NHS
Health Education England

Royal Brompton & Harefield NHS Foundation Trust

Core Medical Training

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. Core medical training (CMT) at the Royal Brompton Hospital received two red outliers, in adequate experience and curriculum coverage. CMT at Harefield Hospital received red four outliers in supportive environment, induction, local teaching and rota design.
Training programme / learner group reviewed	Core medical training
Number of learners and educators from each training programme	The review team met with five core medical trainees at Harefield Hospital and thirteen at the Royal Brompton Hospital. The review team also met with educational and clinical supervisors and the following Trust representatives: • Director of Medical Education • Deputy Directors of Medical Education (both sites) • Educational Leads for Core Medical Training • Divisional Director (Harefield Hospital, Heart) • College Tutor • Guardian of Safe Working Hours.
Review summary and outcomes	The review team identified several areas of good practice, including the local teaching programmes, excellent support for clinical and educational supervisors and the range of learning opportunities available to trainees (see Good Practice section). One immediate mandatory requirement was issued relating to a patient safety concern: • The review team was concerned to hear that core medical trainees (CMTs) were routinely expected to provide prescriptions for biologic drugs for patients with whom they had had no clinical involvement. The review team also noted the following areas requiring improvement: • Trainees had difficulty accessing clinics relevant to their training. • The CMTs advised that they spent much of their time doing administrative tasks including printing discharge summaries, transcribing information between different patient record systems and venepuncture. This was partly due to Trust policies restricting the duties which could be undertaken by nurses and other non-medical colleagues • 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

The review team heard that in August 2017 the general cardiology and cardiac transplant out-of-hours junior trainee level rotas had been merged. These rotas were staffed by core medical trainees (CMTs) and junior clinical fellows. However, this had created a number of difficulties around workload and ability to provide protected teaching time, so the department was restructuring the rotas to separate the two services from February 2019. The new rotas included a reduced out-of-hours commitment and fewer zero days. It was hoped that this would improve the training experience and create more opportunities for trainees to attend teaching, clinics and procedural lists.

The review team heard that the merger of these rotas had created a number of difficulties around workload and ability to provide protected teaching time. In addition, a three-month intensive care medicine (ICM) rotation had been added to the CMT curriculum with movement for three posts from cardiology and transplant to ICM. Therefore, the department was restructuring the rotas with the new rota arrangements due to start in February 2019. The new rotas included a reduced out-of-hours commitment and fewer zero days. It was hoped that this would improve the training experience and create more opportunities for trainees to attend teaching, clinics and procedural lists.

The Divisional Director (DD) advised that outpatient cardiology 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 heard that CMTs were mostly supernumerary in clinics.

There were four recently established physician associate (PA) posts, two in the general cardiology team and two in the transplant team. There was one PA in post in each of these teams at the time of the review and two more PAs were due to commence employment by the end of February 2019.

Royal Brompton Hospital

Trainees had given feedback that some consultants did not carry out regular ward rounds and that this made it difficult to plan their workloads. The EL noted that there was good senior trainee and clinical fellow cover so

CMTs were able to access advice and direct supervision from senior colleagues even if the consultant was not present.

CMTs did not work night shifts in cardiology due to previous concerns about the level of supervision available during these shifts.

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
CMT 1.1	**Patient safety** Harefield Hospital The trainees felt that patient care was safe and that there was good senior rota cover so they were not required to practice beyond their remit. All of the trainees advised that they would be happy for friends and family members to be treated at the hospital. Royal Brompton Hospital	

	The patient care at the Royal Brompton site overall was described as safe and high quality. In some teams, the trainees reported that patient referrals were refused if the wards were short staffed in order to maintain a safe level of care. The trainees advised that in some departments they were required to complete prescriptions for patients they had not reviewed or treated. In order to complete the prescriptions, the trainees described checking three different electronic patient record systems to gather the necessary information. This task was considered to have no educational value and the trainees noted that their lack of familiarity with the patients and the need to use multiple systems increased the risk of making errors. The supervisors were aware of this issue in the asthma subspecialty team and the Deputy Director for Medical Education (DDME) was working with trainees to develop guidelines to prevent this. The DDME indicated that the department had been short of staff who were able to prescribe but that the pharmacy and specialist nurse capacity had increased.	Yes, please see CMT1.1
CMT 1.2	**Appropriate level of clinical supervision** <u>Harefield Hospital</u> The trainees described excellent supervision and training in clinics, stating that they were able to be autonomous to an appropriate degree while being well-supported and encouraged to discuss cases with senior colleagues. Ward rounds were described as being more variable in terms of consultant attendance and trainees indicated that rounds were often led by higher trainees. None of the core trainees reported difficulty in contacting a consultant or accessing senior supervision when needed. The supervisors stated that they were aware that consultant attendance on the cardiology wards was not consistent and that trainees were not informed of when the consultants would attend or run ward rounds. The cardiology department had an assigned consultant each week so there was always a named consultant for trainees to contact. Other departments had named consultants for each day. The supervisors advised that they were working to improve the communication processes so that trainees were made aware of when consultants planned to attend the ward each day and when they would be in clinic or elsewhere. The trainees found the intensive care unit (ICU) rotation useful and advised that it provided good opportunities to practice more complex clinical procedures and complete case-based discussions with supervisors. However, trainees felt that they missed out on clinic opportunities during this rotation. The increase in ICU placements in the CMT programme had significantly increased the number of trainees in the department but the trainees felt that the department had coped well with this and provided a lot of teaching. <u>Royal Brompton Hospital</u> Again, the ward round arrangements and amount of consultant supervision time varied between specialty teams. The trainees reported that consultant-led rounds were less consistent in the interventional cardiology teams but were run on fixed days on the respiratory wards. The trainees suggested that the cardiology consultants were unable to spend much time on the wards as they were rostered for cardiac catheter laboratory lists or other clinical commitments while also being assigned to cover the wards. The trainees reported that clinical supervision and the provision of training in the ICU setting were excellent and that they valued this rotation.	

CMT 1.3	**Rotas** <u>Harefield Hospital</u> The review team heard that the trainees did not have clinics included in their rotas at the start of their rotations. This had led to trainees missing clinics or being informed at short notice that they were assigned to clinics. The trainees had reported this at the local faculty group (LFG) meeting and the rotas had been updated. The Trust had also recruited physician associates (PAs), which improved staff cover on the wards and made it easier for the ward teams to release trainees to attend clinics. The trainees felt that the Trust had responded well to their feedback and that their training experience had improved as a result. At the time of the review, the trainees worked on-call night shifts in the ICU but did not find these shifts valuable for training as their level of clinical skill meant that they were only able to work with more stable patients. However, the trainees found weekends in the ICU more useful as they were able to work alongside a consultant and learn about the more complex patient cases. The supervisors were aware that trainees found night shifts in ICU less interesting than days or weekends, but advised that there was educational value in overseeing care of a group of patients and presenting them to the consultant at morning handover. The trainees were aware of the Trust's plans to change the rota arrangements and reported that they had given feedback on the proposed changes. The supervisors indicated that the first change would be to separate the general cardiology and cardiac transplant team rotas to improve continuity of supervision and patient care. <u>Royal Brompton Hospital</u> The trainees did not work night shifts in the respiratory or cardiology departments and felt that this benefitted their training as it meant that they did not miss training opportunities due to zero days. On-call shifts lasted from 08:00 to 20:30 and the trainees advised that the workloads during these shifts were manageable. During the cardiology rotation trainees had rostered time in clinics but there was no protected clinic time during respiratory or ICU rotations. The trainees reported that there were clinics available, particularly in the respiratory department, but that higher trainees were usually allocated to these clinics, leaving core trainees to cover the wards. When trainees were able to attend clinics, they advised that the supervision was usually good. On rare occasions the trainees advised that they had been in clinic with a higher trainee but no consultant.	Yes, please see CMT1.3
CMT 1.4	**Induction** <u>Harefield Hospital</u> All trainees stated that they had had inductions and been assigned educational supervisors at the start of each rotation, as well as being given login information for the relevant information technology (IT) systems. The initial induction was described as being more tailored to core medical training, whereas the induction to the second rotation was shared with anaesthetics trainees and was less relevant. However, the trainees advised that one of the consultants had given them an additional, informal induction session which they found very useful.	
CMT 1.5	**Handover** <u>Harefield Hospital</u>	

	The trainees reported that handovers took place and were well-run and useful.	
CMT 1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** Harefield Hospital The review team was informed that trainees had good opportunities to learn about acute medical care. In cardiology, the trainees reported that they were sometimes able to see patients through from admission to the cardiac catheter laboratory. Royal Brompton Hospital The trainees felt that they were often used to do administrative tasks or basic clinical tasks. The review team heard that nurses were not allowed to print discharge summaries or to perform venepuncture and cannulation on certain wards even if they were trained and experienced in these tasks. The trainees expressed concern that nurses were not empowered to use their clinical skills or judgement, which led to the nurses becoming deskilled and increased the trainees' workloads. The DDME acknowledged that this was an ongoing challenge and that, while many of the nurses were keen to utilise more of their clinical skills, the nursing staff had high workloads and their managers were reluctant to assign them more tasks. The DDME indicated that trainees had been responsible for clerking elective electrophysiology patients in cardiology but that this task had been reassigned and a nurse-led preassessment clinic had been introduced. The respiratory department planned to introduce spirometry self-monitoring devices to remove the need for trainees to conduct spirometry rounds. When asked why the trainees performed so many non-educational and basic tasks, the DDME suggested that this was partly historical practice which had not changed to meet the demands of modern training and service provision. Staffing levels also presented a challenge in some departments but the review team heard that the Trust had started to introduce advanced nurse practitioners (ANP) and PAs and to increase the numbers of locally-employed doctors.	Yes, please see CMT1.6
CMT 1.7	**Protected time for learning and organised educational sessions** Harefield Hospital There was a local teaching programme for CMT and the trainees reported that they were always released to attend the teaching sessions. Trainees complimented the teaching programme, as well as the specialty-specific teaching in cardiology and ICU. The supervisors informed the review team that trainees had given negative feedback about the practical assessment of clinical examination skills (PACES) teaching but that this had been improved. The trainees advised that they had regular PACES teaching and were able to attend. Royal Brompton Hospital Following trainee feedback, the supervisors reported that the cardiology team had started running specific CMT level teaching, which had been well-received.	
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.**		
CMT 2.1	**Effective, transparent and clearly understood educational governance systems and processes** Harefield Hospital There were regular LFG meetings which included trainee representatives. The trainees found the managers and postgraduate medical education (PGME) team responsive to their concerns and reported that they received updates on actions from the LFG meetings. All trainees advised that they had been taught about whistleblowing at induction and were aware of how to submit Datix reports and exception reports.	
CMT 2.2	**Impact of service design on learners** Harefield Hospital The low rate of exception reports was discussed and trainees advised that they did not submit reports as they rarely worked beyond their rostered hours. Some reported that they had worked late when they first started in their rotations and were learning to manage the workload but after the first couple of weeks this was not necessary. The trainees found the Trust IT systems difficult and time-consuming to navigate as there were multiple systems for different records and in different departments which did not link up. This meant that trainees had to transcribe information between systems when patients were transferred between departments and triangulate information from different systems when writing discharge summaries or prescriptions. The supervisors echoed the trainees' frustrations and advised that the Trust had invested in improving the IT infrastructure but that this would take time. Royal Brompton Hospital The supervisors described the trainees as skilled and dedicated, remarking that they did not get overwhelmed by the complexity of the patient cases. The supervisors advised that the trainees were eager to learn and not afraid to ask questions. The trainees reported that the hospital had an interesting case mix and a good teaching programme. Trainees had given feedback about the teaching in the respiratory department and commended the department for responding quickly. The trainees advised that they had found it difficult to access learning opportunities in some departments, such as cardiac catheter laboratory lists in the cardiology department. It was reported that the ICU rotation provided plenty of skills training, teaching time and good opportunities to work with the specialist nurses. However, the ICU trainee rota did not include clinic time and the trainees reported that there were too many trainees competing to attend limited clinics.	

	The review team heard that the private wards were staffed by resident medical officers during weekdays but that trainees covered these wards out-of-hours. Trainees reported that sometimes the private ward managers had called them to cover the wards when no Resident Medical Officer (RMO) was available. Some trainees had been called by nurses on the private wards to complete discharge summaries, clerk patients and write prescriptions. The trainees did not think this was appropriate and had escalated the issue to the DDME, who was working to clarify the trainees' remit with regard to private patients. The ADME reported that a guidance document had been produced and circulated stating that trainees should only review private patients that they had already seen during ward rounds, to allow the trainees to follow cases and learn more from them. The PGME team had also started inviting the RMOs to the local teaching sessions to make their roles more interesting and build better relationships between them and the trainees. The review lead asked the trainees about the low rates of exception reporting and was informed that trainees did sometimes work late but felt that there was a culture of not exception reporting in the Trust. Some trainees were confused about when it was appropriate to exception report as they had been given conflicting information at their induction and by service managers in practice. The DDME agreed that the Trust needed to change the culture around exception reports. IT was also described as a challenge at the Royal Brompton site due to the need to transcribe information between different systems, particularly in the ICU which had its own medication records system.	Yes, please see CMT2.2
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.**		
	N/A	
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.**		
CMT 4.1	**Access to appropriately funded professional development, training and an appraisal for educators** <u>Harefield Hospital</u> The review team was informed that the Trust was working to update supervisors' job plans and that some did not have time allocated for supervision. The supervisors whose job plans had been updated reported that 0.25PA (programmed activities) was allocated per trainee or clinical fellow they supervised up to 1.0PA but that any	

	additional supervision time beyond this had to be justified. It was reported that supervisors had educator appraisals every three years and were encouraged to attend supervision update training and annual reviews of competency progression (ARCPs). Royal Brompton Hospital The supervisors reported that the Trust had robust processes to ensure they had access to training, continual professional development (CPD) opportunities, educator appraisals and relevant meetings such as the National Association of Clinical Tutors (NACT). All supervisors indicated that they had time allocated in their job plans for educational and clinical supervision. The supervisors commended the work of the PGME team in supporting their professional development.	

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.

CMT 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** Harefield Hospital The supervisors discussed the ways that they tried to make it easier for trainees to complete workplace-based assessments (WBAs) and supervised learning events (SLEs). These included assigning trainees a bay on the ward at weekends so that they could present this bay to the consultant during rounds and identifying cases suitable for SLEs at the start of a clinic. The trainees reported that it was sometimes difficult to get consultants to complete WBAs as they did not see them consistently but that the senior trainees were also able to sign off some assessments. Royal Brompton Hospital The trainees' experience of completing WBAs and acute care assessment tools (ACATs) varied between specialty teams. Trainees who had rotated through cardiology reported that they did not see the consultants very much, which made it harder to complete WBAs, but that it was easier in the ICU where consultants were consistently present and willing to work on assessments.	
CMT 5.2	**Opportunities for interprofessional multidisciplinary working** Harefield Hospital The trainees advised that PAs had recently started working on the wards and that this had improved trainee workloads, as the PAs took on tasks such as administration, venepuncture and cannulation. The supervisors were aware of the positive impact the PAs had and were working to develop learning opportunities for these new colleagues.	

	The review lead enquired whether this would impact on opportunities for trainees but the supervisors advised that the PAs conducted longer term quality improvement projects which were not feasible for CMTs on three or four month placements. There were also plans to train the senior PA to work with the vascular access team. The review team heard that PAs and CMTs were rostered to attend clinics on different days so that they were not competing for the same clinics. Royal Brompton Hospital There were no PAs in the cardiology department although both trainees and consultants felt that introducing them would be beneficial. The trainees noted that the respiratory team included an ANP and that this reduced the trainees' workloads. However, the trainees felt that a lot of the nursing team had been disempowered and deskilled as they were not allowed to carry out tasks they were trained for such as cannulation.	

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.

CMT 6.1	**Learner retention** Royal Brompton Hospital Trainees gave mixed responses when asked whether they would recommend their posts to colleagues. Some trainees felt that certain subspecialty rotations were too long and did not provide good preparation for general medicine higher training.	

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.**
CMT1.1	The review team was concerned to hear that core medical trainees (CMTs) were routinely expected to provide prescriptions for biologic drugs for patients with whom they had had no clinical involvement. HEE regards this as a high risk practice.	This practice should cease forthwith. HEE requires reassurance that this step has been taken. This should be in the form of written communication from the Medical Director or a nominee in the first instance. The Trust should produce a clear policy around this and HEE will follow up in three months to ensure that this is being adhered to.	R1.2

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
CMT1.3	**Royal Brompton Hospital** Trainees should be allocated to the appropriate number of relevant clinics and lists to achieve the competencies outlined in their curricula. For CMT the aim should be to complete 20 clinics per year, so a clinic once every week would be appropriate allowing for a reduction in clinics during ICM rotations.	Please provide copies of trainee rotas including allocation to clinics and lists as appropriate for each trainee's rotation by the end of February 2019.	R1.12
CMT1.6	**Royal Brompton Hospital** The Trust should review the processes and guidelines around the remits of trainees, nurses and other healthcare professionals on inpatient wards. This should include an audit of staff skills to ascertain which staff are competent to perform venepuncture and cannulation. Trainees should not be made to undertake administrative tasks such as printing discharge summaries which could be done by the discharging nurse, a PA or an administrator.	Please provide copies of the audit data and drafts of the amended process and guideline documents by the end of February 2019.	R1.15
CMT2.2	**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.**
	N/A		

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:	22 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.