QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

King's College Hospital NHS Foundation Trust

Clinical Radiology

Risk-based Review (on-site visit)

Quality Review report

14 November 2017

Final report

Developing people for health and healthcare

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Quality Review details

Background to review	On 20 February 2017 Health Education England (HEE) undertook an Urgent Concern Review (on-site visit) to King's College Hospital NHS Foundation Trust to review clinical radiology. During the review, serious concerns were raised in regards to the quality of education and training in clinical radiology posts at King's College Hospital and following the review, HEE suspended training in Specialty Training Year 1, 2 and 3 levels (ST1, 2 and 3). Following the suspension of training, HEE met regularly with the departmental leads at the Trust to support improvements and ascertain progress. Subsequently, the Head of the London Specialty School of Radiology proposed to conduct a further on-site visit at the Trust in order to determine if sufficient changes had been put in place to allow the ST1-3 training posts to be reinstated in the department. In the General Medical Council National Training Survey (GMC NTS) 2017, clinical radiology at King's College Hospital returned the following outliers: - 11 red outliers in: overall satisfaction, clinical supervision, clinical supervision out of hours, reporting systems, workload, team work, supportive environment, curriculum coverage, educational governance, local teaching and regional teaching - Three pink outliers were received in: induction, educational supervision and feedback
Training programme / learner group reviewed	Clinical Radiology
Number of learners and educators from each training programme	The review team initially met with the clinical director, college tutor, training programme director, the deputy director of operations and the clinical director for breast radiology. The team subsequently met with trainees from ST4-5 and a number of the educational and clinical supervisors within the department.
Review summary and outcomes	HEE would like to thank the Trust for accommodating the Risk-based Review (on-site visit) and ensuring that all the sessions were well attended. During the course of the review, the quality review team was informed of some areas that were working well in relation to the education and training of clinical radiology trainees. - The trainees were on the whole positive in relation to the sub-specialty training they received and reported that they received adequate supervision and support. - The review team was encouraged by the number of consultant appointments that had been made to take positive steps to address the deficiencies and workload issues within the department. - The review team was pleased by the positive steps that had been taken by the department in terms of addressing the cultural issues within the department, through the external review being undertaken by South London and Maudsley NHS Foundation Trust. The review team recognised that further work was still to be undertaken, especially in relation to the new consultants who were due to start within the department. However, areas of improvement were also identified and highlighted as follows:

	- It appeared to the review team that there was a disconnect in terms of what clinical supervision the trainees felt they needed and what the consultants felt should be provided. This appeared to lead to some tensions within the department and the department should explore ways to trying to bridge this gap and reach a mutual understanding of supervision requirements at different levels of training. - It appeared to the review team that trainees did not receive the breadth of experience to maintain their core training and trainees faced difficulties in getting second opinions regarding inpatient work from consultants. - In a small number of sub-specialty areas, the trainees reported difficulties in receiving senior review of sub-specialty scans.

Quality Review Team			
HEE Review Lead	Dr Jane Young Head of the London Specialty School of Radiology	**External Clinician**	Dr Deborah Low Consultant Radiologist Barts Health NHS Trust
Trust Liaison Dean	Dr Anand Mehta Trust Liaison Dean Health Education England South London	**Scribe**	Elizabeth Dailly Deputy Quality and Reviews Manager Health Education England, London and the South East
Lay Member	Robert Hawker Lay Representative	**Observer**	John Forster Quality Support Officer Health Education England, London and the South East

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

The quality review team thanked the department for the work they had undertaken in relation to improving the training and education environment and recognised how much effort and care had gone into this work.

The clinical director reported that at the time of the review, they were in the process of expanding the consultant workforce within the department. The review team was informed that at least ten consultants had been appointed, the first of which was due to start in December 2017. The clinical director reported that the department was introducing a new thrombectomy service for stroke patients, for which further neurointerventional radiology consultants were needed. There is also a plan to increase the number of paediatric radiology consultants from four to seven. The clinical director indicated that this would ensure that additional clinical supervision was provided for trainees and have a positive impact upon workload.

The review team highlighted that during the previous visit, the main issues regarding clinical supervision had been in relation to the supervision of acute and inpatient work and asked how the new consultant appointments that had been made would ensure that this supervision was provided. The clinical director confirmed that each of the new consultants who were due to join the department had responsibilities in relation to the acute pathway included within their job plans and would provide training and clinical supervision for trainees in that respect. The clinical director confirmed that a job planning process was due to be undertaken once the new consultants had started and indicated that further consultant appointments would be made to address any gaps the department felt they had in terms of acute pathway supervision.

The clinical director indicated that previously, there had been an inappropriate balance of emphasis placed on sub-specialty work to the detriment of general acute work by consultants within the department. Appointment of the new consultants would address this in-imbalance and ensure that clinical supervision was provided for acute

and general work and develop a routine within the department of consultant involvement in acute radiology, as well as their sub-specialty commitments.

Until the substantive consultant appointments commence working, the review team was informed that there were a number of locum consultants employed within the department, and that the department's time to report for cancer cases had improved during this period. Furthermore, three clinical fellows had been introduced within the department as had an additional sonographer post, in order to ensure that the service could be maintained following the removal of the junior trainees and that supervision was provided to trainees. Additionally, the training programme director indicated that a new radiology delivery manager had recently been recruited who would be responsible for the rotas within the department (previously arranged by trainees), and that it was anticipated that the additional administrative support would be extremely beneficial for the department.

The review team was informed that during the period in which the junior trainees had been removed from the department, the department had been able to continue to provide the requisite service, during a period in which the Trust had responded to four major incidents. The clinical director reported that the department had managed to permanently cover the acute CT and trauma list and indicated that all unreported inpatient scans were sent to the external outsourcing company Medica between 5pm and 9am next morning to be reported.

The review team was informed that the local teaching programme in the department had been redesigned and that teaching sessions were provided for trainees on a daily basis and were consultant led. The training programme director indicated that they had received positive feedback from the trainees. Furthermore, it was reported that the trainees were released in order to attend national and international courses that were held at King's College Hospital.

When discussing the cultural issues within the department that were highlighted at the initial on-site visit on 20 February 2017, the clinical director reported that an external review had been undertaken by South London and Maudsley NHS Foundation Trust (SLAM) across the entire department, which had been multi-professional and involved interviewing consultants and trainees within the department. The clinical director confirmed that the findings of the review had been fed back to everyone within the department and that an away day was being organised to further address the cultural issues highlighted. It was, however, recognised that this was an on-going process and significant work was still to be undertaken. The clinical director also pointed out that since the original review in February 2017 a small number of consultants had left the department and with the starting of the new consultants over the next few months should see a positive change in the departmental culture. The review team therefore enquired as to how it would be ensured that they were aware of the new culture the department was trying to embed. The clinical director reported that they were confident that the new consultants starting within the department would have a significant positive impact upon the culture within the department and the divisional director reported that during their interviews, each consultant was asked a specific question regarding training environment and culture to ensure that they fitted well with the culture the department was trying to instil.

The clinical director reported that the department was in the process of updating a significant number of items of equipment, including the CT, angiography and portable, interventional ultrasound equipment, which they anticipated would have a beneficial impact.

Furthermore, the review team was informed that a radiology management board had been introduced, which was clinically based and had a designated trainee representative.

The college tutor and training programme director confirmed that they met with the trainees regularly, through the local faculty group (LFG) and the 'registrar forum' during which the college tutor met with the trainees on a monthly basis to discuss any issues they had. The clinical director further reported that if the junior trainees were reintroduced in the department, they would ensure that they spoke to the trainees individually and as a group to explain the change that had occurred in the department and inform them how they could raise any concerns. Additionally, it was reported that a mentoring programme would be introduced, with the support of the Director of Medical Education, which would involve mentoring from consultants outside of the radiology department, to ensure trainees felt comfortable raising any relevant issues.

The training programme director reported that in order to create the best training scheme they could, they had visited a number of other schemes across the London geography in order to explore areas of good practice that could be implemented within the department at King's College Hospital NHS Foundation Trust.

The review team was informed that many of the higher trainees wanted more specialist training as opposed to general training opportunities, and that the department was at the time of the review, trying to ensure that core training sessions were included in the teaching timetable, to ensure that the higher trainees did not lose these skills.

The review team was informed that all of the subsequent changes that had been made in the department following the Health Education England Risk-based Review (on-site visit) in February 2017 had been presented

at the 'registrar forums' to ensure that trainees were aware of the work the department was undertaking to address the issues highlighted. Furthermore, it was reported that trainees could access all relevant documents, including those relating to the external review undertaken by SLAM on the central drive.

Findings

1. Learning environment and culture

HEE Quality Standards

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

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

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

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

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

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

Ref	Findings	Action required? Requirement Reference Number
CLR 1.1	**Appropriate level of clinical supervision** There appeared to be a disconnect between the consultants and higher trainees regarding what is an appropriate level of supervision required for the trainee's level of training. The basis of this appeared to lie in different perceptions of the two groups regarding the level of and need for supervision in certain areas, and a lack of understanding and communication regarding the higher trainees request for additional clinical supervision. The trainees indicated that they felt the level of supervision provided needed to be suitable for core trainees in order for core trainees to be adequately supported if reinstated in the department. Whereas, the consultants felt that they were being approached and asked to provide a higher level of supervision than was necessary for trainees at specialty training year 4, 5 or 6 level (ST4-6) and were unaware of some of the motivations expressed by trainees for the level of supervision asked for. The trainees reported that they often requested direct supervision from the consultants to ensure that the department was aware of the number of consultants that would be necessary to provide direct supervision to more junior trainees, if they were reintroduced into the department (as they did not want their previous experience of inadequate supervision to be repeated). The trainees indicated that they did not typically request direct supervision because they felt they were working within their level of competence, but to ensure that a sufficient level of clinical supervision could be provided for core trainees. This was compounded by a perception by the trainees that the consultant 'supervising' was at times unable to provide that supervision as they were already committed to other work, and so they felt this was not meaningful.	Yes, please see CLR1.1a

	They also reported a contradiction in that at times they were told they were supernumerary to service provision – but that this could change if the department needed them to do service work. The clinical and educational supervisors reported that although they were able to supervise and train the higher trainees who were based in the department adequately they recognised that additional clinical supervision would need to be provided for the more junior trainees if the posts were reintroduced to the department, and that at the time of the review there were not enough consultants within the department to be able to provide that level of supervision. However, the review team was informed that they felt this would be addressed with the new consultant appointments that had been made. The supervisors based within paediatric radiology reported that since the removal of the junior trainees, their workload had significantly increased which had limited their flexibility and availability to provide training opportunities for the trainees. The college tutor stated that there was lots of capacity for training within breast radiology in terms of sub-specialty training and commented that the new consultant appointments would also improve the training and clinical supervision in relation to the trainees' acute pathway experience, which would be beneficial for the junior trainees. The review team was informed that at the time of the review, the trainees felt there were not enough consultants within the department to provide adequate clinical supervision for trainees at core level and to sustain a training scheme. The team heard that the consultant staffing level was similar to that of a small district general hospital but that the department was providing a tertiary level of service. The trainees reported that they felt the consultant body was trying extremely hard to provide adequate clinic supervision, but that this was unsustainable due to their workload. The trainees reported that at the time of the review, the inpatient CT scans were reported by locum members of staff who could not provide the same level of training for the trainees. The trainees reported that some locums had been unwilling to verify trainees' reports and that although others were extremely helpful, they were not able to review the reports for complex cases (as they were above their level of ability or experience) and that in such instances, when the locums verified the scans they often provided a proviso stating 'please revise scan with the relevant consultant in the sub-specialty'. The trainees reported that there had been a high turn-over locums covering the inpatient CT and that there appeared to be a lack of ownership of inpatient CT scans. It was reported that the consultants in the department were focused on sub-specialist work and therefore did not cover or take ownership of the inpatient work. The recruitment strategy appeared to be unduly focussed upon hiring more specialised consultants and thus there was concern regarding provision of supervision for acute inpatient scans. However, the Clinical Director stated that all new consultants would have an acute care pathway aspect to their job plan to enable this to be covered. The trainees reported that they were only able to gain experience of acute and in–patient CT scans when working out of hours and at weekends and that during these periods the consultant available did not always have the specialist knowledge to provide a senior opinion in particular specialist areas and therefore the consultants would be less willing to review the scans for the definitive opinion. The trainees reported that the consultants within the department worked extremely hard and that their sub-specialty workload was extremely onerous. The trainees felt that in certain sub-specialties as the consultants' workload was heavy they had less time to review sub-specialty scans reported by the trainees. However, it should be noted that the trainees recognised that this was not due to the consultants being unwilling to provide support and supervision, but was due to their onerous workload.	Yes, please see CLR1.1b Yes, please see CLR1.1c Yes, please see CLR1.1d Yes, please see CLR1.1e Yes, please see CLR1.1f Yes, please see CLR1.1g
CLR 1.2	**Rotas** The trainees reported that the lack of ownership of acute inpatient scans meant that often such scans were not consistently reported during the day and then would be left for the on-call trainee who began their shift at 5pm. The trainees indicated that if there was not an inpatient CT locum consultant during the day, then the scans routinely were	Yes, please see CLR1.2

	not reported until the evening and would either be left for the on-call trainee ~~or~~ would be sent to the tele-radiology company Medica to be reported. The review team was informed that if there was no inpatient CT consultant and scans were sent to Medica, this would not be done until 5pm, regardless of when they were taken. It was reported that this was not a regular occurrence and took place during approximately 20 per cent of shifts and that predominantly such occasions took place if consultants were on leave. Their out of hours' work performed remained phone triage for CT and inpatient urgent ultrasounds (Monday-Friday and no reporting of CT scans) and at the weekend when there were two higher trainees on-calls responsibility for reporting urgent scans.	
CLR 1.3	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The review team was informed that trainees did not receive any significant CT acute and inpatient experience as such sessions were not included within their timetable, which they felt was a detriment to their training. The trainees reported that the best opportunity for reporting acute imaging was when working out of hours. The trainees indicated that there were similar issues in relation to ultrasound experience and that historically, inpatient and portable ultrasound lists were covered by the higher trainees, but since the initial Health Education England visit in February 2017, the lists were covered by a sonographer and consultant. The trainees indicated that due to this, they only received experience during their out of hours shifts but that all would be willing to undertake ultrasound lists with indirect supervision. However, it should be noted that in relation to paediatric ultrasounds, it was felt that as the trainees had not been undertaking portable ultrasounds for a significant period of time, then some additional training may be necessary to ensure they were all competent and able to undertake such paediatric scans. When discussing their sub-specialty training, the trainees reported that they received excellent training opportunities with good training and clinical supervision. The trainees based within interventional radiology reported that the training they received was excellent. They indicated that they could access lots of sessions and were well supported. This was echoed by the trainees within, breast imaging and musculoskeletal radiology who similarly stated that they were well supported, received the necessary level of clinical supervision for their level of training and that the training opportunities were excellent. It should be noted that the trainees indicated that due to the consultant's workload, they still faced issues in relation to getting their sub-specialty scans verified and that as the consultants were so busy, sometimes trainees had to wait five days to have their reports checked. The trainees reported that despite having up to seven specialty sessions per-week, regularly they limited the number of scans they reported and only reported five or six sub-specialty scans per week, as the consultants did not have time to review or go through a higher number of scans with the trainees, which significantly limited the trainees' training experience. This appeared to be particularly problematic within hepatobiliary radiology, and the trainees reported that the consultants were extremely stretched in terms of workload as each had to cover three multi-disciplinary team meetings per week. Due to the consultants' onerous workload, trainees often had outstanding reports for review or verification on a Friday afternoon from earlier in the week.	Yes, please see CLR1.1e Yes, please see CLR1.1e Yes, please see CLR1.3a Yes, please see CLR1.1g Yes, please see CLR1.3b
CLR 1.4	**Protected time for learning and organised educational sessions** The trainees stated that the local teaching sessions within the department had greatly improved and that they were happening on a regular basis and were consultant led. This was confirmed by the clinical and educational supervisors, who reported that there was more consultant engagement and anticipated that the sessions would further improve when the new consultants joined the department.	

2. Educational governance and leadership

HEE Quality Standards

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

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

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

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

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

CLR 2.1	**Impact of service design on learners** The trainees reported that there were not enough work stations within the department for them to report scans. Furthermore, the trainees stated that computers they could report on within the department did not have internet access and therefore the trainees could not access relevant articles or journals which they would have found extremely beneficial. The trainees indicated that they also struggled to access such information on their phones or personal devices due to the poor Wi-Fi signal available which was further exacerbated by the fact that within some areas there was also no 3G signal. It should be noted that the clinical director indicated that there were plans to increase the number of work stations available once the new consultants had started within the department. The clinical and educational supervisors reported that when they began using Medica to report on scans, initially the consultants audited and reviewed all reports to ensure they were of a high standard. The review team was informed that although this was no longer happening in all sub-specialties as the reports were deemed to be of an adequate standard, this was not the case in relation to hepatobiliary radiology and that the quality of the scans was relatively poor. This resulted in the consultants regularly reporting and reviewing all the liver scans that were submitted.	Yes, please see CLR2.1
CLR 2.2	**Appropriate system for raising concerns about education and training within the organisation** Some of the trainees indicated that they felt the way the department responded to any concerns was extremely reactive and that policies, such as whether the trainees should undertake ultrasound lists, were often quickly formulated following meetings which resulted in the trainees often being unclear regarding their roles and responsibilities.	

3. Supporting and empowering learners

HEE Quality Standards

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

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

CLR 3.1	**Behaviour that undermines professional confidence, performance or self-esteem**	

	Some of the trainees indicated that the department had been supportive and accommodating of personal circumstances, but it was reported that on the whole, the trainees perceived that there was an 'us' and 'them' atmosphere between the consultant body and the trainees within the department. The trainees felt that the consultants thought they were lazy and that some consultants had discussed and indicated that some of the trainees were 'incompetent' with other higher trainees within the department.	Yes, please see CLR3.1a
	The trainees reported that although they did not typically request direct supervision from the consultants because they felt they were working beyond their level of competence, but to ensure that a sufficient level of clinical supervision could be provided for core trainees if they were reintroduced within the department, that as a result some consultants had made undermining comments to the trainees questioning their level of competence. The trainees reported that some consultants had asked whether they were competent to undertake certain procedures if they had previously highlighted that supervision had not been provided. The trainees perceived that these questions were asked in an undermining and sarcastic manner, as opposed to trying to genuinely enquire as to the trainees' level of competence.	
	The trainees indicated that since the more junior trainees were removed from the department they have not been able to provide cross cover for each other if one of the higher trainees was on leave. The trainees reported that previously, they had been happy to lead on and cover the biopsy list, but as there were fewer trainees within the department, the trainees had often had to cancel study and annual leave in order to provide cross cover for the biopsy lists. The review team was informed that the trainees had raised this issue and that the lists had therefore become consultant led. However, if the consultant who was responsible for the list was on leave, the higher trainees indicated that they were required to cover the lists, despite the training programme director informing them that they were not to cover the list if the named consultant was on leave. The trainees felt that this often put them in an awkward position with their educational supervisors, who often viewed this as the trainees being 'unwilling' to undertake the lists. Furthermore, the review team was informed that such instances had led to the matrons being upset and angry with the trainees as they felt that six weeks' notice needed to be given regarding annual leave, even though it was not the trainees who were taking annual leave, but the consultants. The trainees reported that they often felt stuck in the middle.	Yes, please see CLR3.1b Yes, please see CLR3.1a
	The trainees collectively reported that there were issues in relation to the sonographers within the department. The trainees reported that the sonographers often spoke to the higher trainees in a negative way and often openly stated that they were 'lazy' and 'unhelpful'.	Yes, please see CLR3.1a
	The trainees indicated that they were concerned that if they raised issues, this may have impacted upon their access to training opportunities.	
	The review team was informed of the external review that had been undertaken by South London and Maudsley NHS Foundation Trust (SLAM) to address the cultural issues within the department. The trainees confirmed that they had all been interviewed individually and that it was useful for all of the issues in the department to be fed back formally. However, the trainees reported since the findings were fed back three months prior to the review, they were unaware of any further work that had been undertaken by SLAM or the department in relation to improving the culture and team atmosphere.	Yes, please see CLR3.1a
	The clinical and educational supervisors reported that the external review undertaken by SLAM had generally been regarded as a positive experience as it brought everyone together to discuss issues, but that they were still in the early stages and that further work needed to be undertaken.	

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities. **4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.**		
CLR 4.1	**Sufficient time in educators' job plans to meet educational responsibilities** All of the educational and clinical supervisors confirmed that they had the requisite Supporting Professional Activity time within their job plans in relation to their educational responsibilities. This was echoed by the college tutor and training programme director.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
CLR1.1 a	When indirect supervision is appropriate for the level of experience of trainees the Trust must ensure that this is clearly identified.	The Trust to provide a timetable of trainee scan lists with named consultant who is providing indirect supervision.	R1.7
CLR1.1 b	The Trust to develop a plan which can be shared to demonstrate how the additional consultant workforce will improve the level of clinical supervision in acute and inpatient work with improved access to senior advice.	The Trust to outline the details of the plan, and submit copies of the communication sent to the trainees, detailing the supervisory arrangements.	R1.7
CLR1.1 c	The Trust to review the role of the locum consultants with regard to training or support of the higher trainees and ensure that they are suitably trained and able to do so.	The Trust to confirm that this has taken place, and demonstrate that all locum staff providing support or supervision to the higher trainees are adequately trained to do so.	R1.7
CLR1.1 d	Where on – call consultants (or locums) are not able to give a definitive opinion on a	The Trust to submit details of the mechanism that has been introduced, and	R1.8

	trainees report – develop a mechanism to flag for review by the relevant specialist in a timely way and mechanism for feedback to trainee	confirmation from trainees that they are receiving feedback (LFG, survey/audit etc).	
CLR1.1e	The Trust to ensure that there is a dedicated, named consultant who takes overall responsibility and ownership of all CT inpatient scans on a daily basis, in order to provide sufficient clinical supervision. This consultant must be available and willing to verify scans when trainees approach them for advice.	a. The Trust to confirm that there is now a rota that delineates a dedicated consultant with overall responsibility for all CT inpatient scans. b. We would like to see a document setting out the duties of the consultant responsible for covering the acute and inpatient CT scan list, which ensures that trainees are provided with appropriate supervision.	R1.7
CLR1.1f	The Trust to review the trainees' access to appropriately supervised inpatient and acute CT reporting and ultrasound within weekly trainee timetables.	The Trust to submit trainee timetables demonstrating that such sessions with named consultant supervisor are now included on a regular basis.	R1.8
CLR1.1g	The Trust to have a mechanism for gathering information from trainees about difficulties in getting senior opinions for acute or special interest work.	The Trust to submit details of the proposed monitoring system to be implemented.	R1.7
CLR1.3b	The Trust to review the relevant consultant job plans to ensure there is adequate time for reviewing higher trainees specialty work and to ensure that trainees reporting numbers in relation to their sub-specialty scans is not capped and limited due to consultant workload.	The Trust to provide confirmation that there is time in consultants' job plans to review specialty scans that are reported by trainees and provide timely feedback to the trainees. The Trust to provide trainee feedback demonstrating that each trainee is able to report the requisite number of sub-specialty scans per week and receive appropriate feedback.	R4.2
CLR2.1	The Trust is required to provide access for radiology trainees to relevant online learning resources for their day-to- day work and training.	The Trust to confirm how they will deliver this with an appropriate implementation time.	R2.3
CLR3.1a	The Trust to continue to work to improve relationships between all members of the imaging workforce, to recognise the difficulties which all groups have been experiencing and develop a collaborative and non – blaming culture.	The Trust to discuss the difficulties created by a perceived imbalance in the role of the consultant and trainee, exploring the reasons for this – and develop a plan with them to address this.	R3.3
CLR3.1b	The Trust to develop a mechanism for ensuring appropriate staffing of biopsy lists with prospective planning of consultant and trainee leave and does not automatically leave responsibility for cover with trainees without planning.	The Trust to confirm such a mechanism has been created and inform HEE of what plans have been put in place to address this.	R1.12

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**

CLR1.3 a	The Trust to ensure that if trainees undertake portable ultrasound lists for paediatric patients, that they have opportunity to refresh their skills to ensure that all trainees fell confident and capable to undertake such ultrasounds out of hours.	The Trust to demonstrate that refresher sessions have been timetabled to support this need.	R1.9

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

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Jane Young
Date:	13 December 2017

What happens next?

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