QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

The Royal Marsden NHS Foundation Trust
Clinical Oncology
Risk-based Review (on-site visit)

Quality Review report

Date: 19 July 2016
Final Report

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Quality Review details

Background to review	Clinical Oncology at the Trust was last visited as part of a conversation of concern in December 2015. At the visit the Trust was issued with two immediate mandatory requirements. The Trust had had a large number of red flags in the GMC National Training Survey since 2014. In the recent 2016 results the Trust had red outliers in 'supportive environment', 'work load' and 'local teaching', there was five pink outliers. The visit team was keen to explore areas within the department surrounding workload and the planned increase use of allied health professionals, access to acute oncology services and administrative tasks. The visit team was also keen to review the following: • To ensure that trainees were not reviewing private patients unless supervised and this was of educational value. • The impact of the split-site working and the team-based structure and the impact of the Trust not having a full complement of trainees. • The formal process in which care of patients were handed over and if patients were lost or misplaced. • Access to local teaching for trainees and if all trainees were able to attend.
Specialties/ grades reviewed	Higher specialty training within clinical oncology
Number of trainees and trainers from each specialty	The visit team initially met with the senior management team this included the medical director, director of medical education, chief operating officer, chief nurse, director of workforce, chief finance officer. The visit team met with the college tutor, education lead and clinical lead for clinical oncology. The visit team met with 12 higher trainees within clinical oncology. The visit team also met with 11 educational supervisors and clinical supervisors.
Review summary and outcomes	The visit team thanked the Trust for organising the visit and the well-attended sessions. The visit team heard of one area of serious concern and an immediate mandatory requirement was issued. • The visit team heard that there was no robust and formalised handover for all three strands of patients (AOS, NHS and private patients) who the higher trainees cared for over the weekend, which was impacting on patient safety and workload. The visit team heard of the following areas that were working well. • The Trust had made considerable improvements following the last visit to the Trust in December 2015, especially within clinical supervision of trainees. • The trainees were all aware of learning from serious incidents through monthly summary emails. • The visit team was informed that there was a good provision of local

	teaching at the Trust and the department was working to move consultant-led teaching to one afternoon a month to enable more trainees to attend. • The visit team heard that the radiotherapy booking was improving with the increase in clerking support. The support of radiotherapy practitioners and dosimetrists had been beneficial to training. • The trainees felt well supported by their consultant body. • The trainees' workload had improved considerably and changes the trainees recommended to the department had been implemented where possible. The visit team heard the following area for improvement. • The visit team heard that the trainees had issues applying for annual leave and some trainees were informed at a short notice if it was declined or their annual leave was not included in the rota. The visit team felt that the Trust needed to review the way in which the rota was organised.

Educational overview – meeting the Trust executive team and educational leads
The visit team heard that the Trust had been focusing on raising the profile of education and training across the organisation and had recently approved at the transformation board a document to look at long term planning for sustainable medical education to improve the education and training provided at the Trust. The director of medical education (DME) was now part of the formal leadership team and had a direct link into the medical director and management executive team. The Trust was the top serious incident reporting Trust in the country and felt that the safe reporting culture had filtered down to the trainees. The visit team heard that there was a tick box on the Datix forms which asked if a junior doctor was involved in the incident and if so the DME was automatically involved. The learning from events was disseminated to all trainees via emails and was reported in the junior doctor forum and in each departments local faculty group (LFG). The Trust had feedback from staff that they wished to have more personal feedback and the risk management team now report back on each incident to the reporter via email and phone. There was a pool of trainees at the Trust which would sit on serious incident panels when a trainee had been involved which aimed to increase trainee engagement and learning. The visit team heard that the Trust had a zero tolerance policy for bullying and undermining behaviours, the Trust had not had a reported incident for 14 months. The Trust management had met with departments already to discuss immediate responses to the GMC national training survey (NTS) 2016 and actions were already underway. The visit team learnt that job planning was an on-going issue and the Trust was in the process of reviewing all trainers' job plans and ensuring that they had adequate time within these plans to carry out educational responsibilities. The Trust had appointed an appraisal lead who would work on developing high quality appraisals. The visit team heard of the Trust's commitment to expanding the non-medical workforce and that currently in post across the Trust they had six nurse consultants, one allied health professional consultant, four therapeutic radiographers, 25 advanced nurse practitioners and a pathway to radiographer reporting in diagnostic radiology. The visit team heard that the Trust was going to review the use of multi-professional workforce within clinical oncology to support trainees and their training experience. This model will be applied to all medical specialties and the Trust was developing a medical model that does not rely as heavily on trainees recognising the challenging environment to fill rota gaps. The model was signed off recently and a report was going to the Trust board in autumn 2016 with full implementation likely to have taken place by 2019. The visit team was informed that the ward based acute oncology doctors managed the non-elective patients at the Chelsea site and the Trust was making appointments to replicate the model at the Sutton site. The Trust had worked closely with the postgraduate dean regarding private patients and the care trainees could provide to these patients. The Trust had created an integrated model of NHS and private patient care and how trainees worked through this model to ensure it complemented their education and training.

Meeting with the college tutor, education lead and clinical lead

The visit team heard that the Trust had been struggling to recruit clinical fellows to fill the higher trainee rota gaps and was regularly using locums.

The visit team learned that the Trust had created two full time posts within the private patient team who administered chemotherapy to private patients.

The education leads commented that they had started investigating the three red flags in the GMC national training survey (NTS) 2016 for 'workload', 'supportive environment' and 'local teaching'.

The education leads were unsure what had caused a red outlier for 'supportive environment' and felt that it could be linked to the shortage of higher trainees and locums to support practice.

The visit team heard that the Trust had some trainees that would also work at Royal Surrey County Hospital for six months and they had a high proportion of less than full time trainees.

The education leads reported that all trainees should be released to attend regional training days.

Quality Review Team			
Lead Visitor	Dr Suzannah Mawdsley, Head of London Specialty School of Clinical Oncology	**External Representative**	Dr Nicola Anayamene, Consultant Clinical Oncologist, East and North Hertfordshire NHS Trust
GMC Representative	Alex Blohm, Education QA Programme Manager, General Medical Council	**Trainee Representative**	Dr Neel Bhuva, Trainee Representative
Lay Member	Jane Gregory, Lay Representative	**Observer**	Mahvish Qureshi, Quality Support Officer
Scribe	Vicky Farrimond, Learning Environment Quality Coordinator		

Findings

GMC Theme 1) Learning environment and culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Ref	Findings	Action required? Requirement Reference Number
CO 1.1	**Patient safety** Please refer to Ref CO1.6, Handover.	

CO 1.2	**Serious incidents and professional duty of candour** The trainees reported that they received email updates summarising the previous months Datix reports and the learning points from these however the emphasis was on the trainees to read these emails. The trainees were informed of the Trust whistleblowing policy at induction and there was guidance available on the intranet.	
CO 1.3	**Appropriate level of clinical supervision** The visit team heard that since the visit in December 2015 an appropriate level of clinical supervision was being provided and only one trainee had been in a clinic without consultant supervision and this was due to a clerical error.	
CO 1.4	**Responsibilities for patient care appropriate for stage of education and training** The visit team heard that the trainees looked after all inpatient private patients at the weekend as there was not a resident medical officer (RMO) and the consultants did not regularly come into the Trust to review these patients. The visit team felt that there was the need for the Trust to appoint a RMO to care for private patients at the weekend.	
CO 1.5	**Rotas** The trainees commented that some of the teams' workloads were excessive and other teams' were manageable. The trainees recognised that the workload differed depending on the team and that overall the workload balanced out over the period of their placement. The trainees reported that there was a perception that the higher trainees were the first point of contact for any inpatient issue during the day and this further impacted on the trainees' workloads and could become unmanageable. The visit team heard that some of the calls would be regarding patients the trainees had not seen before. The trainees commented that they may receive more calls as they carried a cordless phone and it may be easier to contact them than locating the consultants' contact information. The department recognised that some clinics were running over due to the volume of patients and this needed to be addressed as it was impacting on the trainees' workload as they were regularly staying later than their rostered hours. The trainees' timetables had allocated sessions for audit and quality improvement projects but when the trainees were partaking in the MSc course they did not have this time to complete audits or quality improvement projects. All the trainees attended four clinics per week except for one breast trainee who had five. The trainees reported that since the reduction in the private patient workload and the organ at risk voluming and hiring radiographers the trainees' workload was improving. The visit team heard that many trainees had encountered issues with the process of booking study leave and annual leave. These did not appear on rotas despite being signed off with plenty of notice. The visit team heard of an occasion when one trainee had applied for annual leave eight weeks in advance which had been signed off by their consultant and received an email at 4pm on the Friday which was their last day before leave informing them that they could not take the annual leave and if they went it would be considered unauthorised. The trainee felt intimidated by the wording of this email at such short notice. The visit team heard of an occasion when a trainee's MSc course did not appear on the rota onwards despite them still completing the course and they repeatedly contacted the rota coordinators and this was not amended. The trainees reported that they used to complete an annual leave form which the consultant would sign off and the rota coordinator would add onto the rota. However,	Yes, see Ref CO1.5 below

	the new annual leave application process was online using an online rota. The trainees reported that this system had an incorrect number of annual leave days listed for the trainees and it was based on the tax year not the NHS working year. The trainees stated that the consultants were very supportive regarding this and ensured they were able to take their leave allocations. The trainers were aware of the trainees' rota issues and had told the trainees to raise any concerns with them regarding this. The department was in the future aiming to give the ownership of the rota to the trainees.	
CO 1.6	**Handover** The trainees commented that they looked after private patients on the weekend and had limited handover of these patients. As the trainees did not always receive an email handover for the inpatient private patients there had been occasions when there were patients they were unaware of or did not know the patients' plans. The visit team heard that the core trainee handed over as much as they could but sometimes they left before the higher trainee. The visit team heard that the expectation for private patient handover was from the core trainee to the higher trainee who could then contact the on-call higher trainee. The trainees felt this was unsafe as they would hand over a patient whose care they were not familiar with. The trainees reported that the consultants did not come into the Trust on the weekend to review private patients unless they were deteriorating. There were no RMOs on the ward at weekends to look after private patients. The trainees commented that when some consultants were on leave they were unaware who was covering their private patients. The visit team heard that some acute oncology service (AOS) patients had been lost through a poor handover at the weekend and trainees would find patients they were unaware of a day or two later when the nurses notified them or the trainees picked them up on the inpatient list. This included patients with query spinal cord compressions. The education leads reported that higher trainees handed over to each other via email and the consultant in charge of patients handed over to their higher trainee who then handed over to the on-call team. The department was going to implement a new handover system using a training coordinator to send an email communication every Friday regarding who was the consultant on-call and all consultants should hand over to them, which staff member was covering NHS and private patient work and this would then be emailed to the higher trainee on-call.	Yes, see IMR CO.16 below
CO 1.7	**Protected time for learning and organised educational sessions** The education leads commented that due to local teaching starting at 8.30am it was hard to make it bleep free as the postgraduate medical education team was not available to take the bleeps off the trainees. The department had requested trainees put their phones through to the on-call team but the trainees did not do this. The local teaching consisted of journal club on Monday, higher trainee to higher trainee teaching on Tuesday and alternate Thursdays and Friday consultant-led teaching these all started at 8.30am. The department had just made plans to move the consultant led teaching to one afternoon a month with two hours consultant-led teaching and one hour of planning-based teaching from January 2017. The visit team heard that one trainee attended three multi-disciplinary team meetings a week and this limited the trainee's access to local teaching. The trainees reported that the local teaching had improved significantly over the last six months. The local teaching however was not bleep free and the trainees commented they had to put their phones through to the on-call team when they were at teaching. Some trainees commented that it was easier to answer the call themselves than refer to the on-call team. The trainees stated that the consultants were keen to teach and be involved within the	Yes, see Ref CO1.7 below

	local teaching programme. The trainers reported that the week following the visit they were planning on taking all phones away from trainees before they entered local teaching to ensure it was bleep free.	
CO 1.8	**Adequate time and resources to complete assessments required by the curriculum** The trainees reported that they had no problems approaching consultants to complete their workplace-based assessments (WPBAs).	

GMC Theme 2) Educational governance and leadership

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

CO 2.1	**Impact of service design on learners** The office space at Sutton site was relocated following the visit to the department in December 2015 and this had created more of a hub and team belonging. The trainers reported that they felt there had been positive improvements following the visit in December 2015. The department was managing the clinical workload, making trainees progress and work in the department more streamlined and increasing consultant-led services.	
CO 2.1	**Appropriate system for raising concerns about education and training within the organisation** The trainees reported that they were well supported by their consultants and radiotherapy teams however they did not feel supported by the rota coordinators. The trainees commented that they knew how to raise concerns.	

GMC Theme 4) Supporting educators

Standards

S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

CO 4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The educational supervisors stated that they had a job plan template which they completed with regards to where their professional activities (PA) were assigned. They received 0.25 PA per trainee they supervised. The consultants had been asked to upload their job plan which the service managers then reviewed for first sign off.	

CO 4.2	**Access to appropriately funded resources to meet the requirements of the training programme or curriculum** The visit team heard that the director of medical education had ensured all educational supervisors were aware of courses for educational supervision and managing trainees in difficulty.	

GMC Theme 5) Developing and implementing curricula and assessments

Standards

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.

CO 5.1	**Opportunities for interprofessional multidisciplinary working** The Trust had appointed an advanced radiographer in urology at the Sutton site which was helping with trainees' workload of cases and supporting in clinics. The Trust had also appointed two dosimetrists at the Sutton site who carried out organs at risk work and had recently appointed one dosimetrist at the Chelsea site. The Trust was successful in receiving funding from HEE for a palliative radiographer and they have been appointed and were due to start in September/October 2016. The education leads reported that they had created a radiotherapy booking office which had three clerks who worked cross-site and were based at the Sutton site. The addition of the clerking support in radiotherapy supported trainees to complete administrative tasks, the clerks undertake all radiotherapy bookings and there was a dedicated email after 5.30pm for tasks to be sent to the team. There were plans that the clerking support would support the team further by facilitating cord compression pathways.	

Good Practice and Requirements

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
CO1.6	The Trust is to implement a robust and formalised handover for weekend cover which is face to face and supported by a shared and accessible electronic document for all three strands (AOS, NHS and private).	Please respond within five working days.	R1.14

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.

CO1.5	The Trust is to review the way in which trainees apply for annual leave and study leave, how this is approved and included within the rota.	The Trust is to provide evidence of the annual leave and study leave policy, how trainees apply for this and how this is communicated with the rota coordinator. The Trust is to ensure that all approved annual leave and study leave is shown on the rota and any issues are raised with the trainee well in advance. Please provide copies of LFG minutes in which this is discussed.	R1.12, R3.12
CO1.7	The Trust is to ensure that all local teaching is bleep-free.	The Trust is to ensure that all local teaching is bleep free and that trainees do not get called out of teaching. Please confirm that this has happened. Please provide copies of LFG minutes in which this is discussed.	R1.16

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

Requirement	Responsibility
N/A	

Signed

By the Lead Visitor on behalf of the Visiting Team:	Dr Suzannah Mawdsley, Head of London Specialty School of Clinical Oncology
Date:	23 August 2016