NHS
Health Education England

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

Cardiology

Risk-based Review (on-site visit)

Quality Review report

30 April 2019

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	Health Education England (HEE) conducted a quality review of training in the department in December 2018 based on 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. At the review, HEE identified concerns around the procedural experience gained by trainees, particularly in the electrophysiology and interventional cardiology subspecialty teams. 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 mandated that the Trust address this issue and agreed to conduct a follow-up review to ensure that trainees were able to obtain sufficient operative experience to meet the curricular requirements.
Training programme / learner group reviewed	Cardiology
Number of learners and educators from each training programme	The review team met with nine junior doctors at specialty training levels three to seven (ST3-7) or equivalent at the Royal Brompton Hospital. The review team also met with educational and clinical supervisors and Trust representatives including: • Director of Medical Education • Deputy Director of Medical Education • Educational Leads for Cardiology • Divisional Director • College Tutor • Guardian of Safe Working Hours.
Review summary and outcomes	The review team identified several areas of good practice including the increased consultant engagement with training, improved trainee access to operative experience and significantly improved trainee morale. The Trust has demonstrated a commitment to moving trainees between the Royal Brompton and Harefield sites in order to maximise procedural experience and training The review team also noted some areas requiring improvement, including: • The Trust was advised to continue diversifying the workforce by training nurses in independent prescribing and increasing the number of physician associate roles • The Trust was advised to ensure that the increased access to therapeutic experience was sustainable in the long-term, including the availability of training lists at Harefield Hospital

	• The review team encouraged the Trust to involve the trainees in discussions around the hospital at night service and the overnight cardiology on-call rota.

Quality Review Team			
HEE Review Lead	Geoff Smith Deputy Postgraduate Dean, North West London Health Education England	**Head of Specialty School**	Andrew Deaner Head of London School of Medicine and Medical Specialties Health Education England
HEE Representative	Louise Brooker Learning Environment Quality Coordinator Quality, Patient Safety and Commissioning Team, London Health Education England	**Observer**	Louise Lawson Apprentice Quality, Patient Safety and Commissioning Team, London Health Education England

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

The review lead enquired what changes had been made since the previous review in December 2018. The Trust representatives reported that there had been significant work around improving trainees' access to procedural experience and participation in complex cases, as well as encouraging . A consultant-level Trust-employed doctor had been recruited to improve cover on the inpatient wards and allow the interventional cardiology trainee and fellows to be released. The review team heard that the interventional cardiology fellows worked more in the transcatheter aortic valve implantation (TAVI) service and other specialist areas which were not part of the training curriculum so they were not in competition for learning opportunities. The Educational Lead (EL) reported that one electrophysiology trainee had been moved to the Harefield Hospital site earlier than planned as there were more cardiac catheter laboratory lists available there. The interventional cardiology trainee had been allocated regular training lists at Harefield Hospital, which also allowed for greater interaction with other trainees in the same subspecialty. Trainee feedback to the supervisors indicated that procedural numbers and access had improved. Recruitment was underway for an interventional cardiology consultant role which would include training responsibilities. The Director of Medical Education (DME) reported that the training programme had been reviewed against the lists available to identify which lists were most valuable for different levels of training and signpost trainees to these. The EL advised that there were several multidisciplinary team meetings each week and that trainees were able to attend these as well as present cases and facilitate the discussion. The department had converted a vacant room to create an additional clinic room to increase the number of clinic lists available for core medical trainees (CMTs). There was a rota gap at CMT level so it was a challenge for the supervisors and ELs to ensure protected clinic time for CMTs.

The review lead enquired about the culture in the department and particularly the ethos of consultant-delivered care which was previously identified as a barrier to training opportunities for trainees. The EL reported that the supervisors had worked to better understand the trainees' needs and identify lists, cases and elements of procedures that trainees could work on as first operator. It was acknowledged that some cases were too complex or specialist and required the consultant to lead. The Trust had a cross-site working agreement with Chelsea and Westminster NHS Foundation Trust and The Royal Marsden NHS Foundation Trust, which allowed trainees from the other Trusts to access lists at the Royal Brompton Hospital (RBH). The EL advised that this created competition between trainees for certain subspecialty lists which were not available at the other Trusts, for example diagnostic angiography.

The review team heard that there had been extensive discussions around the junior doctor out of hours on-call rota and that it had been decided that the two-tier middle-grade level rota should continue, with the addition of physicians' assistants to take on some tasks and help relieve the workload of the resident on-call doctor. The first on-call doctor was sometimes required to attend the cardiac catheter laboratory or review a patient at The Royal Marsden Hospital (RMH) so it was considered necessary to have a second on-call doctor in case there was an emergency or a patient in the high dependency unit required urgent review while the first on-call doctor was performing a procedure or was off-site. The review leads questioned the educational value of trainees

attending RMH to do diagnostic echocardiograms but were advised that this allowed trainees to carry out clinical assessments and make diagnoses independently. The EL acknowledged that it could be difficult for trainees to ascertain which cases required urgent review and to decline inappropriate referrals. The Head of School suggested that the department could audit these calls and the case outcomes to determine whether trainees were frequently being called to perform non-urgent reviews.

The Guardian of Safe Working Hours (GoSWH) reported that the department had seen an increase in exception reporting rates, following communications through the postgraduate medical education team and supervisors at induction sessions and departmental meetings. The DME advised that the higher trainees were all aware of the exception reporting process but did not want to submit exception reports for working additional hours as they felt that this was part of the role and was inevitable when working in a busy department.

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	**Responsibilities for patient care appropriate for stage of education and training** The trainees acknowledged that the Trust did not provide a typical training experience for specialty trainees at level three (ST3) but that there was sufficient exposure to more straightforward cases during on-call shifts to give a well-rounded experience. The supervisors agreed that there was a good range of patient cases available to prepare trainees for more senior-level training posts at district general hospitals. The supervisors also noted that some sub-specialty teams treated a higher number of complex patients than others which impacted on the ST3 training experience.	
C1.2	**Rotas** The junior doctor on-call rota included one resident and one non-resident doctor each night and during the day on weekends and bank holidays. The on-call doctor covered the cardiology wards and cardiac catheter laboratory at the Royal Brompton Hospital (RBH) and the emergency echocardiography service and cardiology reviews for The Royal Marsden Hospital (RMH). The trainees were unsure whether all cases referred by the RMH were truly urgent, but found it difficult to triage cases over the phone and were reluctant to decline referrals.	

	The review lead asked whether the two-tier rota was necessary given the impact on the day shift rota and access to training opportunities during weekdays. The trainees indicated that it was infrequent for the second on-call to be called in during the week but that two doctors were often needed at weekends and on bank holidays. Since the previous review in December 2018, the trainees reported that nurse practitioners had been added to the night on-call team. The on-call nurse practitioner covered more straightforward calls and tasks such as venepuncture and cannulation. The trainees advised that this had helped to relieve the on-call doctors' workloads but that the nurse practitioners could not prescribe so the first on-call doctor still spent significant amounts of time prescribing basic medications. The review team discussed potential alternative workforce models with the trainees and supervisors. There was an ongoing rota gap at core medical trainee (CMT) level and the supervisors reported that it had been a challenge to maintain locum cover for this post. The supervisors informed the review team that that recruitment was underway for two CMT-level Trust-employed doctors. It was hoped that this would resolve the rota gap and help to stabilise CMT workloads and make it easier for them to access training opportunities away from the wards. A proposal to introduce physician associate roles into the department was in development. The supervisors also advised that an additional CMT-level shift had been added to the rota from 14:30 to 22:00 daily but that this was due to be changed to 12:30 to 20:00 in response to trainee feedback. The supervisors felt that ensuring consistent cover in non-training posts was an important step in improving the training experience in the department. The trainees also suggested that the on-call rota might not require two higher trainees if other posts were fully staffed and that one higher trainee and one CMT or prescribing nurse practitioner could provide sufficient cover. The supervisors noted that the Trust offered subspecialty experience which was not reflected in the current training posts, for example around inherited cardiac conditions (ICC). The Head of School suggested that the Trust liaise with the training programme director about the possibility of arranging honorary contracts for trainees to allow access to this opportunity.	Yes, please see action C1.2a Yes, please see action C1.2b Yes, please see action C1.2c
C1.3	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The trainees reported that the access to procedural experience had improved since the previous HEE review in December 2018. The trainees commended the supervisors for their response to this issue, including changing some rotas to better integrate procedural and ward work, arranging for some trainees to spend time at the Harefield Hospital site, proactively asking about trainees' learning needs and allowing trainees to act as first operator more often. Trainees were also able to attend multidisciplinary team meetings and present cases, which they found educationally valuable. The trainees suggested that further improvements could be made in certain subspecialties, for example by allocating trainees fixed lists or increasing access to specialist echocardiography sessions. The supervisors agreed that more frequent engagement with the trainees was a positive change and that cross-site working between Harefield Hospital and RBH was a good way to capitalise on the training opportunities available at the Trust. It was noted that there were two vacant consultant posts in the interventional cardiology team which impacted on the higher trainees' workloads and ability to access cardiac catheter laboratory lists. The review team heard that there were sufficient lists available to meet trainees' needs.	Yes, please see action C1.3

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	**Effective, transparent and clearly understood educational governance systems and processes** All trainees were aware of the exception reporting process and advised that they were encouraged to exception report at educational and departmental meetings. Several trainees expressed the opinion that staying late at the end of shifts was part of the job. The trainees felt that it was preferable to complete their patients' investigations, notes and treatment plans before leaving rather than handing tasks over to the evening on-call doctor who might not have the relevant subspecialty experience. In imaging and interventional subspecialties, trainees felt that it was better to participate in as many cases as possible rather than finishing part-way through a list and risk missing learning opportunities.	
C2.2	**Impact of service design on learners** The trainees reported that consultant attendance on the inpatient wards had improved significantly and that work on the wards now provided a better balance of service provision and learning opportunities. Most teams did not utilise a 'consultant of the week' model but the trainees advised that the consultants would cover each other's patients where necessary. The supervisors were not aware of any negative impact on trainees from multiple consultants carrying out ward rounds and the trainees did not raise this as an issue. The review team heard that some trainee clinics did not have consultant supervision but that there were consultants in parallel clinics who trainees could contact to discuss cases or request to review patients when needed. The trainees advised that they could always debrief with a consultant by phone or email at the end of a clinic list if they were not physically present. The trainees reported that the interface between the adult congenital heart disease (ACHD) consultants and the surgical consultants was sometimes unclear and that this could result in patients having two conflicting treatment plans. The review team heard that the surgical team on-call doctors were difficult to contact as they only came to review postoperative patients between theatre lists and did not carry bleeps, only mobile phones which had to be called via the hospital switchboard. The trainees found the surgical team helpful in cases where patients suffered surgical complications but advised that there were sometimes issues when the ACHD team had to alter plans set by the surgeons due to a medical complication. The supervisors felt that the two teams worked well together but acknowledged that having more frequent face-to-face case reviews including the trainees could help to resolve any confusion. The supervisors noted that there were daily ACHD rounds and a weekly grand round, as well as multidisciplinary team meetings and weekly meetings with the surgical teams. The trainees suggested that having a dedicated parking space for the on-call junior doctor would help to address some safety concerns about coming into the hospital at night.	Yes, please see action C2.2

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.

C3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees advised that the culture in the department and working relationships between the consultants and trainees had improved. No instances of bullying or undermining behaviour were reported.	

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 supervisors reported that the Trust was in the process of building dedicated training time into job plans but that this work was not complete. The supervisors felt that the Trust culture around training had improved and the need for protected supervision time was being acknowledged.	

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.

	N/A	

Good Practice and Requirements

Good Practice
The Trust had taken significant steps to allow trainees more access to clinics and operative lists, for example by creating an additional clinic room for core medical trainee clinic lists, arranging for higher trainees to access lists at the Harefield Hospital site and working to improve the provision of access to interventional cardiology lists at the Royal Brompton site.
The trainees reported that the consultants were significantly more engaged with training and proactively discussed trainees' learning needs at the start of clinics and operative lists.
All trainees were aware of the exception reporting process and had been encouraged to submit exception reports when appropriate.
None of the trainees raised any concerns around bullying or undermining behaviour in the department
The review team noted a considerable increase in trainee morale since the previous review in December 2018.

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	The Trust should involve the trainees in discussions around the hospital at night service and the overnight cardiology on-call rota.	The Trust is advised to conduct an audit of the on-call rota to ascertain how often the second on-call junior doctor is called in and whether this second on-call role is needed on weekday nights or only during weekends. In addition, the Trust should provide evidence that the trainees have been involved with the discussions about rota redesign, as a minuted meeting. Please provide an update on this issue by the end of June 2019.	R2.3
C1.3	The Trust should ensure that the increased access to therapeutic experience is	Please outline the planned approach to:	R1.15

	sustainable in the long-term, including the availability of training lists at Harefield Hospital.	1. ensuring that trainees are accessing appropriate numbers of procedures 2. managing a situation where this was not being achieved. This would be best provided as a department guideline for trainees and trainers that the education lead and trainers sign up to in order to maintain the sustainability of the improvement. This should be provided by the end of June 2019.	
C2.2	The Trust should clarify the responsibilities and escalation process for patients who are jointly managed by the surgical and cardiology teams.	Please provide confirmation that there is a clear agreement that patients under joint care are reviewed collaboratively and, where management plans differ between teams, that there is a system to highlight this between consultants to facilitate a unified plan. This should include a clear process for the trainees to follow should management plans differ, or an agreement on who the lead consultant is on a case by case basis. Please provide an update on this issue by the end of June 2019.	R1.17

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
C1.2b	The Trust is advised to continue diversifying the workforce by training nurses in independent prescribing and increasing the number of physician associate roles.	The Trust is encouraged to seek advice from the Workforce team at HEE and to discuss potential workforce solutions with the trainees.	R1.7
C1.2c	The Trust should consider the feasibility of introducing ICC training rotations or placements.	The Trust is advised to discuss this with the TPD.	R5.9

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
None	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Geoff Smith
Date:	30 May 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.