QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

The Royal Marsden NHS Foundation Trust
Trust-wide Review

Quality Review report

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Version (if required): Final report

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Quality Review details

Background to review	The Royal Marsden NHS Foundation Trust was last visited in May 2013. In the intervening period, Health Education England had raised concerns about the intransigent issue of trainees being involved in the care of private patients, which offered no educational benefit, and in some cases was detrimental to training and education. Therefore, a key line of enquiry for the visit team was to assess the exact nature of training posts and duties undertaken in relation to their involvement in the treatment of private patients at the Trust. The Trust-wide Review assessed the education and clinical governance structures that were in place to support and facilitate training and education. This included the mechanisms for reporting and escalating serious incidents, how these translated into learning opportunities, and how trainees were supported through that process. In addition, the Review explored the Trust's plans to develop a multi-professional workforce, especially regarding clinical nurse specialists and radiation scientists. **GMC National Trainee Survey results** The results of the 2015 General Medical Council National Training Survey (GMC NTS) warranted a request to review, with 15 red outliers overall, including multiple red outliers generated in Core Medical Training (6) and Clinical Oncology (6). In the 2016 GMC NTS, the Trust received 14 red outliers across the following specialties: **Clinical oncology** • Supportive environment • Work load • Local teaching **Clinical radiology** • Local teaching **Haematology** • Overall satisfaction • Induction • Adequate experience • Local teaching **Paediatrics** • Overall satisfaction • Clinical supervision • Clinical supervision out-of-hours (OOH) • Adequate experience • Access to educational resources **Plastic surgery** • Adequate experience The Trust received 16 green outliers across the following specialties: **Anaesthetics** • Reporting systems **Anaesthetics F2**

	• Overall satisfaction • Clinical supervision OOH • Reporting systems • Handover • Adequate experience • Work load • Access to educational resources • Study leave **General surgery** • Induction • Study leave **Histopathology** • Feedback **Medical oncology** • Reporting systems • Regional teaching **Plastic surgery** • Handover • Work load
Specialties / grades reviewed	The visit team met trainees in anaesthetics, clinical radiology, haematology, palliative care, intensive care medicine (ICM), and pathology. Trainees were from specialty training (ST) grades four to seven.
Number of trainees and trainers from each specialty	The visit team met trainers in anaesthetics, clinical radiology, haematology, palliative care and surgery.
Review summary and outcomes	The visit team observed that a number of positive changes had been instituted across the Trust, particularly with the direction and leadership of the medical education department. Educational leads and trainees reported that the senior management team was very supportive of educational development, particularly the director of medical education. In addition, trainees reported that their educational leads were committed and supportive supervisors. With regard to aspects of the various specialties that were reviewed, oncology training was excellent, but with a relatively narrow focus; a number of trainees reported that it was not necessarily an appropriate place to train for those looking for a more broad-based specialty exposure. However, for anyone planning to have a career in oncology, the Royal Marsden NHS Foundation Trust was an outstanding place to train. The visit team noted a number of areas for improvement across a variety of specialties; in haematology – the visit team noted that the main cause of concern was the trainees' inability to gain experience in bone marrow reporting at the integrated pathology unit at the Sutton site; opportunities to undertake this work were not clearly included in trainees' timetables, and had to be carried out in trainees' personal time as self-directed learning. In palliative care, it was reported that this post provided excellent experience for trainees, but had a very heavy workload. Clinical radiology trainees reported a number of organisational issues relating to trainees being called away from other duties, such as MRI reporting, in order to undertake basic tasks such as fine needle aspirations, biopsies and fluoroscopic studies. The visit team noted that the Trust had a good local faculty group (LFG) structure in place, but lacked a general educational committee or board for LFGs to feed into. The visit team would encourage the Trust to give consideration to establishing an educational committee that would provide a direct reporting

	structure for any issues raised at LFGs. The visit team was concerned that there remained an issue regarding the role that trainees played in the management of private patients at the Trust.

Quality Review Team			
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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
TWR 1.1	**Serious incidents and professional duty of candour** The visit team learned that the Trust had in place a robust system of serious incident (SI) reporting, and was second in the nationwide ranking on the GMC NTS for Trainers, with regard to the experience of a positive culture and confidence in reporting and feedback following any SIs. The Trust DME advised that he operated a triage system of any SIs involving trainees and was the first person to review such Datix reports. The visit team was advised that the DME attended all SI review panels, and that in the event of an unexpected death, such panels would always include an external representative. The Trust stated that it had moved towards a culture of open discussion and dissemination of SI cases and wanted to use every opportunity to translate these cases into learning opportunities - over the last 12 months, the Trust started to invite trainees to sit on SI review panels, which offered immediate learning opportunities for junior trainees. The Trust explained that all headline SIs were cascaded through the organisation and to all trainees in a regular email bulletin that trainees were encouraged to read.	

	The visit team heard that trainees and nurses at the Trust were keen to receive personal feedback if named in a Datix report. Consequently, the Trust had established a system whereby the risk management team and any relevant colleagues gave personal feedback to staff involved in such cases. The Trust advised that it wanted to help trainees to understand such incidents, as well as embed learning opportunities into the post-report process. It was reported that, in the event that a trainee named in a SI left the Trust before the matter be resolved, the DME liaised with the supervisors at the trainee's new Trust to maintain communication. The visit team was encouraged to hear that trainees were fully aware of the Trust's SI procedure and feedback policy. However, in ICM, it was reported that there was a culture of over-frequent Datix reporting, and that it was commonly the case that trainees were named in reports but were not informed until after the event. The visit team learned that the Trust conducted a cross-specialty review every other month, and if any specialty's performance dropped, it would investigate the cause for any such change in performance.	
TWR 1.2	**Appropriate level of clinical supervision** The visit team noted that trainees in the specialties reviewed were generally happy with the level of support they received from their supervisors, and did not raise any serious concerns about the quality of their supervision at the Trust. **Anaesthetics** The anaesthetics trainees reported that they experienced good, one-to-one supervision at all times, apart from during on-call shifts, when supervisors were contactable by telephone. The visit team heard that these trainees felt that their supervision was sometimes 'too close', particularly given that the trainees were already at an established level of competence, being at ST5 and above. **Clinical Radiology** The visit team learned that it was standard practice for ST2+ trainees to sign off scans, including ultrasound, without consultant supervision. **Palliative Care** Trainees reported receiving a good level of supervision. However, the trainees reported that consultants requested trainees to return overnight more often than during other placements. On occasion, trainees reported that in the event that they did not contact the consultant during overnight shifts, the consultant would telephone in the morning to ask why they were not called with an update. **Pathology** Trainees reported that supervision was good, with all reports having to be passed to supervisors to be checked. However, whether or not all checks were completed was dependent on individual consultants.	
TWR 1.3	**Responsibilities for patient care appropriate for stage of education and training** None of the trainees present at the Trust-wide review reported having had to work at a level above their competence.	
TWR 1.4	**Rotas** **Clinical radiology** Trainees reported that their workload was manageable by comparison with other trusts. It was perceived that this was because a minimal amount of acute reporting was required at the Trust. The visit team heard that the majority of on-call radiology work was for private patients, who were scanned more often than NHS patients on-site. The trainees stated that consultants were understanding of any backlog of scans left over and that staff were offered the opportunity to get paid to undertake late lists to	

	clear backlogs. The visit team heard that plain films were not being reported, and that staff shortages meant that there simply were not enough people in the department to report every image that was taken. **Haematology** Trainees raised concerns about the management of their rota, and the pressure caused by gaps in staffing. It was reported that frequent absences of locum doctors placed pressure on trainees, who were left with no choice but to cover night shifts at the last minute when the locum staff did not attend as planned. **Palliative Care** The visit team was informed that palliative care trainees were based at either of the Sutton or Chelsea sites, and that while it was unusual for staff to be called cross-site in the middle of the day or mid-rotation, OOH shifts did very occasionally undertake cross-site working. Trainees stated that the standard palliative care trainee rota covered Monday to Friday between 09:00 and 17:00. Trainees reported that they worked beyond their rostered hours and that they worked an average of three hours extra per day, with a 24 hour on-call every week and a one-in-five 48 hour on-call pattern. The visit team heard that during a weekend on-call shift (between Saturday 09:00 to Monday 09:00), trainees had an average of five hours of broken sleep. At the time of the Review, due to rota gaps and locum cover arrangements (there was only one Chelsea middle-grade trainee sharing responsibility with those in Sutton and two locums who covered on-calls), trainees reported that the Trust rotation was the most demanding they had experienced in their career to date. The visit team was informed that there was a great imbalance in the trainees' workload, despite the presence of a large team of clinical nurse specialists who were supposed to share tasks. The trainees stated that the post could only be recommended to those who did not have any significant commitments outside of the workplace, due to the excessive workload. The visit team was advised that the trainees were unaware of any diary card exercise during their placement, and that trainees' hours worked frequently exceeded the European Working Time Directive.	Yes – see TWR1.4a below Yes – see TWR1.4b below
TWR 1.5	**Induction** In general, trainees reported that they did not receive a proper Trust-wide induction due to the junior doctors' strike action clashing with the scheduled date. Inductions were postponed on numerous occasions and for a number of specialties, their first day onsite was used for mandatory training, as opposed to completion of the local induction. The Trust explained that it had made efforts to improve and streamline the trainees' induction process across both sites. The visit team learned that the implementation of a new e-learning system had improved efficiency and reduced the time spent in induction to only half a day, including the completion of mandatory training. The Trust arranged trainees' identification cards and occupational health registration the day they joined, and offered a named contact and/or facility to each trainee before their first day. The visit team learned that, in the event of any cross-site inductions, the use of video-conferencing facilities removed the need for trainees to travel to the relevant site. It was reported that the Trust monitored trainee feedback on the induction process using a Survey Monkey online questionnaire. This process was established following feedback from trainees at Sutton who stated that they were forced to travel to Chelsea to receive their induction. The Trust DME explained that he wanted to take the induction process out of the classroom, as he believed that giving trainees a named person to welcome them on-site made a real difference and improved trainee engagement. **Haematology** The haematology trainees stated that they were offered a full local induction, but chose the alternative option of a quick briefing, as they had previously worked on-site.	Yes – see TWR1.5 below

	ICM The visit team learned that despite not receiving any formal training in departmental procedures as part of a local induction, they were still able to complete tasks such as prescribing for ITU patients. **Pathology** Pathology trainees reported that their local induction was postponed by approximately four weeks.	
TWR 1.6	**Adequate time and resources to complete assessments required by the curriculum** **Anaesthetics** The trainees reported that supervisors were regularly undertaking case-based discussions and workplace-based assessments. In addition, trainees had the opportunity to attend anaesthetics training days and Intensive Care Society topic study days at the Royal College of Anaesthetists every couple of months. **Clinical Radiology** The visit team was concerned to hear that the Trust's radiology rota system made it difficult for radiology trainees to complete the necessary training in Positron emission tomography–computed tomography (PET-CT) scanning, which was required by the radiology curriculum for level two higher oncology training. The trainee advised that when previously employed at another Trust, they were given clearance to attend the Royal Marsden to complete their PET-CT training. However, when working at the Royal Marsden, trainees could not complete the training that institution offers, as a result of inadequate rota scheduling.	Yes – see TWR 1.8 below
TWR 1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The visit team learned that the Trust initiated a pilot scheme at the Chelsea site that exposed trainees to ward-based acute oncology for non-elective patients. The Trust intended to replicate this model at Sutton and continued to measure trainee responses and patient experience and outcomes. **Anaesthetics** The visit team learned that the anaesthetics trainees were resident at the Chelsea site and spent one supervised week at the Sutton site training in anaesthesia for paediatric oncology patients. Resident cover was supervised by Fellows. Trainees reported that the rotation at the Royal Marsden was quite limited in its focus, and that anaesthetics trainees did not obtain exposure to a wide variety of pathologies while working in the ITU; that placement was reportedly better for offering exposure to perioperative medical care, 48hr post-operative care, and interventions in a level one to two environment. The visit team was advised that any trainee looking for a broad-based placement would be better placed on rotation in a busy acute general hospital. In particular, trainees said that they did not gain enough exposure to paediatric anaesthesia. More generally, it was reported that sub-specialty interests were not frequently accommodated outside of Fellowships, but could be possible with prior arrangement. Overall, the trainees recommended the placement at the Trust, but only to senior trainees that were aware of what the placement entailed, as it was more difficult for more junior trainees. **Clinical Radiology** The visit team was concerned to hear that junior radiology trainees were not receiving appropriate learning opportunities when they attended the Chelsea site; trainees reported that if such trainees were not already experienced in procedures such as gynaecological ultrasound, biopsies and drains, then they would not receive any training in these whilst at the Chelsea site - trainees reported that juniors were	

	expected to be able to complete more complex tasks by the time they rotated to the Chelsea site. The visit team heard that the ultrasound sonographers did not have cover of the ultrasound list, and that higher trainees were regularly left without named consultant supervision and felt unsupported. In addition, the trainees reported that the rota schedule meant that trainees working less than full time were not receiving adequate learning opportunities because their timetables did not match the days that consultants were in attendance. It was reported that the post at the Chelsea site was most beneficial when trainees were at a more senior level, as they were usually left to work independently. With regard to the breadth of learning opportunities, the visit team heard that trainees were very impressed with the quality of their teaching, but raised concerns about the lack of sub-specialty reporting; it was reported that the Trust did not offer adequate training for benign reporting or exposure to musculoskeletal imaging. **Haematology** The DME stated that the Trust was disappointed with the GMC NTS returns for haematology. The visit team was advised that the local education team met trainees and established a list of actions required to make improvements, particularly in the quality of local teaching in laboratories, which had been formalised. The visit team was informed that one of the department's consultants had taken a sabbatical, and that his absence had had a negative impact on haematology training. However, the visit team learned that the consultant had now returned to their post, and the haematology department had also appointed two new haematology consultants a week before the Trust-wide review, which it was hoped would alleviate the pressure on the department. The Trust acknowledged that the department was stretched in terms of consultant presence, and was aware that the staff shortage reflected on training. However, the Trust was optimistic that the new appointments would strengthen the quality of teaching and the haematology department as a whole. Trainees stated that the placement offered unique exposure to ethical discussions, clinical trials, complex diseases and medication pathways, and the stem cell transplant unit. However, the visit team heard that trainees were concerned that the placement was too limited and that overall training needed to be balanced with experience at a general hospital. **Palliative Care** The visit team heard that trainees were generally happy with the exposure that the placement offered, but it was reported that trainees had to work extremely hard with a demanding workload. **Pathology** The trainees stated that they were very happy with the experience received whilst at the Trust, and had the opportunity to see rare and complex cases. The visit team was informed that trainees posted at the Trust were usually at a senior level so were better placed to cope with the workload. It was reported that the Trust's sarcoma unit offered unique experience not widely available in London or across the UK.	Yes – TWR 1.8 below
TWR 1.8	**Protected time for learning and organised educational sessions** **Haematology** The visit team was informed that haematology trainees had formal teaching scheduled on Wednesdays. However, most teaching took place OOH because of consultant availability. Trainees stated that the teaching was very good but the frequency and consistency had tailed off as the year had progressed. It was reported that the new consultant in post had organised teaching on Fridays and brought slides to and from teaching sessions; trainees explained that the lack of a digitised facility meant that there was no opportunity to view slides on projectors remotely across sites as was the case in multi-disciplinary team sessions. The visit team learned that trainees were frustrated by institutional changes to the	Yes – see TWR 1.8 below

	reporting structure at the Centre for Molecular Pathology (CMP) at Sutton. It was reported that the CMP offered integrated, regional pathology services to Trusts, and the Royal Marsden was responsible for the integrated reporting of bone marrow pathology work. The visit team was informed that trainees no longer received opportunities to report here as all work was carried out by consultants; historically, trainees used to review cases in the registrars' room, with consultant oversight. The visit team heard that trainees were very happy with the quality of the teaching at the CMP, but found it very difficult to squeeze this into an already demanding schedule. It was reported that there was a good case mix at the CMP from which trainees could receive great educational benefit. However, the visit team was advised that the Trust told trainees that any teaching received there should be self-directed learning and did not schedule this into trainee rotas. **ICM** The visit team learned that there was a disparity between the amount of teaching offered to junior and senior trainees; it was reported that Foundation year two trainees had a structured educational programme, whereas there was nothing regular aimed at higher trainees. **Pathology** Pathology trainees reported that they had a very well-structured training rota, and received regular training from a number of different consultants at standard teaching or slide-based 'black box' sessions. The visit team heard that the department showed a strong commitment to teaching and that the complexity and frequency of cases was excellent.	
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.**		
TWR 2.1	**Effective, transparent and clearly understood educational governance systems and processes** The visit team was pleased to see the commitment shown by the DME to raising the profile of medical education at the Trust, and the developments that have been made to implement changes across the organisation. The Trust DME explained that his role was to raise the profile of medical education at the Trust from an 'add-on' to being on the same level of importance as patient care, clinical quality and research. It was reported that historically, there was a culture of complacency towards education and training at the Trust, which it had worked hard to break down across the organisation. The visit team heard that the Trust was working to integrate medical education and training across the organisation, with a strong focus on research. It was reported that the Trust Board wanted to meet trainees face-to-face, and met seven trainees for a question and answer session at a recent board meeting. The visit team learned that before the present post-holder joined the Trust, the role of DME operated with blurred lines of accountability. However, a more robust reporting system was now in place, with the DME reporting directly to the medical director, who reported to the Trust Board. The visit team was keen to clarify the Trust's local faculty group (LFG) structure, and was pleased to hear that there was a commitment to LFGs, with one established for each programme taught at the Trust. The DME acknowledged that not every group	

	worked as effectively as others, due to the low trainee numbers in certain specialties. However, it was noted that there was a definite effort to boost trainee attendance, including offering video links to join trainees across sites. It was reported that LFGs were also used to discuss any issues with trainees, in the absence of trainee representatives. The visit team observed that, while the DME was committed to reporting on LFGs and feeding issues through to senior colleagues, there was no formal educational committee structure in place to manage LFGs and any subsequent issues raised. It was reported that there were formal LFG strategies in place for anaesthetics and surgery, but more informal arrangements were made for critical care faculty meetings. The faculty commented that critical care formed part of the local faculty group for anaesthetics and surgery.	Yes – see TWR 2.1 below
TWR 2.2	**Impact of service design on learners** The Trust discussed the existing issue around the use of trainees to administer care for private patients. The visit team heard of the work that the Trust has undertaken with the Postgraduate Dean for north west London in order to manage the integrated model and how the Trust enabled its trainees to work through that model to their benefit. The Trust acknowledged that it has more to do but felt that that it was moving in a positive direction. When asked about the impact of private patient care on trainees' learning opportunities, educational leads acknowledged that the issue remained challenging; most departments followed the integrated model of care, as suggested by HEE. The Trust stated that for this model to work, it was important to provide appropriate supervision and recruit additional staff grade doctors. The Trust felt that the provision of private care gave trainees exposure to invaluable learning experiences, with particular regard to the prescription of off-licence drugs and the complexity of cases. Trainees reported that while the NHS care system offered a good flow and structure, the Trust's management of private patients was markedly disorganised. The visit team heard that trainees experienced a higher level of challenging and heated conversations with patients and their relatives, particularly in relation to the lack of consultant attendance. In one instance, the visit team heard that a palliative care patient at the Chelsea site had not gained access to their named consultant, as that consultant was based at Sutton four days per week. Trainees reported that it was frequently the case that private patients were unable to see their consultant on a daily basis, and it was the trainees who would be left alone to defend themselves during these challenging conversations. The trainees felt that the consultants were not managing the expectations of private patients appropriately, and that the consultant body needed to be more proactive in setting out their availability as part of treatment plans. The Trust expressed a desire to try to avoid short-term measures of improvement and stated that it had developed a strategy for a sustainable medical model that was looking to the future. The visit team learned that this model was in the early stages of development, but the Trust stated that it was happy to share more details later in 2016. The strategy looked at multi-professional roles and how the Trust could improve the integration of these roles into the wider clinical programme.	
TWR 2.3	**Organisation to ensure time in trainers' job plans** The visit team was impressed by the strong support given by the DME to training and educational leads, which was highlighted by tutors in a number of specialties during the Trust-wide Review. The DME reported that time – 0.25 programmed activities (PA) – was now built in to educational supervisors' (ESs) job plans, a move which was supported by the Trust Board and senior management team. The visit team heard that supervisors were generally happy, had in place a good system for maintaining competencies and were supported in undertaking appraisals. The visit team heard that educational leads were given strong support in their educational roles and personal development; cover was provided on occasions where	

	tutors had to miss clinics to attend external courses. It was reported that tutors were well-engaged with LFGs, received regular Trust updates and were encouraged to undertake research.	
TWR 2.4	**Organisation to ensure access to a named educational supervisor** **Clinical Radiology** The visit team learned that the trainees received weekly informal checks from their ES.	
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.**		
TWR 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The Trust was pleased to advise that it had not received a report of bullying or harassment in 14 months. More generally, the Trust reiterated that it had a zero tolerance approach to bullying and harassment, and that reports were escalated to the Director of Workforce, if necessary. Trainees did not raise any concerns about bullying and undermining during the Trust-wide review.	
TWR 3.2	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** It was reported that the Sutton site housed approximately 45 trainees across medical oncology, clinical oncology and core medical training (including General Practice Vocational Training Scheme trainees). The visit team learned that there was no formal education space situated on-campus at the Sutton site. However, meeting rooms were available for use for teaching sessions, as required. It was reported that all simulation training took place at the Chelsea site, with only sporadic sessions held at Sutton. The Trust advised that the postgraduate medical education coordinator spent one day a week at the Sutton site to provide any assistance to trainees based there. The visit team learned that the Trust was keen to ensure that an educational lead was present at all times at both sites in order to avoid a sense of isolation that had previously been reported by trainees at the Sutton site. With regard to the Trust's educational resources, it was noted that both sites had libraries, with the Sutton site's reported as the stronger of the two; a librarian was based on-site at Sutton, and trainees were briefed on all library services and resources in their induction welcome pack and on the staff intranet. It was reported that trainees had access to IT services and educational resources using programmes such as OpenAthens accounts that were set up for them at induction. The visit team was impressed with the paediatric department's psychologist-led bereavement debriefing sessions, which were an invaluable source of support for trainees and the wider department following difficult cases. The Trust advised that while there was strong attendance at these sessions, psychological support was always available for staff. The visit team learned that the DME implemented an internal leadership development programme that was developed by Imperial College Healthcare NHS Trust but adjusted to meet the specific needs of the Royal Marsden. The Trust stated that the project was selected to reflect the Trust's transformation agenda, and was established to develop skills and break down any barriers between clinicians and the management team. At the time of the visit, three clinical oncology and two CMT trainees were involved in the project. The Trust advised that a full range of meetings were held at both sites, and that governance was unified across the Trust. Where possible, the Trust stated that it used video-linking to avoid staff having to travel unnecessarily in order to attend meetings.	Yes – see TWR 3.2 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.

TWR 4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team observed that educational leads felt very well-supported by the Trust's DME, who was described as 'excellent'. The Trust advised that a new system of electronic job planning was in place and was fully operational. The Trust acknowledged that it had more work to do in implementing job planning for all educational leads, but stated that it was a priority for the Trust to ensure that teaching was timetabled for all supervisors.	
TWR 4.2	**Access to appropriately funded professional development, training and an appraisal for educators** The visit team learned that the Trust had appointed an appraisal lead to improve the volume and quality of appraisals undertaken; the Trust was clear that medical education was an integral part of that appraisal process. It was reported that educational supervisors received in-house training sessions, and that the Trust's faculty development programme intensified over the last 12 months to ensure 100 per cent compliance with the GMC's trainer requirements. The Trust was pleased with the results of the 2016 GMC trainers' survey, which returned very positive feedback for the Trust; senior managers felt that the results were a true representation of how its trainers were well-supported and dedicated to education. The visit team was informed that the Trust had a definite commitment to education and training, with particular reference to the DME's role on the clinical advisory team, which directly fed back to the senior management team.	

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.

TWR 5.1	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** **Anaesthetics** Trainees stated that this post was very good for learning and had a lot of positive points; trainees reported exposure to complex procedures – such as total intravenous anaesthesia – that were not often performed at other hospitals. **Haematology** The visit team learned that the haematology trainees were based at both the Sutton and Chelsea sites at one at a time and did not usually need to travel between sites. Trainees stated that they spent three months of their placement at the Chelsea sites and the rest of the time, were on rotation at the Sutton site. It was reported that the sites offered different case exposure, and that the more senior trainee was sent to the	

	Chelsea site; that trainee was supported by a consultant haematologist who was present every day for cover and discussion of any lab issues.	
TWR 5.2	**Opportunities for interprofessional multidisciplinary working** **Trust-wide** The Trust stated that it had taken a broad view to conduct a project looking into the use of multi-professional staff and applied it across medical specialties. The visit team was keen to ascertain how the Trust intended to build a care model that was not heavily reliant on junior doctors. The Trust acknowledged that training posts were at risk in London, and that as an organisation it needed to provide a consistently good experience for trainees and patients; the Trust was keen to specifically develop a multi-professional model that worked towards fulfilling that need, and encouraged learning elsewhere within the organisation. The Trust stated that it was working hard to gather that information in order to develop a solution that was right and affordable for the Royal Marsden. The visit team learned that six weeks before the Trust-wide review took place, the Trust conducted interviews with each specialty to formalise a solid idea of what good practice looks like, and how the model could work across the Trust. The visit team learned that a report on this project was scheduled for release in the autumn of 2016, and that the subsequent implementation was expected to take between two to three years; this was due to the amount of time it was anticipated it would take to develop a multi-professional workforce, including a long lead-in time to train non-medical elements of that workforce. The Trust reported that it had introduced one advanced radiographer, two acute nurse practitioners working in ITU, six nurse consultants, 1 advance nurse practitioner (ANP) consultant, one therapeutic radiologist, four PhD-level radiographers, a diagnostic radiographer and 25 advanced nurse specialists working in surgery as part of medical teams (including one in plastic surgery, who attends clinic and ward rounds). The Trust set out its vision for multi-professional care and explained that it was working towards a holistic model to improve continuity of care and patient experience, and wanted to create a sustainable workforce model for the future. The visit team was advised that the move towards multi-professional working had opened up discussions on the potential for multi-professional team members to be involved in the training of junior doctors. The Trust advised that this would be a natural progression for its workforce, as it would help to avoid historic silo working patterns and pooling of staff. The visit team learned that the DME worked with the chief nurse to break those patterns down, so that trainees could see the range of opportunities available for multi-disciplinary working; discussions have taken place regarding palliative radiotherapy training, which would be delivered to trainees by radiographers. It was reported that F2 trainees received ITU simulation training from nursing staff with cross-boundary competence. The visit team wanted to be kept up-to-date with any developments in these projects, and stated that it was keen to support the Trust, in conjunction with Dr Catherine O'Keefe, Head of Professional Development at Health Education England. Surgical leads reported that the department's ANPs were having a positive impact on trainees' ability to attend theatre and clinics in their capacity to perform tasks once reserved for doctors. The visit team heard that such work could now be split and the department reported a supportive, non-competitive environment where everyone learned from each other. It was reported that the haematology department also benefitted from the use of ANPs to share consenting, ward rounds and patient reviews. The visit team heard that the palliative care trainees were experiencing an imbalance in the duties that were shared with the department's clinical nurse specialists (CNSs) due to the inexperience of new team members. The nurses were described as providing 'excellent' care, but the trainees reported being under a lot of pressure to carry out more tasks than anticipated.	Yes – see TWR 5.2 below

	The visit team learned that there were three radiology trainees based at the Chelsea site. The trainees advised that their posts were spent on six month blocks at each of the Chelsea and Sutton sites. The visit team heard that the clinical radiology department at Chelsea was under-staffed in a number of posts, which had an impact on the day-to-day tasks required of trainees; trainees advised that the lack of a sonographer specialising in thyroid and lymph node FNAs meant that they were interrupted throughout the day to undertake these more basic procedures. It was also noted that the Chelsea site had no capacity for a reporting radiographer.	
TWR 5.3	**Appropriate balance between providing services and accessing educational and training opportunities** The visit team was keen to clarify the nature of the care that trainees were providing to private patients and the educational value that this presented. **Haematology** Trainees reported that they felt pressured to prioritise private patients, who accounted for nearly 50 per cent of the patient population at the Chelsea site. The visit team heard that trainees frequently managed demanding requests for non-clinically urgent tasks on the private medical day unit. In addition, trainees reported that they received more calls from the CNSs on the private day unit than to attend private patients than they received from CNSs responsible for NHS care. The visit team heard that the triage system for the private day unit was not working effectively. **Palliative Care** The visit team heard that it was impossible to escape the impact of private patients, which placed significant demands on time and workload. Trainees reported that they were advised by senior clinicians not to do paperwork for private patients. However, the visit team was informed that trainees frequently felt pressured to do more than they could manage, and frequently experienced angry, verbal abuse from patients and relatives. Overall, trainees were concerned that the lack of consultant input in the care of private patients from the original primary treating team which left trainees exposed. **Radiology** The trainees reported that they received opportunities to undertake MRI reporting for private patients, with consultant sign-off. The visit team heard that trainees were exposed to an interesting and complex case mix with private patient care. However, trainees described a disorganised rota system in operation for sonographer-led private patients' ultrasound lists; of the sonographers on-site at the Chelsea site, only one was authorised to care for private patients, yet private patient imaging continued to be added to their list. Consequently, trainees were called out to assist with tasks that offered no educational value. It was reported that this frequently happened with FNAs and biopsies. More generally, imaging requests were allocated to inappropriate lists, resulting in unnecessary interruptions to trainees' work, which trainees felt damaged patient care and learning. Trainees believed that another trainee needed to be recruited, but warned that it would be difficult to recruit to a Fellowship post; the visit team heard that trainees experienced a good case mix, but were used increasingly for service provision of basic tasks. One trainee reported undertaking ultrasound and fluoroscopy on a daily basis since arriving at the Royal Marsden.	Yes – see TWR 5.3 below

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date

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.**
TWR 1.4a	The Trust is required to ensure that trainees are EWTD compliant; this is particularly relevant to haematology and palliative care.	The Trust is required to undertake a diary card exercise in haematology and palliative care medicine. If the diary card exercise results in confirmation of non-compliance, the Trust must provide a plan detailing how it intends to resolve the breach. The Trust is required to provide the minutes of LFGs and the newly-established educational governance committee, confirming that trainee workload is a standing agenda item and that solutions to staff shortages are being developed to ensure that the training experience is not compromised.	R1.7
TWR1.4b	The Trust is required to review arrangements to cover rota gaps to ensure that the excess workload for trainees is reduced.	The Trust is required to provide the minutes of LFGs confirming through trainee feedback that workload has reduced over a period of three months.	R1.12
TWR 1.5	The Trust is required to ensure that local inductions are held in a timely manner, are comprehensive, and adequately prepare and orientate trainees within their respective departments.	The Trust is required to review local inductions across the Trust and implement any improvements. The Trust is required to monitor the quality of local inductions through internal surveys and discussion at LFGs. The Trust is required to provide the outcome of the review, LFG minutes and any internal survey results. The Trust should also provide any information on the improved induction programme and associated documentation.	R1.13
TWR 1.8	The Trust is required to ensure that adequate time is allocated for protected learning and organised educational sessions. This should include relevant training and further academic opportunities, e.g. PET-CT training for clinical radiology trainees and set time for haematology trainees to report bone marrow at the CMP in Sutton.	The Trust is required to provide haematology training weekly timetables that clearly show protected time to report bone marrow. Training in PET – CT for clinical radiology trainees must be provided. Evidence for these needs to be provided in the form of minuted LFG meetings confirming trainee involvement. The Trust is required to provide training programmes for all trainees within the Trust. The Trust is required to provide LFG minutes that demonstrate that the accessibility of educational sessions is regularly being discussed, that trainees	R1.12

		are able to raise concerns and that solutions are being implemented.	
TWR 2.1	The Trust is required to establish an educational governance committee to discuss training and education issues, and formalise the reporting structure for educational governance within the Trust.	The Trust is required to provide an updated organisational chart that demonstrates the position of the educational governance committee within the organisational structure. This should be corroborated with minutes from that meeting.	R2.1
TWR 3.2	The Trust is required to provide equitable simulation training across both sites.	The Trust is required to provide a simulation programme for both sites that demonstrates that trainees on both sites are able to access adequate levels of simulation training. This should be corroborated with LFG minutes, demonstrating that trainees are able to attend.	R1.20
TWR 5.3	The Trust is required to ensure that patient/relative expectations regarding the daily attendance to patients by the consultant in charge is managed and clearly timetabled, taking into account consultant leave, team cross-cover etc. The role of the trainee in the management of private patients out of hours needs to be clearly identified and agreed within each clinical area. In particular, the triage system in the private day unit needs to be revised to exclude trainees from this routine work. The workload impact of the care of private patients needs to be closely monitored within each specialty as a standing item on the LFG agenda and discussed at Trust level in the education governance meetings.	The Trust is required to provide educational governance meeting and LFG minutes that demonstrate that the workload impact of the care of private patients is regularly being discussed, that trainees are able to raise concerns and that solutions are being implemented.	R1.15

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
TWR 5.2	The Trust should provide regular updates on its multi-disciplinary working project and how this integrates with education and training. It is strongly suggested that the Trust continues to work with HEE on this matter.	The Trust should provide evidence of any correspondence with HEE on this matter.	R5.9

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 Andrew Deaner, Trust Liaison Dean, Health Education England North Central London
Date:	23 August 2016