QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Guy's and St Thomas' NHS Foundation Trust

Medical Oncology

Risk-based Review (on-site visit)

Quality Review report

14 February 2017

Final Report

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Quality Review details

Background to review	The purpose of the Risk-based Review (on-site visit) at Guy's and St Thomas' NHS Foundation Trust in regard to medical oncology was primarily to investigate the concerns that had been raised in relation to the introduction of the resident on-call rota for both medical and clinical oncology trainees and the introduction of the Hospital at Night system. The quality review team felt it was pertinent to explore the impact the introduction of the Hospital at Night system would have upon the learning and training environment.
Training programme / learner group reviewed	Medical oncology
Number of learners and educators from each training programme	The quality review team initially met with members of the Trust senior management team, which included the medical director, head of finance, director of medical education, oncology directorate lead, medical education manager and medical workforce lead. The quality review team met with trainees in oncology and haematology at the following grades: - Foundation Year 1 - Foundation Year 2 - Core Medical Training second year (CT2) The quality review team also met with trainees in medical oncology, at the following grades: - Special training year three (ST3) - Specialty training year six (ST6) - Academic medical oncology trainees The team further met with the local Training Programme Director for medical oncology and the educational supervisors for the medical oncology trainees.
Review summary and outcomes	During the course of the review, the quality review team was informed of a number of areas that were working well with regard to the education and training of medical oncology trainees, such as: - All of the trainees the team interviewed stated that they valued the supervision and support they received from the consultant body within the department. - All trainees reported that they were aware of how to report serious incidents and that there was a strong culture of doing so within the Trust. Furthermore, the trainees commented that they had received thorough feedback when they had reported such incidents. - Trainees at all levels reported that they were involved in treating patients with a wide range of conditions and were exposed to a diverse case mix, which provided good training opportunities. However, the quality review team also identified a number of areas which required improvement. For example: - The review team ascertained that the communications regarding the introduction of the resident on-call and Hospital at Night rota at all levels had been sub-optimal at best and in some instances inappropriate. It was felt that there had been a lack of communication and that following the on-

site visit, Health Education England would be actively involved in any discussions.

- It was reported that the handover system in medical oncology was conducted via an email system and was not sufficiently robust, especially in relation to the weekend handover.
- It was reported that there was no structured higher trainee and consultant ward round on the oncology ward every day, and that they often occurred on an ad-hoc basis once the higher trainees' and consultants' clinic lists had finished.
- The quality review team heard that workload was a significant issue for medical oncology trainees and that trainees at all levels routinely left late, typically between 7-9pm.
- At the higher trainee level, the workload issues were often caused due to the trainees' cross-covering duties, when their fellow higher trainees were on-call at night or on subsequent zero days. The higher trainees felt these workload concerns could cause potential patient safety issues. Furthermore, it was reported that the trainees' onerous workload was also impacting upon their ability to access a range of training opportunities; they found it difficult to take study leave and access a suitable number of clinics.
- There were concerns raised regarding how the Hospital at Night system would work during the day at weekends, as the higher trainees' workload was already excessive, which they felt would be exacerbated if they were also undertaking the relevant Hospital at Night system duties. The review team felt the weekend Hospital at Night rota should not be implemented until a full risk assessment had taken place.

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

Meeting with the Trust Senior Management Team

The Trust reported that the agreed start date for the oncology trainees covering the hospital at night rota would be 20 February 2017.

The Trust confirmed that clinical oncology trainees at ST5 or above would not work on the hospital at night rota. The review team heard the following timelines regarding hospital at night:

- 20 February 2017 – Oncology start
- 1 May 2017 – Renal start

The Trust informed the review team that only two trainees from clinical oncology were eligible to work the hospital at night rota. There were therefore be 31 gaps between the review date and the end of April 2017 on the hospital at night rota, which would need to be filled using locums.

The Trust commented that due to there being fewer renal trainees they would need to review the rota to ensure there was a fair division of workload. The Trust felt that the model for hospital at night on weekday nights was serviceable and they would continue to take feedback and develop further as necessary.

The review team heard that the Trust was looking at introducing the surgery core trainee as resident on-call at night to provide an extra tier of support for the foundation trainees on the ward. This should also reduce the number of surgical calls to the hospital at night team, this was to commence from April 2017.

The Trust reported that they had informed the trainees if they felt any of the calls were outside of their competency they were to refer directly to GCCU.

The Trust commented that the biggest impact of hospital at night was on trainees' day-time working as they would have to take compensatory rest. Due to this the Trust was going to explore alternative workforce skill mix through clinical fellows and physician associates.

The review team heard that the Trust was looking at developing a clinical nurse specialist-led helpline to ensure that calls were screened appropriately and trainees were not being disturbed by calls that other staff members could deal with. The Trust hoped to have the nurse call triage system in place by April 2017.

Quality Review Team			
HEE Review Lead	Dr Catherine Bryant Deputy Head of the London School of Medicine and Medical Specialties	**External Clinician**	Dr John Conibear Consultant Clinical Oncologist, Barts Health NHS Trust
Trainee Representative	Pui Ying Chan, Academic Clinical Fellow in Medical Oncology	**Lay Member**	Jane Chapman Lay Representative
Scribe	Elizabeth Dailly Learning Environment Quality Coordinator		

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement Reference Number
1	**Serious incidents and professional duty of candour** The core medical and foundation trainees the quality review team interviewed described a strong culture of reporting any serious incidents within the department. They all reported that they knew how to report such an incident and that they received detailed feedback regarding any issue they raised.	
2	**Responsibilities for patient care appropriate for stage of education and training** The foundation and core trainees in haematology confirmed that they felt well supported and only provided cover for oncology patients at night. They confirmed that if any patient became unwell out-of-hours, that they could always contact someone and escalate any issues to the intensive care team if necessary.	

	In relation to the foundation trainees working solely in oncology, the trainees indicated that on occasion they felt they were expected to function at the level of a core trainee as opposed to a foundation doctor. However, all stated that there was always someone more senior on the ward (core medical trainees) they could contact with any clinical questions and that the higher trainees in clinic would always attend the ward if necessary and were contactable via telephone.	
3	**Rotas** The foundation trainees expressed that the ward rounds that took place with the higher trainees or consultants typically occurred on an ad-hoc, last minute basis once they had finished their clinic lists. The lack of structure and set time of the ward round meant that often the trainees worked past their typical hours, especially if the ward round did not start until 4.30pm, which was often the case if the higher trainees' outpatient clinic overran. Furthermore, the core medical trainees in oncology commented that the workload when they were on-call at weekends was often onerous, but that this provided them with many training opportunities. In relation to the on-call rota at night for the core medical trainees, they reported that there had not, at the time of the review, been an instance when they needed the higher trainee on-call to attend to see a patient, but that they knew how to contact them with any clinical questions if necessary. In relation to the introduction of the resident oncology on-call rota, the higher trainees reported that this had been initiated as a diary card exercise had demonstrated that the on-call rota that was previously in place, under which the trainees undertook their on-call duties at home, was not compliant with the European Working Time Directive. The trainees indicated that the majority of the on-call work was receiving telephone calls from patients, as opposed to seeing or answering questions from junior trainees regarding inpatients. The higher trainees stated that they felt the telephone calls could be received at home and that the on-call rota did not need to have a resident component, as they had access to the patients notes via the electronic system, and therefore did not need to be on-site. Those who had undertaken a resident on-call shift informed the review team that they had not been asked by any of the junior trainees to attend a patient during the shift and that the majority of the work was in relation to the phone calls. It should be noted, that the Trust outlined plans to introduce a clinical nurse specialist telephone system, who would triage and filter the phone calls that were received and forward only the calls that needed the higher trainees' input. However, it should be noted that the quality review team also heard that the proposed telephone system was a Macmillan funded project which aimed at establishing a regional clinical nurse specialist telephone system, not just for the Guy's Hospital site and although was due to start in April 2017 would only be initiated on an incremental basis. The trainees reported that the new resident on-call rota, which was supposed to operate at 1 in 18, but due to rota gaps was 1 in 15, was having a significant impact upon the learning and training environment within the department. In light of the lieu days that had to be taken following being on call, the trainees reported that they were working 30 per cent fewer day time shifts than previously, which dramatically reduced the amount of clinics they attended, which was crucial for their training and completing their competencies. The Training Programme Director (TPD) reported that the extent of the impact the resident on-call rota had at both a service and training level, had not been fully appreciated prior to its introduction in terms of the amount of lieu days the trainees subsequently had to take. Furthermore, as at the time of the review, there were only four full-time higher trainees in total, often when the trainees were working in the day, they were cross-covering for their colleagues, who were either resident on-call that night or on subsequent lieu days. The quality review team heard that the impact of the cross-covering was two-fold. Firstly, it had a significant impact upon and increase in the trainees' workload which resulted in them typically working beyond their contractual hours until 9pm. The trainees also felt that the significant increase in workload stemming from the need to cross-cover could cause potential patient safety issues. Secondly, it meant the trainees spent the majority of their working days answering bleeps and providing support on the	Yes, please see MO3.1a below. Yes, please see MO3.1b below Yes, please see MO3.2 below. Yes, please see MO3.3 below.

	wards, and therefore meant that they saw very few patients in clinic and were unable to attend multi-disciplinary team meetings (MDTs). Trainees indicated that there had been instances when the workload in relation to providing ward support and answering bleeps had been too heavy, they had been taken off clinics to provide this support. The trainees indicated that the cross-covering impact of the resident on-call rota had had a significant effect upon how much training they actually received and resulted in there being an undue balance between service provision and training opportunities.	Yes, please see MO3.4 below.
	In addition, the trainees reported that the clinical fellows employed by the Trust did not provide cover for the inpatients on the ward and instead were mainly based in the clinics. The trainees felt this was inequitable as the clinical fellows were subsequently receiving more clinical experience and training opportunities. Furthermore, the quality review team heard that the higher trainees could not participate in audit work, due to workload constraints, and that this again was predominantly undertaken by the clinical fellows employed by the department. The trainees felt that one possible solution could be to re-evaluate the role of the clinical fellows in the department and redesign the role to include providing ward cover and answering the bleeps.	
	However, it was reported that the Trust was at the time of the review, in the process of introducing a 'ward registrar of the week' system. During this week, the higher trainee would just cover the ward and undertake no clinic work, which would allow the rest of the higher trainees to solely spend time in outpatient clinics. As the quality review team heard from all the higher trainees, that their clinic time had been reduced due to the intensity of the ward work, the Trust hoped and expected that having one dedicated registrar, or clinical fellow, responsible for the ward would allow for the others to spend more time in outpatient clinics and multi-disciplinary team meetings (MDTs), which was where they completed the majority of their training and competencies. It was further confirmed by the oncology lead for the ward that the clinical fellows would be participating in the 'ward registrar of the week' rota.	Yes, please see MO3.5 below.
	When discussing the introduction of the Hospital at Night rota, the trainees commented that as this rota was an extra component of their resident on-call rota, all the issues the trainees previously raised about their lack of access to training opportunities and clinics, in light of the days they missed due to working out of hours or taking subsequent zero days and the workload issues stemming from cross-covering for the other higher trainees were still relevant. Furthermore, the Hospital at Night system meant the trainees were not just responsible for oncology patients when on site, but also for surgical patients. The trainees indicated that as medical oncology was so specialised, they were not comfortable being responsible for these patients as they would not be familiar with the best treatment plans. The trainees further highlighted that their Annual Review of Competence (ARCP) reflected only specific oncology related in depth problems, and that they were not dual accredited.	
	Moreover, the quality review team heard that the Hospital at Night rota would also be in place over weekends, so the higher trainees would also be covering surgical patients in the day at weekends. The trainees stated that when they were on call at weekends on their normal rota, the workload was onerous; as they were responsible for up to 30 patients, dealt with telephone calls from patients, covered the bleep and saw any new patients. They indicated that the additional duties of the Hospital at Night rota (reviewing the surgical patients also) would significantly add to their already stretched workload and could cause potential patient safety issues.	Yes, please see MO3.6 below.
	The quality review team further ascertained that the distinction that had been drawn between the higher trainees in medical oncology and clinical oncology past ST5, in relation to their ability to participate in the Hospital at Night rota, had been a source of frustration and upset for the medical oncology trainees. The trainees indicated that, in a similar fashion to the system that had been agreed for clinical oncology trainees, they felt that only trainees up to specialty training year four should have to participate in the Hospital at Night rota, as trainees at ST5 and ST6 had completed their MRCP diploma possibly seven or eight years previously, and therefore would be less comfortable treating non-oncology patients.	Yes, please see MO3.7 below
	All trainees stated that prior to the on-call rota becoming resident, they were extremely happy with the training they received at Guy's and St Thomas' NHS Foundation Trust and that they had previously had great clinical exposure.	

4	**Handover** Regarding the medical oncology handover on the ward, the trainees described a system whereby the handover was completed via an email system as opposed to a physical handover occurring. This was also the system in place for the Friday afternoon handover for the weekend and reportedly was so the consultant body could have an oversight of their patients and access the information from their email accounts when they were not on site. The quality review team felt that a more robust and face-to-face handover system should be in place.	Yes, please see MO4.1 below.
5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** In relation to completing their work-based assessments (WBAs), the core medical trainees reported that they found it difficult to complete the requisite number of Acute care assessment tools (ACATs). Furthermore, the foundation trainees in oncology reported that due to the chaotic ward environment they sometimes struggled to complete WBAs and one trainee commented that they had not completed any in their oncology rotation. However, it should be noted that all the trainees proclaimed that the higher trainees and consultants were more than willing to complete their WBAs, but that it was often difficult to find the time with them to do so. Furthermore, the trainees commented that a large proportion of patients they saw came through the acute oncology service, meaning they had already been clerked, which reduced their opportunity to do so. The core medical trainees commented that they were able to access ample outpatient clinic experience. However, the foundation trainees indicated that although they were keen to attend clinics and that the consultants were supported of this, they were unsure whether in practice this would be possible due to the heavy workload on the ward. The core medical trainees in oncology stated that due to the wide case-mix of patients, they received excellent training opportunities and saw patients with a wide range of conditions.	
6	**Protected time for learning and organised educational sessions** The higher medical oncology trainees undertaking the Institute of Cancer Research MSc in oncology, commented that on occasion they had had to miss the course day, when they were required to cross-cover for their colleague. The trainees further indicated that due to their cross-covering duties, they were not able to participate in audits and research or attend MDTs and clinics. The trainees described a working environment which the quality review team encapsulated as being predominantly focused upon service provision as opposed to providing suitable learning and training opportunities for the trainees.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity.

2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.

2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.

7	**Appropriate system for raising concerns about education and training within the organisation** Regarding the discussions surrounding the introduction of the resident on-call and Hospital at Night rota, the higher trainees confirmed that they had voiced their concerns through letters addressed to the senior management team, but that they felt their concerns had not been appropriately addressed by the Trust management and that they had not been adequately consulted and informed of decisions made regarding the new rotas. Furthermore, despite the higher trainees reporting that they all had positive relationships with the consultant body, the review team ascertained that the trainees did not feel they had someone to champion their views and concerns in the meetings regarding the Hospital at Night rota with the Trust. In order to address this, it was confirmed that there had been a change in the directorate management, and that the new clinical director who had been appointed for medical oncology was much more engaged with the trainees and had been holding weekly meetings with them, in order to discuss their concerns. The trainees commented that they felt the new clinical director acted as a good link between them and management. Furthermore, TPD confirmed they had also met with the trainees regularly.	
8	**Organisation to ensure access to a named educational supervisor** All core medical training trainees and foundation trainees reported that they had access to their educational supervisor and met with them regularly. They also confirmed that they all knew who their clinical supervisors were.	

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

9	**Behaviour that undermines professional confidence, performance or self-esteem** The foundation and core medical trainees the quality review team met with all stated that there was a positive culture within the department and that everyone was approachable and friendly. The review team heard that communication between the Trust and the trainees was sub-optimal and in some circumstances inappropriate behavior and had resulted in a disconnect between the trainees and their educational supervisors with the Trust senior management team. The apparent disconnect of communications between trainees and the Trust further fractured working relationships as it was reported that information told verbally in meetings was never corresponded formally to trainees in writing. However, when discussing the introduction of the resident on-call and Hospital at Night rota for the higher trainees, the quality review team ascertained that communication between the Trust and the trainees was sub-optimal and in some circumstances inappropriate behaviour had resulted in a disconnect between the trainees and their educational supervisors with the Trust senior management team. The trainees described feeling indirectly threatened by the Trusts' management team when they raised their concerns and that despite not being subjected to undermining or bullying behaviour by management directly in a one-to-one setting, messages had been passed down through the directorate which had given the trainees this impression.	Yes, please see MO9.1 below. Yes, please see MO9.2 below.

Requirements

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
MO3.1a	The Trust to ensure a structured higher trainee/consultant led ward round takes place. The clinics and ward rounds need to be coordinated so that trainees can attend both.	The Trust to provide confirmation that the new ward round schedules have been implemented. Please ensure this is in place by the end of March 2017.	R1.12, R1.14
MO3.1b	The Trust is to review the clinic templates and ensure that clinics which trainees are attending are not regularly overbooked.	The Trust departmental managers to produce a mechanism to ensure that the clinic templates are adapted to ensure that trainees are not regularly staying behind to complete their clinics. Please ensure this is in place by end of May 2017.	R1.12
MO3.2	The Trust to review the current system for oncology telephone calls and introduce a clinical nurse specialist triage telephone system.	The Trust to confirm that the clinical nurse specialist triage telephone system is in place and provide evidence of the impact this has on trainees' on-call duties, as well as any necessary amendments made. Please ensure this is in place by end of May 2017.	R1.6
MO3.3	The Trust to undertake a diary card exercise for trainees at all level to ascertain their workload.	The Trust to provide the outcome of this diary card exercise and any necessary action taken to address any issues raised. Please ensure this is in place by end of April 2017.	R1.12
MO3.4	The Trust alongside HEE is to audit the resident on call rota and its impact on education and training. Furthermore, the Trust to review the allocation of clinical fellows and re-evaluate whether they can provide cover for the patients on the ward, which would allow the higher trainees to attend more clinics and access more training opportunities.	We suggest that you produce a draft generic work schedule that details the training opportunities available to the trainees and highlighting the expected access. This schedule needs to ensure that higher trainees can attend a suitable number of clinics every week. This draft generic work schedule can then be audited in advance to the introduction of exception reporting. The results of this audit should be available to HEE by mid-April followed by a meeting to discuss the findings before the end of April.	R1.12, R1.16
MO3.5	The Trust to introduce a 'higher trainee ward week' system with protected time to ensure trainees meet curricula requirements.	The Trust to provide an update on the progress of the 'higher trainee ward week' system and the impact this is having upon trainees' ability to access learning and training opportunities. Please audit the experience of trainees on this new arrangement – we suggest that this is taken once this has bedded in but within 3 months. Please ensure this is in place by end of May 2017.	R1.12

MO3.6	The Trust is to ensure that a thorough risk assessment has taken place regarding the hospital at night during weekends.	Please provide HEE with the outcome of this risk assessment prior to implementing the hospital at night weekend cover. This should include an assessment of the activities of the daytime weekend oncology cover with an analysis of the appropriateness of the tasks being carried out and a proposal for how inappropriate duties might be covered. Please ensure this is in place by end of April 2017.	R1.12, R1.16
MO3.7	The trust together with the TPD/College Tutor should review an audit of the interventions that the medical oncology trainees are making as part of their H@N responsibilities and to assess whether initial management of these complications would be consistent with the expectations of the competences of a medical oncology trainee of ST5 or above.	The Trust to provide the outcome of this review and any subsequent changes and action taken. Please ensure this is in place by end of March 2017.	R1.12, R1.16
MO4.1	The Trust to review the email handover system currently in place for the oncology ward and introduce a more robust, face-to-face handover system.	The Trust to confirm that the new handover system is in place and is effective. Please ensure this is in place by end of March 2017.	R1.14
MO9.1	The Trust is to ensure that HEE are included in all communications regarding the hospital at night rota.	Please provide evidence that this action has been met. HEE proposes that the Trust and HEE have a joint meeting every month between the Trust management, trainees, education leads and HEE representatives with an agenda and minutes. Effective immediately.	R3.7, R2.8

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
MO9.2	The Trust to ensure that trainees are aware of how to contact the Professional Support Unit's Individual Support Team.	The Trust to confirm circulation of the link to the website to trainees. Effective immediately.	R3.3

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Catherine Bryant, Deputy Head of the London School of Medicine and Medical Specialties
Date:	10 March 2017

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.