Health Education England

Quality review outcome report

Local office name: Yorkshire and Humber

Organisation: Health Education England

Placements reviewed: Cardiology Programme, School of Medicine

Date of Review: Monday 10th July 2017

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Date of report: 7th August 2017

Author: Kim Mills

Job title: Quality Coordinator

Review context

Background

Reason for review:	Poor trainee survey data
No. of learners met:	12
No. of supervisors / mentors met:	8
Other staff members met:	
Duration of review:	7 hours
Intelligence sources seen prior to review: *(e.g. CQC reports; NSS; GMC Survey)*	GMC survey, HEE YH Survey, School self-assessment.

Panel members

Name	Job title
Mike Hayward	Associate Dean (Chair)
Ian Wilson	Deputy Head of School of Medicine (Trainers only)
Usha Appalsawmy	Leadership Fellow
Margaret Ward	Lay Representative

Executive summary

Representation from the programme was fair with 8 trainers and 12 trainees in attendance, but circumstances precluded external representation from the SAC and full TPD involvement. Those trainers and trainees who could not attend were given the opportunity of submitting written comments. These were provided by 5 trainees and 2 trainers.

The following areas were highlighted as requiring action and further details of the issues and proposed actions are shown in the Educational Requirements section.

- Induction
- Access to Simulation
- Clinical Supervision
- Curricular requirements v trainee perception of competence/ use of OOP in final years of training
- Training in generic competencies

- Regional Teaching
- Improved Organisation and strategic leadership of the programme
- Poor training environment at NLAG

In reality there are three separate programmes (East, South and West) operating relatively independently of each other. Rotations are organised by the respective TPDs who meet three times a year. However, the Panel was of the opinion that, despite the efforts that have been made to do so, there was a need to improve the strategic leadership/whole programme organisation. This is reflected in the issues outlined in the report and a red flag for educational governance in the GMC trainer survey. The School of Medicine and TPDs must rectify this in order to address many of the required actions of this report and in particular induction, regional teaching (HEEYH is only one of two regions to get a red flag for regional teaching both in 2016 and 2017) simulation and training in generic competencies. The panel accepted however that improved organisation would be facilitated by a greater involvement from Programme Support.

In the early years of training there is a great demand on the registrars to provide service work for Acute Medicine which competes with cardiology training. Trainees have difficulty attending the catheter labs and echo and pacing training because of service commitments. The curriculum has been modified in recent years to accommodate the consequences of service overload but with such a large programme of 60 or so registrars, all at different points in their training and doing different sub-specialties, the service overload means that the jig-saw is very complex one for TPDs. It is not within the remit of this Programme Review to address the demands of Acute Medicine and the effect it has on specialty training. However, this is an area that the School should be constantly evaluating and leading in the actions required to reduce the deleterious effects on training.

Experience between the units is varied, for example, with regard to the availability of echo and pacing experience particularly at DGHs early in training. (The majority of trainees start the programme at a DGH). This reflects the different organisation of the units concerned and to whom the responsibility falls to organise lists; each centre has benefits and limitations. Under these circumstances it is incumbent in the organisation of the rotation to ensure that the limitations of one department are covered elsewhere on the rotation; there is a feeling amongst trainees that at present this is 'hit and miss'. Only 68% of trainees in the GMC survey agreed with the statement in the GMC survey "I could easily complete all of my core competencies in ST3 to ST5. However, the ARCP evidence is that trainees infrequently fail to complete core training and that a national agreement to extend training in cardiology by one year for trainees who cannot meet core competencies in the first three years is rarely used in Yorkshire. The Programme must explore whether the trainees' perception is as a result of the very high demands of Acute Medicine or the variation between units and whether such a variation in training between units is inevitable/desirable and/or whether the training needs of each trainee could be addressed in the rotations in a more planned fashion.
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There is no centralised induction to the programme, this is left to individual educational supervisors. An opportunity to set expectations of the programme is thus lost. There seems to be a mis-match between the requirements of the curriculum and registrar expectations particularly with regard to numbers of procedures. Many, if not all, trainees undertake an OOPT/E toward the end of their training whilst retaining their NTN. This adds to the overall number of rota gaps which impacts on the training of the 'in programme' trainees.

Trainees are encouraged to undertake OOPR (with reputable grant awarding authorities eg MRC, BHF) usually between the ST5 and ST6 transition. This is planned up to two years in advance to ensure that funds are in place. 70%+ achieve higher degrees. Trainers told the Panel that local research projects are not encouraged and trainees are directed instead to QI projects.

In the local HEE and GMC surveys and testimony at the programme review, the trainees state that educational supervision is good and there was obvious good rapport between the trainers and trainees during the break at the review.

In each of the three tertiary centres there are concerns about clinical supervision. Each of these units is responsible for providing a non-interventional cardiology service at the other hospital(s) in the city. At present this service is being provided entirely by trainees without consultant supervision. At one centre trainees have been involved in a resulting SI and the issue has been flagged by the CQC. Following this consultant morning cover was arranged but this has since lapsed. Training at NLAG was noted to be of a poorer standard than at other centres

The School website is not used by trainees and some of the trainers did not know a website existed. All agreed that providing it was populated with in-date material much more could be made of this resource.

School support for the TPDs is discussed below. There were notable achievements in the self-assessment report provided by the south rotation TPD: All CCT candidates have been appointed to posts in a suitable time frame. Two successful NIHR CLs are in post currently, one recently appointed to the prestigious Wellcome trust Clinical Research Career Development Fellowship. One CL was awarded Young investigator of the Year prize at BCIS. 4 interventional sub-specialty trainees have been competitively appointed to BCIS Overseas interventional fellowship

Sign off and next steps

Report sign off

Outcome report completed by *(name)*:	Kim Mills
Chair's signature:	Mike Hayward
Date signed:	September 2017

Findings and conclusions

Risk scores (*1 – 25; see Appendix 2 for breakdown*)

Scores prior to review:	*Multiple risk scores can be included, if several programmes/professions are covered in the report. For example* *Emergency Medicine ACCS: Impact 2 – Likelihood 3 = 6* *Foundation Year 1: Impact 3 – Likelihood 3 = 9* *Nursing: Impact 3 – Likelihood 3 = 9*
Proposed scores following review:	

Patient / learner safety concerns

Any concerns listed will be monitored by the organisation. It is the organisation's responsibility to investigate / resolve.

Were any patient/learner safety concerns raised at this review?	**YES**
To whom was this fed back at the organisation, and who has undertaken to action?	
The review chair, Mike Hayward fed the following back to Joseph John (TPD East) and Robert Sapsford (Deputy TPD West).	
Brief summary of concern	
Concern 1 NLAG was singled out by trainees as a unit where training was poor. This was also evidenced in the GMC survey with 8 red and 5 pink flags and showing a marked deterioration from previous years. There was also written evidence from two trainees. There is currently one trainee in Grimsby (NLAG). The Grimsby unit in particular was described as dysfunctional with approximately 90% of time spent on service commitment with very little educational inputs. The trainee at Grimsby should be removed and Scunthorpe allowed 6-12 months to address their training issues before consideration is given to removing trainees from this unit also. Immediate action required. **Action taken**. Trainee has moved from Grimsby to Mid Yorks. The Trust raised no objections to this, as they are not currently in a position to train. (2 consultants & 1 locum fulfilling 5-6 consultant workload). Service reconfiguration is planned with a move of cardiology from Scunthorpe to Grimsby. **Action planned** Plan to leave post fallow at present – will review situation for August '19. As a result of this move, the west rotation has gained one trainee at the expense of the east, this will be redressed at the next recruitment round. Concern 2. See *20170710_HEEYH_RQ3* Supervision	

Educational requirements

Requirements are set where HEE have found that standards are not being met; a requirement is an action that is compulsory.

Were any requirements to improve education identified?		**YES**
Reference no.	**Programme / specialty:**	**Learner / professional group:**
20170710_HEEYH_RQ 1	*Cardiology*	*Higher Specialty Doctor*
Related Domain(s) & Standard(s)	*HEE Domain 3*	
Summary of findings	**Induction –** Induction to the programme is currently conducted during initial meetings between individual trainees and their Educational Supervisor. Each Educational Supervisor will do this differently and may impart slightly different information about curricular requirements and programme management to their trainees which creates inconsistency. The trainees reported that they would find a repeat of induction at ST5 useful. A complicating factor is that is that trainees in the East and South start in post on 1st August whereas trainees starting in post in the West start on 1st September. This is a historical arrangement and there is a desire on the part of the trainers for the start dates to be synchronised.	
	Required Action Start dates to the programme must be unified allowing induction for ST3s to be regional and all trainees to have a generic introduction to the programme, possibly as part of a training day. This will be assessed at the end of March 2018 **Action planned** Programme induction to be included in the first Regional Teaching day of the new year (September). All three TPDs to attend this session emphasizing unity of Yorkshire Programme. Should include induction to Advanced Modular Training in ST6/7 and explanation of extended Cardiology Training Programme from 5 to 6 years (see JRCPT web-site). Agreement on Start Date of the programme to August across all localities. LGI to be phased in to accommodate 13 OOPEs.	

Reference no.	Programme / specialty:	Learner / professional group:
20170710_HEEYH_RQ 2	*Cardiology*	*Higher Specialty Doctor*
Related Domain(s) & Standard(s)	*HEE Domain 3*	
Summary of findings	**Simulation** – There is one simulation course each year run at Bradford for ST3 & 4 trainees. Otherwise there is reliance on national courses although it was reported that the financing of these (from industry) is under threat or has ceased. One registrar commented "if I have had a period away from the cath lab when I eventually get there I've forgotten how to put the kit together". There is a 'teaching bag' (simulator kit) at Sheffield but its use could be better promoted. Better use of simulation might increase exposure to procedures in the cath lab and thus 'in programme' achievement of curricular competencies.	
	Required Action Trainees should not be performing procedures on patients unless they have shown prior competency with the kit in a simulation setting and they will need to renew simulation competencies from time to time especially after a significant period of time away from interventional training. If national courses are in decline the School and Programme must urgently review how simulation is going to be delivered, promoted and assessed using local, regional and supra-regional resources. All trainees must have equal exposure and opportunities to train in a simulated environment. The costing for trainer input into simulation needs evaluating as Trusts are getting more reluctant to release their consultants for educational activities. See also promotion of soft skills such as Human Factors training below. This will be assessed at the end of March 2018. **Action planned** Simulation training originally initiated by National Society and successful programmes in Yorkshire in 2014 and 2015. Courses dependent on good will from trainers as Trusts holding consultants to annualized contracts and not releasing Consultants for Simulation Training without "pay-back". Little incentive to motivate trainers and same principle applies to Regional Training Programme. TPDs planning a course for 2018. New simulation programmes being established in Yorkshire – Surgical Skills for Device Implantation (LGI), and possibly Cardiothoracic Surgical Skills course to be combined with Cardiology (in development at Castle Hill). All courses to be advertised on re-vamped School Website. Simulation training provided annually at National Society 3 day conference – trainees advised to book well in advance	

Reference no.	Programme / specialty:	Learner / professional group:
20170710_HEEYH_RQ 3	*Cardiology*	*Higher Specialty Doctor*
Related Domain(s) & Standard(s)	*HEE Domain 3*	
Summary of findings	**Supervision** – Across the programme there are tertiary centres, each has a Cardiology unit in one hospital and another hospital that requires cardiology consultant supervision which trainees are currently covering. Consultants (not on site) are available by phone but generally the trainees are dealing with complex patients with co-morbidities on an unsupervised basis. This has led to SUIs in at least one unit. Joseph John (TPD) has raised this issue with the Medical Director for the Hull units a number of times; however, no permanent changes have been made. CQC have commented on this issue and for a period of time Hull Royal Infirmary did have a consultant presence in the morning for four days a week but this has since lapsed. The trainees reported that they are finding it difficult to cope in this environment; it is impacting on training and is a potential patient safety issue. The south TPD stated that he had resisted efforts by the local trust to put trainees into service clinics with no consultant supervision.	
	Required Action A named on-site consultant supervisor is required in all hospitals and clinics to ensure that trainees are not working in an unsupervised environment. If the work outlined above is pure service work which is not achieving curricular competencies then it must be undertaken by other staff and trainees released back into, for example, more procedure sessions. This will be re-assessed at the end of June 2018 **This is a patient safety issue** **Castle Hill/HRI.** Cardiology based at Castle Hill, but trainees at HRI seeing acute cardiology. Joseph John has tried to ensure senior cover by approaching Trust leadership at all levels from Clinical Director to Chief Exec, without success. There remains no consultant cover at HRI, so trainees (all levels on rotation) are working unsupervised, seeing acute cardiology patients. Significant Patient safety issue as well as intolerable for trainees. **Action planned** Fiona Bishop/Ian Wilson to ask the Dean to write to the Medical Director about this patient safety issue. **SJUH/LGI** LGI trainees (ST5,6) go to SJUH for ½ day daily & named consultant (for week) is available to go across on request. 2 consultants rounds a week to review patients. Therefore, not so much of a training issue, but a Patient Safety issues remains logged at QM– therefore need to let Medical Director know. **Action planned** Fiona Bishop/Ian Wilson to ask the Dean to write to the Medical Director about this patient safety issue. **Northern General/Royal Hallamshire**. There are no acute admissions at Hallamshire. therefore, cardiology ward referrals only. Consultant on call at Northern – trainees are expected to call them. The TPD has opposed requests for an unsupervised trainee led clinic at the Hallamshire **Action planned** Fiona Bishop/Ian Wilson to ask the Dean to write to the Medical Director about this patient safety issue.	

Reference no.	Programme / specialty:	Learner / professional group:
20170710_HEEYH_RQ 4	*Cardiology*	*Higher Specialty Doctor*
Related Domain(s) & Standard(s)	*HEE Domain 5*	
Summary of findings	**Curricular requirements versus perception of competence use of OOP in final years of training** – There seems to be a disparity between the procedural numbers stated in the curriculum and the numbers the trainees perceive they require and indeed whether this perception is for reasons of patient safety or competitive edge on a national basis. Almost all the trainees reported that they felt it necessary to undertake a one to two-year fellowship at the end of their training in order to feel fully competent to take on a consultant role. At present the majority of these are facilitated by an OOPE/T in the final years of training; this has been encouraged by the cardiology SAC. However, with the loss of LATs, this produces rota gaps which in turn impacts on the training of 'in programme' trainees' (acknowledged in the programme self-assessment and written comments from trainers). In many specialities, fellowships are undertaken post CCT with release of the NTN and lessening of rota gaps. This is a complex area but one which requires discussion. The School needs to know whether these OOPEs are for curricular requirements, and if so why this training cannot be provided by the programme, or whether for structural interventions such as TAVI (transcatheter aortic valve implantation), a procedure not mandated in the curriculum for CCT, and which more properly should this be experienced as a post CCT fellowship (as per SAC guidance).. Because of their impact on the training of others are OOPE/Ts self-perpetuating? This must be balanced by the wish to have our trainees competitively placed for their post CCT employment (fellowships as well as consultant posts). Not to do so would have a serious effect on recruitment to the programme. It is important that the School manage trainee expectations in terms of the areas covered by the curriculum (see induction above).	
	Required Action The School must investigate the OOPE/T rates for cardiology trainees in Yorkshire compared to other HEE regions. The School/TPDs must undertake a curriculum mapping exercise of all the units to see if trainees can acquire curricular competencies 'in programme'. And if not, which competencies are missing, why they are missing from the programme and whether this can be rectified within the programme. The School/TPDs must use the information gained in the mapping exercise to plan a trainee's course through the programme so that deficiencies in one unit are covered by the next. The School/TPDs must investigate whether other means of achieving missed competencies could be used such as day release or shorter periods of OOPE/T. The School must make the case for any OOPE/Ts towards the end of training. This will be assessed at the end of March 2018 **Action planned** National problem with service work in Acute Medicine detracting from Cardiology training. Was addressed by SAC in 2015 with GMC approval to extend Cardiology Training to 6yrs and allow Dual CCT. 6th year can be used to extend cardiology training and so achieve adequate numbers of procedures, especially PCI and E/P. Extended training beyond this now encouraged as Post CCT Fellowship – particularly relevant to Structural Intervention (eg TAVI) and advanced E/P. OOPT now difficult following withdrawal of LATs. This principle to be covered at Induction and no need to issue ARCP 3 if procedure targets on ARCP grid not met because of excessive service pressure (ARCP 2 adequate in this situation assuming no other problems, and extra training to spill over into 6th year).	

Reference no.	Programme / specialty:	Learner / professional group:
20170710_HEEYH_RQ 5	*Cardiology*	*Higher Specialty Doctor*
Related Domain(s) & Standard(s)	*HEE Domain 5*	
Summary of findings	**Trainees working on zero days and 'Rota Registrars'**- Trainees reported that they are coming in to work on zero days in order to attend training opportunities particularly for procedural competencies. The trainees reported that this practice had become 'the norm'. It was questioned as to whether trainees are indemnified in this instance. It was noted that the task of organising service and on call rotas and assigning trainees to educational supervisors in Leeds has fallen to a trainee. While the trainee appeared comfortable with the role it is important that the trainee receive extra time to complete these complex and time-consuming tasks as well as receive training and feedback on the generic competencies involved.	
	Required Action The School must establish whether trainees are using zero days to achieve curricular requirements in which action should be taken to rectify this. It must also establish if trainees are indemnified (particularly for procedures) if they are attending work on zero days through their own diligence to boost experience. Trainees performing administrative duties must be given the time for these and training and feedback in the generic competencies involved. Assigning Educational Supervisors is not a trainee role as specific ESs may be chosen for confidential supportive educational reasons. They must be assigned well in advance of the rotation by the TPD or a local consultant. This will be assessed at end of December 2017. **Action planned** Needs to be stated clearly at induction that trainees must get clarity from the employer about indemnity if they plan to work on zero days to gain extra experience. Again – emphasis on programme extension to 6yrs to accommodate this deficit.	

Reference no.	Programme / specialty:	Learner / professional group:
20170710_HEEYH_RQ 6	*Cardiology*	*All doctors in training*
Related Domain(s) & Standard(s)	*HEE Domain 5*	
Summary of findings	**Regional teaching** /Generic Competencies– The trainees reported that they find regional teaching valuable and have been invited to input into shaping the content of the teaching days in order to address any learning needs; however, they do not feel that they have sufficient sessions. There are currently six days arranged through the year, and some trainees find it difficult to attend if they are on call or following nights. The trainees referred to GIM on call commitments as one of the factors interfering with their ability to attend training opportunities. In addition to the planned six days, attendance at GIM RCP days and BCS days is encouraged. None of the trainees were familiar with Human Factors training. Training in other generic competencies also seemed sparse and not in line with curricular requirements (pages 56-90) although the trainees exuded confidence that they would be able to deal with such matters and felt that training in soft skills impinged on time for clinical skills. This attitude is likely to continue unless the training teams find ways of robustly teaching and assessing such skills in line with GMC requirements. Regional training days and other forms of centralised teaching could be used to advantage but local trainers should also acknowledge and be willing to train in this field.	
	Required Action The School must establish regional training days as focus for programme/curricular delivery both clinical and generic and assess the feasibility of running them, perhaps 8 rather than the current six times a year. Trusts and local rota co-ordinators must be made aware that this is a mandatory part of training and of the consequences of not releasing trainers and trainees to attend. It needs to develop other methods of delivering central teaching such as accessing eLearning for health for Cardiology (echo, basic CT, MRI and clinical genetics. It also needs to cost benefit national rather than local training (eg ACHD course being held in London) This will be assessed at the end of March 2018 **Action planned** Rather than increasing Regional Training Days, emphasis should be placed on Trusts becoming more flexible and releasing Trainees for these sessions. In addition, extra training days are laid on by the National Society twice a year – one in London and one in Manchester. On-line education is proliferating and to date, no trainee has been issued an ARCP 3 on account of not achieving the ARCP grid requirement of 60% attendance. The 6 regional training days cover the entire curriculum and repeats every 3 years. Generic training eg Human factors is included in simulation training and can also be introduced to regional days. Regional training will continue at 6 days- on a 3-year cycle.	

Reference no.	Programme / specialty:	Learner / professional group:
20170710_HEEYH_RQ 7	*Cardiology*	*Higher Specialty Doctor*
Related Domain(s) & Standard(s)	*HEE Domain 2*	
Summary of findings	**Education Governance and Leadership** – The programme historically ran as three strongly independent entities and the present links between South, West and East rotations were thought by the Panel to be relatively loose without much central strategic direction or control of the programme as a whole. In the GMC trainer survey, the programme received red flags for educational governance, support for trainers and trainer development. Several of the required actions in previous sections require a regional approach to be effective. Other matters such as the national shortage of echo technicians (which is impacting training) need a pan-deanery approach Some units offer a better training experience than others and work should be done to identify the shortfalls in training and also to publicise the areas that work well and to share successful initiatives The self-assessment submission states that "the three area TPDs envisage a more pan-deanery approach to enable us to swap StRs between the three different areas so that curricular competencies can be achieved in a timely manner by trainees of all grades. At present several things combine to make this difficult: different rotation start/change dates, lead versus trust employer, trainees returning from OOPs" This summer the changeover of TPDs combined with HEE's internal reorganisation has led, on occasions, to relationships between the TPDs (and one external assessor for PYAs) and the administrative staff being less than ideal. This does training no favours.	
	Required Action The Panel was made aware of possible TPD retirements/appointments. The School must find ways of supporting three new TPDs (however much educational experience they may have) and ensure that the aim of achieving a 'more pan-deanery approach' (with strategic direction) is achieved. It must ensure trainer development and support as well as that given to trainees. It must explore the different employment practices that at present prevent trainees being moved easily to a training post on a different rotation. It must ensure that the internal administrative difficulties of this summer are resolved and that the expectations of HEE office staff and TPDs are managed to prevent conflict. It must make better use of the School website to enable better communication with trainers and trainees and reduce the administrative burden. This will be assessed at the end December 2017. **Action planned** HoS proposed option of having more TPDs (2 per rotation) but all agreed that they preferred the current model of TPDs & deputy TPDs which allowed for succession planning. The outgoing TPD for the West has offered to lead the group & represent them at the SAC (unpaid). There appeared to be general agreement to this, but an alternative would be for each TPD to attend one SAC meeting per year as there was limited support for one TPD to adopt this role in view of time commitment and Trust reluctance. The TPDs were supportive of intra-deanery transfers where indicated, although they were keen to arrange exchanges where possible, so one area did not end up being disadvantaged in terms of numbers of doctors (they have demonstrated their readiness to do this by the move of the Grimsby trainee to Mid Yorks). The TPDs communicate regularly and will provide joint induction from later this year.	

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that are worthy of wider dissemination, deliver the very highest standards of education and training or are innovative solutions to previously identified issues worthy of wider consideration.

Learning environment / Prof. group / Dept. / Team	Good practice	Related Domain(s) & Standard(s)
Cardiology South	An audit showed a high burden of internal referrals at STH led to a registrar leading the development of an electronic referral system which trainees commented has eased their workload.	
Cardiology South	STH has initiated a monthly meeting with the StR group so there is a free exchange of issues, ideas and exploration of common problems	

Appendix 1: HEE Quality Framework Domains & Standards

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), evidence based practice (EBP) and research and innovation (R&I).
1.4. There are opportunities for learners to engage in reflective practice with service users, applying learning from both positive and negative experiences and outcomes.
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 services.
1.6. The learning environment maximises inter-professional learning opportunities.

Domain 2 – Educational governance and leadership

2.1 The educational governance arrangements measure performance against the quality standards and actively respond's 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 leadership promotes team-working and a multi-professional approach to education and training, where appropriate.
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.

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 and / 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.

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.
4.5 Educators are supported to undertake formative and summative assessments of learners as required.

Domain 5 – Developing and implementing 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.

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.

Appendix 2: HEE Risk matrix

Likelihood	RAG RATING MATRIX				
5. Almost Certain	G	A	A/R	R	R
4. Likely	G	A	A/R	R	R
3. Possible	G	G/A	A	A/R	R
2. Unlikely	G	G/A	A	A	A/R
1. Rare	G	G	G/A	G/A	A
Impact	1. Negligible	2. Minor	3. Moderate	4. Major	5. Significant

Likelihood	RAG RATING MATRIX				
5. Almost Certain	5	10	15	20	25
4. Likely	4	8	12	16	20
3. Possible	3	6	9	12	15
2. Unlikely	2	4	6	8	10
1. Rare	1	2	3	4	5
Impact	1. Negligible	2. Minor	3. Moderate	4. Major	5. Significant

Score	Likelihood	Impact
1	Rare: • Will probably never happen • Could only imagine it happening in rare circumstances	Negligible: • Very low effect on service/project/ business area • No impact on patients/trainees/public/staff • No reputational impact, i.e. no press interest • No financial loss
2	Unlikely: • Do not expect it to happen • It is possible that it may occur	Minor: • Minimal disruption to service/project/business area • Limited impact on patients/trainees/public/staff • Minimal reputational impact • Limited financial loss
3	Possible: • Might occur • Could happen occasionally	Moderate: • Moderate impact on service/project/business area • Moderate level of impact on patients/trainees/public/staff • Medium level of reputational impact • Medium financial loss
4	Likely: • Will probably happen in most circumstances • Not a continuing occurrence	Major: • Major effect to service/project/business area • Major level of impact to patients/trainees/public/staff • Major impact on reputation, i.e. Major press interest • Major financial loss
5	Almost certain: • Expected to happen • Likely to occur in most circumstances	Significant: • Loss of service/project/business area • Detrimental effect on patients/trainees/public/staff • National press coverage • Significant financial loss

16