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Pan-London Quality and Regulation Unit

Imperial College Healthcare NHS Trust
Medical Oncology
Specialty Focused Visit

Quality Visit Report

3 November 2015

Final Report

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Visit Details	
Trust	Imperial College Healthcare NHS Trust
Date of visit	3 November 2015
Background to visit	Medical oncology was visited due to concerns raised in the GMC National Training Survey 2015. The specialty received numerous negative outliers in the recent survey, particularly in: overall satisfaction, clinical supervision, adequate experience, supportive environment, workload, access to educational resources and local teaching.
Visit summary and outcomes	The visit team met with the divisional director for medical education, the chief of service, and the unit training lead. The visit team then met with seven medical oncology trainees between specialty training (ST) years three – six. Finally the visit team met with eight of the clinical and educational supervisors in medical oncology across various jobs including gynaecology and breast. Trainees were very positive about the acute ward week that they were assigned to. This was shared with the clinical oncology trainees and was approximately a one in 20. The pre and post clinic briefings offered excellent service, education, and patient safety. These did not appear to be routinely followed in all clinics, and the department should implement pre and post clinic briefings for all clinics, for all tumour types as it appeared to be invaluable to the trainees that regularly attended. All the trainees were released for one day a week to attend the Institute of Cancer Research (ICR) Oncology Master's Degree qualification course. The trainees were all released every week without fail; they were expected and allowed to attend, with no issues made regarding attendance. The induction programme required a review and improvements. There was disparity between the standard of the induction received by different levels of trainees and those who started at other times outside the main changeover dates. The Trust should ensure that all trainees are allocated an educational supervisor, on inception to the Trust. There was one local faculty group (LFG) meeting for medical oncology, which occurred 10 days before the visit. The visit team would like to see the continuation of this practice with regular meetings with all levels of trainees and consultants involved. There appeared to be an isolated incident, where a trainee in the medical oncology breast job was unable to regularly attend the multi-disciplinary team meeting (MDT), which prevented full curriculum coverage. The visit team heard of potentially serious patient safety concerns, and the Trust was issued with two immediate mandatory requirements, with regards to the prescribing of chemotherapy and consultant supervision in clinics.

Visit team			
Lead Visitor	Dr Catherine Bryant, Deputy Head of London School of Medicine	**External Clinician**	Dr Sheena Mitchell, Director of Medical Education, The Whittington Hospital NHS Trust
Trust Liaison Dean	Dr Chandi Vellodi, Trust Liaison Dean	**External Clinician**	Dr Jackie Newby, Consultant Medical Oncologist, Royal Free London NHS Foundation Trust
Visit Officer	Michelle Turner, Quality and Primary Care Manager	**Lay Member**	Diane Moss, Lay Representative

Findings			
Ref	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**
GMC Theme 1) Learning environment and culture			
MO1.1	**Patient safety** The clinical and educational leads stated that trainees that had not been signed off for chemotherapy prescribing were fully supervised in clinics, and did not prescribe any chemotherapy until they were fully signed off by the chemotherapy lead consultant. The trainees confirmed that they had all had their competencies signed off for chemotherapy prescribing. The trainees reported that they had been able to prescribe chemotherapy as early as week one in ST3. The trainees indicated that until they were fully confident, they were not able to prescribe new chemotherapy to patients, but would be able to prescribe repeat chemotherapy. The trainees reported that clinics were not assigned specifically for chemotherapy; there were some clinics that had mixed patients. However, the gynaecology job had a good clinic model, with a chemotherapy clinic in the morning and a patient follow up clinic in the afternoon, which the trainees felt worked well. The trainees reported that there was a consultant who was responsible for the sign off of chemotherapy prescribing. The visit team heard of the training programme that trainees undertook prior to sign off, which consisted of a consultant explaining the prescribing protocols, training on Aria by a pharmacist and self-directed learning, reading the chemotherapy handbook which had 96 pages. When starting in post all trainees were trained how to use the Aria electronic system by the pharmacists, they were then issued passwords for the system, but this only enabled read only access. By the end of the first week in post, the trainees would meet with the chemotherapy consultant lead who would assess the trainee's knowledge on how to assess patients, toxicity and grading and then make a decision on the trainees' competencies. The trainees confirmed there was no workplace-based assessment (WPBAs) or formal assessment on chemotherapy prescribing prior to sign off. After sign off, they received an amended log in, which allowed them to fully prescribe chemotherapy. The visit team heard of trainees in only their second week as an ST3, attending clinics and re-prescribing chemotherapy and assessing if patients were fit for new courses of chemotherapy without having undertaken any WPBAs to assess their knowledge or competency. The visit team heard of one incident when a specialty trainee that had left the rotation had prescribed two weeks of chemotherapy to a patient, the new ST3 trainee without having chemotherapy training then signed off the prescription without a review of the patient. The visit	Trainees were being asked to prescribe chemotherapy to patients without having reviewed the patient (there are fellows reviewing patients but they are not able to prescribe). All chemotherapy patients reviewed by the fellow should have the prescription signed off by a consultant. Furthermore, trainees were being allowed to	**Red** Immediate Mandatory Requirement

	team heard of one trainee that had missed the main chemotherapy induction with the other cohort of trainees, and had learned the system and protocols from the pharmacists only and had been able to prescribe chemotherapy for two weeks before the chemotherapy lead signed the trainee off. The trainees reported that there were clinical fellows in some clinics (particularly breast clinics) who could document reviews but not prescribe chemotherapy onto the Aria system. The fellow would email a list of chemotherapy to the trainees for them to approve. The trainees rarely had the time to discuss the patients with the fellow, nor see the patient in person. The trainees stated that although this was not ideal, they implicitly trusted the experience and knowledge of the fellow. The clinical and educational supervisors reported that there was a formal process for chemotherapy prescribing. Consultants agreed prescriptions and toxicity of all new patients with trainees. The chemotherapy handbook included specific guidelines on prescribing and modifying toxicity levels. The clinical and educational supervisors confirmed that they did not regularly refer to the handbook with trainees but they discussed all modified prescriptions. The clinical and educational supervisors stated that chemotherapy was never administered on the same day that patients were reviewed or prescribed, this allowed for ample opportunity for trainees to discuss toxicity levels with consultants if they had concerns. They stated that all trainees had the opportunity to discuss patients and chemotherapy doses with a consultant, they would be unhappy to hear if any trainee did not do this. They commented that if there were discrepancies in the process they would put plans in place to address it, but they stated it was not a structural problem, and perhaps job plans needed adjusting. The clinical and educational supervisors reported that ST3 trainees were not allowed to approve dose changes or prescriptions until they were fully trained, and had attended clinics with consultant supervision. The visit team heard that all trainees must fully read the handbook and watch a video on prescribing before being signed off. The pharmacy always checked the blood results of patients. All new patients were reviewed by a consultant, and no new chemotherapy was prescribed without a consultant present. Trainees would review patients for repeat prescriptions but there was always a consultant available in the next clinic or by telephone. The clinical and educational supervisors stated that trained fellows attended clinics in Hammersmith Hospital but they were unable to fully prescribe. The fellows were shadowing clinics as part of their training but were unable to sign off or prescribe chemotherapy. The clinical and educational supervisors stated that it was a rare circumstance for trainees to prescribe chemotherapy for patients who had been seen by other staff. This had previously been a problem in the breast clinic but had been resolved. The fellow in the breast clinic had only been able to approve patients for 'Fit for Systemic Anti-cancer Therapies (SACT), the visit team heard that the fellow was undergoing chemotherapy training at the time of the visit and was about to be signed off. The visit team heard that the aim for the future was to have pharmacists in all clinics that will be responsible for oral prescriptions.	independently prescribe chemotherapy at a very early stage at ST3. National chemotherapy competency levels advise that it would normally take around a month, to move to this level of competence (level 3) and would only occur after workplace-based assessments (WPBAs) on the job, which do not appear to be formally taking place before being authorised. All trainees are required to have WPBAs on the job before being authorised to prescribe chemotherapy.	

M01.2	**Appropriate level of clinical supervision** The educational leads stated that the department had introduced a 'pre-meet' and 'post-meet' for all clinics in which each patient was discussed with the trainee, consultant and nurse. This had reduced the workload burden of the busy clinics because the nursing staff were able to start taking bloods, which ensured the patient was ready for consultant review. The sessions had allowed for trainees to take on greater responsibility to an appropriate level of training, which had empowered them. Every patient was reviewed prior to the clinics, which had been noted as an efficient way of prepping for the next week's clinic. The pre-clinic discussions, allowed decisions to be made regarding some patients being reviewed by only specialist nurses. Post-clinic reviews had been implemented, which looked ahead to the next clinic and what needed to be undertaken prior to the clinic. The team looked at clinic capacity and staff availability to ensure it was appropriate. The trainees reported that the consultant presence and clinical supervision at clinics was variable. The trainees stated that they did not always have consultant supervision in chemotherapy clinics. Some of the consultants had clashes in their timetables with multi-disciplinary team (MDT) meetings, which prohibited their attendance to clinics. One consultant had a clash of an MDT meeting on another site, which factoring in travel times meant they rarely arrived with more than 30 minutes before the end of clinic. The consultants corroborated that there had been issues previously with other clinical commitments impinging on clinic times but that timetables had been restructured to avoid this. The consultants also stated that even if late, consultants would attend and were still available to discuss all patients, if needed. The trainees confirmed that they were always able to telephone consultants for advice on patients, but they were not aware of formal consultant cover arrangements in place. Trainees that had been in the Trust for many years, stated that this had been allowed to run for several years. Many of the clinics now had a pre-meeting; this had been trialled at the breast job at Charing Cross Hospital and had worked really well. The trainees were pleased to hear that this was being rolled out across all of the specialty jobs. The trainees commented that annual leave applications were being accepted a lot later than they used to be, which resulted in clinics not being cancelled due to adequate staffing levels. It had been indicated to trainees that the strict eight week rule for leave requests was to be re-implemented to address the concerns of clinic cover. The clinical and educational supervisors reported that ST3 trainees did not attend clinics for the first week and then shadowed consultants in clinics for a period dependent on capabilities. They stated that it was an invaluable process in order for the trainees to fully understand how the clinics were run, and how patients were treated. The clinical and educational supervisors stated that at Charing Cross Hospital there was a pre-clinic meeting and briefing of patients. This had been normal practice at Hammersmith Hospital for over ten years as up to 40% of the patients were on clinical trial so the model was needed, and the good practice had been rolled out to both sites. There were two hours outside of clinic with the consultant, clinical nurse specialists (CNS) and trainee to discuss all cases and put	Clinics must always have consultant supervision or a named consultant supervisor for the clinic. There should not be a consultant clinic scheduled when a consultant is off site and if a consultant is on leave, clinics must be reduced and should remain reduced.	**Red** Immediate Mandatory Requirement

	plans in place for future clinics. The clinical and educational supervisors reported that there was always a named consultant in clinics or available for cover if needed. If the consultant was unavailable for any reason, the trainees could contact them by text message or telephone call. The trainees were never left unsupported. In addition to this, no clinics were run in isolation so there was always an experienced nurse or consultant in the proximity. The clinical and educational supervisors stated that all consultants reduced clinics when on leave; they would cut clinics to a maximum of eight patients per specialty trainee with a minimum of six weeks' notice. However, the administrative teams back filled some of the empty slots without notifying the specialty trainee or the consultant. The first they were aware on some occasions was at the clinic. This was an issue at the time of the visit, and the consultants were actively managing clinic lists on a weekly basis to ensure that cut clinics were not being increased.		
MO1.3	**Responsibilities for patient care appropriate for stage of education and training** The trainees, whom had been on the rotation for five or more years, stated that there had been many changes to the department, many processes were much more formal and there had been a definite improvement. The trainees stated that the gynaecology job was the hardest on the rotation, and the trainee timetable meant that this role was allocated to the first year trainee, ST3. The trainees suggested that as a group they should review the jobs in the department in order to make them more appropriate to the level of training. The trainees indicated that the job was good, and enabled the trainee to build confidence quickly but it was a mentally demanding and emotionally draining job and there was potential to make junior trainees feel demoralised in their first placement. It was suggested it would be better placed for a senior level trainee who would be able to manage the workload and the mentally demanding aspects of the role more sufficiently. The trainees reported that there was a disparity between jobs with some appearing to be much harder than the others. The rotation was 'sold' to trainees that the good and bad jobs alternated. The nature of oncology training was different to other specialties in that the posts were based on specific tumour types and therefore the ability to balance the workload across the trainees was limited. There were limited opportunities to leave work early, whereas other specialties had cross cover and trainees could leave on time.		
MO1.4	**Rotas** The educational and clinical leads reported that the ward module operated a consultant of the week model. A medical oncology and a clinical oncology trainee were on the on call rota, so there were two trainees available at weekends and out of hours. The week rota was shared by trainees in both specialties and they worked for the full week on the ward, alongside the consultant of the week. There was no distinction on the ward of who was responsible for which patients.		

	The trainees stated that they had minimal interaction with clinical oncology. Except for when they rotated on to the oncology ward for a week block which was alternated between the higher specialty trainees in each department. The ward had a medical oncology consultant of the week responsible for the care of patients and the out of hour's rota was supported by both a medical oncology and clinical oncology consultant. The trainees indicated that due to the number of trainees across both departments, the ward week was approximately a 1:20. They commented that they all enjoyed the ward week. They found the ward week to be a great opportunity for exposure to patients and to work alongside a consultant. The visit team heard that the trainees also enjoyed the experience of working with the junior and core trainee doctors. Unfortunately the structure of the service meant that it was difficult to work regularly with the core trainees, except when on the ward week and the trainees would welcome the opportunity to mentor and develop the core trainees more. The trainees stated that improvements to the post would be to have increased access to reviewing patients on the ward, and to build relationships with the staff in the department. Oncology trainees found themselves working in silos. From the core medicine trainee point of view it was good for them to have senior input from the specialty trainees on the ward, and for a specialty trainee point of view, regular meetings with consultants could be rolled out to build a strong support network. Some trainees had discussed the implementation of regular meetings with consultants, and this was potentially being rolled out for some jobs, the trainees felt this would develop their understanding of the topic and would improve their knowledge and skills over time.		
M01.5	**Induction** The clinical and educational leads stated the generic induction was difficult to carry out with different rotation dates. Many of the trainees that rotated into the department had been on the rotation for many years, and so were aware of the Trust and department. The feedback from these trainees was to have less of a formal induction and more on changes within the department, and information on clinical trials and prescribing. The visit team found that these areas of improvement had been addressed. New specialty trainees had a full induction on governance requirements, lectures, on call rota and prescribing. All trainees attended a thorough departmental induction. It was commented that some inductions were not as good as they could have been. The department was looking at ways of increasing the written guidance to trainees, to provide more comprehensive knowledge on prescribing, tumour types etc. The trainees reported that they did not all receive a thorough induction when they started in post; this was a particular concern for the trainees that started out of sync with the main rotation. The visit team heard that the ST3 trainees who had started in August 2015, had received information prior to starting in post, and felt well prepared. Trainees that had returned from leave (maternity or out of programme experience) had not been fully re-inducted to the Trust but, it was indicated that they felt prepared.	The induction programme requires review and improvements and must be made available to trainees starting out of sync. There was a disparity between the quality of the induction received by different stages of trainees. There must be a robust induction for all trainees regardless of when they start during the year.	**Amber** Mandatory Requirement
GMC Theme 2) Educational governance and leadership			

M02.1	**Effective, transparent and clearly understood educational governance systems and processes** The educational leads stated that the GMC National Training Survey highlighted concerns with the workload in the department which they were well aware of. The department was keen to reduce the impact of the heavy workload on trainees and trainers, which would possibly improve completion of audits, and attendance to governance meetings. This was a difficult issue to address as patient numbers were steadily increasing. The Trust received a lot of tertiary referrals from different sites. The department was constantly looking at resources and patients, with the aim to reduce the administrative burden on trainees. The educational and clinical leads stated that there were regular meetings throughout the year with the training programme director to discuss trainees, but there was no committee in place to discuss the whole rotation. The Trust had one consultant who had taken on the role of educational lead for the trainees. The consultant had regular meetings with the training programme director based at Chelsea and Westminster Hospital but there was no formal training programme management committee (TPMC) meeting structure with trainee representation and regular minuted meetings. The clinical and educational supervisors reported that there had been discussions in the department for the recruitment of associate specialists or senior fellows, to support the clinic service and increased workload. The vacancies were advertised on a continual basis. We also heard that trainees valued the skills and knowledge of clinical nurse specialists (CNS) and if they were absent this impacted negatively on their workload. The Trust reported that numbers of CNS had increased within the Trust but there were on going issues with recruitment and retention of staff.	The Trust is required to address the impact of workload on the training environment and consider the use of alternate workforce to support the department. Although the visit team heard that the department has had their first LFG meeting the week prior to the visit, the department must implement an effective local faculty group meeting with trainee reps, in which issues impacting on training such as the workload issue and training opportunities available within the rotation can be discussed and resolved.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement
M02.2	**Impact of service design on learners** The educational leads stated that there had been changes to staff within the department over the years, and it was identified that there was no allocated person for trainees to discuss concerns with, this resulted in the local education and training lead being appointed in December 2014. The trainees reported that the change in leadership had not been communicated to staff. The trainees were unaware of the new appointment to the local education and training lead for the department until they attended the annual review of competence progression (ARCP) and were informed by the panel. The trainees reported that there had been a loss of Clinical Nurse Specialists (CNS) and consultants within the department, which had detrimentally affected workload. The department found it particularly difficult to recruit to upper gastrointestinal (GI) CNS. The department actively trained band five nurses to become band six, but this meant that the nurses would leave the Trust to go to other jobs and the department had vacancies. Rolling recruitment to the band five posts for haematology, urology and GI. They indicated that the firms without a CNS did have an increased workload, and the teams which had CNS were great for service and education. All		

	tumour groups had CNS, gynaecology had three CNS. The trainees at Hammersmith Hospital stated that there was limited administrative support, which left the trainees with a heavy burden of tasks with limited educational value. They would spend excessive amounts of time calling patients, booking beds on the ward, liaising with other hospitals. The trainees stated that at Hammersmith Hospital there was a pre-clinic meeting the week prior to a clinic. This had been the case for many years in the ovarian clinic. It was the only way to ensure the clinic ran to time and to ensure all patients were contacted. The clinical and educational supervisors stated that there had been a 20-25% increase in the CNS posts over 18 months but many vacancies. .		
MO2.3	**Appropriate system for raising concerns about education and training within the organisation** The educational and clinical leads stated that the first local faculty group (LFG) was held ten days prior to the visit. The trainees reported that they had been invited to two departmental meetings, that may have been LFGs but they did not appear to be an open fora for discussion or for trainees to raise concerns. They felt it had been a management meeting that passed on information regarding Trust or departmental changes. The clinical and educational supervisors reported that within the department there were regular management meetings and monthly grand rounds to which all trainees were invited by email. The clinical and educational supervisors stated that they encouraged participation in quality improvement projects and audits. The department planned to send a list of possible audits to all trainees, to encourage pro-activeness in completion of audits. The Trust offered a link scheme in where a trainee could work in conjunction with a manager on a service development project.	The Trust is required to continue the LFGs and demonstrate continuing practice through the minutes and register. The Trust is required to ensure that all trainees are aware of clinical governance meetings and M&M meetings and are encouraged to attend as part of their training.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement
MO2.4	**Organisation to ensure access to a named educational supervisor** The educational leads reported that all trainees were allocated an educational supervisor, as well as a consultant for the relevant tumour group. The trainee was able to call a consultant when in need of advice. The trainees stated that they had all been allocated a clinical supervisor, but there was confusion with regards to the allocation of an educational supervisor. The visit team heard of incidences when trainees had not been officially allocated an educational supervisor, but had been able to raise concerns to a consultant who they considered to be their mentor. The educational supervisors stated that trainees had meetings at the start of the rotation to discuss what they wanted to achieve, then formal meetings at the midway point and end of rotation. Furthermore, there were regular informal meetings.	All trainees should all be aware of, and be allocated an educational supervisor who has the requisite GMC trainer accreditation. This should occur within two weeks of starting their post.	**Amber** Mandatory Requirement
MO2.5	**Systems and processes to identify, support and manage learners when there are concerns**		

	The trainees reported that they had opportunities to present cases at the morbidity and mortality (M&M) meetings. Learning from clinical incidents was encouraged. Trainees had received mixed levels of feedback following the reporting of a clinical incident. The specialty trainees who had been in post for longer periods regularly received emails regarding initiatives and meetings within the department, but the newer trainees, particularly ST3s were unaware of such opportunities. The educational and clinical supervisors reported that they had an email distribution list for the department and this was updated regularly. All current trainees on the rotation were included in emails and invited to departmental meetings. It was clarified more recently, that the academic trainees were not on the email list and this was updated to ensure they can attend all meetings.		
GMC Theme 3) Supporting learners			
MO3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The trainees confirmed that they had generally all developed relationships with consultants who they could turn to for pastoral care if required.		
MO3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The clinical and educational leads reported that the professional support unit of the London local education training boards (LETBs) had been working to address the trust-wide concerns with behaviours. This was not highlighted as a specific area of concern for medical oncology but it was for clinical oncology, and as negative behaviours often manifested from high workload it was felt that medical oncology should also be involved. The trainees stated that they did not feel bullied or undermined. However, the trainees reported that they had experienced less than positive communications due to pressures on the service but they did not take this personally, as trainees felt it was not intended to be belittling. New structures had been implemented, and LFGs had been developed as well as grand rounds and faculty meetings. It was felt to be a beneficial exercise and could appropriately address concerns.		
MO3.3	**Academic opportunities** The trainees stated that they all had the opportunity to join the two-year master's degree (MA) qualification course which was self-funded. Trainees had all received study leave for one day per week which was in excess of their study leave allowance. The visit team heard that the trainees had experienced difficulties with learning the oncology job, as well as attending the academic course, particularly for trainees in their first year. It was suggested by the trainees, that future trainees may benefit from attending the MA from their second year in training. The course was good for morale of trainees and personal and		

	professional development, but the trainees would often stay at work later to finish tasks as they felt they had limited time due to only four days in the Trust.		
MO3.4	**Regular, constructive and meaningful feedback** The trainees indicated that constructive criticism was minimal in the department. They felt that the benefits of regular feedback would be paramount to progression in the specialty, but it was limited if available at all.		
GMC Theme 4) Supporting educators			
MO4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The educational and clinical leads stated that there was a requirement to update training for the trainers. The educational and clinical leads stated that there were three trained educational supervisors but by the end of November 2015 all ten consultants would be fully trained and up to date as educational supervisors. The trainers stated that they were all clinical supervisors and a number were educational supervisors. The educational and clinical supervisors stated that they had all received training for their role as trainers. Those who were due to update their training were booked for sessions over the coming months. They confirmed that they felt supported by the Trust to complete the GMC mandated training for trainers.	The Trust is required to provide evidence that all trainers within the department have been completed all of the GMC mandated training for trainers.	**Amber** Mandatory Requirement
MO4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The educational and clinical leads stated that all consultants had time in their job plans, for programme activities (PAs). The educational and clinical supervisors stated that they all had recognised time in job plans for their roles. However, this was not specifically allocated into timetables and the distribution and allocation of time for educational tasks was a challenge. The consultants took an integrated approach to service and training. The implementation of the pre and post clinic discussions enabled trainers to add an educational focus, which was often lacking due to the heavy clinical workload.		
GMC Theme 5) Developing and implementing curricula and assessments			
MO5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The trainees reported that there were no medical oncology inpatients at the Hammersmith Hospital (Charing Cross Hospital had the ward referred to previously) and so their training was based in clinics. The trainees reported that the department had a heavy workload. Trainees often		

	felt that they had to cover clinical commitments and there were missed learning opportunities because of this. The trainees stated that most of the multi-disciplinary team meetings (MDT) were held at 8am, so trainees could attend in their own time. Many trainees had attended regular MDT meetings and found them to be excellent. However, the visit team heard of one example of a clash with the MDT and breast clinic which restricted the trainee attending the MDT (having only attended four in six months) and they had to cover the clinical commitments of the role and manage the clinic without consultant supervision. The clinic was attended by many palliative patients. This appeared to be an isolated case, as many of the other timetables had been amended to remove any potential clashes. The visit team heard that some jobs were particularly administrative heavy. The department was looking at various strategies to improve the balance of the workload, and envisaged going forwards that there would be more nurse led clinics. The educational and clinical supervisors reported that there appeared to be mixed views within the department by trainees regarding satisfaction of posts. The heavy workload affected many trainees. The visit tam heard that there had been a review of the overbooked clinics and with a process to change the focus to decrease the workload. There had been ongoing problems as trainees had chosen to complete their administrative work rather than attend MDT meetings which were a missed opportunity.	For Medical oncology training, attendance at the relevant tumour type specific MDT is an essential component of training in that tumour type and must be prioritised within trainee timetables. The Trust is required to ensure trainee attendance at the relevant tumour type specific MDT meetings. The Trust is required to provide an update regarding the implementation of nurse led clinics. This must be accompanied by an audit of trainee clinic workload and how this affects trainees' ability to attend training opportunities.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement
MO5.2	**An educational induction to make sure learners understand their curriculum and how their post or clinical placement fits within the programme** The trainees reported that although they all received a written handbook regarding the specialty. It would have been useful for the trainees who had not seen specific tumour groups (i.e. gestational trophoblastic disease) previously, to receive a lecture at the start of the rotation explaining in more detail the pathway and treatments available for these patients. The trainees stated that the implementation of this would be lifesaving, although they did confirm that patient safety had not been adversely affected without specific training being provided.	The Trust is required to provide oncology site-specific information at induction.	**Amber** Mandatory Requirement
MO5.3	**Opportunities for interprofessional multidisciplinary working** The educational and clinical leads stated that there was regularly run joint grand rounds and audit meetings within clinical oncology. The visit team heard that the leads from each department were putting together a joint educational programme for trainees across both specialties. The trainees reported that there was no combined teaching for the trainees in clinical oncology and medical oncology. They were aware of plans in place to instigate combined teaching where suitable for the curriculum. The trainees stated that they were made aware of joint grand rounds taking place in oncology, but the trainees who had started more recently (2014-2015) did not appear to be on the department mailing list, and so were not notified of certain events within the department. The management had informed trainees that a joint quality and safety meeting was being set up.	The Trust is required to provide evidence that demonstrates that there is combined teaching for clinical and medical oncology trainees and that all trainees are on the mailing list so that learning events can be communicated to all.	**Amber** Mandatory Requirement

MO5.4	**Appropriate balance between providing services and accessing educational and training opportunities** The educational and clinical leads stated that at the time of the visit there was no departmental teaching. However, the trainees all attended a self-funded MA course, which provided sufficient learning. The educational and clinical leads reported that local teaching was being set up for Wednesday afternoons, which appeared to be the most convenient time for all trainees and consultants. The teaching would encompass the grand round once a month, a monthly joint meeting with clinical oncology and the remaining two weeks of the month would be consultant bedside teaching. This would be protected time as the only clinic which ran at this time finished by 3.30pm. One of the specialty trainees would hold the bleep each week, so the responsibility would be spread throughout the department to minimise disturbance. The trainees commented that there was no official local teaching due to trainees attending the MA course. The trainees indicated that they were aware of colleagues in other trusts which offered local teaching alongside attendance to the master's course. The trainees reported that they received minimal learning directly from consultants; the majority of what they had learnt from tumour sites was from their teaching for the MA. The trainees were aware of the implementation of a weekly teaching timetable which would include joint grand rounds with clinical oncology. The visit team heard that the time slot for the new teaching timetable unfortunately clashed with a clinic at the Hammersmith Hospital. The consultant of the clinic had been informed that trainees were to be released for the teaching. The visit team heard of the disappointment this had caused the trainees as this was a particularly excellent training clinic and with the time it would take to travel between the sites, it was a significant loss to their educational experience. The visit team heard that this particular clinic would routinely finish between 5-7pm.	The Trust is required to provide dial in facilities at Hammersmith Hospital, in order to maximise the time the trainees would have in the clinic and ensure updated email list to all trainees to ensure they are aware of teaching.	**Amber** Mandatory Requirement

Good Practice	**Contact**	**Brief for Sharing**	**Date**
N/A			

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
The Lead Provider is required to set up regular TPMC meetings.	Prof. David Cunningham – Lead Provider

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Catherine Bryant*

Date:	*8 December 2015*