QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

The Royal Marsden NHS Foundation Trust
Core Medical Training
Risk-based Review (on-site visit)

Quality Review report

Date: 19 July 2016
Version (if required): Final report

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Quality Review details

Background to review	The Trust was overdue a Trust-wide review, last receiving one in May 2013. Since this time there had been the intransigent issues of trainees involved in the care of private patients that could be detrimental to training and education. A Conversation of Concern (CoC) was held on 14 December 2015 to review the education and training provided within clinical oncology and the trainees' involvement in the care of private patients. At this time, the visit team identified an exceptionally high workload that was exacerbated by a high volume of private patient care which trainees were expected to undertake. Due to these concerns, the GMC placed the clinical oncology department under enhanced monitoring in December 2015. Against this background, the visit team was keen to explore how trainees felt about their involvement in the care of private patients and the impact this had on their workload. Regarding core medical training (CMT) specifically, a visit was held in February 2015 where concerns were raised regarding the adequate training exposure afforded to core medical trainees in a specialist environment. The visit team was keen to review the curriculum coverage for trainees whilst working in such a specialist environment. The Trust generated six red outliers in the General Medical Council National Training Survey (GMC NTS) in 2015 for 'overall satisfaction', 'clinical supervision', 'clinical supervision out of hours', 'adequate experience', 'supportive environment' and 'feedback'. The visit team was keen to explore the current situation and trainee experience related to all of these indicators. It was noted that in the 2016 GMC NTS, the Trust generated white outliers for all indicators at the Chelsea site, with the exception of 'reporting systems' which was grass. However the Sutton site generated one red outlier for 'local teaching' and six pink outliers for 'overall satisfaction', 'clinical supervision out of hours', 'induction', 'adequate experience', 'access to educational resources' and 'feedback'. The differing experiences of trainees between the Chelsea and Sutton sites were to be explored, including workload at both sites as well as the involvement of trainees in the clinical assessment unit (CAU) at the Chelsea site and the medical day unit (MDU) at the Sutton site.
Specialties/ grades reviewed	The visit team met with CMT year 1 and CMT year 2 trainees across various firms including haematology, sarcoma, medical oncology, gynaecology, urology, palliative care and gastroenterology.
Number of trainees and trainers from each specialty	The visit team met with the following trainees and trainers: • Six CMT trainees based at the Chelsea site, • Three CMT trainees, including general practice vocational training scheme (GPVTS) trainees, based at the Sutton site, • Two clinical and educational supervisors based at the Chelsea site, • One educational supervisor (although not with responsibility for CMT trainees) at the Sutton site. In addition, the visit team also met with: • The clinical lead for palliative care who was also the training programme director (TPD) for CMT, • The educational lead for CMT.
Review summary and outcomes	The visit team thanked the Trust for accommodating the visit. It was noted that the attendance at both the trainee and trainer sessions was slightly lower than expected and that only nine out of 18 trainees were present. Furthermore there was representation from only three trainers across both the Chelsea and Sutton

sites.

The visit team identified various areas that were working well regarding education and training at the Trust, including the following:

- The visit team heard that the clinical supervision structure was clear and that trainees knew who to call on for supervision. Clinic weeks worked well and trainees knew what was expected of them.
- The trainees reported that they received good exam support and found journal clubs of high educational value. Trainees noted that it was easy to get study leave and the Trust was very accommodating around this.
- The trainees noted that the weekly support meetings with the TPD were valued.
- Workplace-based assessments were easy to obtain and educationally useful on the clinical assessment unit (CAU); these were much more difficult to obtain at the Sutton site and on general wards at the Chelsea site.
- The visit team was informed that there were no issues with rotas, apart from rota gaps at the Sutton site.
- The visit team heard that the critical care outreach arrangements worked well and provided particularly good out of hours support.
- The trainees felt well supported by the two CAU consultants.
- The educational supervisors felt well supported by the clinical lead for palliative care / training programme director (TPD) for CMT and the director of medical education (DME). Trainers reported that they received adequate programmed activity (PA) allocation.

Areas for improvement were also identified, as follows:

- The visit team heard that the medical handover was not adequate and that comprehensive records of these meetings were not kept. The handover of surgical patients following night shifts at the Chelsea site was often difficult and the CMT trainees on call overnight regularly stayed late to finish this.
- The trainees reported that they would appreciate a greater breadth of oncology topics in their local teaching programme (which was perceived to be predominantly focused around palliative care).
- The trainees noted that there was not a culture of 'on the job' teaching at the Trust except on the CAU. 'On the job' teaching was lacking on mega-firms and it was reported that there was a lack of awareness of the educational needs of the CMT trainees.
- There was a lack of uptake of bleep-free teaching at the Sutton site; the training programme director (TPD) stated that there was a facility for this but that it was not being used.
- It was noted that the local haematology induction was very good but other firms felt that there was little or no induction suitable for their level of work.
- Since the CoC on 14 December 2015, higher trainees in clinical oncology covering gynaecology and urology had limited/no responsibility for private patients, which meant this responsibility had since fallen on the CMT trainees (with these trainees escalating directly to consultants). They felt unsupported in this work, particularly when on call.
- Overall satisfaction was variable between firms (in terms of recommending the post to other trainees). The CMT trainees felt that they would rather rotate between firms than spend six months on one firm. These trainees felt that six months was too long to spend in one firm.
- The educational experience gained in treating private patients had limitations and trainees perceived that they received most of the benefit of working with

	private patients in general within the first few weeks. There were a lot of competencies around cultural diversity, working with interpreters and communications that could have been used as a more directed learning opportunity with more consultant supervision and immediate feedback/ workplace based assessments. The visit team was informed by the CMT trainees at both the Chelsea and Sutton sites that they would only recommend posts at the Trust to CT1 trainees with an interest in oncology. These trainees noted that they would not recommend the post to CT2 trainees as some felt that they had been deskilled by the post.

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

The visit team met with the following members of the Trust's senior management team (SMT):

- Medical director
- Director of medical education (DME)
- Chief nurse
- Director of workforce
- Chief financial officer (CFO)
- Chief operating officer (COO)

The COO summarised the Trust's progress since the last visit and advised the visit team that the Trust was encouraged by the 2016 GMC NTS results as these showed an improvement compared to those of 2015. It was noted by the COO that the Trust had more work to do in terms of developing the education and training at the Trust and that there was a strategy in place to achieve this aim. This strategy was threefold and included more trainee participation at the Trust's Board level. The Trust's Board was keen to have more face-to-face contact with trainees and as result, six or seven trainees subsequently attended the Board meetings. The Trust's Board had been reviewing the long-term plans regarding education and training and had started working on an initiation document that had been agreed at the Trust's transformation committee. As it was being reviewed at the highest levels within the Trust, this demonstrated the importance that the Trust placed on education and training. Moreover the DME had a direct line of communication into the Trust's Board and executive team.

Furthermore since the last visit, the Trust had introduced an acute oncology service (AOS) at the Chelsea site, whereby acute oncology consultants managed ward-based emergency patients. It was noted that the Trust had plans to replicate this model at the Sutton site. Regarding private patients, the COO confirmed that the Trust had been working on developing a formal private care model and was communicating with trainees around this.

The Trust confirmed that it had not reported any bullying and undermining incidents in the last 14 months and that there was a zero tolerance policy on this.

The Trust's chief nurse highlighted that the Trust was moving towards a holistic and multiprofessional approach to healthcare, as part of its overall aim to ensure it had a sustainable workforce. At the time of the visit, there were 25 advanced nurse practitioners who worked as part of the medical team, including within theatres and the intensive therapy unit (ITU) as well as therapeutic radiology practitioners. This approach had implications for education and training as the Trust was working to encourage trainees and allied health professionals to work collaboratively and avoid silo working. It was noted that some simulation training was already carried out by simulation nurses so collaboration between medical and non-medical staff was already underway at the Trust.

Regarding incident reporting and how this was fed back to trainees for learning purposes, the DME advised the visit team that he had sight of all Datix forms where there had been trainee involvement. Educational supervisors were also sent details of incidents involving trainees for who they had supervisory responsibilities. Furthermore there was trainee representation at resultant serious incident panels, at which the DME was also present. Learning around these incidents was disseminated at junior doctors' forums and local faculty group (LFG) meetings. In addition, an email listing all serious incidents with trainee involvement and subsequent learning was cascaded amongst trainees and staff. The visit team heard from the Trust that staff and trainees had requested that they receive individual and more detailed feedback following Datix submissions. The team confirmed that they had started to feedback individually to all trainees and staff who had submitted a Datix. This included email and phone contact. The Trust confirmed that incident reporting was Trust-wide and included private care. Incident reporting across the Trust was reviewed regularly and areas where reporting had dipped were engaged

with.

The visit team heard that a paired learning programme around internal leadership development had been customised for The Royal Marsden NHS Foundation Trust by the DME, from a model developed by Imperial College Healthcare NHS Trust. This program aimed to remove barriers between clinicians and management and the sustainable medical model was one stream of this project.

It was noted by the Trust that job planning for trainers was an ongoing project and a priority going forward. An appraisal lead had been appointed who worked with the DME and reported into the medical director and the main challenge was ensuring that the Trust was carrying out high quality appraisals across the board.

Quality Review Team			
Lead Visitor	Dr Jo Szram, Director of Medical Education, Royal Brompton and Harefield NHS Foundation Trust	**External Representative**	Dr Joel Mawdsley, Consultant Gastroenterologist, Chelsea and Westminster Hospital NHS Foundation Trust
Lay Member	Catherine Walker, Lay Representative	**Trainee Representative**	Dr Chukwudera Eruchie, Medical Education Fellow, Health Education England
Observer	Laura Stackpoole, Quality Support Officer	**Scribe**	Kate Neilson, 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
CMT1.1	**Appropriate level of clinical supervision** The visit team heard from the CMT trainees at both the Chelsea and Sutton sites that they received adequate levels of clinical supervision, both during the day and out of hours, and that there were clear lines of escalation for seeking advice. These trainees always knew who to contact for support in terms of the responsible higher trainee and the consultant. It was noted by these CMT trainees that consultants were approachable and that they could contact them on their mobile phone and they were happy to discuss patients and give advice. The CMT trainees advised the visit team that whilst the higher trainees in surgical specialties were not always on site out of hours, they would come to the hospital if required. Similarly, these trainees reported that they received good support from the	

	intensive therapy unit (ITU) when needed.	
CMT1.2	**Responsibilities for patient care appropriate for stage of education and training** At both sites, trainees felt under more pressure to get investigations for private patients completed immediately compared to those for NHS patients. These trainees reported that they spent time liaising with consultants in other hospitals, which increased their workload and they noted that a consultant-to-consultant discussion may have been more appropriate and less time consuming. <u>Chelsea site</u> The visit team heard that the CMT trainees spent variable time on the care of private patients, dependent upon their specialty ranging from 30-40% in sarcoma to 60% in gastroenterology); CMT trainees in haematology spent most of their time looking after private patients. It was noted that since the last visit, the higher trainees in clinical oncology covering gynaecology and urology had limited responsibility for private patients, which meant that a lot of the responsibility had since fallen on the CMT trainees. The visit team was informed by the CMT trainees that consultations with private patients usually took longer than those for NHS patients and that they often generated more investigations and liaison with other specialties. The trainees also felt that private patients had greater expectations surrounding their care than NHS patients so were more demanding. All of these factors meant that there was then a knock-on effect in terms of increased levels of time spent with patients and administrative work generated for trainees to complete. It was acknowledged by these CMT trainees that exposure to private patient care and the related duties this entailed, such as use of translators and experience of overcoming cultural barriers, was beneficial to their training and future careers. However, these trainees suggested that they received the benefit of this work within the first few weeks of their placement and that it was not necessary to complete a six month placement of such work. The visit team heard from some trainees that they felt deskilled by the post due to the lack of embedded teaching at the Trust and high levels of administrative work and an absence of exposure to the wide range of acute medical problems. <u>Sutton site</u> The CMT trainees based at the Sutton site advised the visit team that they spent between 30-50% of their time on the care of private patients. There was some trainee concern raised around legal indemnity and whether they were covered for private patient procedures such as ascetic drains. Trainees then confirmed that they could seek clarification around this from the clinical lead for palliative care / TPD for CMT or the educational lead for CMT and had done so. The CMT trainees based at the Sutton site reported that the six month placement was felt to be too long and that they had reached saturation in terms of learning within two months.	
CMT1.3	**Rotas** The CMT trainees based at the Sutton site informed the visit team that there were issues with rota gaps at the site due to staff shortages. The TPD for CMT explained that these rota gaps were due to a combination of sick leave, maternity leave and trainees having left posts and that it was harder to fill posts and recruit locums at the Sutton site compared to Chelsea. It was noted by the CMT trainees that they would rather have rotated between firms than spend six months on one firm as it was felt that this was too long. The visit team was informed that one palliative care placement was advertised as oncology rather than a palliative care post, so was misleading.	Yes. See CMT1.3a below. Yes. See CMT1.3b below.
CMT1.4	**Induction** The TPD and educational lead for CMT advised the visit team that all trainees	Yes. See

	received a Trust induction on day one and a local induction on day two of their placement, at which time trainees were briefed about their responsibilities and lines of escalation for private patients. This arrangement did not appear to be robust for recent trainees; the visit team heard from the CMT trainees based at both the Chelsea and Sutton sites that those who commenced their placement in April 2016 did not receive a formal induction due to the disruption caused by the junior doctors' strike. Those trainees who had started their placement in January 2016 did receive a full induction. The CMT trainees were told by the Trust when they commenced in post that they would be looking after private patients and that funding from these patients was then reinvested into the NHS so would benefit NHS patients. However all of the trainees advised the visit team that expectations regarding their exact responsibilities for the care of private practice patients were not clarified by the Trust. It was noted that the incoming CMT trainees were briefed on private patients from the outgoing CMT trainee. The trainees informed the visit team that they had requested clarity around what their responsibilities entailed in relation to private patients but this had not been forthcoming. Trainees in palliative care reported that it was clearer for them than for other trainees around private patient responsibility. The TPD and educational lead had planned a more comprehensive induction programme including private patient duties to commence from August 2016.	CMT1.4 below.
CMT1.5	**Handover** <u>Chelsea site</u> Regarding the handover arrangements at the Chelsea site, the CMT trainees reported that the morning handover (following night shifts) worked well with the medical teams but was more challenging when handing patients back to the surgical teams as the trainees did not always know who was responsible. As a result trainees were often delayed in finishing their shifts. Regarding written records of handover, the CMT trainees advised the visit team that a list was kept by the outreach team which indicated the most acutely unwell patients that had been handed over but did not contain any further detail of the meeting. <u>Sutton site</u> The visit team was informed that the weekend handover at the Sutton site involved trainees completing a spread sheet to track patients which they felt was an effective system. The evening handover also worked well but there were a few issues with the weekend handover of new patients. Furthermore whilst the handover of sick patients was good, the "hand back" of patients admitted from Friday evening and over the weekend was not. The CMT trainees advised the visit team that the morning handover worked well. There were no issues regarding the handover of surgical patients, which may have been due to the fact that there were very few such patients at the Sutton site. It was noted by the CMT trainees that there were limited written records of handover.	Yes. See CMT1.5 below.
CMT1.6	**Protected time for learning and organised educational sessions** The CMT trainees advised the visit team that despite the red outlier in the 2016 GMC NTS for 'local teaching' on the Sutton site, the local teaching programme rotated between the Chelsea and Sutton sites and that video conferencing was ultilised on both sites. It was noted that the trainees on the Sutton site did not practice bleep-free attendance at teaching, although there was a system in place to facilitate this whereby a member of the medical education team at the Chelsea site held the bleep. The trainees reported that at the time of the visit, the majority of teaching sessions were related to palliative care only and that they would have appreciated a more varied programme. The visit team heard that there was a journal club at both the Chelsea and Sutton sites which worked well with active CMT trainee input. It was noted that the AOS week on the CAU was very good. Additionally a consultant on the gynaecology firm had recommended reading to trainees. However other than this, teaching and educational input was limited at the Trust. The trainees perceived that teaching was not embedded into the culture of the Trust, especially	Yes. See CMT1.6 below.

	at the CMT level. It was noted by these trainees that consultants used unfamiliar acronyms and terminology without explaining these to the CMT trainees, which highlighted the lack of teaching within the CMT posts at the Trust.	

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.

CMT2.1	**Appropriate system for raising concerns about education and training within the organisation** The trainees noted that the weekly support meetings with the TPD and educational lead for CMT were valued and that this was an arena where they could raise concerns, which were addressed in a timely manner.	

GMC Theme 3) Supporting learners

Standards

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

CMT3.1	**Access to study leave** The visit team heard from the trainees that it was easy to obtain study leave and the Trust was very accommodating around this.	
CMT3.2	**Regular, constructive and meaningful feedback** The CMT trainees at both the Chelsea and Sutton sites advised the visit team that they received limited feedback regarding their communication skills with patients from consultants but that this could have been a beneficial learning experience. It was noted that they did do this during simulation-based teaching but would be keen to have supervised practice on inpatients as part of ward rounds. The clinical and educational supervisors advised the visit team that a lot of the communication with patients was observed by trainees rather than practical experience. It was felt that in the case of difficult conversations, it was more appropriate for consultants to do these. They noted that there was usually a debrief with trainees after difficult conversations to discuss how the consultant could have handled it differently.	Yes. See CMT3.2 below.

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.

CMT4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The educational supervisors felt well supported by the clinical lead for palliative care / training programme director (TPD) for CMT and the DME.	

	The visit team heard from the clinical and educational supervisors that they received 0.25PA per trainee for their supervision duties. The TPD and educational lead for CMT confirmed that they received an additional 1PA from the Trust for their educational duties. The educational supervisors confirmed that they received reminders about which trainees they would be supervising prior to trainees commencing in their post which included details about what was expected of their supervisory role.	
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.**		
CMT5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The CMT trainees advised the visit team that the support from trainers around assessments and signing off their ePortfolios was variable, with less than half of the consultants supportive of these activities. It was noted by these trainees that whilst consultants completed the majority of assessments, higher trainees were happy to assist with this also. The CMT trainees based at the Chelsea site completed a week on the CAU, which meant that they had exposure to patients under supervision from consultants and could do the majority of their workplace-based assessments at this time. These trainees confirmed that the consultants within the CAU were very supportive around signing off ePortfolios. The visit team heard from the CMT trainees based at the Sutton site that completing workplace-based assessments, including the acute care assessment tool (ACATs), was more challenging than for those trainees based at the Chelsea site. The CMT trainees based at the Sutton site worked in a more isolated way and there was not an opportunity to complete workplace-based assessments when on the day unit as consultants were not available to assess these. These trainees informed the visit team that they spent much time chasing consultants to complete assessments, especially around the time of Annual Review of Competence Progression (ARCP) deadlines. It was noted that the GPVTS trainees at the Sutton site did not have any issues with completing workplace-based assessments.	Yes. See CMT5.1a below. Yes. See CMT5.1b below.

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
N/A			

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
CMT1.3a	Trust to review the rota gaps within the CMT rota at Sutton site and ensure that there is a Human Resources (HR) policy in place around recruiting to vacant posts.	Trust to submit copies of the new rota as well as evidence that this had been sent to trainees. Compliance with this action should be monitored through LFG meetings.	R1.12
CMT1.3b	Trust to review the placements for CMT trainees and ensure that they receive a more varied experience across different firms and spend a maximum of four months within one firm.	Trust to submit copies of the new rota as well as evidence that this had been sent to trainees. Compliance with this action should be monitored through LFG meetings.	R1.12
CMT1.4	Trust to ensure that CMT trainees across all firms and at both sites receive a formal Trust and local induction when commencing on placement, even those trainees who commence placement mid-year. The local induction should clearly outline the exact responsibilities that CMT trainees have regarding private patient care. including lines of escalation for private patients.	Trust to submit confirmation of induction arrangements as well as induction material which should include the expectations, responsibilities and lines of escalation for private patients. Trust to circulate an induction survey to trainees and submit feedback received. Performance of induction should be monitored through LFG meetings.	R1.13
CMT1.5	Trust is required to revise the rotas to instate time for a formal medical morning handover to the surgical teams at the Chelsea site with a specified time and place. The Trust is required to ensure that written records of the handover are kept.	Trust to submit copies of the revised rota that includes a specified time and place for a formal medical morning handover to the surgical teams at the Chelsea site. Compliance with this action should be monitored through LFG meetings.	R1.12/ R1.14
CMT1.6	Trust is required to review the content of the sessions offered as part of the teaching programme at both sites. The programme needs to both cover the competences and be integrated in a clinical programme of teaching that fully engages the trainees. Trust to ensure that the teaching programme covers a range of sessions from across different firms. Trust to confirm the arrangements for bleep-free teaching to trainees at the Sutton site.	Trust to submit copies of the revised teaching programme in the form of a timetable of the teaching sessions and formats of these for the academic year. In addition, evidence that this has been circulated to trainees and consultants should be submitted. Trust to submit copies of communications sent to trainees at the Sutton site regarding the arrangements to facilitate bleep-free teaching. Compliance with this action should be monitored through LFG meetings.	R1.16
CMT3.2	Trust to ensure that trainees receive regular and constructive feedback on their performance, including communication skills.	Trust to submit a statement detailing how CMT trainees receive feedback on their performance, including their communication skills. Compliance with this action should be monitored through LFG meetings.	R3.13
CMT5.1a	Trust to ensure that all trainers are trained on the ePortfolio system so that they are able to complete ePortfolios for trainees	Trust to submit a list of trainers with responsibilities for CMT trainees, indicating whether they are trained on the	R5.9

	for who they have supervisory responsibilities.	ePortfolio system with a plan of action for those who are not yet trained. Compliance with this action should be monitored through LFG meetings.	
CMT5.1b	Trust to ensure that CMT trainees based at the Sutton site have access to workplace-based assessments including ACATs.	Trust to submit a statement detailing how CMT trainees based at the Sutton site will receive workplace-based assessments, including ACATs. Compliance with this action should be monitored through LFG meetings.	R5.10

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
	N/A		

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 Jo Szram, Director of Medical Education, Royal Brompton and Harefield NHS Foundation Trust
Date:	18 August 2016