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Pan-London Quality and Regulation Unit

North Middlesex University Hospital NHS Trust

Clinical Oncology

Quality Visit Report

Date of visit: 24 March 2015

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Health Education
North Central and East London

CONVERSATION OF CONCERN REPORT

Visit Details	
LEP	North Middlesex University Hospital NHS Trust
Specialty	Clinical Oncology
Date of visit	24 March 2015
Background to visit	It was brought to the attention of Health Education North Central and East London (HENCEL) that there were a number of education and training concerns regarding clinical oncology at North Middlesex University Hospital NHS Trust. HENCEL, as responsible commissioner for the Trust and as the accountable body to the General Medical Council, were obliged to investigate and act upon these concerns. With this in mind, this Conversation of Concern was organised to explore the specific serious issues and focused on concerns regarding: 1. Trainees not receiving the required training. 2. Trainees conducting clinics with inadequate or no clinical supervision. 3. Trainees being asked to undertake tasks beyond their competence. The Trust was last visited in relation to clinical oncology on 11 June 2012, and two actions remain open.
Visit summary and outcomes	The visit team met with the senior management team, followed by a meeting with the Clinical Lead and College Tutor. The visit team then met with seven trainees currently in clinical oncology training across all stages of training, including Foundation. Finally the team met with nine clinical and educational supervisors. The visit concluded with feedback being provided to the senior management team including the Medical Director and Director of Medical Education (DME). Overall, the visit team was pleased with the efforts made by the department to improve the training experience for trainees. There had clearly been a lot of activity in the previous few months to address the issues that had been raised. There was clearly a body of committed and enthusiastic trainers, which the trainees felt supported by. Furthermore, the trainees commented that the DME was a positive aspect of education in the Trust, and was a great support to all trainees. The visit team heard that following the reconfigurations at Chase Farm Hospital, the department workload increased greatly but that processes in place appeared to be addressing this. Generally speaking the workload was reported to have improved. There had been an increase in staffing levels and the visit team wished the department luck in recruiting to the vacant posts. The triage of acute oncology service (AOS) was a positive development; the trainees indicated that they were grateful for the service and not just for them but for their colleagues in medicine too. The Clinical Nurse Specialist (CNS) role in lung cancer was well viewed by trainees, and exploring expansion into CNS for more oncology specialties may be of benefit to the department and training environment. The visit team heard of the difficulties in recruiting to non-training grade clinical oncology posts which was also a national issue. If the middle grade posts did not attract the calibre of applicant the Trust was looking for, the visit team recommended that alternative options be reviewed i.e. specialised nurses and additional consultant posts. There were reports of a heavy phlebotomy workload for trainees; the visit team recommended that the Trust looked at recruiting further phlebotomists, physician's assistants or equivalent staff to ease the workload of trainees and allow time for educational tasks. HENCEL was developing nurse specialist roles and would welcome the discussion of developments.

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	There was one consultant assigned to the role of Educational Supervisor for the full cohort of four clinical oncology trainees. Although this was an appropriate number of trainees to work with, there was a slight worry regarding the sustainability of only one person covering this role, particularly when they were employed part time. The job plans of educational roles required review to ensure appropriate and allocated educational time. Radiotherapy job planning was included in consultant timetables and job plans which were much improved. Trainees were receiving set radiotherapy planning sessions, which was a noticeable improvement. It was recommended that the department aimed for trainees to have two radiotherapy planning sessions per week; the minimum requirement was for one full session per week, but an extra session would be beneficial for trainees. A dedicated educational space with a computer had been provided to the trainees which was commended. The discussions between the Trust and University College London Hospital regarding the takeover of the library services potentially had many benefits. Trainees reported that they experienced difficulties with accessing online journals and this could address this issue. The collaboration between LEPs was recommended. Dedicated academic teaching and peer review had been included in the weekly timetable, which were positive developments. However, the visit team recommended that the department reviewed the process of releasing trainees to the regional teaching. The Trust was reminded that regional teaching was mandatory for all trainees. The visit team heard that the handover process was recently updated but there were concerns that it was not fully embedded. It would be recommended that an individual consultant takes responsibility of the handover process, to ensure it was being run efficiently. The consultants were not required to attend the handover, but to just ensure that it was working as effectively as possible. The Trust was reported to be the only one in the sector to have not yet invested in an Electronic Patient Record (EPR) system. The visit team recommended that the Trust review the investment into an EPR to increase the potential of recruited applicants to the Trust. The visit team were encouraged to see the changes that had been made, and noted that they would like to review clinical oncology training at the next Trust-Wide Review or Specialty Focused Visit that takes place.

Visit team

Lead Visitor	Professor Tim Swanwick, Postgraduate Dean for HENCEL	**Head of School**	Dr Gill Sadler, Head of School of Clinical Oncology
Lead Provider	Dr Suzannah Mawdsley, Training Programme Director	**Lay Member**	Mrs Kate Rivett, Lay Representative
General Medical Council	Professor Alastair McGowan, GMC Enhanced Monitoring Associate	**General Medical Council**	Ms Samara Zinzan, Quality Assurance Programme Manager
Visit Officer	Miss Michelle Turner, Quality and Visit Officer		

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Findings				
GMC Domain	**Ref**	**Findings**	**Action and Evidence Required. Full details on Action Plan**	**RAG rating of action**
1	1.1	**Handover** The trainees stated that there was no formal handover in the department. There was a handover list of patients to review, but this was not in a particular order and so was not always easy to refer to. The visit team heard of an incident when a trainee had been contacted by a consultant asking why they had not reviewed a particular patient over the weekend who had a cord compression, but the trainee had not been aware that the patient required review. The visit team heard that trainees would proactively contact the on call trainee to highlight any patients requiring an urgent review. The clinical and educational supervisors stated that the handover had recently been updated. Previously, there had been separate lists for each ward or firm but this was merged to one. They confirmed they needed to re-educate the trainees on the importance of handover from a Good Medical Practice point of view and that the onus was on the individual consultant teams to complete this satisfactorily. The visit team heard that there was no administrative support for the handover, and no one consultant was in charge of the overall process. No department process existed to ensure an effective handover took place.	The handover process had been updated but there were still areas that required improvement, including ensuring that a robust process was in place which was fully embedded into the department. An individual consultant should take responsibility of the handover process as a whole, to ensure it is being run efficiently, so that all patients are handed over appropriately. It may also be beneficial that the consultant who is on call for that weekend should either attend a handover on the Friday or have contact with the on call registrar for the weekend to ensure the handover has taken place appropriately.	Amber Mandatory
5	5.1	**Radiotherapy Planning** The senior management team stated that the Trust had three radiotherapy machines including a skin machine. It was confirmed that job planning was reviewed in 2014 and time for radiotherapy planning had been included. The College Tutor and clinical directors stated that there was set time in a consultant's timetable for radiotherapy planning. The vacancies in the department impacted upon the time available for radiotherapy planning. There was an issue with cancer pathways and the time constraints on reviewing patients. Some radiotherapy planning was still being completed out of hours due to time constraints. Most were planned with a four day lag, to ensure trainees had the time to review the radiotherapy plans. The visit team heard that they had introduced peer review radiotherapy planning on a Friday which had been well received.	Radiotherapy planning was included in consultant timetables and job plans appeared much improved. Trainees were receiving some set radiotherapy planning sessions, which was a noticeable improvement. However, timetable issues and over-running clinics meant that in practice the job plans were not always adhered to. This led to planning starting particularly late in the day, with trainees staying much later than their rostered finish time to ensure they met the curriculum requirements. All trainees should receive one session per week of radiotherapy	Amber Mandatory

		The trainees reported that they did not have allocated time for radiotherapy planning. They were happy with the quality of radiotherapy planning training they received, but the time was not guaranteed or protected in consultant job plans. Dependent on the trainees and consultant timetables, radiotherapy planning may not be started until late in the afternoon and therefore would continue until 8 or 9pm. The trainee was with the consultant during this time, but could not start any earlier as the consultant and/or trainee was often at clinics off site. The visit team heard that despite the late finishing of radiotherapy planning, trainees had not been encouraged to start later or leave earlier another day to make up the time. The clinical and educational supervisors reported that they had experienced difficulties with non-oncology colleagues understanding the importance of radiotherapy planning time. Sufficient time had not always been included in consultant job plans, and continued to be an issue.	planning, which must be evidenced to the visit team. It is recommended that the department aims for trainees to have two radiotherapy planning sessions per week, and that specific time slots are allocated to consultant job plans. Consultant job plans to be provided as evidence that this is allocated.	
5	5.2	**Curriculum** The core medicine trainees commented that they were usually based on the ward, to support the workload there. The visit team heard that they had experienced difficulties with attending clinics whilst in post. This was not an issue specific to oncology, but appeared to be a concern for many core medicine trainees across the region. The core medicine trainees reported that they had taken study leave to guarantee exclusion from ward duties and to ensure they could attend clinics and complete assessments. The trainees stated that there was a good provision of palliative care in the Trust and they had been able to access this educationally.	Core medicine trainees were covering service provision and were not automatically allocated to clinics, in line with their curriculum requirements. The core medicine trainees should be included in the rota with specific clinic time allocated.	Amber Mandatory
6	6.1	**Induction** All trainees confirmed that they had received a thorough Trust and departmental induction and had no concerns.		
6	6.2	**Educational Supervisor** The visit team heard that there was only one educational supervisor in the department who was responsible for the four trainees. The visit team heard that the educational supervisor was also the lead for induction planning. There was support provided to the educational supervisor by other consultants in the team, but the job planning review in 2014 had allocated only 0.5 programmed activities (PA) for the role. However, the College Tutor also had an allocation of 0.5 PAs.	There was one consultant assigned to the role of educational supervisor for the full cohort of four clinical oncology trainees. Although this was an appropriate number of trainees to work with, this may not be sustainable with only one person covering this role, particularly when they were employed part time. The job plans of	Amber Mandatory

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		The trainees reported that they felt supported in post, and would have no concerns with raising issues to the educational supervisors. The trainees confirmed that the acting DME had been hugely supportive to all trainees, and would often stop trainees in the corridor to ask if educational needs were being met.	educational roles require review to ensure appropriate and allocated educational time.	
6	6.3	**Rota** The junior trainees reported that they spent approximately 90% of their time on the ward. The job was beneficial to trainees who may opt for oncology as a career but the rota was a concern. If one junior was on leave and then someone off sick, they stated 'it was difficult to cope'. The visit team heard that locums had been filling the gaps on the rota. The senior management team stated that there was an occasion when the service manager contacted a trainee directly regarding providing non-rota cover. It was during a time of a bed crisis and the manager had been reminded that it was inappropriate to contact trainees directly no matter how good their personal relationships were.	Trainees were completing tasks of limited educational value due to the workload of the department and staffing vacancies. The visit team requires that the rota and staffing should be reviewed and evidence provided of protocols regarding escalation of staffing difficulties	Amber Mandatory
6	6.4	**Out of Hours** The trainees stated that the out of hour's rota was firm based and started at 5pm. The rota was combined with haematology, oncology and specialist HIV (Human Immunodeficiency Virus) teams. The out of hours bleep was known as the 283 bleep. The junior trainee carried this, between 5-8.30pm and it was then handed to the higher trainee. The trainees reported that the out of hour's workload was variable, and greatly depended on the staffing numbers on the ward as to what was required of the out of hours team to complete.		
6	6.5	**Staffing** The senior management team reported that there had been issues with gaps in the rota. The Trust had advertised for two non-training middle grade doctors to fill the gaps in the rota and ease the workload of the trainees on the ward. Unfortunately, the calibre of applicants had not been to the standard required. The department continued to actively advertise these posts. The senior management team confirmed that the department had been three consultants short during the last six months due to maternity, sick and compassionate leaves. There was an advert for locums to cover these slots, but had no successful applicants. The pressures	The Trust had experienced difficulties with filling vacancies within the department. The visit team requires an update on the numbers of staff and an action plan for covering the workload if recruitment is once again not successful.	Amber Mandatory

		on the department and trainees during this time were noticeable. The Trust confirmed that they have discussed the recruitment concerns with the London School of Clinical Oncology and operations recruitment team at Health Education North Central and East London. The Trust were looking at the possibility of making the middle grade post a training post which could increase the potential of applicants. The senior management team confirmed that there were nine clinical oncology and four medical oncology consultants in post. All posts were joint contracts with another Trust, University College London Hospital NHS Foundation Trust, Royal Free London NHS Foundation Trust or The Princess Alexandra Hospital NHS Trust. This was an added difficulty to the consultants, as they all had work commitments off-site. The new middle grade posts, once recruited to, would be based on the ward which would free up time for trainees to attend clinics and concentrate on their radiotherapy planning sessions. The department had one associate specialist who had their own practice and peripheral clinics. The College Tutor and Clinical Director confirmed that the workload was heavy within the department, however, if they had a full cohort of consultants and staff it would be manageable. It had been suggested that if the middle grade posts could not be filled, they would possibly submit a business case for consultant expansion. They would look to see if there was a need for a specialised consultant, but over the years the department had rolled back on certain tumour types as there were not enough cases to continue meaningful practices. The trainees stated that the Trust had been training physicians' assistants that were on two wards but there was uncertainty if they were yet easing the workload of trainees. The clinical and educational supervisors reported that the Trust had been advertising for two Trust grade doctors to be responsible for the ward, which would release trainees for other tasks and would prevent overload on planning and clinic attendance. There was a will from the Trust to fill the posts but the applicants had not been to the required calibre. The visit team heard that there were on-going discussions between the UCLPartners training programme director and the post graduate dean regarding the possibility of Trust funded trainee posts. The clinical and educational supervisors confirmed that the department had been looking at expanding nurse led chemotherapy clinics as there were not enough chemotherapy trained Clinical Nurse Specialists (CNS). The visit team heard that the department had trained Lung Cancer CNS which worked well in the department and had eased trainee workload.		

6	6.6	**Workload** The senior management team confirmed that the department had managed satisfactorily with the staffing levels and unit set up, until the closure of the emergency department at Chase Farm hospital. The Trust workload increased to a much higher amount than predicted and there was no plan in place to cover the heavy workload. The emergency medicine workload increased as a higher number of patients (currently and previously receiving treatment) were now being seen in just one emergency medicine department when previously, had been seen across the two centres. The trainees stated that there had been a period of time post local reconfigurations that they had noticed a distinct impact and increase in the workload at the Trust. The trainees reported at the time of the visit that this had now eased out and had been much more manageable. The trainees commented that the unit continued to be busy but there was a valuable caseload in the Trust which had good educational value. The trainees reported that there were twenty four patient beds on the oncology ward, and sometimes patients on the outlier wards in the podium or tower. The trainees indicated that if the Trust had an electronic patient record system it would greatly improve the workload of the department and the staffing activity. The trainees stated that there were times that they were completing tasks with no educational value. Phlebotomy services were requested by handwritten forms, which impacted on the workload of junior trainees.	The Trust was the only one in the sector to have not invested in an Electronic Patient Record (EPR) system. It is recommended that the Trust reviews the investment into an EPR to increase the potential of recruitment applicants to the Trust.	Green Recommendation
6	6.7	**Acute Oncology Service (AOS)** The senior management confirmed that clinical oncology trainees had at no point been asked to act as general medical doctors. There had been occasions when the admitting team in emergency department had referred a patient to clinical oncology but the patient was no longer actively receiving cancer treatment and so this was a confusion that was easily addressed. The acute oncology service since implemented had eased the acute workload for trainees. The acute oncology service had three consultants in post, and the possibility of expansion had been discussed within the Trust. The clinical directors reported that the core medicine trainees were holding the bleep for	There had been concerns raised with patient referrals of those admitted to the emergency department, and not actively being treated by the oncology department but still referring to the oncology team. An audit of oncology admissions is required, to ensure trainees do not have to provide inappropriate general medical care.	Amber Mandatory

		triage; they had commented they were not confident to hold the bleep which led to the specialty trainees volunteering to take the bleep. This then had a knock-on effect with the trainees planning sessions as they were pulled to the ward or emergency department. This was addressed with the setup of the acute oncology service, now responsible for the holding of the bleep. The lead chemotherapy nurse had held the bleep when there was no one from the AOS team available. It was decided at the last consultant meeting that the consultant responsible for the specialty ward round would hold the bleep for the day. The visit team heard that the AOS consisted of two medical oncologists and one clinical oncologist. The department was recruiting to acute oncology nursing staff and looking at developing in this area; these would be Clinical Nurse Specialists. They had not yet considered nurse consultants. The trainees reported that workload of the department had improved since the introduction of the AOS. The AOS strategy experienced delays in implementation but was now fully up and running. Unfortunately, the AOS rota consisted of only five staff. Some of the clinical supervisors commented that clinical oncology team consultants were used as general physicians, with an interest in oncology, and that the Trust did not appreciate the specialist nature of their roles. The visit team heard that patients referred from the Emergency Department were not all actively receiving treatment but would have had cancer at some point; it was thought that many patients should not be referred to oncology. Many of these patients fell onto the workload of the core and higher trainees. The clinical and educational supervisors stated that the Trust was slow at creating the AOS; the full complement of staff had only been in post since October 2014. It was a newly established team, and as such it would take a while to fully embed and develop pathways.		
6	6.8	**Local Teaching** The Clinical Lead and College Tutor stated that teaching was not bleep free. The trainees were informed at the induction to raise concerns to a consultant if they were being bleeped during teaching and it will be addressed. The trainees confirmed that teaching was not bleep free. During the course of the hour teaching they may be bleeped once or twice, and therefore it was not considered to be an issue, or particular disruptive.	The teaching within the department was not bleep free. The visit team requires the Trust to complete an audit of bleeps during the organised teaching with a look to become bleep free protected sessions.	Amber Mandatory

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		The trainees stated that there was academic teaching on Monday mornings, which was run by the senior trainees. Until 9.30am the teaching was usually undisturbed but after this, there would be many bleeps. The time was not ideal, but previous to this it was being held at lunchtime which created many more disturbances. There was a new peer review meeting being held on a Friday, but this had only started four weeks prior to the visit. The clinical and educational supervisors confirmed that there was dedicated teaching on a Monday morning and the newly established peer review had been a success. Trainees were mandated to attend these sessions.		
6	6.9	**Regional Training** The visit team heard that as the department had minimal numbers of trainees there were sometimes issues with releasing trainees to the regional training days. This had impacted on the clinical commitments of the department.	The visit team requires that the department reviews the process of releasing trainees to the regional teaching. The Trust was reminded that regional teaching was mandatory; takes place just three times per year and all departments should be releasing trainees.	Amber Mandatory
8	8.1	**Educational Resources** The Clinical Lead confirmed that the trainees had been allocated an office space with one computer; there was a plan for a further two. This was challenging to provide, but it was essential as the trainees had been using clinic offices for private study and were intermittently interrupted by staff which caused unnecessary disturbances. The Clinical Lead and College Tutor commented that the department was currently fourth in line to have the computers updated as part of the Trust upgrade system. The Clinical Lead and College Tutor confirmed that library access was discussed during the induction, as this had generated repeated red flags in the GMC National Trainee Survey. The trainees had all been to the library during the induction. There were discussions with the senior management for UCLH to take over the library services within the Trust. This should increase the access available to trainees. The trainees confirmed that they were aware of library resources. However, the senior trainees experienced issues with accessing journals. The journals available to trainees registered for Royal College of Radiologists exams were much better than those available to the Trust. Trainees stated that they had poor access to Athens, which is an online journal	The discussions between the Trust and UCLH regarding the takeover of the library services potentially had many benefits, as trainees reported that they experienced difficulties with accessing online journals and this could address this issue.	Green Recommendation

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		repository.			
Good Practice			**Contact**	**Brief for Sharing**	**Date**
N/A					
Other Actions (including actions to be taken by Health Education North Central and East London)					
Requirement			**Responsibility**		
N/A					

Information and reports provided to the team prior to the visit							
DME Annual Report	*No*	Regulator Reports/Data	*No*	LFG Reports	*No*	MEM minutes	*No*
GMC Survey - trainees	*Yes*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*Yes*		
PVQs - trainees	*Yes*	PVQs - trainers	*No*	Result of school survey	*No*		

Signed	
By the Lead Visitor on behalf of the Visiting Team:	Dr Gill Sadler /Dr Suzannah Mawdsley
Date:	8 June 2015