only be assigned responsibility for updating records for patients they have personally reviewed or treated.	Please add a discussion of this action to the LFG agenda and provide copies of the next two LFG meeting minutes including trainee feedback on this issue.	R5.9h
C1.4b	**Royal Brompton Hospital** The department should clearly communicate the importance of procedural experience for training to all clinical supervisors and cardiac catheter laboratory staff. The department should audit laboratory lists to determine the number of cases where trainees act as primary operator and the reasons why they are not able to operate on the remainder of cases.	Please provide evidence of communication to consultants and cardiac catheter laboratory staff around this issue. Please provide the results of the audit at the end of February 2019.	R1.15
C1.4c	**Royal Brompton Hospital** Trainees should be allocated to the appropriate number of relevant clinics and lists to achieve the competencies outlined in their curricula. Each trainee should attend a minimum of one clinic per week.	Please provide copies of trainee rotas including allocation to clinics and lists as appropriate for each trainee's subspecialty by the end of February 2019. Please also provide records of the number of procedures carried out by each trainee in procedural subspecialties, including the type of procedure and whether the trainee was first operator.	R1.15
C2.1	**Both sites** The Trust should proactively encourage exception reporting and this should be made a standing item at LFG meetings.	Please provide exception reporting data for the next three months (January to March 2019) and copies of the LFG minutes for this period including discussion of reporting rates.	R2.2

Recommendations

Rec. Ref No.	Recommendation	Recommended Actions	GMC Req. No.
C1.3	**Royal Brompton Hospital** The two-tier trainee on-call rota impacts negatively on access to training opportunities during the day and is not justified by the workload or level of tasks carried out.	The department is advised to review the trainee on-call arrangements and to replace the current two-tier trainee rota with one which includes one trainee and a nurse practitioner or physician associate.	R1.7

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

Requirement	Responsibility

HEE plans to conduct a follow up review in 2019 and requires reassurance that trainees are able to access interventional training and gain procedural experience as required by the curriculum.	HEE

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Andrew Deaner
Date:	23 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.