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Health Education England

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Pan-London Quality and Regulation Unit

The Royal Marsden NHS Foundation Trust
Clinical Oncology
Conversation of Concern

Quality Visit Report

14 December 2015

Final Report

THE NHS CONSTITUTION
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Visit Details	
Trust	The Royal Marsden NHS Foundation Trust
Specialty	Clinical Oncology
Date of visit	14 December 2015
Background to visit	There had been concerns regarding the training environment of the clinical oncology department for three years with intransigent issues resulting in triple red outliers in the General Medical Council National Training Survey (GMC NTS) since 2013. The Trust had been visited on regular occasions to address the issues but there had been little progress made. The Conversation of Concern (CoC) was triggered as a result of a report by the Education Team Development Service (ETDS) following a meeting with clinical oncology trainees. Prior to the CoC the GMC placed the clinical oncology department under enhanced monitoring in December 2015. At the CoC the ETDS report was confirmed by the trainees the visit team met with, as an accurate representation of the views of the trainees and endorsed the notion that progress had not been made to improve the training environment. The report highlighted a lack of systems for identifying and supporting struggling trainees, an exceptionally high workload that was exacerbated by a high volume of private patient care which trainees were expected to undertake. There was also a lack of teaching and informal feedback by consultants, which did not optimise the obvious training opportunities in the institution. The visit team needed to assess whether the internal report had catalysed any sustainable change that could support trainees.
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit and for all the well-attended sessions. The visit team met with the senior management team, the college tutor, and clinical lead for clinical oncology, the clinical and educational supervisors and the clinical oncology trainees. There were fifteen trainees from specialty training grades three (ST3) to seven (ST7). The visit team was reassured by the changes made by the Trust in light of the ETDS report and the improvements this had made to the majority of trainees. The visit team was equally reassured to hear that because of these changes, the trainees had started to feel valued by the consultant body and in the main trainees had begun to optimise the training opportunities at the Trust. It was however, unfortunate that the trainees reported that they still did not feel valued by the Trust and the visiting team fed back to the Trust senior management team that they should work to amend the trainees' perception. During the weeks before the visit, the consultant body had realised that their inert attitude towards training had been a detrimental factor to both training and education. The visit team was pleased to find that the consultants were now aware that by increased engagement with the trainees they were part of the solution. The newly revised one- on-one consultant time with trainees was hugely appreciated by the trainees and ensured that most trainees would now recommend the Trust for training. There was an agreed sense across the visit team of a climate of change but it was not yet clear whether these changes would be sustainable. At the time of the visit, there was a large compliment of trainees so rota gaps were relatively few. However, when the visit team considered the trainee numbers in the system moving forward into 2016, it was likely that more rota gaps would occur and the visit team were concerned that the improvements that had been made would not be sustainable if further significant gaps in the trainee workforce occurred. In addition, concerns were also raised regarding the gaps across the wider workforce including administrative support, radiographers, and clinical nurse specialists (CNS) because the visit team found this support was based on an expedient, of bank and agency staff. The visit team heard of the Trust's intention to ameliorate the trainees' workload but there was little robust implementation other than the stated plans. The visit team recommended the use of developing advanced multi-professional roles because of the significant impact this would have on the Trust's capacity to offer postgraduate medical education and training. This could be achieved by accessing the wider professional development services, the Professional Support Unit (PSU) and the multi-professional faculty development services through Health Education England.

	The visit team issued two immediate mandatory requirements (IMR) regarding the continued role of trainees in delivering private care, which was to cease immediately unless identified by the patient's consultant as an educational opportunity. The second IMR involved trainees undertaking unsupervised second opinions of new patients that also needed to cease immediately.

Visit team			
Lead Visitor	Dr Julia Whiteman, Postgraduate Dean, Health Education North West London	**GMC Representative**	Dr Rosie Lusznat, Associate Dean for Post-graduate Medical Education, Health Education Wessex
Head of School	Dr Suzannah Mawdsley, Head of the London School of Clinical Oncology	**GMC Representative**	Alexandra Blohm, Education Quality Assurance Programme Manager
Lay Member	Catherine Walker, Lay Representative	**Healthcare Professions Representative**	Dr Catherine O'Keeffe, Dean for Healthcare Professions, Health Education North West London
Visit Officer	Lizzie Cannon, Quality and Visits Officer		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
GMC Theme 1) Learning environment and culture			
1.1	**Patient safety** At the Clinical Oncology Specialty Focused Visit on 13 February 2015, a patient safety concern was identified with kilo-voltage (KV) imaging being used for spinal cord compressions on the weekend, instead of computed tomography simulation (CT sim). The college tutor stated that after this visit in February 2015 the issue was incorporated into a quality improvement project that focused on a phased implementation of clinical mark up with portal imaging over a six-month period. This involved a voluntary weekend rota for the radiographers, which incorporated radiographers working on both sites. The visit team heard that this protocol for spinal cord compressions at the weekends had been tested over the weekends starting in October 2015, which demonstrated that the protocol was successfully embedded and provided CT sim for spinal cord compressions. The senior management team also confirmed that the new induction policy, which was in the process of being formalised, included the provision for trainees to be fully competent to provide spinal cord compressions via CT sim but that if necessary, consultants were available and	The Trust is required to provide the new induction policy for comment.	Mandatory Requirement

	accessible.		
1.2	**Serious incidents and professional duty of candour** The trainees stated that they knew how to submit a serious incident form but felt they had no remit to do so. The visit team was concerned to hear this and the implication that incident reporting by trainees was not encouraged by the Trust.	The Trust is required to clarify and formalise the process of raising and submitting serious incidents to trainees, ensuring that trainees feel empowered to do so.	Mandatory requirement
1.3	**Appropriate level of clinical supervision** The college tutor stated that the number of clinics the trainees undertook had been reduced to four consultant-supervised clinics in line with trainee feedback. However, the visit team heard that trainees were still attending approximately five to six clinics per week, with variable clinical supervision levels that were not tailored to the competency of the trainees. The visit team heard that the clinics were running at capacity and had the propensity to overrun. This was exacerbated by the fact that there were no pre-clinic meetings for some consultants and trainees to run through the list together and that clinics were not cancelled if the consultant was absent. The trainees stated that it was common for trainees to be left to see new patients without consultant supervision and these could be new patients who needed a second opinion. The visit team was very concerned to hear this as it not only constituted a patient safety concern but trainees stated it made them feel quite uncomfortable. The visit team issued an immediate mandatory requirement.	The Trust is required to monitor the number of clinics trainees attend each week to ensure that the agreed limit of 4 clinics is not being breached. The Trust is required to provide appropriate clinical supervision in clinics dependent on the trainees' level of competence. The Trust is required to ensure that no trainee gives second opinions in any setting.	Mandatory requirement Mandatory Requirement Immediate Mandatory Requirement
1.4	**Rotas** The visit team heard that there had been a diary card exercise in late November 2015 but not all trainees had been contacted, but the trainees had been asked to explain the reasons for staying over the rostered hours. The trainees also stated that they had received no feedback, at the time of the visit. The senior management team stated that to ease the number of zero days the trainees had to take to ensure the rotas were compliant with the European Working Time Directive (EWTD) the Trust had appointed two trust-grade doctors. However, the appointments had not yet started because of being non-European Union graduates and the Trust were waiting for the GMC to approve the paperwork. The Trust also stated that there had been an external charity funded post that was offered to the clinical oncology department but that this was still in progress and funding had not been confirmed. The college tutor confirmed the two trust-grade posts and stated that the Trust was looking to train up trainees who wanted to become trust-grade doctors too. The trainees stated that when on zero days the Trust hired a locum who the trainees knew had been 'forced to tears' because of the high workload and did not receive the administration support necessary. The visit team was concerned that although the trainees' workload had been reduced	The Trust must provide feedback to trainees about all diary card exercises they complete. The Trust is required to ensure that trainees' rotas continue to be EWTD compliant but without the resource of zero days.	Mandatory requirement

	the causes of a high workload had not been solved and instead the symptoms had been moved for the trainees onto locums. This could also have possible implications for the retention of future staff, which could then affect the trainees' workload in the future. The trainees corroborated this view point stating that there was always a constant volume of work to be done which unless the Trust fully supported the implementation of more staff the positive changes that had occurred after the internal meeting in November 2015 would not be sustainable. The college tutor stated that there were ongoing meetings with the senior management to review staffing issues and to analyse whether gaps could be pre-empted allowing human resources to be mobilised faster. The visit team can report that there was palpable scepticism amongst the trainees regarding how sustainable the changes made after the ETDS report in November 2015 would be, especially regarding the rotas. The trainees stated that the rotas were very fragile, because of the lack of trust-grade doctors and job shares not being filled. This had been felt acutely by trainees in the last rotation but the current rotation had improved although the workload was still very high, there were limited people who could cover the gaps in the rota and some job shares will still empty. The trainees stated that there was a culture of acceptance regarding the workload and that staff persevered as everyone, including the consultants were very busy. The trainees stated that because of this they did not feel able to speak out if they were struggling with the high workload. This culture could also permeate to managers where it was reported that a trainee had not been allowed leave due to a sudden family emergency. The trainee was told that it was the responsibility of the trainee to find cover through a swap. However, other trainees stated that acquiring annual or compassionate leave was not difficult.		
1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The senior management team stated that the private patient arm of the Trust was growing quickly and was predominantly affecting the Fulham Road site. As a result the staffing model for private patients would have to be remodelled, which, it was stated, would plan to decrease trainee input into the care of private patients. The visit team heard that the resident medical officer (RMO) model already existed for medical oncology and worked across both sites for private patients. This was not the case for clinical oncology but the CEO stated that there was an agreement to invest in RMOs for clinical oncology in April 2016. The consultants confirmed that there had been a change in the management's attitude who had realised that a commitment to appointing to RMO roles for clinical oncology was a necessity. The visit team heard from the senior management team that the Trust was looking at a wider organisational approach to ensure that clinical oncology trainees do not undertake inappropriate roles; this included medical physicists, radiographers, and clinical nurse specialists (CNS). The senior management stated that the Trust was in the process of training up two advanced radiography practitioners, which was a yearlong course; this meant a lag time for direct results, but two job share posts, equivalent to one whole time equivalent post, were to complete in		

	January 2016. The senior management team stated however that the use of CNS had been slightly remiss because CNS tended towards early diagnosis and surgery, not radiotherapy. However, the Trust was working to encourage more CNS into radiotherapy. The visit team heard that it was the intention of the Trust to build upon these numbers and the Trust had made a bid to Health Education North West London. The consultants reported to the visit team that there would be a need to invest in the wider workforce to support the workload of consultants, trust-grade, and trainee doctors, to ensure that the changes made could be sustainable. The senior management team stated that as of 1 December 2015, the consultants, not the trainees, were the primary contact for private patients and the trainees were not undertaking radiotherapy planning for private patients. The visit team heard that the new induction pack included the updated protocols on trainees' involvement with private patients. The college tutor and clinical lead confirmed that the trainees were not undertaking radiotherapy planning or contouring and the associated administration, except for emails. This was to be carried out by the consultants and the private patient administration team. This might have been true for some areas of clinical oncology, but trainees, especially in head and neck, still carried out radiotherapy planning on the Fulham site. The college tutor and clinical lead stated that trainees could still be responsible for some of the care of private patients who did not have a general practitioner while undergoing treatment at the Trust. However, the department was working with the RMOs in medical oncology to alleviate the trainees' workload in ambulatory care. The visit team similarly heard that the trainees were still expected to undertake the care of private patients in emergencies, but trainees were no longer called to the medical day unit. The trainees stated that there was a reasonable expectation to see some private in-patients because of the high number of private patients on the Fulham site and if the trainees were on-call. The trainees confirmed that there had been a significant decrease of trainee involvement with private out-patients. The college tutor stated that the intent was that gradually trainee involvement with private patients would be reduced over approximately a six-month period. It was reported that the timescale was dependent on how quickly the Trust could appoint a good standard of trust-grade doctors, so that the quality of patients' care was maintained. The visit team also heard that this was an activity in cultural change, especially regarding the consultants who were beginning to appreciate that the trainees' role was not to deliver care to private patients. The visit team heard from the consultants that they had not been aware of just how much work the trainees had been undertaking for private patients but the consultants felt confident that with the better feedback channels the amount of private patient work for trainees would be minimised. The visit team heard that the consultants and trainees had received an email clarifying that trainees were not expected to care for private patients. However, the reaction from the consultants had been variable with some confirming to the trainees that they did not have to see private patients. The visit team heard from the trainees that there were some excellent training cases form private patients that the consultants liked the trainees to be involved in. The CEO stated that the Trust had produced a draft policy for the role of trainees regarding	The Trust is required to ensure that trainees are not involved in any routine private patient activity unless there is a clear educational benefit; this includes the cover for inpatients. The educational benefit needs to be identified and agreed by the patient's consultant.	Immediate Mandatory Requirement

	private patients, the business conduct policy which had been circulated to the consultant for comment before it was to be released to the trainees and published on the website. The visit team heard that the Trust had approved two band four positions, which at the time of the visit were filled with bank staff. These administrative posts were responsible for the scheduling and booking of radiotherapy appointments. This had helped to reduce some of the administrative workload for the trainees. The college tutor confirmed this and added that the intention was to set up an administration hub, which trainees could access across both sites. It was reported that the Trust was investing in a 24-hour helpline for April 2016, which would involve a senior nurse taking queries form the public and would ease the workload that had commonly fallen on the trainees. The trainees indicated that since the internal meeting in November 2015 trainees were receiving a lot less phone calls because the superintendent was triaging patients and sending patients through to the consultants. The trainees stated that they felt empowered to inform the switchboard that the first contact for a private patient would be the consultant. The college tutor and clinical lead for clinical oncology stated that they had engaged with the trainees to address the workload issues and gain feedback on the training experience. This had been used for organ at risk voluming. The visit team heard that medical dosimetrists had been appointed to the Sutton site, although this post would have cross site responsibility, to alleviate the workload of the organs at risk voluming, which adds little to radiotherapy training. However, trainees on the Fulham site stated there was no such person, but there was an action plan open to recruit someone. Trainees at the Sutton site confirmed that an agency staff member had been employed to alleviate the organs at risk workload on trainees. The visit team heard that the trainees had concerns that if the Trust could not employ an equally high standard permanent staff member then this would not be a sustainable change. The visit team heard that the Trust anticipated that one whole time equivalent dosimetrist would be established at each site in 2016. The college tutor stated that the number of specific tumour groups trainees had previously been expected to cover in the six-month post had not been feasible and was detrimental to trainees' training and educational experience. The visit team heard that trainees were now supposed to cover two tumour sites per six-month post, with four consultant-supervised clinics per week. The visit team heard that on average trainees were still attending at least five clinics per week.	The Trust is required to provide the business conduct policy.	Mandatory Requirement
1.6	**Protected time for learning and organised educational sessions** The college tutor stated that the department had reviewed the consultants' job plans with a focus on ensuring that trainees were able to have three hours of supervision with consultants, this could		

	be one hour per consultant in a firm or three hours per week with the same consultant. The college tutor stated that this was effective in most consultants' job plans and that by January 2016 this would be the normal process. The trainees confirmed that the trainee timetables and consultant job plans had been synchronised to ensure three hours of specified training time. However, the trainees in head and neck had not yet been allocated time, because the consultant was on annual leave. The trainees were unsure as to whether this was sustainable because a consultant had been on annual leave and no alternative arrangements had been made to ensure that the trainees still received the one to one training. The visit team heard that the consultants had lost the concept of training but the visit team was pleased to hear that the majority of consultants were now engaged and enjoyed training the trainees. The consultants stated that it had taken time for them to realise that the trainees wanted and appreciated the consultants' time to optimise the training experience. The college tutor stated that the new job plans, which identified time for one to one training time with the trainees, had solidified the cultural change towards increased consultant-trainee contact time. The visit team was pleased to hear that after the internal report in November 2015 the change to training was immediate. The trainees stated that those consultants who had not been overly supportive or engaged in training before had made a concerted effort to change the daily routine to incorporate training. The trainees stated that they really appreciated and valued the one on one time where they would review radiotherapy plans with the consultants. The visit team heard that the majority of trainees would now recommend the posts, because of the learning now available because of increased contact time with the consultants.		
GMC Theme 2) Educational governance and leadership			
2.1	**Systems and processes to identify, support and manage learners when there are concerns** The senior management team stated that the first conduit for trainees who needed or wanted more support was the trainee's educational supervisor; this could then be escalated to the college tutor. The senior management team also stated that the director of medical education could be involved to look at the trainee's issue and identify whether it is a personal, clinical or Trust issue and address accordingly. The college tutor confirmed that it was the role of the educational supervisor to highlight any issues trainees may be experiencing. However, the college tutor stated that this had not always been particularly effective and was trying to ensure that the department was supportive and approachable for the trainees, with the increased engagement of trainees. The visit team heard that the college tutor had met with all of the trainees individually and the trainees stated that the college tutor was very good and approachable. The trainees reported that not all of the consultants were approachable but assured the visit team the educational supervisors were accessible and there was always someone trainees could access for support. The chief executive officer (CEO) stated that there was an opportunity for trainees to feedback on their training to the board at the training risk committee. The visit team also heard from the senior		

	management meeting that there were also Schwarz Rounds and a junior doctor forum for trainees. However, the visit team heard from the college tutor and clinical lead that trainees can sometimes find the junior trainee forum quite intimidating. The visit team heard from the trainees that there was certainly a culture at the Trust that impeded trainees asking for help because trainees were expected to already have a very high level of knowledge, which was not always a realistic expectation. The chief of nursing also stated that there had been a Trust investment in staff support counsellors who were external to all staff and worked across both the Fulham and Sutton site.		
GMC Theme 3) Supporting learners			
3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees articulated a feeling of being valued by the consultants, but this had not permeated through to the Trust as a whole. The trainees stated that there was a perception of different rules for the consultants compared to the trainees regarding annual leave. Multiple consultants were allowed annual leave simultaneously leaving trainees unsupported and still undertaking clinics. The trainees also felt undervalued by the Trust because of the lack of facilities the trainees had and the Sutton site especially was stated to have inadequate spaces for trainees. There was no bullying behaviour identified by the trainees but it was reported that the manner of teaching through the audit meeting could be slightly undermining as trainees could be highlighted for a lack of knowledge in front of junior colleagues. However, trainees stated that this was just the method of teaching for consultants and it was not deliberately meant to be undermining. The trainees stated that one of the reasons why the teaching had improved was because the trainees were more senior and knew more in comparison to a year ago.		
3.2	**Access to study leave** The senior management team stated that study leave was given to trainees who identified an educational opportunity, had discussed this with the educational supervisors and then applied. The trainees would normally be able to attend if there was internal cross covering or a locum to back fill the position. It was reported that the standard protocol was an internal swap because finding locums in clinical oncology was usually difficult. The trainees stated that access to study leave was variable depending on the consultants, with some trainees being denied study leave. The visit team heard from the trainees that study leave was used for the Institute of Cancer Research's (ICR) masters' course for ST3-ST5 trainees and study leave for additional reasons was almost frowned upon. Many of the trainees stated that because there was such a high workload trainees had not asked for study leave.	The Trust must ensure access to study leave is fair and consistent for all trainees	Mandatory requirement
GMC Theme 4) Supporting educators			
4.1	**Access to appropriately funded professional development, training and an appraisal for**		

	educators The visit team heard that the consultants had appreciated the director of medical education's support regarding the training for trainers as the consultants stated that not all were natural trainers and needed development. The visit team was pleased to hear that there was an external medical education lead for clinical oncology to develop the trainers and assist in pastoral support.		
4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The educational and clinical supervisors stated that historically the Trust had not understood how clinical oncology worked and how this translated into a job plan. However, the consultants stated that the Trust had become more engaged and the consultants now had a template job plan, which contained ten programmed activities (PAs) which included PAs for educational responsibilities. The consultants also stated that the Trust had supported the increased numbers of consultants with an additional five in three years. The consultants stated that there was a process of translating the original consultant job plans on to the new template and then uploading onto the software 'Circadian' that would highlight any discrepancies in the consultants' job plans. However, this had had been delayed as the software did not have the relevant infrastructure for clinical oncology job plans as clinical oncology jobs had become more complex.	The Trust must ensure appropriate time for training is factored into all consultant job plans where the consultant has teaching and supervisory responsibilities.	Mandatory requirement
4.3	**Access to appropriate resources** The senior management team stated that the Trust had recently invested in the software 'Up To Date' that could be accessed at home, on mobile devices and the Trust's intranet. The senior management team recognised that the information technology (IT) system was not as efficient as it could be and that there was an action plan to review the IT system. The senior management team also stated that there was access to journals via the ICR. The visit team heard from the college tutor that there had been an investment in desks, printers, scanners and phones, which were all allocated close to the higher trainee offices and clinical areas, which would be ready by January 2016.		

Good Practice	Contact	Brief for Sharing	Date

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

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Julia Whiteman*
Date:	*11 January 2016*