QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

London North West Healthcare NHS Trust
Clinical Radiology
Risk-based Review (on-site visit)

Quality Review report

Date: 06 July 2016
Version: Final

Developing people
for health and
healthcare

www.hee.nhs.uk

THE NHS
CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	In October 2014, London North West Healthcare NHS Trust was established, following the merger of Ealing, Central Middlesex and Northwick Park Hospitals. This resulted in significant reconfiguration to service and its subsequent impact on training and the training environment. This Risk-based Specialty review was requested by the Head of School for Clinical Radiology, as a result of the on-going concerns regarding the overlapping training needs of interventional radiologists and vascular surgeons. Furthermore, the specialty had not been reviewed for a number of years, and the concerns highlighted following the publication of the 2015 General Medical Council National Training Survey (GMC NTS) warranted a request to review. In the GMC NTS, clinical radiology received three red outliers: • 'Clinical supervision out of hours' – 15% of trainees knew who their clinical supervisor was out of hours, but stated that they were not easy to access; 23.08% of trainees rated the quality of out-of-hours supervision as 'poor. • 'Access to Educational resources' – 20% of trainees rated access to the library as 'poor' or 'very poor'. 20% of trainees rated access to online journals as 'poor' or 'very poor'. 27% of trainees rated access to the internet as 'poor'. 20% of trainees rated access to a space for private study as 'poor'. • 'Regional teaching' – 46.67% of trainees reported that specialty-specific teaching was not provided on a regional-wide basis. 37.5% of trainees said that regional teaching was provided on a less frequent basis. Additionally, the department received a pink outlier for 'supportive environment', with results showing that: • Seven per cent of trainees strongly disagreed that the working environment was supportive; seven per cent of trainees strongly disagreed that staff were treated fairly; seven per cent of trainees disagreed that staff treated each other with respect; just fewer than seven per cent of trainees strongly disagreed that the working environment built confidence of doctors in training. Seven per cent of trainees strongly disagreed that senior colleagues would be open to their opinion.
Number of trainees and trainers from each specialty	The visit team had the opportunity to meet 13 of the programme's 19 trainees within clinical radiology, working across training grades one to five. In addition, the visit team spoke with the training programme director, lead provider training lead, divisional director, and educational and clinical supervisors.
Review summary and outcomes	The visit team thanked the Trust for accommodating the visit and ensuring good attendance at all the sessions. Overall, the visit team was pleased to find a faculty that was engaged with training and education and had a well-run and structured training programme. The core-training curriculum was particularly well-structured, organised and internally monitored. This included excellent engagement with the clinical and educational supervisors. Through the Lead Provider model, the Trust had excellent links with other Local Education Providers enabling sub-specialty training to be fully optimised. The visit team learned that the clinical radiology department was operating under significant financial constraints, with a low capital threshold expected to maintain facilities across all sites. However, financial planning had accounted for the replacement of vital radiology equipment over the following financial year.

	The visit team was concerned to learn that scans taken out-of-hours (OOH) were regularly left unchecked by consultants until Monday morning, and in cases of bank holidays, until the following Tuesday. An Immediate Mandatory Requirement (IMR) was issued, in light of the significant risk posed to patient safety. In addition, trainees reported that they did not consistently receive feedback on serious incidents reported on Datix, and the visit team was concerned that this may act as a deterrent to any future reporting. The visit team heard that the clinical radiology department was working with reduced staff numbers, and trainees experienced busy rotas, particularly with the out-of-hours on-call rota; a number of trainees commented that they were too busy to take any rest. Clinical supervisors reported that they were under significant pressure to balance work and training commitments. The educational resources facilities, especially wireless fidelity services (WiFi) were limited and inadequately supported education and training. The acute radiology team was structured in a manner that was service focused and tended to impede training opportunities, particularly experience of acute computed tomography (CT) and magnetic resonance (MR) reporting There was a culture of bullying amongst the acute surgical team towards the radiology team. This had the potential to affect relationships which could affect patient safety.

Quality Review Team			
Lead Visitor	Dr Jane Young, Head of the London School of Clinical Radiology	**External Representative**	Dr James Pilcher, Consultant Radiologist
Trust Liaison Dean / County Dean	Dr Orla Lacey, Trust Liaison Dean,	**Trainee Representative**	Dr Gary Cross, Trainee Representative
Lead Provider Representative	Dr Adrian Marcus, Consultant Radiologist	**Scribe**	Lizzie Cannon, Learning Environment Quality Coordinator
Observer	Jennifer Quinn, Learning Environment Quality Coordinator		

Findings

GMC Theme 1) Learning environment and culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Ref	Findings	Action required? Requirement Reference Number
1.1	**Patient safety** The visit team was concerned to discover that there was no robust system in place to ensure that scans were checked by a consultant out of hours, between 5pm on Friday to Monday morning. On Bank holidays or the Easter weekend, this had the potential for scans to go unchecked by a consultant from Thursday to Tuesday. This posed a serious patient safety concern. It was reported that there was a good interventional radiology (IR) transfer process from Ealing Hospital (EH) to Northwick Park Hospital (NWP), which did not depend on clinical radiology trainees. The EH Emergency Department (ED) process was described as 'fully functional'. The visit team was informed that the Trust was working with Hillingdon Hospitals NHS Trust to improve OOH IR cover and intensive treatment unit (ITU) beds. The visit team enquired whether there were any plans in place to move work from EH ED and was informed that there were none in place; consultant on-call rotas were separate. Longer term plans may change surgical cover at EH. The visit team learned of the Trust's plans to monitor the EH ED service with a view to reducing the service provision, so that services would no longer be mirrored across EH and NWP. The visit team also heard that the consultant on-call rotas were already separate. The radiology department stated that it did not want to move in the event of future service reconfiguration, and told the visit team that *Shaping a Healthier Future* would result in the loss of surgical cover. The department said that it believed that leading the rota would not be cost effective, but if that were to happen, seven day working would need to be in place in order to provide a safe and efficient service.	Yes – see CR1.1 below
1.2	**Serious incidents and professional duty of candour** Trainees stated that they always reported any serious incidents through Datix but that feedback was not always given, a fact that may potentially act as a deterrent to reporting.	Yes – see CR1.2 below

1.3	**Appropriate level of clinical supervision** The trainees stated that they were uncertain of who their supervisor was when working in IR for core training. This only applied to the IR attachment. The visit team learned that this problem was singular to the IR department, and trainees reported that in all other areas, they received good levels of clinical supervision and found the consultants to be approachable and supportive. The clinical supervisors acknowledged that they were under pressure and experienced tension in the search to find equitable time for their clinical service work and their educational responsibilities towards trainees. However, most supervisors said that they found the time to balance out both responsibilities. The visit team learned that the clinical radiology department experienced difficulties in recruiting adequate numbers of staff, and was currently working with a deficiency of seven radiologists. The visit team was advised that approximately 50 radiologists were employed across the Trust – with 11 at Ealing Hospital (EH), and about 40 based at Northwick Park Hospital. The Trust advised that it did not employ any locums. **On-call cover** The visit team was keen to gain clarity on the department's on-call arrangements, and learned that trainees did not cover EH overnight – these shifts were covered by consultants. Weekend on-call working was described as challenging to resource; there was no seven-day working system in place, and staff who did attend at the weekend did so voluntarily. The visit team was advised that the department was in the process of implementing a new seven-day working plan. The radiology team advised that consultants were approachable and attended onsite in the event that a trainee had called to raise any concerns. The visit team was told that a number of consultants came in at the weekend as a matter of routine, and spent a few hours on site during the day. However, this was at odds with the trainees' comments, which stated that consultant attendance at weekends was not a matter of routine. Prior to commencing on call, trainees were encouraged to undertake on-call assessments. In addition, trainees had the opportunity to shadow on-calls for three to four months with the most senior trainees to help check scans etc.	Yes – see below CR1.3 Yes – see below CR2.1
1.4	**Rotas** The trainees reported that while the daily volume of urgent work was manageable, the out-of-hours volume was high. Trainees advised that they worked on a partial shift system, and were happy to work to this pattern as it meant that they performed fewer on-calls and were able to do more daytime work as a result. The shift patterns covered a 16 hour resident shift and between 9 am and 5pm at the weekend. The trainees said that they reported an average of 24 scans between the hours of 5pm and 9am, which necessitated a resident radiologist. The visit team heard that trainees were constantly busy OOH and had no protected rest. The rota design covered a 16 hour shift on rota work for a 24 hour call, resulting in the inability to guarantee protected rest. The banding for that rota was set at 1b. The visit team observed that the supervisors believed that rest was possible within this arrangement, in contradiction to the trainees' experience. Clinical and educational supervisors (CSs and ESs) recognised that the OOH and weekend work was so busy with diagnostics that there was not an opportunity to	Yes – see below CR1.4

	benefit from assisting or performing interventional cases. The director of the IR programme expressed frustration at unused training capacity. Currently the IR consultants did not have time in their job plans for clinics. This would be an area for future development to deliver training for subspecialty IR trainees.	
1.5	**Induction** The trainees reported that they were satisfied with the induction they had received from the Trust.	
1.6	**Handover** The visit team learned that there was no formal, written handover policy in place. However, the trainees advised that they had face-to-face handovers at the end of their shifts, flagging any outstanding scans on the list and would not leave until this was complete.	Yes – see below CR1.6
1.7	**Protected time for learning and organised educational sessions** With regard to teaching, supervisors advised that teaching was timetabled within their commitments. The visit team was advised that training was scheduled every Tuesday and Friday morning, and Monday and Thursday lunchtimes. Supervisors confirmed that general teaching was scheduled at NWP and CMH each Monday and Friday. In addition, supervisors explained that trainee attendance was variable, as expected. The visit team was concerned to hear of the inadequate provision of educational resources and facilities, such as adequate access to Wi-Fi (60 minutes a day), restricting access to online journals and textbooks; this was inhibiting educational opportunities. Furthermore, the visit team learned that there was no provision of assistance for trainees or trainers to upload radiology cases on to the OSIRIX teaching database, which would increase their ability to develop this resource. The supervisors reported a severe shortage of teaching rooms, making it very difficult to conduct one-to-one meetings and teaching sessions. The visit team learned that 24 registrars shared a room that was originally intended for use by four members of staff. The supervisors advised that they had escalated this issue on numerous occasions but no action had been taken.	Yes – see below CR1.7 Yes – see below CR1.7

GMC Theme 2) Educational governance and leadership

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

2.1	**Impact of service design on learners** The visit team heard that the initial planning process for the merger with EH and CMH had begun over three years ago, and the process reached completion last year. The visit team learned that the planning was better this time around. However, the view	

	was taken that the financial planning undertaken by the Trust Development Authority and NHS England was insufficient. EH did not have enough staff and needed to grow. The visit team was advised that EH was no longer in financial balance, as a result of the merger. Furthermore, commissioning, contracts and other related aspects led NWP to merge, and the visit team was told that NWP remained a larger challenge financially. The Hospital had a team of improvement directors, and the visit team was informed that the Trust was no longer in the bottom 20 ranking, resulting in a good trajectory to clear its debt in the following three years. More general financial concerns were disclosed to the visit team: the Trust was operating with a low capital allowance of £13million for the clinical radiology department to maintain everything across all sites, including commissioned services. The Trust managed to budget £28million for this financial year. However, all radiology equipment had to be purchased from that as well. The radiology department was in need of approximately £5.5million over the following year, as the interventional radiology suite was coming to the end of its operational life, and various items of equipment were due to be replaced in the following months. The visit team was advised that despite these challenges, financial planning was underway, and the department had agreement for the receipt of critical items next year. The visit team was told that the Trust did not outsource any of its radiology reporting, and that this was being considered as part of a wider appraisals process looking at options for some of the OOH work. At the time of the visit, the Trust had one fixed magnetic resonance (MR) scanner, and one portable MR unit.	Yes – see below CR2.1a Yes – see below CR2.1b
2.2	**Organisation to ensure time in trainers' job plans** The divisional director told the visit team that the Trust endeavoured to limit the number of trainees to four per supervisor, and was working to recruit more educational supervisors; the radiology had an established process in place to do so. The Trust sought people with good experience, who showed interest in education. The visit team was informed that the Trust was keen to encourage candidates who had an established interest in academia. In addition, the visit team was advised that the director of medical education (DME) had conducted appraisals and was part of the job planning committee. With regard to clinical supervision, the visit team heard that most consultants did supervise and that trainees' supervisors were named on ePortfolio. The visit team heard that only named clinical supervisors had been appraised, and that the Trust was in the process of encouraging those individuals to train as educational supervisors, with an additional 0.25 PA (programmed activity) per trainee. In addition, the visit team heard that the Trust offered free study days to relevant individuals to maintain their GMC required training.	
2.3	**Systems and processes to make sure learners have appropriate supervision** The visit team heard that clinical supervisors (CSs) were concerned that changes to Trust remuneration policy had resulted in a loss in opportunities for close supervision of trainees; certain lists were less attractive for consultants to run, and the reduction in capacity for lists to run in parallel out of hours means that trainers had reduced ability to supervise trainees closely. In order to deliver the increased demand, a proportion of ultrasound and musculoskeletal lists were done outside of the routine working day and were not available for training. The increased demand and limited capacity (of rooms) meant that trainers were unable to run parallel lists.	

GMC Theme 3) Supporting learners

Standards

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

3.1	**Behaviour that undermines professional confidence, performance or self-esteem** No trainees experienced bullying or undermining within the radiology department. However, the trainees reported a culture of bullying among a group of acute surgeons (not including those based at St Mark's Hospital). Furthermore, the trainees said that as a result, the acute surgery department was the only department in the whole Trust that they did not work easily with. The visit team learned that trainees reported this to their supervisors who were supportive and escalated the issue. The CSs and ESs said that they were aware of the difficult on-call working relationships and would be willing to participate in any actions, or training between the groups that would enhance working relationships, which would also benefit efficiency and improve patient safety.	Yes – see below CR3.1

GMC Theme 4) Supporting educators

Standards

S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The visit team heard during the senior management team meeting that the Trust had a low percentage of named clinical and educational supervisors and clinical supervisors trained within the GMC trainer framework. The clinical director for clinical radiology stated that they had attended the job planning committee and the educational supervisor component was included in this. The visit team heard that the majority of the radiology consultants were trained clinical supervisors and they were encouraged to attain the GMC standards.	Yes – see below CR4.1
4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team heard that educational supervisors had time written into their job plans for their supervisory work, whereas clinical supervisors (CSs) did not, and had to find time within their working week to conduct supervision.	

GMC Theme 5) Developing and implementing curricula and assessments

Standards

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.

5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team heard that the core training programme for clinical radiology was very well-structured and responsive to trainee needs, with CSs for each training block responsible for setting objectives and delivering training with an individual approach, but placed emphasis on a team approach for delivery of the curriculum with colleagues. A number of CSs described having regular one to one interaction with trainees, and had a good idea of how trainees were progressing through the programme. The visit team heard that musculoskeletal CSs wanted to implement a regular review of the delivery of the curriculum, training and training opportunities, with a view to making it a regular part of their role; it was hoped that the completion of this assessment of the programme would result in a number of changes to the training provision, including more trainee exposure to more plain films. CSs raised concerns about the fact that the Trust was still unable to recruit an adequate number of sonographers. With regard to reporting radiographers, CSs reported that trainees had stated that they had difficulty in getting plain films reporting experience, as all such work was carried out by radiographers. However, the CSs made the decision to involve radiographers in training, to work support the trainees. The visit team heard that there was such a shortage of ultrasound rooms that training opportunities were lost, because trainers did not have the time or space to work in parallel with trainees and the focus was on service delivery. The visit team was impressed with the strong links that the radiology department had developed with other Lead Providers (LP), and the range of opportunities that this presented to trainees to develop their skills and experience. The training lead for Imperial LP reported that trainees had the opportunity to undertake training at the Royal National Orthopaedic Hospital, Stanmore, Harefield, Charing Cross, Great Ormond Street and St Mark's Hospitals. In years four and five, these placements were tailored to trainees, with the objective of gaining wider experience e.g. to more MR imaging. Recent examples of the use of such links included trainees rotating to Charing Cross Hospital to receive training in lower gastrointestinal (GI) radiology and to the Intestinal Imaging Centre at St Mark's Hospital. The visit team heard that trainees usually undertook these placements as a full rotation. However, a number of trainees had completed such placements on a split basis, spending a few days each week at other sites.	
5.2	**Appropriate balance between providing services and accessing educational and training opportunities** The visit team learned that inpatient acute imaging was managed by a dedicated team of three to four higher trainees, supervised by two to three consultants who were responsible for completing all outstanding work at end of each day. This team dealt with inpatient ultrasound, MRI and fluoroscopy. The visit team was advised that consultants were responsible for allocating work to trainees. The average working day was reported to cover 9am to 5pm/6pm.	Yes – see below CR5.2

	Trainees stated that the department was very busy and the focus was on getting the job done, as opposed to the provision of training. The Trust admitted that there had been problems with this system in the past, and trainees had been invited to provide feedback. The visit team learned that on those days where the consultant cover was less focused on training, no one noticed that the same trainees undertook the same tasks frequently, which limited trainees' overall exposure and training opportunities. However, the Trust advised that it made changes to this system, and started to schedule a daily named lead acute consultant, which it was reported was working much more successfully. The trainees reported that, when working in the acute radiology team, obtaining practical experience and teaching was difficult. The trainees explained that, historically, when working on the acute imaging team, they were allocated cases to report and the consultant would manage the telephone system and supervise them. However, the visit team learned that this practice had changed, and consultants would now do most of the reporting, with one higher trainee on duty who answered calls and requests continuously but did no reporting. The Trust intended to increase cover until 7pm with the introduction of an additional consultant for the department.	
5.3	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The visit team learned that core trainees were not gaining enough practical interventional radiology (IR) experience, as the trainers were 'far too busy'. A number of senior trainees were concerned about the fact that they did not yet feel confident to perform IR procedures, as they were not doing enough to gain an appropriate level of experience. Some trainees explained that they had undertaken a disproportionate level of vascular work compared to non–vascular IR and were therefore not as confident as they would expect to be at the end of their third year of training in the more general non–vascular IR procedures such as chest drains and abscess drainages. The trainees also expressed concern that they were not gaining experience of acute spinal MRI scanning OOH (cord compression or trauma), particularly in comparison to trainees at other schemes. A number of trainees were concerned that the exposure to neurological MRI was limited, which meant that they did not feel confident dealing with such cases.	Yes – see below CR5.3
5.4	**Opportunities to develop clinical, medical and practical skills and generic professional capabilities through technology-enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation** The visit team heard that there was potential for, but no current uptake of sub-specialty training in IR. The radiology team explained that they had not recent sub-specialty IR trainee as the linked training scheme which they come from had a shortage of IR trainees themselves. The changes in the configuration of the service had also impacted on confidence in ability to deliver the training for a while.	
5.5	**Opportunities for interprofessional multidisciplinary working** The visit team learned that the interventional radiology department had worked on an initiative to bring together IR and vascular surgery service and training, and treat patients in a process of collaborative working. The IR team was keen to share procedural expertise across the department. The visit team heard that IR sub-specialty trainees would have good access to cases of angioplasties, but reduced exposure to operative and hybrid theatre cases. There is	

	potential for experience of cholecystectomies drainages and biopsies. The visit team heard that the IR team had an 8am meeting every morning, with vascular surgeons, theatre staff, anaesthetics and angio nurses also in attendance. The unit operates in a completely different way to other training programmes in London. The visit team was informed that there appeared to be a reticence from some core clinical radiology trainees to perform any invasive procedures, but it was noted that they were constrained by the business of their acute diagnostic work. The visit team recognised the good working relationships across the IR/vascular initiative and recognised that the department had unused training potential.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
Core radiology trainees can access training and work flexibly with other TPDs and trainers across the North West London training scheme.	Gillian Bane, Tony Chambers	Through the School of Radiology Executive and TPD update day.	

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
CR1.1	The Trust is required to review the level of risk and the level of seniority of trainees who are reviewing scans out-of-hours. This review must ensure that the level of consultant support is adequate for the acuity and complexity of the scan and level of experience and competence of the trainee.	The Trust is required to provide the outcome of the review within five days, as stipulated on the IMR form.	R1.1

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
CR1.2	The Trust is required to provide timely and efficient feedback to trainees after submitting a Datix form. The Trust should also ensure that learning events from serious incidents are held and trainees are able to attend regularly.	The Trust is required to provide the programme of learning events from serious incidents. This must be corroborated with LFG minutes to provide evidence that trainees receive feedback.	R1.3
CR1.3	The Trust is required to ensure that trainees are always informed of and are aware of who their clinical supervisor is in IR for core training.	The Trust is required to explain how they will be made aware of their designated person in IR. This should be reviewed at LFGs and recorded in the minutes.	R1.7
CR1.4	The Trust is required to ensure that trainees are able to take a four hour, uninterrupted rest period, when working within the partial shift system.	The Trust is required to undertake a diary-card monitoring exercise to ensure that trainees are compliant with the European Working Time Directive (EWTD). This must be corroborated with the LFG minutes to demonstrate that trainees are able to take adequate breaks.	R1.12

CR1.6	The Trust is required to formalise the handover procedure within the clinical radiology department. This should ensure that trainees no longer have to stay late to handover scans and ensure that no scans are missed or unaccounted for.	The Trust is required to provide the new, formalised handover procedure and LFG minutes, which monitor the effectiveness of the new handover.	R1.14
CR1.7	The Trust is required to provide adequate educational resources to ensure that trainees can optimise the training environment. This includes an IT system with free and unlimited WIFI (to access STATDX), adequate provision of teaching rooms and support for regular input to the digital OSIRIX library of scans.	The Trust is required to provide the minutes and attendance list of the LFG which demonstrate that trainees now have to provide evidence of access to unlimited WIFI, teaching rooms and support for the digital library as reviewed and recorded in the LFG minutes.	R1.16
CR3.1	The Trust is required to ensure that bullying and undermining behaviour toward the radiology department from the acute surgical team ceases immediately.	The Trust is required to provide a plan of how the relationship between the two departments shall be improved and this should be detailed within minutes from the LFG which demonstrate trainee feedback on the progression of this issue.	R3.3
CR4.1	The Trust is required to ensure that all trainers are trained within the GMC trainer framework.	The Trust is required to provide a list of the trainers within the radiology department and evidence of the correct modules completed.	R4.1
CR5.2	The Trust is required to ensure that the learning and teaching opportunities within the acute imaging team are distributed equitably amongst trainees to ensure they receive a broad range of learning opportunities when working within the team.	The Trust is required to provide the minutes and attendance of the LFG which demonstrate that trainees are able to access learning opportunities within the acute imaging department.	R5.9
CR5.3	The Trust is required to ensure that there are sufficient opportunities for practical experience in interventional radiology for core trainees.	The Trust is required to provide the minutes and attendance of the LFG which demonstrate that core trainees are able to access sufficient practical procedures in non-vascular interventional radiology.	R5.9

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
CR2.1a	The Trust should provide updates to HEE and the London School of Clinical Radiology regarding the Trust's progress on the reconfiguration of services, and any changes in OOH working (ED outsourcing) any increase in equipment and facilities, including the outsourcing of reporting out of hours and remote viewing for consultants. This update should focus on how these changes will influence education and training.	The Trust should provide updates (including regular reviewing of work OOH and the possibility of remote viewing for consultants) to HEE and the London School of Clinical Radiology.	R1.15
CR2.1b	The Trust should ensure that is required to outline the future provision of MRI services, as there is limited access for trainees in this modality and the loss of access to Mount Vernon (East of England) posts will reduce	The Trust should provide updates to HEE through business planning and keep this matter under review (as evidenced by minutes from LFG meetings)	R1.15

	this even further. The Trust should give strong consideration to the introduction of additional MRI scanning equipment, in order to improve the level of experience gained by radiology trainees.		

Signed	
By the Lead Visitor:	Dr Orla Lacey
Date:	23 August 2016