Health Education England

The Royal Marsden NHS Foundation Trust

Paediatrics

Risk-based Review (on-site visit)

Quality Review report

28 February 2019

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	The General Medical Council National Training Survey (GMC NTS) 2018 results for Paediatrics returned six red outlier results; overall satisfaction, clinical supervision, clinical supervision out of hours, handover, regional teaching and study leave. The survey also returned three pink outlier results for adequate experience, educational governance and rota design. Similar issues were raised by trainees in the specialty school survey, for example a lack of formal training in clinic, understaffing, lack of induction or preparation for on-calls and rota changes being made at short notice.
Training programme / learner group reviewed	Paediatrics
Number of learners and educators from each training programme	The review team met with four trainees at specialty training grades two to eight (ST2-8). The review team also met with educational and clinical supervisors and the following Trust representatives: • Director of Medical Education • Deputy Director of Medical Education • Postgraduate Medical Education Coordinator • Guardian of Safe Working Hours • Divisional Director for Cancer • Nursing Director for Cancer • Educational Lead • College Tutor.
Review summary and outcomes	The review team thanked the Trust for the efforts made in facilitating the review. Several areas of good practice were identified, including the level of engagement from the Educational Lead and supervisors, the willingness of the department management to make changes based on trainee feedback and the proactive approach to stabilising the rota and diversifying the workforce (see Good Practice section below). The review team also identified some areas requiring improvement: • Trainees at specialty training level three (ST3) were classified as higher trainees whether or not they had taken the Membership of the Royal College of Paediatricians examinations • A more robust policy was required around support for ST2 and ST3 trainees starting in post, who face a steep learning curve • Handover was not always consultant-led • There were inconsistent arrangements for trainee access to clinics • The attending consultants for the inpatient wards had to divide their time between the wards, clinics and other commitments • Simulation training sessions were only run every six months

	• The trainee representative was active and attended local faculty group and consultant meetings but other trainees were not encouraged to attend • Trainees working out of hours were responsible for prescribing chemotherapy for day care patients. The trainees were involved in multidisciplinary team (MDT) discussions of these patients but were not usually responsible for their care The Trust required more succession and workforce development planning for the advanced nurse practitioner team.

Quality Review Team			
HEE Review Lead	Geoff Smith Deputy Postgraduate Dean, North West London Health Education England	**Deputy Head of Specialty School**	Ruth Shephard Deputy Head of London Specialty School of Paediatrics and Child Health Health Education England
External Clinician	Atefa Hossain Training Programme Director Consultant Paediatrician, St George's University Hospitals NHS Foundation Trust	**Lay Member**	Robert Hawker Lay Representative
HEE Representative	Louise Brooker Learning Environment Quality Coordinator Quality, Patient Safety & Commissioning Team, London Health Education England		

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

The Director of Medical Education (DME) discussed some of the steps taken since the General Medical Council National Training Survey (GMC NTS) 2018 results were released. These included creating more opportunities for trainees to give feedback, mitigating the impact of rota gaps on training and clarifying the responsibilities of educational and clinical supervisors. The Education Lead for Paediatrics (ELP) advised that the department had overrecruited to non-training junior doctor posts in order to mitigate against rota gaps. When rota gaps were identified, the ELP advised that the department tried to plan ahead to ensure cover, either by substantive staff or by locums. Due to the specialist nature of the department, there were not many locums who could work there. The department also employed advanced nurse practitioners (ANPs) who covered some of the work in the day unit and so reduced the workload for junior doctors. The department had received positive feedback from trainees and other staff around multidisciplinary working. The ELP had instigated monthly meetings with the trainees and the trainee representative attended the departmental consultant meetings.

There had been an increase in consultant staffing in the department so there were now six consultants in the bone marrow transplant (BMT) and haematology transplant team (the liquid team) and five consultants in the solid tumour and neurology team (the solid team). Each team had a named attending consultant each week who covered the inpatient wards and carried out two full ward rounds a week, daily board rounds and additional reviews of sick patients as required. On the junior doctor rota there were four trainees at specialty training levels two to eight (ST2 to ST8) and four clinical fellows, as well as one vacant training post.

The ELP reported that all trainees gained experience working with both teams, but at ST3 the trainees were allocated to the liquid team for their day shifts and covered both teams during out of hours on-call shifts. The ST3 trainees also attended multidisciplinary team meetings (MDTs) and clinics with the solid team. The review team questioned whether this provided sufficient experience for ST3 trainees to cover this service overnight and was informed that most out of hours care for solid tumour patients involved routine chemotherapy prescribing and managing drug side effects, which were similar for both patient groups. Trainees at other levels rotated between both teams in six-week blocks.

The ELP estimated that there was around one case per month where a patient became acutely unwell out of hours resulting in the on-call consultant being required to come in. The review team heard that these were usually patients awaiting transfer to St George's Hospital. The Royal Marsden and St George's Hospital had formed a joint paediatric oncology centre and there was an inreach service to transfer patients to the acute unit at the St George's site when needed. Prior to working nights on-call, junior trainees were given inductions and a period of supernumerary working. The length of time before commencing on-call shifts varied according to trainee level and the ELP advised that the department took trainees' individual levels and needs into account when planning this.

The Guardian of Safe Working Hours (GoSWH) stated that paediatric oncology trainees at ST3 and above submitted six exception reports between April 2018 and January 2019, all of which related to working beyond planned hours. The review lead enquired whether this rate seemed correct or whether trainees might be underreporting and the GoSWH advised that this rate was slightly lower than other specialties with similar numbers of trainees, but that it seemed correct for the way that the department ran.

There had been no serious incidents involving trainees within the department in the six months prior to the review. The ELP reported that there were regular audits of patient outcomes and the results of these were reported to divisional and Trust management. Complaint, compliment and Datix data was also reviewed by divisional management. The department held joint meetings with the team at the St George's site to review patient outcomes and feedback. The Divisional Director reported that the department received good feedback and compliments from patients and their families.

The review team heard that the department offered monthly group sessions with a psychologist for all staff to discuss and reflect on difficult cases and obtain support. The Nursing Director for Cancer advised that individualised support had been arranged for some team members when needed.

The department ran six monthly simulation training for resilience and safety (STRS) sessions and there were opportunities to attend the adult oncology team simulation training sessions.

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**
P1.1	**Patient safety** The trainees all felt that the service was safe and that the paediatric, anaesthetic and nursing teams worked together effectively to manage emergencies. In particular, the trainees commended the nursing teams for their skill and efficiency in identifying and escalating concerns. The trainees advised that acutely unwell patients were transferred to St George's Hospital and that this process worked well.	
P1.2	**Appropriate level of clinical supervision** The review team heard that there were daily board rounds for both the solid and liquid teams and that consultants in both teams led ward rounds twice per week. The trainees acknowledged that this was unusual but were unsure how the department could implement daily consultant-led ward rounds without a reduction in consultants' clinic and cross-site working commitments. The trainees also noted that this system allowed them time to thoroughly review patient cases and plan their work prior to presenting cases to the consultant. The supervisors advised that sick patients would be seen daily by a consultant but that many of the patients were more stable. The department also employed a specialist BMT fellow who conducted additional reviews of these patients.	Yes, please see action P1.2
P1.3	**Responsibilities for patient care appropriate for stage of education and training** The review lead asked about the status and responsibilities of trainees at ST2 and ST3 in the department and was informed that ST3 trainees were expected to take on more responsibility than those at ST2. The supervisors indicated that the Trust policy was based on Department of Health guidelines which allowed trainees at ST3 and above to prescribe intrathecal medications, although not all ST3 trainees would have completed their Royal College of Paediatricians and Child Health (RCPCH) membership examinations (MRCPCH). It was noted that the national guidance did not differentiate between adult oncology, where all ST3 trainees would hold MRCPCH, and paediatrics, where they may not.	Yes, please see action P1.3
P1.4	**Rotas** The review team was informed that the paediatric oncology ward had 18 beds and that there were typically three or four paediatric patients in the Teen Cancer Trust (TCT) unit. The wards were staffed by two doctors on the liquid team and one on the solid team and the trainees advised that a typical caseload was six patients each. The junior rota was short by 0.4 WTE (whole time equivalent) at the time of the review. If there were rota gaps or staff on leave, the trainees reported that cover was usually arranged in advance. The trainees stated that reliance on locums had reduced and that substantive staff were willing to work additional shifts to cover gaps as this was only occasionally required.	

	The trainees advised that they were rarely required to work late as the evening handover had been moved to 16:00, allowing more time to complete administrative tasks before the end of the shift.	
P1.5	**Induction** The trainees felt that there was a steep learning curve for ST2 and ST3 trainees commencing their posts in the department but that after this initial phase they were more confident and prepared to work autonomously. Prior to working nights on-call, the trainees reported that they worked out-of-hours alongside a colleague to prepare them. The trainees indicated that consultants were proactive in contacting more junior trainees on-call to discuss the patient list. The on-calls involved responding to queries from doctors at regional hospitals, but the trainees advised that most of these were straightforward and they were able to contact the consultant on-call if needed. None of the trainees felt reluctant to ask the consultant to come in if needed and none of them had experienced a consultant refusing to come in. The supervisors reported that all trainees completed competency assessments prior to starting night shifts and that the timeframe for this varied depending on each trainee's level of skill and confidence. The supervisors emphasised the level of support available to trainees from consultants, clinical fellows, nurses and advanced nurse practitioners (ANPs).	Yes, please see action P1.5
P1.6	**Handover** The review team heard that there were handover meetings at 08:15 and 16:00 each day where all inpatients and shared care patients were discussed. The trainees reported that handover could last between 15 and 60 minutes and that the attending consultants often did not attend the 16:00 handover as they usually reviewed the patient list separately during the afternoon. If a consultant was not present for each team, the trainees advised that a senior clinical fellow would deputise.	Yes, please see action P1.6
P1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The trainees had mostly been able to attend clinic although this had not been consistent. This had been fed back to the department and it was agreed that clinic time would be included in trainee rotas in future. Although the department had beds at St George's Hospital for acutely unwell patients, the trainees advised that they rarely worked there. The trainees did not feel that this was a missed learning opportunity, as they gained experience of more acute care when working with complex transplant patients.	Yes, please see action P1.7
P1.8	**Protected time for learning and organised educational sessions** Some trainees had experienced difficulty attending local teaching, so the department had changed the teaching schedule to allow all trainees to attend. The trainees advised that they were able to book study leave and attend external teaching and conferences. The supervisors reported that there were also opportunities for trainees to attend Institute of Cancer Research training, present cases at meetings, carry out audit projects and attend journal clubs.	
P1.9	**Access to simulation-based training opportunities**	

	The trainees had attended one simulation training session but felt that these sessions should be more frequent to ensure they were properly prepared to manage acutely unwell or rapidly deteriorating patients. It was suggested that monthly training sessions would be more helpful, possibly using *in situ* low fidelity simulation.	Yes, please see action P1.9
P1.10	**Organisations must make sure learners are able to meet with their educational supervisor on frequent basis** All trainees had an allocated educational supervisor (ES) and had formal supervision sessions at the start, mid-point and end of each rotation. The trainees reported that they were able to meet with their ESs between these formal meetings as needed and that they often had the opportunity to work with their ESs. The review team heard that trainees were usually able to complete workplace based assessments (WPBAs) with supervisors but that this could be more difficult for senior 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.

P2.1	**Effective, transparent and clearly understood educational governance systems and processes** There was one trainee representative in the department who attended the local faculty group and consultant meetings. The review team was informed that the ELP and trainee representative typically followed up on the action points from meetings and were responsible for disseminating information and seeking feedback to inform the meetings.	Yes, please see action P2.1
P2.2	**Impact of service design on learners** The review team heard that trainees at ST3 and above working out of hours were responsible for prescribing chemotherapy for day care patients. The trainees were involved in multidisciplinary team (MDT) discussions of these patients so were aware of their treatment plans but were not usually responsible for their care. The supervisors reported that these prescriptions were for straightforward cases and were checked by pharmacists the following day as well as by the consultant prior to administration. The trainees did not believe that this practice was unsafe as the prescriptions were checked, they were able to seek advice from the consultant or pharmacist on the day shift if needed and the patients were typically on standard treatment protocols which the trainees were familiar with. As part of their induction,	

	trainees were given written information about prescribing chemotherapy and had to be signed off by a clinical supervisor before they began to complete these prescriptions. The supervisors reported that there were prescribing pharmacists who were able to prescribe some chemotherapy but that they could not prescribe medication for intrathecal administration or for patients undergoing their first cycle of chemotherapy. The review lead questioned whether this process offered sufficient protection for trainees in the case of a serious incident relating to the treatment and whether it aligned with the GMC Good Medical Practice guidance. The review team agreed that there were safeguards in place to check the prescriptions and ensure any errors were highlighted before the drugs were ordered.	Yes, please see action P2.2
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.**		
	N/A	
4. Supporting and empowering educators		
HEE Quality Standards **4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.** **4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.**		
P4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The ESs had all undergone supervision training and appraisals. The ESs reported that the PGME team monitored their training compliance and ensured that they undertook update training when needed.	
P4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The review team heard that there was a job planning exercise in progress. The supervisors advised that supervision work was included in their SPA (supporting programmed activity) time, but that the planning exercise aimed to ensure that supervisors had 0.25PA allocated per trainee and that supervision of clinical fellows was recognised.	
5. Developing and implementing curricula and assessments		
HEE Quality Standards **5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.**		

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

P5.1	**Opportunities for interprofessional multidisciplinary working** The department employed ANPs and was working to train more. The supervisors discussed the difficulty of recruiting to these specialist posts, which meant that most ANPs were internally trained and promoted. An ANP working on the TCT ward was due to leave the Trust and the trainees expressed regret and concern about the potential impact of this on the team.	Yes, please see action P5.1

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

P6.1	**Learner retention** The trainees reported that they enjoyed working in the department and felt well-prepared for the next stages in their careers and training. All trainees said that they would recommend their posts to colleagues. The trainees noted the positive impact of changes made in the department such as the improved teaching programme and reduction in rota gaps. The supervisors advised that trainees and clinical fellows often chose to return to work in the department for out of programme years, drug development training or other clinical fellow posts.	

Good Practice and Requirements

Good Practice

The trainees were enthusiastic about their training, felt well-supported and described good access to learning opportunities.
The trainee representative was dynamic and active in escalating trainees' ideas and concerns.
The department had over-recruited to clinical fellow posts to mitigate against rota gaps, which had a significant positive impact on trainee experience. The trainees advised that any rota gaps were managed proactively.
The trainees reported good working relationships with the nursing staff and advanced nurse practitioners (ANPs), describing them as skilled and knowledgeable colleagues.
The Education Lead had made significant improvements to training based on trainee feedback, for example by moving the weekly teaching to a different day in order to encourage attendance.
The supervisors were engaged with training and were supported by the postgraduate medical education team.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	None		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
P1.3	The department should review the roles and tasks assigned to trainees at specialty training level three (ST3) who often have not taken the MRCPCH examinations.	Please provide a job plan for the ST3 trainee role showing that the responsibilities align with the RCPCH guidance around pre-membership trainee roles. Please provide this by the end of May 2019.	R1.9
P1.5	The Trust requires a more robust policy around support for ST2 and ST3 trainees starting in post, who face a steep learning curve. This could include additional support when starting night shifts and the competency assessment list which is already in development.	Please provide documentation of the support and competency assessment for ST2 and ST3 trainees by the end of May 2019.	R1.9
P1.6	The department should ensure that both morning and evening handover are consultant-led.	Please provide documentation of trainee feedback confirming that all handover sessions are consultant-led by the end of May 2019.	R1.14
P1.7	The Trust should ensure that all trainees have regular access to clinics.	Please provide documentation of trainee feedback confirming that all trainees have sufficient access to clinics to meet their training needs. Please provide this by the end of May 2019.	R1.15
P1.9	The trainees and the wider team require more frequent simulation training sessions.	Please provide evidence of a monthly simulation training programme by the end of May 2019. These sessions could be incorporated into the existing teaching programme and could take place in clinical areas or the simulation centre.	R1.20
P2.2	The review team heard that junior trainees working out of hours were responsible for prescribing chemotherapy for day care	Please provide documentation of the governance structure around this practice. In particular, please demonstrate that this	R3.1

	patients. The trainees were involved in multidisciplinary team (MDT) discussions of these patients but were not usually responsible for their care. The Trust should consider the governance structure around this practice, taking into account the GMC Good Medical Practice guidance. The review team noted that there were measures in place to check the prescriptions and ensure patient safety.	aligns with the GMC Good Medical Practice guidance. The Trust may wish to consider whether this role is appropriate for an ST3 trainee pre-membership. Please provide this by the end of May 2019.	

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**
P1.2	The Trust should consider increasing the consultant presence on the wards to allow more time for training.	The Trust should consider cancelling clinics and other commitments for one attending consultant each day	R1.12
P2.1	The Trust should consider increasing trainee involvement in and attendance at departmental and LFG meetings.	The Trust is advised to review the governance structure and arrangements for departmental meetings to encourage more trainees to participate.	R2.1
P5.1	The Trust is advised to consider the succession and workforce development plans for the ANP team.	HEE can provide advice and guidance to support this if required.	R5.9

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
None	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Geoff Smith
Date:	4 April 2019

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.