Health Education England

HEE Quality Interventions Review Report

St George's University Hospitals NHS Foundation Trust
Cardiac Surgery
Multi-professional Review

South London

15 & 16 July 2021

Report date 9 November 2021

Final

Review Overview

Background to the review:	Cardiac surgery trainees were removed from posts at St George's University Hospital in autumn 2018 due to concerns around: • A lack of appropriate caseloads and case mix necessary to sustain training; • The fact that the training environment was not conducive to the teaching and oversight of the trainees; and • The learning environment. HEE was concerned that the above would adversely affect training opportunities trainees would receive. The Trust had been subject to ongoing monitoring by NHS Improvement, the Care Quality Commission, the General Medical Council, Clinical Commissioning Groups and Health Education England (HEE). HEE conducted further reviews on 28 February 2019, 13 May 2019 and 5 November 2019. The conclusion of the report from the review on 5 November 2019 noted that, '*It was agreed that HEE would conduct a further quality review in April 2020 to meet with representatives of the multi-disciplinary team in cardiac surgery. This would allow HEE to better assess the level of change which had taken place, discuss the impact of the serious harm review and decide whether trainees could be placed in the department from October 2020.'* The purpose of this further review was to assess the learning environment within the department so that a decision could be taken by HEE as to whether to reinstate trainee placements. However, due to the COVID-19 pandemic it was agreed to postpone this review, initially to October 2020 and subsequently to July 2021. The suspension of training was extended to 30 September 2021. The review was planned, and this report was drafted according to HEE London's usual review processes: • Notification of the proposed date was sent to the Trust Postgraduate Medical Education (PGME) team on 29 March 2021, along with initial information about who should attend the review and what information was required from the Trust in advance of the review • A draft timetable was sent to the PGME team on 28 May 2021 • Information for attendees and a final timetable were sent to the PGME team on 24 June 2021 • The panel held a pre-review meeting on 18 June 2021 to consider the information provided by the Trust and to use this to formulate the panel's key lines of enquiry • The report was prepared and conclusions reached based on feedback received from review

attendees, including junior doctors, healthcare learners, consultants, healthcare staff, Trust managers and education leads, as detailed in the *Who we met with* section below
- The draft report was shared with all panel members on 26 July 2021 for editing and confirmation that it accurately reflected the feedback given by review attendees
- Once the panel had agreed on the draft report, it was shared with the Trust PGME team on 10 August 2021 so that they could distribute it to the review attendees and feedback any changes to factual details which had been incorrectly recorded.

The Independent Mortality Review of Cardiac Surgery at St George's University Hospitals NHS Foundation Trust March 2020 (also known as the Lewis report) was published in the interim period between this quality review and the previous one in November 2019. Given the time that had elapsed since its publication and the fact that the Lewis report does not focus on the learning environment within the cardiac surgery department at the Trust, which was the main focus of this HEE quality review, the conclusions of the Lewis report did not impact on this review. Therefore, it did not form part of the evidence base considered by the review panel in preparing for the review or in deciding to extend the suspension of training. The requirements and recommendations arising from this review, and the decision to extend the suspension of training, are based solely on feedback received from review attendees.

The report of Phase 3 of Gill Bellord's work with consultants in the department (the Bellord report) was released to the Trust in March 2021. This report focused on team-working, values and interprofessional behaviours within the department. However, a copy of this report was only received by HEE on the day of the review and there was therefore no opportunity for the review panel to consider the content of the report and include this within their key lines of enquiry for the review. Of note, none of the review attendees raised the Bellord report and its content in their feedback to the panel (although the 2019 phase of Gill Bellord's work was briefly mentioned in the presentation given during the educational and clinical supervisor session.) Therefore, the Bellord report did not form part of the information considered by the review panel and did not form the basis for the findings, requirements and recommendations outlined below. As noted above, the requirements and recommendations arising from this review, and the decision to extend the suspension of training, are based solely on feedback received from review attendees.

	HEE notes that the Bellord report acknowledges some improvements within the cardiac surgery department and that no behavioural issues were highlighted as part of the report. Whilst the content of the report and the acknowledged improvements within the department were not referenced in the feedback provided by review attendees, it is hoped that the requirements and recommendations listed in this quality interventions review report, alongside those made in the Bellord report, will support the Trust to make further improvements, and that the extended training suspension period will allow time for such improvements to be made and embedded within the department.
Subject of the review (e.g. programme, specialty, level of training, healthcare learner group)	Cardiac surgery

Who we met with:	The review panel met with the following learners: • Five Locally Employed Doctors (LEDs) in cardiac surgery • Seven anaesthetics trainee doctors • Nine healthcare learners covering nursing, healthcare support workers, healthcare science, pharmacy, and allied health professions. The review panel also met with the following Trust representatives: • Deputy Team Leader for Cardiac Operating Department Practitioners (ODPs) • Principal Dietitian • Lead Radiographer • Representatives from the Cardio-thoracic ICU Pharmacy Team • Deputy Lead Pharmacist • Allied Health Professionals (AHP) and Therapies Lead • Practice Supervisors/Mentors, Assessors and Educators from Cardiac Surgery and Intensive Care Unit (ICU) • Team Leader for Cardio-thoracic Physiotherapists • Cardiac ICU Matron • Cardiac Theatres Matron • Chief Nurse • Head of Nursing Theatres • Cardiac Surgery Education Lead (medical) • Cardiac Surgery Consultants • Cardiac Surgery Care Group Lead • Cardiovascular Thoracic Deputy General Manager • Divisional Director of Operations • Deputy Chief Medical Officer • Deputy Chief People Officer • Chief Operating Officer • Director of Medical Education • Medical Education Manager • Simulation Lead • College Tutor for Anaesthetics • Freedom to speak up Guardian.

Evidence utilised:	The review panel received the following information and documents from the Trust in advance of the review: • Staff survey 2020 slide pack - Critical Care • Staff survey 2020 slide pack for Cardiology CAG and Medical Management Directorate • Staff survey 2020 slide pack for Cardiothoracic Directorate - v1.0 • Friends and Family Test and inpatient surveys results • ADME Report Cardio-Thoracic surgery April 2021 • Cardio-Thoracic surgery Local Faculty Group minutes 31-03-21 • Mentor allocation 2021 • Trust presentation for session with clinical and educational supervisors • Teaching programme. The review panel also considered information from the General Medical Council (GMC) National Training Survey (NTS) 2019 and 2020 and Health Education England's (HEE) National Education and Training Survey (NETS) 2019 and 2020. This information was used by the review panel to formulate the key lines of enquiry for the review. The content of the review report and its conclusions are based solely on feedback received from review attendees.

Review Panel

Role	Name / Job Title / Role
Quality Review Lead	Geeta Menon, Postgraduate Dean, South London, Health Education England
Deputy Postgraduate Dean	Anand Mehta, Deputy Postgraduate Dean, South London, Health Education England
Specialty Expert	Celia Theodoreli-Riga, Head of School for Surgery, Health Education England
Specialty Expert	Chris Sadler, STC Chair, North London Anaesthetics Programme, Health Education England
School of Nursing Representative	Anna McGuinness, Head of Clinical Education Transformation, Health Education England
Allied Health Professionals Representative	Chloe Keith-Jopp, Allied Health Professional Clinical Fellow, Health Education England
Pharmacy Representative	Shane Costigan, Associate Head of Pharmacy, Quality and Operations, Health Education England, London and Kent, Surrey & Sussex
GMC Representative	Kevin Connor, Principal Education QA Programme Manager, General Medical Council

HEE Quality Representatives	Paul Smollen, Deputy Head, Quality, Patient Safety & Commissioning, Health Education England Louise Brooker, Deputy Quality, Patient Safety & Commissioning Manager, Health Education England Learning Environment Quality Coordinator, Health Education England
Lay Representative	Roz Thornton, Lay Representative
Learner Representatives	Cardiac Surgery Learner Representative Nursing Learner Representative

Executive summary

The review panel would like to thank the Trust for accommodating the review.

The review panel acknowledged that there was evidence of improvement and several areas of good practice to note. The review panel was pleased to hear that learners from other specialty or professional groups were aware of the issues in the cardiac surgery department but did not feel that these directly impacted them. The learners who met with the review panel said they felt well-supported by their respective teams and that they felt able to ask questions and raise concerns to their supervisors and mentors.

The review panel was pleased that there was some evidence of improvement to the culture within the department, however the review panel felt that there were still considerable improvements needed to ensure a suitable learning environment for surgical trainees.

Lack of appropriate and clear communication was a common thread in what was reported to the review panel. The junior doctors working in the department did not have a forum to feedback to the consultant group and there was a disconnect between what was reported by the cardiac surgery consultants and the locally employed doctors (LEDs).

The review panel felt that there was not enough evidence provided to demonstrate improvements and a suitable learning environment, as such HEE will not place trainees back into the department until further improvements have been made. The Trust representatives mentioned in the presentation that if the suspended training posts were reinstated, they would prefer a more junior trainee to be placed in the department initially. However, the review panel felt that a higher trainee would be more suitable to begin this process as they would have more experience of cardiac surgery training.

The review panel suggested that once the implementation of the south London cardiac surgery network is complete this would be a useful mechanism to utilise for phased reintroduction of trainees to the department. It was noted that this would be contingent on the Trust demonstrating further improvements to the culture and learning environment, satisfactory to HEE approval.

Based on the information received and considered by the review panel, the suspension of training has been extended by HEE until 31 March 2022. This report includes a number of requirements and recommendations for the Trust to take forward and HEE plans to conduct a follow-up review in early 2022 to assess the Trust's progress in meeting the requirements. Initial responses to the requirements below, as well as updates against the requirements set at previous reviews, will be due on 1 December 2021.

Review findings

The findings detailed in the sections below should be referenced to the quality domains and standards set-out towards the end of this template. Specifically, mandatory requirements should be explicitly linked to quality standards. Not all of HEE's domains and standards have been included, only those that have a direct operational impact on the quality of the clinical learning environment, which a quality review will be most likely to identify (although this does not preclude other standards outlined in the Quality Framework being subject to review, comment and requirements where relevant).

Mandatory requirements

Mandatory requirements and Immediate Mandatory Requirements (IMRs) should be identified as set out below. IMRs are likely to require action prior to the draft Quality Review Report being created and forwarded to the placement provider. The report should identify how the IMR has been implemented in the short term and any longer termed plans. Any failure to meet these immediate requirements and the subsequent escalation of actions to be taken should also be recorded if there is a need to.

All mandatory requirements should be detailed in this section. The requirement reference should work chronologically throughout the report and link with the right-hand column in the 'Review Findings' section. Requirements identified should be succinct, SMART and not include the full narrative from the detailed report. Any Requirements should clearly relate to improved achievement of HEE Domain & Standards by the placement provider.

Immediate Mandatory Requirements **Completion of immediate requirements will be recorded below. Subsequent action to embed and sustain any changes may be required and should also be entered below with relevant timescales**		
Requirement Reference number	Review Findings	Required Action, timeline, evidence
	N/A	N/A
Requirement Reference number	Progress on immediate actions	Required Action, timeline, evidence
	N/A	N/A

Mandatory Requirements The Quality Review Panel will consider which individual or collective findings from the intervention will be added to the Quality Reporting Register, determining the relevant risk score, ISF rating and reflecting the accepted QRR narrative conventions.		
Requirement Reference number	**Review Findings**	**Required Action, timeline, evidence**
CS1.2a	The review panel was concerned to hear that feedback from consultants to LEDs was limited and was often given in an inappropriate manner.	Please provide evidence that this issue has been discussed with the consultant body and measures have been put in place to ensure regular and appropriate feedback is available to the LEDs. Please also provide feedback from the junior doctors to demonstrate improvement in this area. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS1.2b	In addition to other reports of inappropriate behaviour, the review panel was also concerned that there were several reports of a blame culture within the department, particularly directed towards LEDs.	Please conduct activities to measure the culture of the cardiac surgery department and provide evidence that this has been carried out in addition to the results the activities produce. This could include psychological safety or cultural climate measures. For example, Manchester Patient Safety Assessment Framework and Safety Attitude Questionnaire. Please see some suggested resources for this below: • https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwin2oDo8pnyAhVA_7sIHfErDukQFnoECBoQAw&url=https%3A%2F%2Fnjl-admin.nihr.ac.uk%2Fdocument%2Fdownload%2F2027924&usg=AOvVaw3T1E0TQAkh4TkianPSU0HZ • https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwihwrT18JnyAhXGsKQKHQJDCZoQFnoECCUQAw&url=https%3A%2F%2

		Fwww.mdpi.com%2F2227-9032%2F7%2F4%2F127%2Fpdf&usg=AOvVaw23xA3XHcNSCBTrPE5o_BMa • https://www.health.org.uk/sites/default/files/MeasuringSafetyCulture.pdf • https://www.midss.org/content/team-learning-and-psychological-safety-survey Please also provide HEE with a copy of the report/s generated from the Trust's NHS England and NHS Improvement guided cultural improvement work. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS1.2c	There were multiple accounts of inappropriate behaviour, poor communication and teamworking from cardiac surgery consultants. The review panel was concerned that the cultural issues identified previously had not been resolved.	Please ensure that all cardiac surgery consultants attend mandatory team-based simulation training to address cultural and behavioural issues. This could include Non-Technical Skills for Surgeons (NOTSS) and civility training. Please provide evidence that this has been completed and that there is engagement from all cardiac surgery consultants. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS1.4	The review panel noted a disconnect between consultants and junior doctors in cardiac surgery. The junior doctors felt that they lacked a consistent mechanism or forum for effectively escalating concerns or providing feedback to consultants.	Please provide evidence that this issue has been discussed with the consultant body and provide a document outlining clear escalation pathways for junior doctors. Please also provide evidence that the junior doctors have been made aware of the escalation pathways and feedback from the junior doctors to demonstrate this is no longer an issue. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS2.1	It was reported that there was variation and inconsistency in the clinical practice between consultants in cardiac surgery. This could be challenging for learners and colleagues.	The Trust must support the department in conducting an audit/review of compliance with standard operating procedures and implement measures to align practices to improve consistency. Please provide evidence of this work and evidence of trainee feedback that this is no longer an issue. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS2.2a	The consultants in cardiac surgery were reported to be variable in terms of their engagement with training, participation in Local Faculty Group	Please ensure that all consultants in cardiac surgery regularly engage with the LFG meetings.

	meetings, and acceptance of feedback which could be challenging for learners and colleagues.	Please provide evidence that all consultants attend and participate in LFG meetings. These meetings should be minuted and have an updated action log. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS2.2c	The LEDs and cardiac surgery consultants reported that there was no educational governance infrastructure which allowed regular sharing of feedback from the LEDs to the consultant body and senior management in the cardiac surgery department.	LEDs and other relevant trainees should be included in the department's LFG meetings, to enable a forum for raising issues and providing feedback. Please provide evidence that LEDs and other relevant trainees are invited to, attend, and are supported to actively participate the meetings. These meeting should generate attendance records, minutes, and an updated action log. Please also provide feedback from the junior doctors to demonstrate improvement in this area. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS2.2d	The review panel was concerned that some consultants insist on complete silence in theatre which could prevent issues or concerns from being raised and does not support an educational environment. The review panel acknowledged that there are times when this is necessary however this needs to be communicated clearly and appropriately. All team members should be clear on how to raise concerns in this situation.	Please provide evidence that this issue has been discussed with the consultant body and measures have been put in place to ensure concerns can still be raised, and that there is appropriate and clear communication from consultants when this situation is necessary. Please also provide evidence from junior doctors and the relevant healthcare learners that this has been addressed and is no longer an issue. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS4.3a	The review panel felt that the clinical and educational supervisors in the department would benefit from refreshing their supervisor training, as there had not been any trainees in the department for a number of years.	Please ensure all clinical and educational supervisors update their clinical and/or educational supervision training. Please provide evidence that this has been completed by all supervisors in cardiac surgery. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.
CS4.3b	It was unclear from the feedback from the cardiac surgery consultants whether educational supervisors in the department were undergoing annual reviews to include their full scope of practice as educators.	Please provide evidence that the educational supervisors have had an educational annual review and are regularly engaging with the educational appraisal process. Please submit this evidence by 1 December 2021, in line with HEE's action plan timeline.

Recommendations

Recommendations are not mandatory but intended to be helpful, and they would not be expected to be included within any requirements for the placement provider in terms of action plans or timeframe. It may however be useful to raise them at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Recommendation	
Related Domain(s) & Standard(s)	**Recommendation**
CS2.2b	The review panel suggest that there is a specified agenda item for education and training in integrated governance meetings to ensure educational issues and updates reach a wide range of colleagues.

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the Quality Review Team, enable the standards within the Quality Framework to be more effectively delivered or help make a difference or improvement to the learning environment being reviewed. Examples of good practice may be worthy of wider dissemination

Learning environment / Prof. group / Dept. / Team	Good practice	Related Domain(s) & Standard(s)
Simulation	The Trust has developed a good multi-professional simulation training programme, which would benefit from more consistent consultant engagement within the cardiac surgery department.	1

HEE Quality Standards and Domains for Quality Reviews

Domain 1 - Learning environment and culture
1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users. **1.2.** The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours. **1.3.** There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I). **1.4.** There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative. **1.5.** The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge. **1.6.** The learning environment promotes interprofessional learning opportunities.

HEE Standard	HEE Quality Domain 1 - Learning Environment & Culture	Requirement Reference Number
1.1	**Serious incidents and professional duty of candour** The review panel was informed that serious incidents were discussed at director level with the medical safety officer and clinical governance teams. It was noted that trends in Datix reports were discussed at care group meetings.	
1.2	**Bullying and undermining**	

	Healthcare supervisors and management representatives noted that overall the consultants were more approachable than they had been previously and were more open to discussion. They described an improved environment where staff felt able to approach consultants in theatres and the intensive care unit (ICU) to discuss treatment plans, audits and other issues. However, it was noted that more junior colleagues or learners may not feel as comfortable with particular consultants. Healthcare learner representatives confirmed that they felt more comfortable raising concerns with some consultants more than others. Some consultants were described by healthcare learners as being quite intimidating and advised that some consultants did not always behave professionally. It was noted that the locally employed doctors (LEDs) doctors did behave more positively towards the healthcare learners. Healthcare supervisors reported that healthcare learners raised issues with senior healthcare staff who would then take these issues to senior managers or the consultants. Healthcare learners discussed that they had witnessed inappropriate behaviour from the consultants on ward rounds which was directed at the LEDs. The review panel was informed that feedback was not delivered appropriately and was often delivered in a public setting on the ward. It was also noted by healthcare learners and anaesthetic trainees that there was a blame culture within the department, with blame often directed at LEDs. It was reported that this affected the atmosphere and made colleagues feel uncomfortable. Healthcare supervisor representatives reported that previously the environment was difficult, and the atmosphere was tense, however it was more positive than before. Some described the cardiac unit as having a good atmosphere and culture for training. It was noted that several changes had been implemented following the review of the department, and people were more welcoming of learners on cases. The review panel was informed by the healthcare supervisors that communication between teams had also improved, and colleagues were more comfortable raising concerns across different teams. Anaesthetic trainees reported that communication from cardiac surgery consultants was variable. It was acknowledged that given the high stakes nature of cardiac surgery it was quite stressful at times, however it was noted that some consultants could be difficult and exhibit poor communication skills and inappropriate behaviour, particularly when there were issues. It was reported that shouting was not uncommon both in and out of theatre. It was discussed that there seemed to be a wider cultural problem in cardiac surgery training. Anaesthetic trainees reported that they would often raise issues to the LEDs about inappropriate behaviour they had witnessed towards them, but the behaviour was not noticed by the LEDs until it had been pointed out by trainees. The Trust management representatives advised that the issues around culture and communication raised in 2017 and 2018 had been dealt with formally and comprehensively. The consultants who participated in the review felt that their interactions with junior doctors were positive and that communication within the consultant body had improved, creating a positive learning environment on the wards, in ICU and in clinics. The review panel heard that the Trust had followed the recommendations set by NHS England/Improvement starting with an investigatory phase in late	Yes, please see CS1.2a and CS 1.2b Yes, please see CS1.2c

	2018 which had not highlighted any serious concerns, though the need for overall cultural change was acknowledged. The Director of Medical Education (DME) advised that the Postgraduate Medical Education (PGME) team had investigated the departmental culture but found this had already begun to change, so very little intervention had been needed. The Trust management representatives reported that the department had introduced a 'flat' hierarchy model to encourage staff and learners at all levels to speak up and raise concerns without fear of blame. The review panel enquired whether the department had utilised tools such as psychological safety measures and was informed that it had not.	
1.4	**Appropriate levels of Clinical Supervision** The LEDs reported that they had worked with all of the consultants. It was confirmed that two out of the six LEDs were allocated to specific consultants, whilst the remainder were allocated to work with different consultants at different times. Some LEDs believed working solely with one consultant was more beneficial for progression. The review panel was advised by healthcare learners that there was always help available if needed. The nursing learners reported that they were well supported by the nursing teams and the practice educator team.	Yes, please see CS1.4
1.4	**Appropriate levels of Educational Supervision** The LEDs reported that there was a lack of educational supervision and feedback from consultants was minimal. It was noted that regular educational supervision meetings were not taking place and many of the LEDs did not have a named educational supervisor. The LEDs advised that a small fraction of the consultants supervised the group. However, in contradiction to this, the cardiac surgery consultants reported that all LEDs had been allocated a supervisor.	Yes, please see CS1.2a
1.6	**Multi-professional learning** Healthcare learner representatives informed the review panel that the service was fast paced, and the ward could be a challenging place to work due to patients with high-risk medications and co-morbidities. It was reported that there had been previous concerns about the management of the patients on the ward, therefore the pharmacy team had implemented discharge checklists and ensured pharmacy representation at ward rounds. The review panel was advised that there had been attempts to reinstate these measures after the peaks of the COVID-19 in 2020 and early 2021, but it had been difficult to ensure attendance of pharmacy trainees at ward rounds. The culture towards the multi-professional team was discussed. Healthcare learners reported that they were usually integrated well into teams, and the atmosphere had improved. It was also noted that communication was usually good. Healthcare supervisors reported that healthcare colleagues felt more valued and were asked for their feedback and opinions. However, some healthcare learners reported that the response from consultants was variable when asking questions; learners advised that some consultants would get frustrated and would not communicate appropriately or clearly with the learners, particularly when under pressure. Some healthcare learners reported that they felt well supported by the theatre team. It was also acknowledged that the anaesthetic team had been good with answering questions and explaining procedures to the nursing learners. Healthcare learners advised that the anaesthetic team were positive towards them and communicated clearly.	

	Anaesthetic trainees reported that the nursing staff, allied health professionals (AHPs) and consultants working within ICU were very supportive of junior doctors. Trainees advised that ICU managers and senior clinical staff had worked to create a flat hierarchy model and encouraged trainees to voice their ideas and opinions. The LEDs reported that the relationship between the anaesthetic and cardiac surgery teams was collaborative and professional. The healthcare supervisors advised that there was multi-professional training including cardiac surgeons, nurses, and trainees on the ICU and it was confirmed that the cardiac surgeons were involved in ICU teaching. It was also noted that the cardiac surgeons were involved in teaching for nurses when possible and that there were a number of cardiac surgery-based study days for the nursing staff. It was asked whether there was an opportunity for pharmacy team members and AHPs to attend the multi-professional educational activities. Healthcare supervisors confirmed that there were efforts to include these groups, but it was difficult as some of the activities, particularly simulations, were not planned in advance. The review panel was informed that overall there was a good approach to multi-professional teaching and including AHPs in this, which helped teams to feel more integrated. The Trust management representatives explained that the multi-professional training had been running since 2013 and a mobile simulation training unit had been introduced in order to increase participation.	

Domain 2 – Educational governance and leadership
2.1. The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met. **2.2.** The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training. **2.3.** The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership. **2.4.** Education and training opportunities are based on principles of equality and diversity. **2.5.** There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

HEE Standard	HEE Quality Domain 2 – Educational Governance and Leadership	Requirement Reference Number
2.1	**Effective, transparent and clearly understood educational governance systems and processes** The review panel was advised that the morbidity and mortality meeting (M&M) was on the same day as the care group meeting. It was reported that the lead pharmacist attended these meetings and nursing staff were involved in M&Ms where possible. It was also noted that all staff were invited to attend the M&M whereas previously they had not been. The review panel was advised that the M&Ms were more inclusive and that this had significantly improved over the last two years. Cardiac surgery consultants provided a presentation on the culture and the history of the department and noted that the department been through challenging periods in the past and had trained many successful surgeons. The review panel was informed that the Trust was very interested in being part of the integrated system for providing cardiac surgery across south London. The cardiac surgery consultants notified the review panel that they	

	believed a more junior trainee would be suitable for reintroduction to the department as they would benefit most from the current service activity. It was suggested that this could be expanded to other trainee levels upon satisfactory feedback. The representatives believed that a higher trainee would not be suitable due to lower case volumes and due to the high-risk surgeries only being performed by one consultant.	
2.1	**Impact of service design on users** It was reported that the junior doctor office, which was utilised for cardiac surgery teaching, was re-allocated by the Trust and was not accessible to doctors in the department for a prolonged period, therefore teaching was reportedly not possible due to lack of a suitable venue. The review panel heard that this issue was escalated to senior management repeatedly and it was noted that it had been difficult to resolve. However, the review panel was advised that the Trust had recently returned the office space to the junior doctors. The LEDs informed the review panel that the rota was designed for nine to 12 junior doctors, but they were working at a one in six or seven rota. The review panel was informed that gaps in the rota were being filled by locum doctors (both in house and external), cardiac surgery consultants acknowledged that this was a difficult problem. The LEDs were reportedly covering both thoracic and cardiac services. It was reported that the rota was organised by one of the consultants on a weekly basis, until a permanent rota was established. The cardiac surgery consultants reported that the aim was to have a fully staffed rota of trainees and LEDs to ensure an equal opportunity for all medical learners. The review panel was advised by LEDs that the multi-disciplinary team meetings (MDT) took place daily from Monday to Friday. The meetings were attended by cardiology consultants, cardiac surgery consultants, and the cardiology and thoracic surgery trainees. The review panel was informed that cases at MDTs were prepared and presented by trainees and the meetings were documented by pre-assessment nurses. The LEDs reported that they felt comfortable raising concerns and sharing opinions at MDT meetings. LEDs reported that there was no representation from the anaesthetics team at the MDTs and the consultants discussed the cases with the anaesthetic team beforehand. It was acknowledged that there used to be representation from the anaesthetic team, but this was no longer the case. It was not clear if the anaesthetics team were included on the mailing list for the MDTs, which were being held virtually. Some healthcare supervisors reported that there were limited multi-disciplinary discussions on the cardiac surgery ward due to the availability of the consultants, who were often in theatre by the time the other professional groups reviewed the patients. It was noted that due to this issue the LEDs were often involved in a considerable amount of communication back and forth between these AHPs and the consultants. The review panel was advised that there was sometimes a disconnect with the AHP recommendations for complex patients. The review panel was informed that the department utilised a consultant of the week model. It was advised that there were twice daily ward rounds, in the morning and evening, which included attendance from the consultant, senior nursing staff, LEDs and relevant trainee doctors. It was noted that	

	healthcare learners felt able to ask questions and raise concerns during ward rounds, however the inclusion of such learners had not been maintained well during the COVID-19 pandemic. Healthcare supervisors reported that, as the ICU was not purely a cardiac ICU, it was impractical for a cardiac surgery consultant to attend the ICU ward round. It was confirmed that cardiac surgery patients were reviewed by the 'consultant of the week' for cardiac surgery, and decisions were made by them prior to the ICU ward round. The anaesthetic trainees reported that if there were issues with different management plans between cardiac surgery and ICU, this was escalated to and dealt with by the consultants. It was reported that there was an ICU trainee based on the unit at all times to allow a fast response to issues. The review panel was informed that if there was an issue with a cardiac surgery patient this was usually escalated to an ICU doctor and a cardiac surgery doctor simultaneously. The Trust management representatives reported that standard operating procedures (SOPs) had been put in place in order to make various aspects of treatment more consistent, for example preparing patients for surgery and dealing with post-operative bleeding. This had been done following previous HEE reviews as well as recommendations from other regulators. However, the review panel was informed that these SOPs were not always followed closely. It was also reported that there had been difficulty in getting SOPs or guidelines approved by the department, though the reasons for this were unclear. Healthcare learner representatives felt that there was a culture of lack of consistency and there was a lot of variation in consultant approach and opinions on treatment. Anaesthetic trainees reported that the cardiac surgery consultants often did not work well together. Healthcare learners described the use of the World Health Organisation (WHO) surgical safety checklist and team briefings as impressive and noted it was done well. Some anaesthetic trainees confirmed that the WHO checklist was used comprehensively and noted that there was always an opportunity to discuss issues. Other anaesthetic trainees described the quality of the checklists as average but did not report any issues. Healthcare learners confirmed that team briefings and de-briefings were being carried out and all attendees were introduced. The review panel was advised that only those who had attended the team briefing were allowed in theatre. However anaesthetic trainees reported that introductions at team briefings were sometimes variable. It was noted that the lead surgeon usually attended the post-surgery de-brief meeting, however this was not always the case and if they were unavailable, the assisting surgeon would lead the meetings. It was noted that the de-brief meetings were more effective when the lead surgeon was in attendance. The healthcare learners reported that people were encouraged to raise concerns during the de-brief meetings. Anaesthetic trainees reported that sometimes consultants did attempt to show gratitude to the team at de-briefings. It was reported that the junior doctors were usually responsible for leading the sign-out for post-operative care. ICU healthcare supervisor representatives reported that there was usually a surgeon present for handover of patients to ICU. It was noted that the consultant surgeons were not always available and if this were the case a junior doctor would attend.	Yes, please see CS2.1
2.2	**Appropriate systems for raising concerns about education and training**	

	The cardiac surgery consultants discussed the Local Faculty Group (LFG) meetings which were led and facilitated by the PGME team. It was not clear how well the consultant body engaged with these meetings. The Director of Medical Education (DME) explained that the PGME team had met with different groups in the department over time but that the junior doctors and faculty tended to attend separate meetings as it was thought that it could be difficult for the LEDs to raise concerns in front of the consultants. The cardiac surgery consultants confirmed that there was not a formal forum where the consultants would meet with the junior doctors to discuss issues. It was reported that the LEDs had to raise issues with their named consultant who would raise issues at consultant meetings on their behalf. It was acknowledged that this meant there was no consistent, formal meeting for junior doctors to give and receive feedback. The DME highlighted the reinstatement of the teaching programme and work to improve clarity around supervision as positive changes arising from meetings with LEDs and learners. The review panel heard that the anaesthetics department held six LFGs per year with good trainee participation, and that no particular concerns had been reported around the learning environment. Anaesthetic trainees reported that some of the cardiac surgery consultants insisted on silence in theatre which made communication between the anaesthetic team and the consultant variable. It was also noted that this made it difficult for trainees to ask questions. The Freedom to Speak Up Guardian (FtSUG) explained that there was work ongoing to increase use of the service and raise awareness of the FtSUG role, including training 20 champions across the organisation. At the time of the review, there was no champion within the department. The FtSUG advised that the Trust's approach to responding to concerns had changed for the better although there were still issues with more junior staff or those at lower pay bands feeling able to report concerns in a timely way.	Yes, please see CS2.2a Yes, please see CS2.2b and CS2.2c Yes, please see CS2.2d

Domain 3 – Supporting and empowering learners		
3.1. Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required. **3.2.** Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes. **3.3.** Learners feel they are valued members of the healthcare team within which they are placed. **3.4.** Learners receive an appropriate and timely induction into the learning environment. **3.5.** Learners understand their role and the context of their placement in relation to care pathways and patient journeys.		
HEE Standard	**HEE Quality Domain 3 – Supporting and empowering learners**	**Requirement Reference Number**
3.1	**Regular constructive and meaningful feedback** The LEDs informed the review panel that there was a lack of communication from cardiac surgery consultants. The review panel also heard that anaesthetic trainees had not witnessed much interaction in theatre between LEDs and consultant cardiac surgeons.	Yes, please see CS1.2a

	The healthcare learners reported that sometimes the cardiac surgeons would not allow adequate time for the learners to carry out their tasks, such as 'scrubbing' prior to procedures. It was acknowledged that where this had occurred it had been escalated to the practice educators and subsequently revolved.	
3.4	**Induction (organisational and placement)** Some healthcare learners reported that initially they did not know where to go to access help.	

Domain 4 – Supporting and empowering educators

4.1. Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.
4.2. Educators are familiar with the curricula of the learners they are educating.
4.3. Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.
4.4. Formally recognised educators are appropriately supported to undertake their roles.

HEE Standard	HEE Quality Domain 4 – Supporting and empowering educators	Requirement Reference Number
4.3	**Educational appraisal and continued professional development** The cardiac surgery consultants informed the review panel that there were four approved educational supervisors in the department. It was noted that educational supervisors would need refresher training on the curriculum as they were somewhat out of practice given that there had not been any trainees in the department since 2018. It was noted that the supervisors had been keeping some skills up to date by supervising the LEDs. It was unclear whether the educational supervisors were undergoing an educational appraisal although it was advised that some of the supervisors were still involved in the Annual Review of Competence Progression (ARCP) process.	Yes, please see CS4.3a and CS4.3b

Domain 5 – Delivering curricula and assessments

5.1. The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.
5.2. Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.
5.3. Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

HEE Standard	HEE Quality Domain 5 – Developing and implementing curricula and assessments	Requirement Reference Number
5.1	**Placements must enable learners to meet their required learning outcomes** A number of LEDs felt that there were not enough education experiences appropriate for their level of training and education needs. It was reported that the current training environment was not optimal as there were many restrictions on the department which impacted on what the LEDs were permitted to do. These restrictions included the volume and type of operations and supervision. However, it was noted that the LEDs had not been well-informed about the reason for the restrictions and the changes which the department had undergone (the main restriction that had been	

	placed on the department by NHS England/Improvement was around the level of risk in which all but one of the consultants were permitted to operate within). Cardiac surgery consultants advised the review panel that despite the restrictions on high-risk cases they were working normally for the most part. LED representatives acknowledged that there had been improvements since 2018 but reported that they believed the educational experience would improve once restrictions had been lifted and trainees had been returned. It was also noted that whilst the volume of cases was lower due to the restrictions, some LEDs reported that they were receiving adequate training and experiences. It was noted that this was largely due to the relationship which had been established with the consultant they had been allocated to. The cardiac surgery consultants informed the panel of the various postgraduate and professional qualifications and achievements that LEDs had accomplished whilst working within the department. The review panel was told that there had been small-group teaching sessions to help with preparation for professional qualification exams. It was also noted that the LEDs had published 14 publications and 13 abstracts. The cardiac surgery consultants noted that the department was proud of the achievements of the LEDs during their time in the department. The LEDs advised that they were not undertaking any additional postgraduate qualifications at the time of the review. Cardiac surgery consultants reported that the department had offered opportunities for junior doctors to present cases, conduct audits and undertake other relevant educational opportunities. It was also noted that locum doctors were included in educational opportunities that were offered. However, they acknowledged that some consultants were more invested in training than others. The Trust management representatives noted that consultants and trainees had access to courses such as Cardiac Surgery Advanced Life Support (CALS) and Non-Technical Skills for Surgeons (NOTSS), as well as external courses such as the Human Factors training run by the Society for Cardiothoracic Surgery. Nursing learner representatives reported that there had been a delay in working with their assigned mentors which had caused a delay in assessments and competencies being signed off. It was noted that in some cases the mentor did not complete the initial interview or supervision meeting with the learners.	
5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The review panel was informed that formal teaching sessions for medical learners in cardiac surgery, such a journal clubs and a formalised teaching programme had been put in place, but these were stopped due to the COVID-19 pandemic and had yet to re-start at the time of the review. The review panel was advised that prior to the COVID-19 pandemic there was junior doctor-led scheduled teaching session every two weeks. The review panel was informed that the teaching was to be reinstated following the return of the junior doctor office space. The LEDs advised that they were involved in theatre cases one to three days a week. It was reported that the cases were usually coronary artery bypasses, ablations, and some emergencies. Some LEDs reported that they	

	predominately assisted in theatres, this was confirmed by the cardiac surgery consultants. The LEDs advised that the learning environment could be improved by offering more opportunities for junior surgeons to be the primary operator on cases and through better feedback. The cardiac surgery consultants reported that they believed the LEDs should be supervised closely until they were more advanced in their clinical skills. It was reported that the supervisors would ensure junior doctors were familiar with more basic techniques such as opening and closing, cannulation and harvesting of the mammary artery before moving on to more advanced techniques such as anastomoses. The review panel was informed by cardiac surgery consultants that opportunities for development of surgical skills was dependant of the progression and competency of the individual LED. Anaesthetic trainees informed the review panel that opening and closing was common practice for the LEDs but it was less common for the LEDs to lead on more complex procedures. It was also reported that LEDs would often argue with each other in theatre about their competence. Healthcare learners reported that in complex cases it was more difficult to ask questions as people would be concentrating more closely. It was advised that in these cases learners would direct any questions to senior colleagues or the practice educators afterwards as the cardiac surgery consultants required silence. The review panel was also advised that healthcare learners were not always permitted to be involved with complex cases. This was confirmed by healthcare supervisor representatives.	Yes, please see CS2.2d

Domain 6 – Developing a sustainable workforce
6.1. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes. **6.2.** There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities. **6.3.** The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service. **6.4.** Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

HEE Standard	HEE Quality Domain 6 – Developing a sustainable workforce	Requirement Reference Number
6.1	**Retention and attrition of learners** When asked if healthcare learners would recommend the post to colleagues, all learners confirmed that they would recommend the post as their educational experience had been very good. Anaesthetic trainees reported that it seemed as though the LEDs were unhappy with their training, and it was noted that many were looking forward to leaving the department.	

Report sign off

Quaity Review Report completed by *(name(s) / role(s))*:	Louise Brooker, Deputy Quality, Patient Safety & Commissioning Manager
Review Lead name and signature:	Geeta Menon, Postgraduate Dean, South London, Health Education England
Date signed:	9 November 2021

HEE authorised signature:	Geeta Menon, Postgraduate Dean, South London, Health Education England
Date signed:	9 November 2021

Date final report submitted to organisation:	9 November 2021

What happens next:

Any requirements generated during this review will be recorded and monitored following the usual HEE Quality Assurance processes.
As part of our intention to development a consistent approach to the management of quality across England, Quality Reports will increasingly be published and, where that is the case, these can be found on HEE's national website. Information from quality reports will usually be shared with other System Partners such as Regulators and Quality Surveillance Groups