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Clinical Radiology
The Royal College of Radiologists

A guide to the process for service reviews conducted by the Service Review Committee

Faculty of Clinical Radiology

Contents

1. Introduction

The Service Review Committee (SRC) was established by the Board of the Faculty of Clinical Radiology in 2000 to assist The Royal College of Radiologists (RCR) in responding appropriately and consistently to requests to review service provision in clinical radiology departments where trusts or equivalent bodies in the UK health service were concerned about standards or performance issues across a service. The SRC is chaired by the current Medical Director, Professional Practice, Clinical Radiology of the RCR.

The RCR has no statutory right to inspect or accredit clinical services. However, there are circumstances when advice is sought from the RCR. The SRC is a professional and lay committee of the College, which oversees and manages the review process. The SRC membership acts as an advisory body to the chair in general, and also offers advice and support to its members engaged in individual reviews. The aim of reviews is to independently review departments of clinical radiology in the interests of maintaining high-quality radiology services, and to support services in difficulty or with challenges. This document has been created to provide a background briefing on the processes which will be followed in requesting and conducting a service review. It is intended to inform trusts, departments and individuals and to provide an overview of the steps to be taken throughout the process. It should be read in conjunction with the *College Review of Radiology Services, Fourth edition*, which establishes the principles for the work of the SRC. This document is subject to regular review and updating by the SRC.

While there are different types and names of organisations delivering healthcare across the four countries in the UK, this document will refer to ‘trusts’ throughout for ease of reference.

This document replaces the previous edition, *The process for service reviews conducted by the service review committee* (2012), which has now been withdrawn.

2. Patient safety

If, at any point during the process of a service review – that is, from the initial request, during the review visit itself, or the subsequent reporting phase – the RCR becomes aware of any serious concerns which may have an implication for patient care or safety; it reserves the right to immediately refer the appropriate information to the relevant regulatory body. This could mean an escalation of the concerns to the General Medical Council (GMC) or, as appropriate to the location of the service, to the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, or the Regulation and Quality Improvement Authority (Northern Ireland).

The RCR also reserves the right to suspend a review process, including mid-visit on the advice of the review team leader, if it identifies any patient safety issues which it feels require immediate attention. The RCR may in such circumstances suggest certain actions which must be undertaken within a specified time period before the review process can be resumed.

3. Scope of RCR service reviews and individual performance

Service reviews undertaken by the SRC will always focus on whole departments or services and not individuals.

The RCR is clear that its service reviews will not be used as a means of assessing the clinical competence of individuals or as a vehicle for employers to use when seeking to develop a remediation plan for individual doctors about who they may have a concern.

Where a trust does have concerns about the performance of an individual clinician which have been substantiated by the organisation's own investigatory procedures and where further assessment of the doctor is required, it is recommended that the assistance of the National Clinical Assessment Service (NCAS[†]) or, where there is a potential fitness to practise issue, the General Medical Council (GMC) Employer Liaison Service, should be sought. The RCR has good and longstanding relationships with both bodies and will do all it can to ensure that these relationships are maintained and developed.

If during the course of a service review visit the review team identifies any concerns about the performance or conduct of an individual doctor which is deemed to endanger patient safety, the RCR will immediately bring such matters to the attention of the relevant authorities. In the first instance, this will be the chief executive and medical director of the trust itself; however, the RCR also reserves the right to inform the GMC of such concerns.

[†] As of 1 April 2013 the NCAS is an operating division of the NHS Litigation Authority (NHSLA)

4. Overview of the service review process

4.1 Initial enquiries and formal request process

4.1.1 Enquiries regarding the service review process can be made by contacting the RCR Professional Services Executive Officer on 020 7405 1282. The Professional Services Executive Officer may refer the initial contact information to the Chair of the SRC for consideration.

4.1.2 The Chair of the SRC may at this stage choose to engage in some initial dialogue with the trust either directly or via the Professional Services Executive Officer. If, after the initial dialogue with the trust, the Chair of the SRC believes that a service review may be an appropriate and likely course of action, they will write to the trust's chief executive (see Appendix 1 for an example letter) asking them to submit to them, in writing, a formal letter of request for a service review. This formal letter of request from the trust's chief executive must be addressed to the Chair or Vice-Chair of the Service Review Committee, c/o the Professional Services Officer, The Royal College of Radiologists, 63 Lincoln's Inn Fields, London WC2A 3JW.

4.1.3 In the formal letter requesting a service review, the trust's chief executive should, in line with Section 2.10 of the *College Review of Radiology Services, Fourth edition*:

- Clearly define, in writing, the problem as seen by the trust, and the reason(s) for the request
- Indicate (a) whether a referral has been made to NCAS, the GMC or similar organisation and (b) whether any employment tribunals or other related legal processes have either been completed, are in progress, or are expected to commence during the service review process
- Give details of the steps already taken to try to resolve the problem and their outcomes.

4.1.4 The Vice-Chair of the SRC will undertake the role of the Chair in relation to review arrangements and processes if there is any potential conflict of interest involving the Chair of the SRC in a particular service review.

4.1.5 The trust will be informed that the review team will only consider issues relating to professional standards or areas of concern which have been dealt with by the trust procedures for clinical governance, critical incident reporting or risk management. This is to ensure that the issues for review have been subjected to the necessary level of scrutiny at local level to properly identify them as representing an unacceptable standard of service.

4.1.6 The Chair of the SRC will discuss the formal request for a review received from the trust's chief executive with other College Officers and SRC members and subsequently decide whether to proceed with the review process.

If the Chair of the SRC decides that a service review is not appropriate, they will write to the trust's chief executive and indicate the reasons for having taken that decision.

4.1.7 If the trust does meet the requirements of Section 2.10 of *College Review of Radiology Services, Fourth edition*, the Chair (or Vice-Chair) of the SRC will, following consultation with other College Officers and SRC members, appoint a review team leader and notify the trust's chief executive of this fact.

4.1.8 The review team leader may undertake either a preliminary visit, or telephone discussion (depending on the complexity of the problem) with a contact at the trust who has been identified by the trust's chief executive. The purpose of the preliminary visit/discussion is for the team leader to be fully briefed by the trust and provided with any necessary background information and documentation.

The outline terms of reference and the established review process methodology will be discussed as part of the preliminary visit/discussion. A preliminary visit may not be necessary if the Chair of the SRC and review team leader feel that the trust has already supplied sufficiently detailed information on the issues faced by the service.

4.1.9 Following the preliminary visit/discussion, the final decision on whether to proceed with the full service review visit will be made by the Chair of the SRC after consultation with the team leader.

4.1.10 If the decision is taken not to proceed with the review, the Chair of the SRC will write to the trust's chief executive to inform them of the decision and the reasons for it.

4.1.11 If, following the preliminary visit/discussion, the Chair of the SRC agrees to conduct the formal review visit, they will agree with the appointed team leader the draft Terms of Reference (Appendix 2) which will be presented to the trust's chief executive or nominee (such as the medical director) for final agreement.

4.1.12 The Chair of the SRC will confirm formally in writing to the trust's chief executive that the SRC will conduct a formal review visit (Appendix 3). The final offer to conduct a review will include a letter of agreement and a Deed of Indemnity (Appendix 4) which must be signed by the trust's chief executive and returned to the Chair of the SRC before the review visit can be undertaken. Also included in the final offer pack will be:

- Full details of the fees which the trust will incur for the review visit will be provided (Appendix 5)
- Final agreed Terms of Reference
- An information management protocol dealing with confidentiality in respect of any requests received by the trust under the Freedom of Information Act 2000 (Appendix 6)
- The names of the review team members
- Standard core data questionnaire to be completed and returned by the trust (Appendix 7).

These documents, together with the *College Review of Radiology Services, Fourth edition* and this guide to the process for service reviews will form the basis of the agreement between the RCR and the trust for the review visit. Once agreed, the details of this signed documentation cannot be changed without the consent of both the Chair of the SRC, and the trust's chief executive.

In summary, (as in Section 2.10 of *College Review of Radiology Services, Fourth edition* and Appendix 3), the trust will be requested to:

- Inform all the involved local trust staff members that an external review of the department of clinical radiology has been requested
- Agree the Terms of Reference and methodology with the RCR
- Indemnify the RCR and the review team
- Agree that the proceedings of the review and all related documentation will be treated as absolutely confidential by the trust and its employees
- Agree to abide by the protocol on information management
- Arrange and fund the appropriate administrative support for the review team, including the provision of an independent stenographer
- Provide suitable and private office accommodation to allow the review team to conduct its work in absolute confidentiality
- Identify a single point of contact who should be a senior clinician or manager

- Reimburse direct expenses and recompense appropriately the members of the review team through the RCR
- Agree to formulate an action plan in response to the review recommendations and respond to the RCR's request for information on progress with the action plan within six months of receipt of the formal report and recommendations from the Chair of the SRC
- Provide in writing the core standard data needed to inform the review, and any other information deemed necessary by the Chair of the SRC (see Appendix 7).

4.1.13 Confirmation by the trust of its acceptance of the terms of the review will be the receipt by the RCR of the signed agreement letter and Deed of Indemnity.

4.1.14 The team leader will then brief the team members, with the definitive agreed terms of reference, visit programme including timings and list of staff members to be interviewed and make available to team members all relevant core data and supporting documentation which will help to inform the visit (see Appendix 7).

4.1.15 The RCR will make a provisional booking via a suitable agency for an independent stenographer. Final arrangements and payment for the stenographer must be organised by the trust and approved by the team leader in advance of the review.

4.2 The team leader and team

2.1.1 The team leader is appointed by the Chair (or Vice-Chair) of the SRC who may also seek advice on this decision from other RCR Clinical Radiology Officers.

4.2.2 The team is appointed by the Chair (or Vice-Chair) of the SRC, who may also seek advice on this decision from other RCR Clinical Radiology Officers.

4.2.3 The appointed team leader will brief the team members on the purpose of the review in relation to the agreed terms of reference and with reference to all supporting information provided by the trust.

4.2.4 All members of the review team will have received recent and appropriate training in the conduct of a review.

4.3 The review visit

4.3.1 The visit to the trust will be in accordance with Sections 4–6 of the *College Review of Radiology Services, Fourth edition*. The principles of natural justice should be observed on all occasions.

4.3.2 The trust will be asked to circulate a briefing note to all of the individuals invited for interview in advance of the review.

4.3.3 An independent stenographer, organised and funded by the trust, must be used to provide a transcript of all formal interviews (Appendix 7). Interviewees will be informed that transcripts of their interviews will be kept confidentially in hard copy and electronic format by the RCR, as a safeguard for them, for six months following formal acceptance of the report by the trust (see Section 4.3.5). The transcript will remain the property of the RCR (see Appendix 6). All members of the review team will normally be present at interviews but, where this is not possible, at least two team members will be present. Any other form of formal contact with individuals (such as telephone interviews) should be minuted and signed by the individuals concerned.

4.3.4 If, during the visit, the team feels it is necessary to change the terms of reference or methodology, they will discuss this with the Chair of the SRC prior to making any changes in consultation with the trust. Any revised documentation must be checked with the RCR before it can be agreed.

4.3.5 Written records will be kept in accordance with the RCR information management protocol (Appendix 6).

4.3.6 The team leader is responsible for the conduct of the visit, including final decisions on who may be interviewed or be present during interviews.

4.3.7 The RCR (namely, the Vice-President, Clinical Radiology), and SRC should be kept informed about the progress of the review.

4.3.8 The team leader may (following discussion with the Chair of the SRC) suspend or terminate the review if it is discovered that the context of the review has changed.

4.3.9 If during the course of a review visit, the team leader discovers immediate concerns about patient care and safety they may (following discussion with the Chair of the SRC) seek to suspend or terminate the review, specify immediate action to be undertaken by the trust within a given timeframe or suggest that the Chair of the SRC escalates the concerns to the appropriate regulatory bodies.

5. The report

5.1 Draft 1

The team leader and team members will prepare the initial draft report (see Appendix 8 for an example of the structure of a report). The Professional Services Executive Officer at the RCR will provide administrative support. All pages should be clearly marked as 'Draft 1' and dated. The completed draft report should be sent to the Chair of the SRC for discussion with Clinical Radiology Officers to ensure it does not conflict with RCR policy, in accordance with Section 4.5 of *College Review of Radiology Services, Fourth edition*. Interviewees will have been told at the beginning that evidence will not appear against their name in most circumstances.

5.2 Draft 2

The Professional Services Executive Officer will make any required amendments to Draft 1 as directed by Clinical Radiology Offices and send the updated document, marked as Draft 2, to the Chair of the SRC for information. The team leader may choose to send Draft 2 to other individual members of the SRC for comment. Draft 2, minus the recommendations, will subsequently be sent to the Chief Executive of the trust for confirmation of factual accuracy only.

5.3 Final report

5.3.1 The review team will, facilitated by the Professional Services Executive Officer, produce Draft 3 incorporating amendments as appropriate and this will be sent to the Chair of the SRC. The final report will be agreed by the Chair of the SRC and the review team, in consultation with Clinical Radiology Officers, as appropriate. The final report, signed by the Chair of the SRC, including recommendations, will then be sent to the trust's chief executive, in accordance with the Terms of Reference for the review. The report with recommendations will also be sent to the chair of the trust board and medical director.

The RCR reserves the right to fulfil its obligations as a professional body and refer the report to other appropriate or proper bodies (for example, the GMC or, as appropriate to the location of the service, to the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, or the Regulation and Quality Improvement Authority) where issues of patient care or safety are involved.

5.3.2 A copy of the final report will be tabled at the next SRC meeting. Draft reports will also be tabled at SRC meetings as 'works in progress'.

5.3.3 Written records will be kept in accordance with the information management protocol (Appendix 6).

5.3.4 A summary report of key themes from reviews may be produced annually by the SRC for publication and/or forwarding to the Secretary of State for Health.

5.4 Follow-up

5.4.1 A follow-up letter will be sent to the trust by the Chair of the SRC six months after presentation of the service review report to ascertain progress following the review. The team leader may seek an informal follow-up visit to assess progress.

5.4.2 There will usually be a follow-up visit six to nine months after final receipt of the report.

6. Information management

6.1 All service reviews will be conducted confidentially, and all information or documentation generated by reviews shall be treated in accordance with the RCR information management protocol (Appendix 6).

6.2 The transcript of any interviews conducted as part of the review, the draft report and the final report remain the property of the RCR.

6.3 In relation to personal data, the RCR and the trust will abide by the Data Protection Act 1998.

6.4 Although, the Freedom of Information Act 2000 does not directly cover the RCR, the Act does have an indirect effect to the extent that the RCR shares information, generated in the course of the service review process, with the trust. The RCR, therefore, requires that in commissioning a service review, the trust abides by the information management protocol set out in Appendix 6.

7. Review team expenses

7.1 The expenses for the review team should be sent directly to the Professional Services Executive Officer at the RCR.

7.2 The review team expenses will be processed by the RCR accounts department.

7.3 The RCR accounts department will produce an invoice to be sent to the trust for payment which will include all review team member charges and expenses, plus the agreed RCR administrative fee (see Appendix 5).

Appendix 1. Example letter in response to an initial service review enquiry

Dear [Chief Executive]

We are in receipt of your request for The Royal College of Radiologists (RCR) to undertake a service review in the department of radiology. The process of a service review is undertaken according to RCR policy as outlined in the *College Review of Radiology Services, Fourth edition* and governed by *A guide to the process for service reviews conducted by the Service Review Committee*. I have enclosed copies of both documents with this letter.

The RCR is keen to ensure that the process of a service review evaluates whole services to ensure that any review is performed in context. The RCR is also keen to ensure that internal processes have been exhausted prior to commencing a service review visit. **It is therefore crucial for the Service Review Committee (SRC) to receive an outline of the problem(s) that are perceived by the trust, information on the processes that have been followed in order to attempt to resolve them, and their outcomes.**

The RCR must be informed of any outstanding issues and particularly if any other bodies, such as the General Medical Council (GMC) and the National Clinical Assessment Service (NCAS) are involved and if the trust is aware of any legal advice having been sought.

Allegations of poor performance on the part of an individual will usually be investigated by the GMC, the NCAS, or other appropriate body, rather than the SRC. Service reviews will not be used as a means of assessing the clinical competence of individuals or as a vehicle for employers to use when seeking to develop a remediation plan for individual doctors about who they may have a concern.

If, at any point during the process of a service review – that is, from the initial request, during the review visit itself, or the subsequent reporting phase – the RCR is made aware of any serious concerns which may have an implication for patient care or safety, it reserves the right to communicate the existence of these concerns immediately to a higher level. This could mean an escalation of the concerns to the General Medical Council or, as appropriate to the location of the service, to the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, or the Regulation and Quality Improvement Authority.

Please note that any review would be conducted according to the terms of the information management protocol established by the RCR, a copy of which is available from the RCR website: www.rcr.ac.uk

Please note that the review team will only consider issues relating to professional standards or areas of concern within the service which have been dealt with by the trust procedures for clinical governance, critical incident reporting or risk management. This is to ensure that the issues for review have been subjected to the necessary level of scrutiny at local level to properly identify them as representing an unacceptable standard of service.

If we agree, following your response to this letter, that the request falls within the brief of the Service Review Committee, I will appoint a service review team leader who will then be in touch with you to organise a preliminary discussion or visit.

Yours sincerely

Dr

Medical Director Professional Practice, Clinical Radiology
Chair of the Service Review Committee, The Royal College of Radiologists

Appendix 2. Example terms of reference

Terms of Reference for the review of the radiology service at XX Trust

Background
The trust is seeking an independent external review of its diagnostic radiology service. The major challenges centre on clinical governance and safety, leadership and the recruitment and retention of consultant radiologists.

The purpose of the review is to suggest and agree a plan of action and clear strategies to address these key areas.

The assessment will be based upon RCR guidance, recognise best practice and may evaluate available benchmarking against other comparable services.

Themes to be considered are bulleted below.

Clinical governance and safety

- Review of trust governance procedures
- Quality assurance processes
- Policies for discrepancies and the effectiveness of its application within the service
- PACS and IT

Operational leadership and effectiveness

- Operational, clinical and professional leadership within the service
- Team structures and team working
- Representation of the radiology service within the wider trust management structure
- Lines of responsibility internally, between radiologists, radiographers and management

Service sustainability and development

- Strategies for development of the service including workforce planning
- Recruitment and retention of consultants
- Recruitment and retention of radiographers
- Sub-specialty radiology and relationships to tertiary providers
- Forward service strategy
- Service accreditation

Exclusions

- The service review is not intended to in any way assess the clinical performance of individual radiologists.

Appendix 3. Example of a formal letter confirming a service review

Formal confirmation of the review of the radiology service at [XX] NHS Trust

I am writing further to your letter of [date] in which you requested the help and advice of The Royal College of Radiologists (RCR) in respect of a review of the radiology service at [XX] Trust.

I can now confirm that the RCR has formed a review team of the following representatives, namely Dr X, Consultant Radiologist and team leader, Dr Y, Consultant Radiologist, and , Mr/s A ,Radiographer and Ms/Mr Z who has agreed to act as a lay representative. The appointed review team leader, Dr X, has conducted preliminary discussions with your trust's medical director and shared the details with me.

The proposed review will be subject to the following terms and conditions and enclosed documents, which must be agreed in writing by the trust before the review can proceed. The provisional dates of [enter dates] for the review to take place will be confirmed upon receipt of the signed Deed of Indemnity (1.1 below) plus a signed copy of this letter confirming the trust's agreement to the contents of the documents at 1.2 to 1.6 and the points specified in paragraph 2 below.

1. Enclosed documents

1.1 Deed of Indemnity – this has been drawn up with regard to the various parties involved. On the understanding that it is acceptable to you, I should be grateful if you would sign two copies of this document, before witnesses, retain once copy and return the other to me at the RCR.

1.2 *College Review of Radiology Services, Fourth edition*

1.3 The latest version of *A guide to the process for service reviews conducted by the Service Review Committee*

1.4 The information management protocol.

1.5 The Terms of Reference for the service review

1.6 Standard core data questionnaire – to be completed and returned with the agreement letter. Please note that the more detailed the information you can provide to us prior to the review, the better and more productive will be the investigations of our reviewers.

2. Other key points

2.1 All those involved – the specialists within the department, the medical director or chief executive of the trust – should be informed that the review is taking place.

2.2 The trust's local clinical commissioning groups (CCGs) must be informed that the trust has commissioned a review.

2.3 In accordance with the information management protocol (enclosed), the review must be carried out in an open and informal manner in discussions with all parties involved. All proceedings of the review and all related or generated documentation will be treated as absolutely confidential by the trust and its employees. The trust agrees to be bound by the information management protocol and to convey this to all those employed or engaged by the trust who will be participating in the review. In accordance with the protocol, the trust will notify the RCR what its procedures will be and what use it intends to

make of the review report. Should this vary during the review or as a result of the report, the trust should advise the RCR beforehand.

2.4 The draft report will be sent to the chair and chief executive of the trust. The RCR encourages the trust to share it will all who have taken part in the review.

2.5 The final report of the review team should be made available by the trust to all those concerned.

2.6 The fees and expenses of the review team must be met by the trust. The level of fee has been determined by the RCR in the light of the perceived complexity of the review and will be a three day review (see the enclosed schedule of payments for 2014).

2.7 The RCR administrative costs of £1,355 (2014 charges) for setting up this review must also be met by the trust.

2.8 Appropriate facilities for the visit, including administrative and secretarial support to the team and its meetings, must be organised and provided by the trust to the satisfaction of the review team leader. To ensure the accuracy of the information upon which the report is based, the trust will be required to arrange and pay for an independent stenographer. The RCR will make a provisional agency booking for this service, which the trust will be required to confirm to the agency directly.

2.9 A named individual for the review team leader to contact and liaise with concerning the visit must be identified by the trust.

2.10. All reviews will inevitably take a 360° approach. If the review highlights significant issues outside the strict terms of reference agreed with the trust, then the review team reserves the right to investigate these issues.

2.11. In accordance with paragraph 5.1 of the information management protocol, the transcript of any interviews and the draft and final reports will remain the property of the RCR. Transcripts of interviews will be kept confidentially in hard copy format or on disk by the team leader, or by the RCR, until the RCR receives the trust's response outlined under item 2.12 below.

2.12. In line with 2.10 of the RCR's *College Review of Radiology Services* (enclosed), the trust should agree to formulate an action plan in response to the recommendations in the Final Report of the review and to respond to the RCR's request for information on progress with any action points in the action plan no more than six months after delivery of the Final Report.

2.13 In line with 7.2 of the RCR College Review of Radiology Services (enclosed) if, at any point during the process of the service review (from the initial request, during the review visit itself, or the subsequent reporting phase) the RCR is made aware of any serious concerns which may have an implication for patient care or safety, it reserves the right to immediately refer the appropriate information to the relevant regulatory body. This could mean an escalation of the concerns to the General Medical Council or, as appropriate to the location of the service, to the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, or the Regulation and Quality Improvement Authority.

Once I have received from you the signed Deed of Indemnity and one signed copy of this letter (sign and retain a further copy for yourself) confirming agreement to the documents and points outlined above, I will ask Dr X, the review team leader, to contact you to finalise arrangements for the review. The review cannot commence until these documents have been received.

Finally, I hope that this letter and the enclosures cover all of the relevant points to enable this review to take place as speedily as possible. If there are any further points which need to be clarified, please feel free to

contact me via the Professional Services Executive Officer at the RCR (Tel: 020 7406 5926 or email: sarah_griffin@rcr.ac.uk)

Yours sincerely

Dr

Medical Director Professional Practice, Clinical Radiology
and Chair of the Service Review Committee, The Royal College of Radiologists

Signed in confirmation of the trust's agreement to these terms:

…….. Dated ……..

Appendix 4. Example Deed of Indemnity

THIS DEED OF INDEMNITY is made on the DD/MM/YYYY

BETWEEN:

(1) **XX NHS TRUST** ('the Trust') whose principal place of business is XX XX.

and

(2) **THE ROYAL COLLEGE OF RADIOLOGISTS** ('the RCR') whose address is at 63 Lincoln's Inn Fields, London WC2A 3JW.

WHEREAS:

1. The Trust has asked the RCR to assist it in resolving a problem ('the Problem') within the Trust Radiology Service relating to the problems associated with leadership; future sustainability of radiology services and clinical governance and safety.

2. The RCR has proposed that the review team leader, Dr XX, the review team member, Dr XX the review team member, Dr XX the review team member and the lay member, XX, ('the review team') be jointly appointed to investigate the Problem and to recommend a solution for the Trust in accordance with the *College Review of Radiology Services, fourth edition*.

NOW THIS DEED WITNESSES as follows:

1. The Trust shall hold harmless and indemnify the RCR and the Review Team from and against any and all claims, losses, charges, liability (whether civil or criminal), damages, fines, financial impositions, compensation or costs (including legal costs) suffered or incurred by the RCR, the Review Team or its members, their servants or agents as a consequence of any claim made or action taken by any third party claiming to be affected, prejudiced or damaged by any act or omission by the Trust as a result of or in disregard of advice or recommendations made to the Trust by the RCR or the Review Team.

2. The indemnity set out in paragraph 1 is intended to include, but not be limited to, any claim for defamation or wrongful or constructive dismissal taken by any clinical radiologist who is the subject of any action taken based upon any advice or recommendation made to the Trust by the RCR or the Review Team. The indemnity set out in paragraph 1 is not intended to include any intentionally dishonest, fraudulent, criminal or malicious act of the RCR or the Review Team which arise from any steps taken to resolve the Problem.

3. The Trust shall, wherever appropriate, take independent legal advice on the possible consequences for it, the RCR, or the Review Team if it acts on or disregards any advice or recommendation by the RCR or the Review Team to resolve, ameliorate or otherwise deal with the Problem. Subject to any contrary obligation of confidentiality, such advice shall be disclosed to the RCR and to the Review Team who shall treat such advice in confidence.

4. The methodology and aims of any investigation of the Problem shall be as outlined in the current version of College Review of Radiology Services. The Trust has had the right to make representations to the RCR about the methodology and aims.

5. The RCR reserves to itself the right to recommend pursuance of disciplinary procedures or referral to the General Medical Council (GMC) where expertise or performance falls below minimum acceptable

standards. The RCR reserves the right to bring the report and transcripts of any interviews to the attention of such other bodies or persons as it sees fit.

6. If, at any point during the process of the service review (from the initial request, during the review visit itself, or the subsequent reporting phase) the RCR is made aware of any serious concerns which may have an implication for patient care or safety, it reserves the right to immediately refer the appropriate information to the relevant regulatory body. This could mean an escalation of the concerns to the General Medical Council or, as appropriate to the location of the service, to the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, or the Regulation and Quality Improvement Authority.

7. The transcript of any interviews and the final report remains the property of The Royal College of Radiologists.

8. In the event that the Trust and the RCR agree that the services of a clinical expert are required to review specific cases on an anonymous basis, the clinical expert will be covered under the terms of indemnity as set out in paragraph 1.

IN WITNESS WHEREOF the Parties have executed this Agreement as a Deed.

SIGNED BY [NAME OF HOSPITAL TRUST]
Name: (please print name)
Job title:
Signature:
In the presence of: (please print name)
Job title:
Witness signature:
Date:

SIGNED BY THE ROYAL COLLEGE OF RADIOLOGISTS
Name: (please print name)
Job title:
Signature:
In the presence of: (please print name)
Job title:
Witness signature:
Date:

Appendix 5. Service review charges (2014)

1. The service review team fee is based on the length of any individual review and incorporates all work undertaken by the members and the lead in connection with the review. The 2014 rates:

   - One-day review: Member £665, Leader £1,665
   - Two-day review: Member £1,335, Leader £2,500
   - Three-day review: Member £2,000, Leader £3,330.

2. The size of the review team and the period of the review (and hence the total fees payable) should be agreed in advance between the trust and the review team leader.

3. Where there is a follow-up visit, this will be charged to the trust on the following daily basis:

   - £335 for the review team members
   - £515 for the team leader.

4. If the review visit or follow-up visit is cancelled by the trust within 14 days of the agreed date(s), the trust will be invoiced for the number of clinical experts' planned attendance days at the agreed rate.

5. The team leader will collect from team members all expenses and notification of to who payment shall be made. Team members shall determine whether the visit shall be undertaken during their own or NHS time. If the latter, they should identify to which authority the fee should be paid.

6. In addition to the fees, trusts are required to meet clinical experts' direct costs, the costs of the review (including the stenographer) and the RCR's administration fee of £1,355 (2014 rate).

7. The RCR will pay all expenses and fees to the clinical experts as required by the team leader and will invoice the trust for the total fees paid to review team members, their direct expenses (travel etc), plus the agreed RCR administration fee.

8. These rates are adjusted according to inflation annually.

9. In the event of the review being cancelled by the trust, there will be a cancellation fee.

Appendix 6. Information management protocol

The Royal College of Radiologists (RCR) considers it is important to the production of an accurate and effective review report, which will assist in service improvement both locally and in the application of learning points more widely, that all involved in the review process can participate in an open, constructive, fair, equal and co-operative way.

The RCR readily accepts that the trust or equivalent body will have disclosure obligations under the Freedom of Information Act 2000. Furthermore, disclosure to appropriate third parties of some information generated by service reviews may be a positive element in the overall strategy of improving radiology services for the benefit of patients and may assist radiology departments to perform better and to avoid or overcome problems. It is recognised that the trust will need to reflect on and use reports provided to them internally. The RCR also considers it vital that reports are used and recommendations and actions implemented; an important part of the review process is follow-up to evaluate progress on the recommendations and actions included in the report. However, to ensure that all individuals will feel that they can participate and contribute on an agreed basis in the review process, the review team will give an assurance of confidentiality, non-attribution or anonymisation to individual participants, and therefore needs to guarantee that the trust will ensure that such assurances are respected. An independent stenographer must be appointed to maintain this principle.

This is an outline of the principles to be adopted in relation to information generated by the review process and the handling of requests by third parties for disclosure of some or all of that information. Throughout this document, 'trust' will be used for ease of reference to refer to the different types of health organisations delivering healthcare across the UK.

1. Confidentiality

1.1 All service reviews will be conducted confidentially, and all information or documentation generated by reviews shall be confidential to the trust and the RCR. If, at any point during the process of the service review, (from the initial request, during the review visit itself, or the subsequent reporting phase) the RCR is made aware of any serious concerns which may have an implication for patient care or safety, it reserves the right to immediately refer the appropriate information to the relevant regulatory body. This could mean an escalation of the concerns to the General Medical Council or, as appropriate to the location of the service, to the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, or the Regulation and Quality Improvement Authority (see paragraph 7.2 of *College Review of Radiology Services*).

1.2 In relation to personal data, the RCR and the trust will abide by the Data Protection Act 1998.

2. Disclosure

2.1 The RCR has no general objection to disclosure within the trust of certain information arising from reviews such as:

- Letters and formal documents relating to the request for a review, the terms of reference and methodology, the arrangements and so on, provided that any reference to the names of individuals under scrutiny or means of identifying them are removed
- Core data about the department provided by the trust for the review team
- Administrative data such as records of contacts, visits, dates of meetings etc, again provided that any reference to the names of individuals under scrutiny or means of identifying them are removed
- The contractual arrangements between the RCR and the trust, including fees.

2.2 By their very nature, however, service reviews inevitably deal with inherently sensitive information, which might be contained in a variety of documentation, including but not limited to:

- All comments given to the review team, whether in documents or verbally, or at interviews, recorded in transcripts/stenographer records
- Details of and/or comments about the trust's individual practitioners or managers who may be under scrutiny during a review
- Minutes of team meetings
- Personal notes kept by review team members
- The draft and final reports
- Communication with the RCR about specific issues discussed during reviews, and records of discussion of those matters within the RCR.

If any request under the Freedom of Information Act received by a trust is found to cover information of this sort, or if there are any enquiries or requests from third parties [this includes individual radiologists or their advisers who may be thinking of suing the trust or the RCR] concerning such information, the trust must consult the RCR before responding to the enquiry or request and be bound by any refusal by the RCR of consent to disclosure.

3. Retention of records

3.1 The RCR will keep written records of all contacts during the service review (including any summaries of telephone calls) until six months after the RCR's follow-up letter is sent, which is approximately six months after the delivery of the final report, regardless of whether the trust responds. After this point (approximately 12 months after the review), all such records will be destroyed by the RCR. For the avoidance of doubt, the remaining or retained documentation will be the formal documents surrounding the establishment of the review and the report itself.

4. Review of cases

4.1 Any such review conducted during a service review will not form part of the review documentation or report.

5. External statements

5.1 During the review process and until the completion of the follow-up process which will be undertaken six months after the delivery of the final report of the review, the trust should ensure there is express agreement with the team leader and the Chair of the SRC about any statement concerning the review given to an external agency. Similarly, the RCR will ensure that the trust is content with any statement about a review that it might make.

6. The trust's use of the review report

6.1 The trust accepts that the transcripts of any interviews, the draft report and the final report will remain the property of the RCR.

6.2 In using the report for its purposes, it is recognised that the trust must take all appropriate steps to ensure that the report is considered as necessary to ensure that it is implemented. However, the trust should ensure that all individuals who receive the full report are aware of and respect its confidentiality.

6.3 In confirming that a review should proceed, the trust should state what its procedures will be and what use it intends to make of the review report, such usage to be in accordance with the principles set out here. Should this vary during or as a result of the report, the trust should advise the RCR.

Appendix 7. Standard core data questionnaire

Information required in support of a RCR service review (this list is not exhaustive and will be edited as required for each review).

Trust and management

1. Brief description of hospital, including size of population served, number of beds etc, and the department of clinical radiology including number of rooms, equipment available, etc. (This information may be contained in your most recent radiology appointment job description.)
2. Include standard trust activity template? CQC compliance statement.
3. Diagram showing the management structure of the trust and radiology service (medical and non-medical) and clearly identifying those with a management role in the radiology service.
4. Service level agreements (SLAs), if any, with radiology components.

Workforce

5. Names of radiology consultants in post indicating number of sessions worked and the agreed job plans of all consultant radiologists.
6. Details of any consultant vacancies and of any consultant staff turnover in the past three years.
7. Provide whole-time equivalent (WTE) for the following:
   - Radiographers and helpers
   - Nurses
   - Secretarial and clerical staff.

Workload and service delivery

8. The most recent consultant departmental timetable.
9. Agreed reporting protocols and turnaround times.
10. Current waiting times for examinations, particularly abdominal ultrasound, CT, mammography, barium studies, interventional procedures, plain films.

Benchmarking from NHS England (if participants)

11. Number of examinations performed with specialty breakdown if available (last three financial years).
12. Individual consultant reporting figures with specialty breakdown (last three financial years).
13. What and how many examinations are conducted/reported by extended role radiographers?
14. What examinations are available to GPs on direct access?

Governance

15. Details of audit activity performed during last 12 months.
16. Evidence of discrepancy or errors meetings held in the past year (including attendance records and minutes)
17. Are all radiologists able to fulfil The Royal College of Radiologists' continuing professional development (CPD) requirements?

18. Consultant appraisal completion, other staff IPR completion rates.
19. Sickness absence.
20. Services offered to primary care. Local competitors including community radiology services.
21. Details of any complaints and their outcomes, other indicators of patient experience; for example, surveys, informal patient/carer feedback, clinical incidents or plaudits in the last three years. Examples of patient leaflets/information.
22. Feedback from clinical users outside Radiology services.

Appendix 8. Example structure of a review report

1. **Terms of Reference for the review**
   The terms of reference as agreed with the trust at the outset of the service review should be incorporated here. The review will assess responses and relate findings to terms of reference questions. Tight and explicitly detailed Terms of Reference are crucial for conducting the review and formulating findings.

2. **Introduction/background**
   This section will set out the background to the trust's request for a review and the timeline leading up to the review. It will also give a short summary of the setting, staffing and structure of the radiology service being reviewed.

3. **Methodology of the review**
   This section will outline the methods used by the review team including questionnaires, interviews and site visits.

4. **List of personnel involved including all interviewees**
   The trust will provide a list of all personnel interviewed including their job titles.

5. **Service review findings**
   - Review findings should be addressed to the Terms of Reference.
   - Findings relating to imaging considerations should be broken down by modality/sub-specialty.
   - These should be findings NOT recommendations.

6. **Specific responses to Terms of Reference questions**
   It is useful to include a section which identifies specific responses to each of the Terms of Reference.

7. **Summary and recommendations**
   Summary and recommendations will be review-specific. Typically recommendations might relate to:

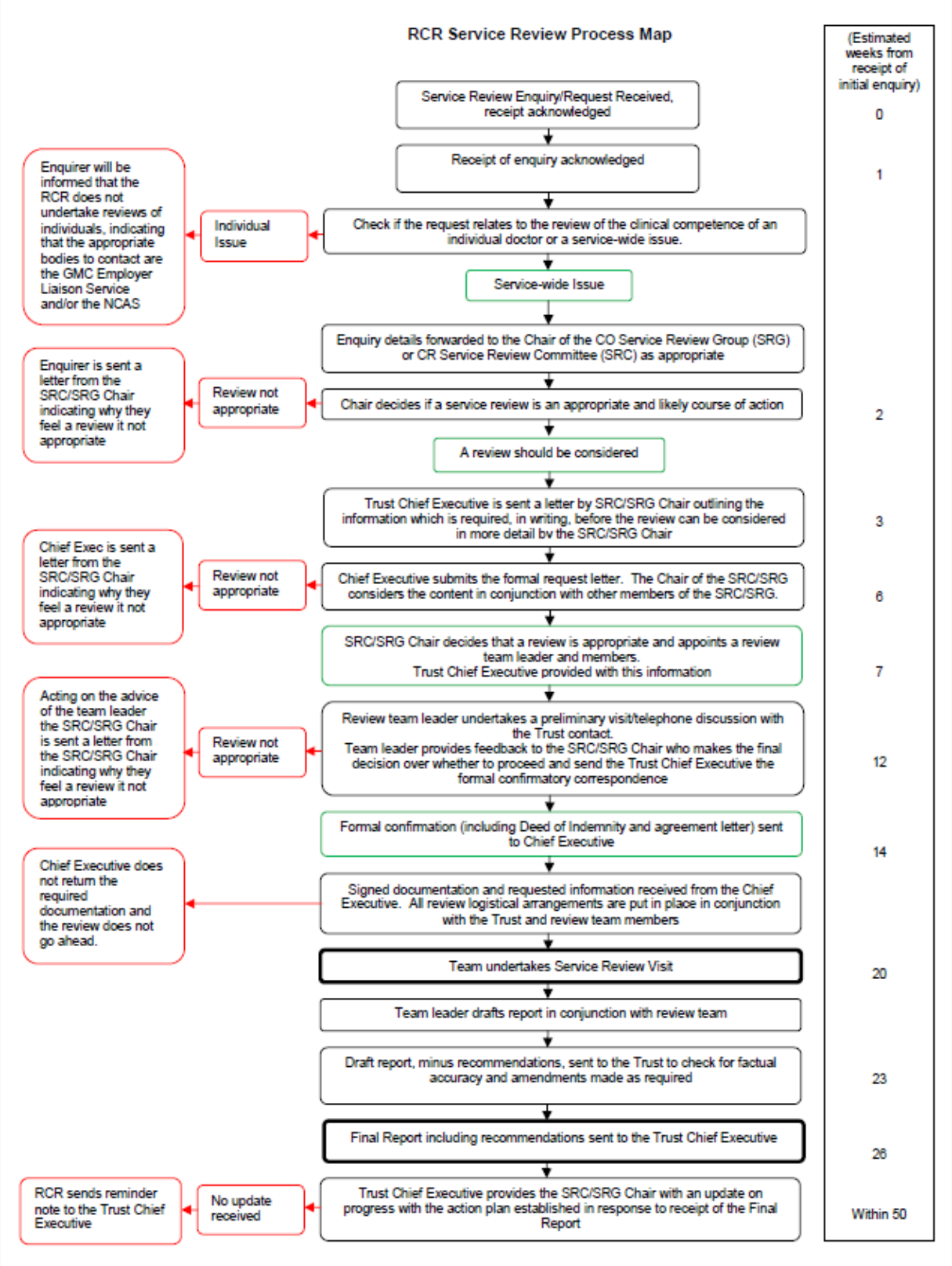
   - Department and trust management structure
   - Department culture and interpersonal relationships
   - Sub-specialisation
   - Clinical governance
   - On-call service
   - Review of the referral process for imaging
   - Skill mix, staffing and workload
   - PACS
   - Equipment and physical facilities
   - Private practice.

8. **References**
   References to any documents mentioned in the report should be provided, including author details and date of publication

9. Appendices

Typically appendices will include data and information collated and collected as part of the review and referenced in the substance of the report

Appendix 9. Service review process map



Appendix 10. External advisory and reference bodies

The following organisations have an interest in performance and reviews of NHS and independent sector organisations, and individual doctors. The service review process may include reference to their activities or systems. The geographical jurisdiction is indicated beside the web address for each body.

British Medical Association (BMA)
www.bma.org.uk (UK)
The BMA is the doctor's professional organisation established to look after the professional and personal needs of its members. The BMA represents doctors in all branches of medicine all over the UK. The BMA is a voluntary association with over two-thirds of practising UK doctors in membership and an independent trade union dedicated to protecting individual members and the collective interests of doctors. Policies are decided by elected members, mainly practising doctors and supported by a professional staff who work with other bodies to meet its objectives. The BMA is not responsible for registering doctors, which is the responsibility of the General Medical Council (GMC). It does not discipline doctors, which is the province of the employer, and/or the GMC.

The Care Quality Commission
www.cqc.org.uk (England)
The independent regulator of all health and adult social care providers in England, CQC monitors compliance with the Essential Standards of Quality and Safety through:

- Unannounced inspections of registered providers on a regular basis and at any time in response to concerns
- Maintaining a quality and risk profile for each registered provider which combines information from a range of sources to indicate where risks lie
- Working in partnership and sharing information with other organisations.

When standards aren't being met, the CQC has powers to issue fines or warnings, stop admissions into a service and suspend or cancel a service or location's registration. www.cqc.org.uk

General Medical Council
www.gmc-uk.org (UK)
The General Medical Council (GMC) protects patients by making sure only those doctors with the right knowledge, skills and experience can practise medicine in the UK.

The GMC measures doctors against the standards set in its core guidance, *Good Medical Practice*. Its fitness to practise procedures allow it to investigate and take standards is in question. When investigating a complaint, the GMC may carry out a performance assessment involving third party interviews, case note reviews, tests of knowledge and direct assessment of clinical skills.

The aim of the GMC's fitness to practise procedures is to protect patients, not to punish doctors. So wherever possible the GMC will try to find ways to support a doctor to address the problem with their performance and to return to work. But if a doctor is found to be a serious threat to patients, the GMC can permanently remove their right to practise medicine in the UK. This is the most serious outcome of its fitness to practise procedures. Other outcomes include restricting the circumstances in which doctors can work, asking them to work under the supervision of another doctor or to do additional training to address a problem.

Healthcare Improvement Scotland
www.healthcareimprovementscotland.org
Healthcare Improvement Scotland supports healthcare providers by: providing evidence for improvement (advice, guidance and standards); support to put that evidence into practice (implementation and improvement support to bring about measurable improvements in care) and scrutiny of services (providing public assurance about service quality and safety by making their findings public). This scrutiny includes inspections of hospital cleanliness (through its subsidiary the Healthcare Environment inspectorate), the care of older people in acute hospitals and reviewing how NHS Scotland boards manage adverse events.

Healthcare Inspectorate Wales
www.hiw.org.uk
In Wales part of the HIW role is to review and inspect NHS and independent healthcare organisations. Services are reviewed against a range of published standards, policies, guidance and regulations. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services.

Independent Reconfiguration Panel
www.irpanel.org.uk (England)
The Independent Reconfiguration Panel (IRP) is the independent expert on National Health Service (NHS) service change. Set up in 2003, the IRP advises the Secretary of State for Health on contested proposals for health service change in England. The IRP also offers informal support and guidance to the NHS and other organisations on achieving successful change. The IRP is made up of experienced clinicians, managers and lay members who have wide-ranging expertise in clinical healthcare, NHS management, involving the public and patients, and handling and delivering successful changes to the NHS. The panel is led by the IRP Chair and supported by the Secretariat.

Monitor www.monitor-nhsft.gov.uk (England)
Monitor is the sector regulator for health services in England. Its job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. It exercises a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences it issues to NHS-funded providers.

National Clinical Assessment Service
www.ncas.nhs.uk (England, Wales, Northern Ireland)
The service was established in 2001 to assist trusts by providing confidential support on how to deal with situations where the performance of individual practitioners gives cause for concern. Since April 2013 NCAS is a division of the NHS Litigation Authority (NHSLA). The support which NCAS provides ranges from telephone advice through involving health, behavioural and clinical performance. The on-site clinical assessment will normally include direct observation of practice, review of clinical records, review of the work environment, collection and consideration of views from colleagues and patients, assessment of clinical decision-making, information provided by the practitioner and the employing/contracting body and an interview with the practitioner.

NHS Litigation Authority (NHSLA)
www.nhsla.com (England)
The authority is a not-for-profit part of the NHS established to manage negligence and other claims against the NHS in England on behalf of member organisations, resolving disputes and advising on patient safety as well as work on human rights case law and handling equal pay claims. Under the Clinical Negligence Scheme for trusts, NHSLA sets standards for safe care and assesses NHS providers against these as well as sharing learning from claims to help improve safety.

The Regulation and Quality Improvement Authority
www.rqia.org.uk (Northern Ireland)
RQIA registers and inspects a wide range of health and social care services. Its inspections are based on minimum care standards which will ensure that both the public and the service providers know what quality of services is expected. It does not have jurisdiction over NHS organisations, which are planned by Department of Health, Social Services and Public Safety (DHSSPS) and delivered by Health and Social Care Northern Ireland.

Independent Healthcare Advisory Services (IHAS)
www.independenthealthcare.org.uk/ (UK)
The Independent Healthcare Advisory Service (IHAS) is a trade body for the independent healthcare sector. Impartial amongst its members through England, Wales, Scotland and Northern Ireland, IHAS provides the mechanism for otherwise competitive members to share innovation, knowledge and expertise for the common good.

Independent Sector Complaints Adjudication Service (ISCAS)
www.independenthealthcare.org.uk/ (UK)
The Independent Sector Complaints Adjudication Service (ISCAS) is the recognised complaints management framework in the independent healthcare sector, serving patients, the public and healthcare organisations. The ISCAS Code of Practice (the Code) sets out the standards that ISCAS members agree to meet when handling complaints about their services.

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