

Service reviews

Process guidance for clinical oncology and clinical radiology

November 2022

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Document control and terminology

This document sets out the approach to service reviews managed by The Royal College of Radiologists (RCR). It supersedes *Service reviews: Process guidance for clinical oncology* (2021) and *Service reviews: Process guidance for clinical radiology, fifth edition* (2021) and combines the previous specialty-specific guidance documents into one, reflecting a modernised approach to reviews, service demand and current policy thinking.

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May 2022	0.1	First draft merging clinical oncology and clinical radiology 2021 service review documents
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1 Introduction

- 1.1 Service reviews undertaken by The Royal College of Radiologists (RCR) aim to help UK trusts, health boards, networks and independent sector providers to improve the quality of their service through a supportive, independent peer-review approach. With the backing of the RCR, trained multidisciplinary review teams bring up-to-date knowledge and experience, liaising with clinicians on site to understand the characteristics of their service, identify what works well and offer bespoke, workable recommendations towards further improvement.
- 1.2 This document sets out the current RCR end-to-end process for conducting reviews in the UK. It includes the scope of the service review, details of governance arrangements and the process for reviewer selection and team composition. It builds on previous approaches to RCR service reviews, aligning with current practice in oncology and radiology, the approach from other medical Royal Colleges and the reality of service need and delivery. The RCR's role in the review process mainly relates to problems that require the specific expertise of RCR Fellows, members and multidisciplinary colleagues in assessing the quality of care provided by a whole department or service. The RCR does not conduct reviews of individual practice, but there is evidence that the poor performance of doctors is often reflective of a department that is itself in difficulty and that poor performance may often reflect poor support, overwhelming workload or inadequate facilities.
- 1.3 This document is for patients, the public, clinicians and managers, including those commissioning reviews. Patients, their families, carers, healthcare workers and taxpayers have a right to expect that a modern healthcare system will have established frameworks to ensure the safety and quality of healthcare provision.
- 1.4 NHS organisations are committed to clinical governance and quality improvement, underpinned by the governments of the four UK nations, the General Medical Council (GMC) and the health inspectorates: the Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW), Healthcare Improvement Scotland and The Regulation and Quality Improvement Authority (RQIA) in Northern Ireland. In radiology, the development of the Quality Standard for Imaging (QSI),¹ together with the Diagnostic Imaging Dataset (DID)² and the Getting it Right First Time (GIRFT) programme,³ have also helped to ensure that radiology services are monitored, performance is benchmarked and support is given for continuous improvement. For clinical oncology, measures such as cancer waiting times, the National Radiotherapy Data Set (RTDS)⁴ and the soon to be introduced clinical and dosimetry metrics used to inform the Quality Improvement Toolkit may be helpful.
- 1.5 For the purposes of this document, the referring organisation, such as a health board, education body, NHS trust, foundation trust, independent provider, commissioner or government body will generally be referred to as 'the client' and the focus of review would be the 'service' under review.
- 1.6 The RCR promotes high-quality patient care in clinical oncology and clinical radiology. The RCR publishes advice, including good practice guides and standards,^{5,6} and has established robust mechanisms for developing and maintaining these standards. Service reviews will be carried out in accordance with the latest guidance, standards and recommendations from government, educational and regulatory authorities. Where a reference in this document has been superseded the most recent version applies. A list of key RCR and other national guidance supporting effective service delivery is provided in **Appendix 5**.

The strategic aims of the RCR (published December 2019) include:

Workforce – support excellent, safe patient care by working collaboratively on standards across imaging and oncology.

Be the experts – highlight to the public and stakeholders the contribution our specialties make to safe, evidence-based patient care.

Membership – support our Fellows and members to deliver the best care for patients for their entire career regardless of where and how they practise.

RCR service reviews apply our organisational and clinical expertise to the complex challenges that services experience, supporting those working in imaging and oncology to deliver safe, evidence-based patient care.

2 Principles underpinning service reviews

Definition and scope

- 2.1 An RCR service review is defined as an invitation to visit and comment upon a current service. This will normally be the whole of the oncology or radiology service or a specific pathway such as breast radiotherapy or interventional radiology. A review may be requested where there are concerns about how a service or part of the service is performing, or to provide an external assessment following, for example, reconfiguration or change of leadership, completion of an action plan, recruitment or workforce challenges.
- 2.2 The RCR has no statutory right to inspect, accredit or review clinical services and carries out service reviews under this guidance by invitation from the client organisation; recommendations made are advisory only. **Responsibility for the ongoing safety and governance of a service remains with the client's operational management at all times.**
- 2.3 At the time of writing, the RCR does not carry out reviews of individual clinicians' practice nor undertake case note review, although comparative performance of individuals within teams will be reviewed. Where a service review has raised questions about an individual or where new enquiries relate primarily to an individual, the client will be directed to alternative options for resolution which could include:
- The internal maintaining high professional standards (MHPS) process⁷ and NHS case investigator advice⁸
 - Contact with the NHS Resolution Practitioner Performance Advice adviser⁹
 - Discussion with the assigned GMC Employment Liaison Adviser¹⁰
 - Advice from the relevant commissioning organisation (as appropriate).
- 2.4 The review team will only consider cases which have been dealt with by the client's procedures for clinical governance, critical incident reporting or risk management. This is to ensure that the cases examined have been subjected to the necessary level of scrutiny at local level to identify them properly as representing an unacceptable standard of service.
- 2.5 Requests to review whether a service provides a suitable environment for training would usually be referred to the Deanery or Local Education and Training Board (in England), or the equivalent bodies in Wales, Scotland and Northern Ireland. It is important that findings from RCR reviews that may have implications for the continuation of training placements are shared appropriately for the protection of patients and staff. Findings from training reviews would usually be requested by the RCR if a service review is being conducted and the review manager would seek to link with the Deanery, Regional Adviser and Head of School.
- 2.6 Requests for oncological or radiological expertise for other roles such as medico-legal opinions, expert witness for court reports and serving on expert panels are outside the scope of service reviews at the time of writing.

Approach to conducting reviews

- 2.7 The service review process aligns with review and assessment arrangements undertaken by other organisations such as medical Royal Colleges, the CQC and the regulatory bodies in Wales, Scotland and Northern Ireland. It reflects the principles set out in the joint Academy of Medical Royal Colleges (AoMRC) document *A framework of operating principles for managing invited reviews within healthcare*.¹¹
- 2.8 A service review will usually involve input from all staff working in or with the service, as relevant to the agreed scope of the review, including clinical oncologists, medical oncologists, radiologists, radiographers, nurses, medical physicists, managers and administrators, and may include direct input from patients who have used the service or their representatives.
- 2.9 A service team under review must consent to their participation in the review and understand the nature of the review process. Reviewers are objective, independent of other authorities and expect to work in a climate of fairness, openness and trust. All evidence reviewed should be relevant to the issue in hand and those under review must have the opportunity to present their views.
- 2.10 Each review will have its own terms of reference, carefully negotiated and agreed at the start of the review and specifically designed within the scope of this guidance to be robust yet fair to all concerned.
- 2.11 It is important that any review proceeds and completes as swiftly as possible within the terms of reference to minimise any anxiety, ensure that the discussions and recommendations arising from the review remain relevant and enable the service to deliver the highest possible quality of care.
- 2.12 RCR service reviews will always consider the impact of current and proposed service arrangements on patients and carers and the quality of care experienced by them. Reviews will always examine and comment on the mechanisms for engagement by the client to ensure the voice of patients is continuously heard. Where appropriate within a review, direct patient input will be sought.

Patient safety

- 2.13 If at any point during a service review – from initial request to the report and follow-up – the RCR becomes aware of any serious concerns that have an implication for patient care or safety they will immediately inform the medical director or their representative. The RCR reserves the right to suspend the review until the concerns are mitigated or addressed. A referral to the regulatory authorities may be necessary but prior to any such action the client representative must be formally notified to enable them to mitigate or address the concerns and make any notification themselves.

3 Initial contact between the client and the RCR

Consideration of requests

- 3.1 The flowchart in **Appendix 1** sets out the service review process in full, from receipt of the initial enquiry to completion of the review and any follow-up activity.
- 3.2 Requests for an RCR service review may arise as a result of:
- Findings of a CQC report
 - A recommendation of the National Health Service Resolution, Practitioner Performance Advice (NHSR PPA) team supporting an individual doctor
 - The collective performance of a department giving cause for concern
 - Disagreements between the hospital management and the department (in terms of performance, workforce, workload or resources)
 - The hospital management and the department (working together) seeking an independent review of local services and the resources assigned to them
 - Perceptions that an individual team member is under performing and that the root cause is partly or completely due to the way the department is managed
 - Merger, reconfiguration or senior leadership changes proving difficult to embed.
- 3.3 All initial requests and enquiries would usually come from the medical director, clinical director or chief executive of the client body and be directed to the RCR Professional Practice team (professionalservices@rcr.ac.uk, +44(0) 207 405 1282). Where individual clinicians make contact, they will be encouraged to discuss the potential for a review with their clinical director and seek their support to approach the RCR.
- 3.4 Following initial contact, the RCR Head of Professional Practice and relevant Medical Director, Professional Practice (MDPP) will discuss with the client the details of the request for help and determine whether a service review is appropriate or whether alternative routes for assistance and advice may be more suitable (see paragraphs 2.3, 2.4).
- 3.5 If it is agreed that a service review should take place, the RCR and client will discuss and document the details of the request including, for example:
- The problem as seen by the client and the reasons for the request
 - Whether any referrals have been made to the NHSR PPA, GMC or similar organisation, or if any employment tribunals or legal processes have been conducted, are in progress or are expected to commence
 - What steps have been taken so far to address the concerns giving rise to the request.
- 3.6 These data will enable discussions on the scope, terms of reference, timescales, cost and contractual arrangements for the review. A lead reviewer and review manager would usually be identified by the RCR at this stage, together with suitable review team members to determine availability and to schedule the visit.
- 3.7 Throughout this preparation, discussions are confidential and should be conducted in a climate of openness and trust. A review should not be portrayed nor perceived as punitive and all involved should be positive about the benefits of an independent expert assessment. Where the review manager and lead reviewer feel that more could be done locally to resolve the situation they may suggest this and postpone the review request. No fee is chargeable in such cases.

- 3.8 The terms of reference must be agreed by all parties involved, including the team under review. They must be realistic and considered to be achievable by the RCR team; time spent initially ensuring clarity and consensus will reduce the time taken and risk of potential misunderstanding later in the review.
- 3.9 The RCR team will keep notes of communications on a standard proforma and these will be retained in line with the information management protocol (see **Appendix 2**).

Contractual correspondence

- 3.10 Once the key details have been agreed, the RCR will send a formal letter confirming the review to the client representative. This letter will include:
- Full details of the fees that the client will incur, including reviewer and RCR fees, accommodation, travel and subsistence expenses
 - Final agreed terms of reference
 - Details of the information management protocol (see **Appendix 2**)
 - Details of the review team members
 - A data questionnaire for advance information to be completed and returned by the client
 - Contractual terms and conditions for the review
 - Deed of indemnity
 - A request for payment of a deposit for the review to proceed.
- 3.11 These documents, once signed, together with this process guidance, will form the basis of the contract for the review and can only be changed with the agreement of the medical director or chief executive on behalf of the client, and the lead reviewer and the chair of the service review panel (SRP), which is usually the relevant Medical Director, Professional Practice.
- 3.12 The client will be required to:
- Inform all staff within the service that an external review has been requested
 - Agree the terms of reference and seek input and agreement from staff working in the service under review
 - Indemnify the RCR and the review team
 - Agree that the review and all related documentation will be treated as confidential by the client and its employees
 - Agree to abide by the information management protocol
 - Arrange the appropriate administrative support for the review team visit
 - Provide suitable private office accommodation/meeting room for the review team to conduct its work and interviews with confidentiality
 - Identify a single point of contact who should be a senior clinician or manager
 - Provide purchase order details and payment of deposit and final balance promptly
 - Agree to formulate an action plan in response to the review recommendations and respond to the RCR's request for information on progress within six months of receipt of the formal report and recommendations

- Promptly provide the core data and any relevant additional information as requested by the RCR before during or after the visit to minimise any delay in completion of the review.
- 3.13 When the RCR receives the signed agreement letter and deed of indemnity, the client will be deemed to have confirmed its acceptance of the terms of the review.

4 The review visit: preparation and conduct

Pre-visit discussion

- 4.1 During the more detailed negotiations, particularly for complex reviews, it can be helpful to arrange a pre-visit discussion involving the lead reviewer, review manager and key individuals from the client's team. The purpose of the pre-visit discussion is to offer an opportunity for client staff to understand what to expect, and to enable the RCR team to contextualise the service they are visiting and explain the preparation needed ahead of the visit. The pre-visit discussion will normally be conducted remotely.
- 4.2 The session would usually cover the following:
- A guided tour of relevant department(s) if appropriate
 - Meeting with relevant directors
 - Clarification of purpose of the review and any political/contextual factors
 - Explanation of the RCR's terms and conditions (set out in the contractual letter)
 - Finalising terms of reference
 - Composition of the review team
 - Explanation of the process, timescales and expectations with respect to visit support and pre-visit information requirements.

Reviewer selection

- 4.3 The review team usually comprises two consultants (either clinical radiologists or clinical oncologists, as appropriate to the review), a radiographer and a lay reviewer supported by a non-medical review manager (RCR staff). If appropriate to the service under review, other relevant clinicians will also be part of the team (for example, a medical oncologist or clinical scientist). Review team members are drawn from an established list of suitably trained individuals with the skills and experience to undertake the work required. At the present time these individuals are generally drawn from the SRP (see Section 6). The team is appointed by the chair of the SRP working with the Head of Professional Practice.
- 4.4 One of the consultants will act as lead reviewer; they will have previous experience of conducting reviews. Where specialist oncology or radiology expertise is required and is not available from the list of trained reviewers, a suitable consultant will be identified as the second reviewer. They will be selected based on the role description for reviewers. Reviewers who have not undertaken the induction training will be thoroughly briefed on the process and approach by the review manager and will be supported by more experienced members of the review team.
- 4.5 The radiographer reviewer will be an experienced practitioner who has undergone induction training alongside radiologist/oncologist reviewers. The RCR advertises for interested parties through The Society and College of Radiographers (SCoR). Where there is a need for nursing input, the Royal College of Nursing (RCN) would be asked to advertise the role/s, and appropriate training would be delivered.
- 4.6 Review teams benefit greatly from the involvement of a lay reviewer. This is an individual who has undergone training for review work and may be a member of the RCR Lay Member Panel or be a lay reviewer working with another Royal

College. The skills and insights these colleagues bring are valuable to the review team and provide an objective challenge to the process. Lay reviewers often have management, organisational development or patient involvement experience to offer.

Induction and refresher training

- 4.7 All reviewers should undertake RCR induction and refresher training every three years. This training enables them to:
- Be objective and non-judgemental in gathering evidence
 - Seek confirmation of facts and events from more than one source (triangulation) and record the sources of evidence
 - Look for evidence to substantiate or refute any criticisms or complaints made
 - Only use evidence that relates to the specific remit of the review
 - Base judgements on standards and statutory requirements where applicable
 - Be aware of the provisions of the Equality Act 2010¹²
 - Maintain confidentiality at all times.
- 4.8 Any potential conflicts of interest, perceived or actual bias or prejudice or connections with the organisation or individuals being interviewed, must be declared by the reviewers as soon as these are known. This is to ensure there is no potential for challenge to the objectivity or independence of the review resulting from real or perceived bias by any members of the review team. Connections are common – particularly in smaller specialties – and do not necessarily mean that a reviewer cannot participate; in some circumstances, prior knowledge can be helpful, but openness is key.
- 4.9 Throughout the initial phase, the client has the opportunity (in confidence) to propose or reject individual reviewers who meet the RCR criteria to ensure that the review is objective and independent. However, the final selection of reviewers is made by the RCR, taking into account any comment from the client's team.

Advance information – core data

- 4.10 The core data and other information requested from the client provides brief but relevant information in advance of the visit to familiarise the reviewers with the context and background. Examples of the core data are outlined in **Appendix 3**. The data requested should be shared securely through uploading to the RCR's portal.
- 4.11 All NHS organisations have a Caldicott Guardian who has a responsibility to protect the confidentiality of healthcare information; equivalent roles will exist in the independent sector. The client must make the Caldicott Guardian aware of the review and any pertinent information being disclosed. The client is responsible for obtaining any consent to share personal patient data, if required, and for uploading material to the portal.
- 4.12 The client should provide the core data and information outlined in **Appendix 3** no later than **three weeks** prior to the visit date. If the essential information is not provided in good time, the review visit may need to be postponed and the cost of the review may need to increase accordingly.

Arranging the visit programme

- 4.13 Based on the terms of reference and advance information, the review manager and lead reviewer will suggest areas of enquiry for the review team. The reviewers will need to speak with a range of staff involved. The interview programme agreed between the RCR team and the client would usually include:
- Chief executive and/or medical director or their representative
 - Clinical or service director for oncology/radiology
 - Consultant and staff and associate specialist (SAS) radiologists/oncologists and trainees
 - Radiographers, nurses, surgeons, physicists and other professionals working within or with the service – including picture archiving and communication system (PACS) reporters from other sites if appropriate
 - Risk management/clinical governance staff
 - Directorate manager
 - Commissioners or service planners
 - Relevant operational or administrative staff (for example, those responsible for booking appointments or managing rotas)
 - Patient Advice and Liaison Service (PALS) or customer feedback staff
 - Patient/carer representatives.
- 4.14 The RCR will arrange the accommodation and travel for the review team, who will usually convene the evening before the visit commences. This enables the review team to plan the review and pool their understanding of the issues and the information gleaned from the advance documentation.
- 4.15 Ahead of the visit, the RCR will prepare a briefing to be shared with all those participating in the review. This provides details of the team, a summary of how the review will work, information about confidentiality and (usually) the terms of reference. We have found this helps put interviewees at ease and ensures that everyone involved understands the nature of and approach to the review.

During the visit

- 4.16 The reviewers would usually first meet the medical director or chief executive to understand together the context of the visit and run through expectations and the detailed programme. Sometimes the whole service can be invited to a short initial presentation. It is usually helpful to tour the facility as this provides context, makes the team visible and may triangulate some statements.
- 4.17 The review team will usually stay together for the interviews and tour but may split up if there are diary clashes, a large number of staff seeking to contribute or for more specialist conversations where a large team may appear intimidating to interviewees. Interviews (including telephone interviews) should have at least two members of the review team present; if this is not possible, careful notes should be taken and agreed by all parties present.
- 4.18 All interviewees will be given contact details of the review team and invited to share any further thoughts with the team where relevant. This may be by means of an advance survey, a survey following the visit or both.

- 4.19 If any issues or concerns arise that cannot be dealt with immediately or if there is a request to amend or extend the terms of reference, the review manager and lead reviewer should seek written advice from the chair of the SRP or the Head of Professional Practice prior to discussing this with the client.
- 4.20 At the end of the review visit, the team may meet with the senior representatives from the service to:
- Check the factual content of the information gleaned
 - Draw attention to anything that causes concern regarding patient safety
 - Provide preliminary feedback on key issues where possible.
- 4.21 It is good practice (depending upon the scope of the terms of reference) for the review team to meet all staff together at the end of the visit and feedback informally with thanks and headline findings. Where there are complex issues, the lead reviewer and review manager may decide this would not be appropriate.

5 After the review visit

Communicating initial findings and producing the draft report

- 5.1 Following the visit there may be additional calls to interview those unavailable on the visit dates. Further information may have been requested or offered during interviews and people may contact the team with additional information. A brief online survey will usually be circulated by the client contact soon after the visit, seeking comments on the review process and any further information that individuals wish to contribute.
- 5.2 The reviewers will endeavour to finalise their views and plan the report content by the end of the visit. Within two weeks of the visit, the RCR review manager will send the client contact and the medical director a short letter summarising the initial findings from the visit and seeking any additional information required to complete the report. If there are urgent concerns or recommendations emerging from the review, this letter provides formal notification and may include a requirement to inform the regulator of the situation if it cannot be immediately addressed.
- 5.3 The review manager and lead reviewer will draft the written report in conjunction with the other reviewers. Reports will usually follow a template approach, based on the terms of reference and findings of the visit. They should be succinct, add value, with clear judgements and (where appropriate) challenging recommendations, rather than simply reflecting back what the team were told. Benchmarking and notable practice elsewhere will be included where this is helpful. Recommendations will be brief and structured to enable an action plan to be developed by the client organisation.
- 5.4 The draft report will be sent to the MDPP and the Executive Director for Education and Professional Practice (or their representatives drawn from the service review panel (SRP)) within around four weeks of the visit to provide a quality assurance review of the report. A member of the SRP will usually be involved in reviewing every report, either as a full reviewer or a quality assurance (QA) reviewer. Reviewers will be SRP members.
- 5.5 The appointed QA reviewer(s) will provide objective commentary on the report, including confirmation that the opinions and interpretation of compliance with standards are appropriate and represent the views and current policy of the RCR. Following this input, the report is checked by the reviewers and sent to the client representative for comment.

Finalisation and distribution of the report

- 5.6 The draft report will usually reach the client within around eight weeks of the visit if all requested information has been received, and the review manager will confirm dates as the report progresses. The client is invited to share the draft with a small number of colleagues to provide comments on accuracy or any suggested amendments to improve implementation of the recommendations. It is important that, wherever possible, input is obtained from the clinical lead to maintain the openness of the process.
- 5.7 These returned comments would be considered by the review team and the report may (or may not) be amended. The final report will be sent to the chief executive, medical director and trust board chair (or equivalent) within 10 working days of receiving the client's comments, together with a response to the comments made.

- 5.8 It is expected that the client will share the final report with as many of those who contributed as possible, and with the trust board (or equivalent) or in public where appropriate. The RCR will endeavour to structure and phrase the report to reflect this. Occasionally where there are sensitive findings or concerns relating to an individual, the lead reviewer or the MDPP will write separately in confidence to the medical director or their nominee about those issues. Follow-up will be arranged by the review manager.

Action arising

- 5.9 The RCR has no statutory authority to require action following a service review and can only give recommendations and advice to a client. Any action taken as a result is the responsibility of the client. Following the review, the client should share their action plan with the RCR in full to support effective follow-up on the actions taken and progress made.
- 5.10 Where concerns are raised over safety or staffing, the RCR would expect the client to notify the regulatory authorities promptly of the review, recommendations and action plan. If, during the review or follow-up period, the RCR deems that action taken in response to concerns or recommendations is insufficient to mitigate safety concerns, the SRP reserves the right – in the public interest but still in confidence – to authorise further action which may include reporting the findings directly to the appropriate regulatory or commissioning authority. The chief executive of the client organisation would always be notified if this was being considered.
- 5.11 Six months after the final report has been issued, formal contact will be scheduled between the lead reviewer, review manager and the client to discuss the impact of the review visit and progress against implementation of the recommendations. This will normally be conducted remotely. Feedback will also be sought in confidence (through an online survey) on the conduct of the review to assist in continuous improvement in service. A second approach may be made one year after the review to check completion of actions.

Media, public interest and learning from reviews

- 5.12 Some reviews, often those relating to reconfiguration or service change, may be conducted in the public domain; for others the client commits to publish the final report. If press interest is expected, the approach to any media enquiries will usually be agreed with the client in advance. For unexpected approaches, the RCR would usually refer the enquirer back to the client, simply explaining the background to our service review process.
- 5.13 The RCR may use the findings from reviews to compile summary articles and thematic reports for journals, newsletters or wider publication. Unless the review is in the public domain already these will be anonymised, but consistent with good practice the organisations involved will usually be approached ahead of publication to confirm acquiescence with the report.

6 Governance, independence and accountability

Service review teams and the service review panel

- 6.1 Service review teams (SRTs) aim to provide an independent review of structure, organisation and practices within the department and the relationship to the wider client organisation to ensure quality care is provided in departments of clinical oncology or clinical radiology. Given this aim, the SRT seeks to work with an ethos of openness in its conduct.
- 6.2 SRTs will be drawn from a trained service review panel (SRP) that will meet regularly for training and sharing best practice. The SRP will operate under the oversight of the RCR Medical Directors, Professional Practice (MDPPs).
- 6.3 The membership of the SRP comprises clinical oncologists, clinical radiologists and independent lay members. The RCR MDPPs will lead the SRP and a medical member would lead any meetings if both MDPPs are absent. Ex-officio members include the RCR President and the Vice-Presidents. The SRP will aim to maintain at least three independent lay members. The usual term of office for sitting members will be five years. A second term of office can be agreed with the MDPPs on behalf of RCR Officers.
- 6.4 The membership of the SRP will reflect the diverse nature of departments of clinical oncology and clinical radiology as well as providing a geographical spread. RCR Fellows in good standing are chosen on the basis of documented experience in management within departments of clinical oncology and clinical radiology. Lay members are selected following an application process and vacancies are advertised through the RCR and other respected sources. Vacancies for oncologist and radiologist members of the SRP will be advertised in RCR communications to Fellows and members. Co-opted radiographer members will be selected in collaboration with The Society of Radiographers (SoR).
- 6.5 Fellows or members who wish to apply for selection will be asked to submit an abbreviated curriculum vitae and will be chosen with maintenance of the diversity of the SRP in mind.
- 6.6 The SRP monitors the confidential reports of review teams, defines the structure, timescales and circulation of reports and reflects on procedures generally. This is important for continuous refinement of the framework under which the SRP operates.
- 6.7 Significant flexibility is required in the process of communication between members of the SRP, including the scheduling of meetings and in the process of selection of review teams; this is managed by the MDPP together with the Head of Professional Practice. The MDPP considers which decisions can be resolved through appropriate communication with relevant member(s) of the SRP and which require full meetings to ensure the necessary speed of response is achieved.

Authority, accountability and indemnity

- 6.8 The RCR undertakes reviews on behalf of an authorised individual in the client body. For service providers this is usually the medical director as responsible officer or chief executive as accountable officer depending upon the nature of the review. Responsibility for receiving, disseminating and acting on the reports lies with them or their nominated representative. Review reports provide advice only and the RCR

and reviewers will be indemnified by the client in the case of any litigation resulting from implementing any advice or recommendations within the report.

- 6.9 Reviews and the individuals involved in conducting them must be, and be clearly seen to be, wholly objective and independent. There are a number of mechanisms in place to mitigate the risk of allegation of bias or inappropriate influence:
- Reviews are conducted primarily to assess compliance with formal standards
 - Reviewers are usually selected from a pool of experienced clinicians who have met specific skills and knowledge criteria and received relevant training
 - There are always at least two medical reviewers, a radiographer reviewer and staff support on visits, plus a trained lay reviewer where appropriate
 - The lead reviewer must have successfully completed at least two reviews
 - All reviewers are required to declare any conflict of interest
 - Organisations or individuals being reviewed agree the review team membership
 - There is a clear sign-off process to challenge the report content and conclusions
 - At least one member of the SRP is usually involved as a QA reviewer or full reviewer.

Where serious concerns are raised

- 6.10 If issues of patient safety are raised or identified at any time, the reviewers will advise the client immediately and discuss what urgent action has been or should be taken, if any. This may be additional scrutiny, more detailed review, supervised or temporary restricted practice, additional governance/senior clinical checks or, potentially, suspension of a service and diversion of referrals. Such situations are extremely rare and any concerns raised and action taken would usually involve the regulatory bodies and commissioner/health board action.
- 6.11 Sometimes there are issues arising from a review which need to be notified to the medical director and/or which need to be communicated confidentially rather than set out in a report that is likely to be widely circulated. In such situations, a letter will be agreed by the review team and sent by the Head of Professional Practice on behalf of the review team. The chair of the SRP and lead reviewer will be involved in agreeing the letter content and the SRP will be advised at its next meeting.
- 6.12 The RCR maintains good working relations with the NHR PPA team and the GMC and may discuss anonymously or specifically any issues relating to an individual doctor. Depending upon the issues under review, the RCR may recommend to a referring client that a service review is not the appropriate course of action, and that these bodies are more appropriate to approach.

Confidentiality, records handling and retention

- 6.13 The nature of reviews means that the SRP and any review team must ensure that data and information specific to the review is treated as strictly confidential by all parties involved, to promote participation by all in an open, equal and fair way. The RCR will not disclose to the public, or any individual not directly involved, any details of the review or its involvement without the permission of the medical director, chief executive or authorised representative of the client, unless there is an

overriding reason; for example, urgent safety concerns where the regulator and/or commissioner must be notified and/or public interest.

- 6.14 A decision to disclose information to third parties without consent of the client will only be made by the SRP in consultation with RCR Officers and where there is lawful justification for doing so. It is recognised that the reports may reach the public domain as part of a consultation or be disclosed under a Freedom of Information¹³ request and will be drafted with due consideration of possible intentional or incidental publication (that is, where it was not intended that the report be published but the report has to be disclosed as part of wider events).
- 6.15 Reviewers will ensure that all those who are interviewed as part of the review understand that while the process is confidential, the evidence they share with the review team will be corroborated by the team against evidence given by other participants, where possible. It will also, in most circumstances, be used within the report, though not in a way that attributes it to them individually.
- 6.16 The review process, including any information created, received, stored or exchanged, will comply at all times with the UK Data Protection legislation, which is currently the General Data Protection Regulation (GDPR)¹⁴ and the Data Protection Act 2018,¹⁵ information governance principles and the NHS Code of Confidentiality.¹⁶ These apply in particular when dealing with any confidential and personal information.
- 6.17 The RCR uses a centralised collaboration tool – SharePoint – for transmitting documents related to reviews. Most NHS bodies can use this system but where there are difficulties, secure email or encrypted USB drives can be used instead. While final reports of reviews will be securely retained by the RCR indefinitely, and the RCR will retain other documents in line with the information management protocol, reviewers will return or securely dispose of all other information received in relation to the review as soon as the final report is completed and accepted by the client. This includes any copies of the information that have been made and any email correspondence. Where reviewers are storing documents locally for the purpose of the review, they must ensure they have put adequate security measures in place in line with data protection legislation.
- 6.18 Any of the individuals who participate in the review process are entitled under data protection legislation to submit a subject access request (SAR) to the RCR requesting any information in relation to the review which is about them. This may include, but is not limited to, recordings of interviews, any correspondence in relation to a review, reviewers' notes and the report (where the latter identifies specific individuals by name or job role). If the RCR receives a request, the Data Protection Officer will be informed, and the RCR's SAR procedure will be followed. The RCR may discuss the request with its lawyers, if necessary, before releasing material. Individuals submitting a SAR to the RCR may also submit a SAR to the client, and the client will respond in accordance with their own SAR procedure.
- 6.19 Unless the RCR has the data subject's consent to do so, it will not disclose any material relating to any review interviews to the client as this would breach the duty of confidentiality to the individuals. The RCR will also not disclose to the client any details of SARs received in relation to a review without the data subject's consent as this would be in breach of data protection legislation.

- 6.20 The RCR may occasionally receive a request for disclosure from a third party such as the GMC. Each case will be dealt with in line with RCR's information governance procedures and UK data protection legislation. The RCR will only ever disclose information to a third party where there is a legal obligation to do so and the data subject will usually be informed unless there is a legal reason that prevents this.

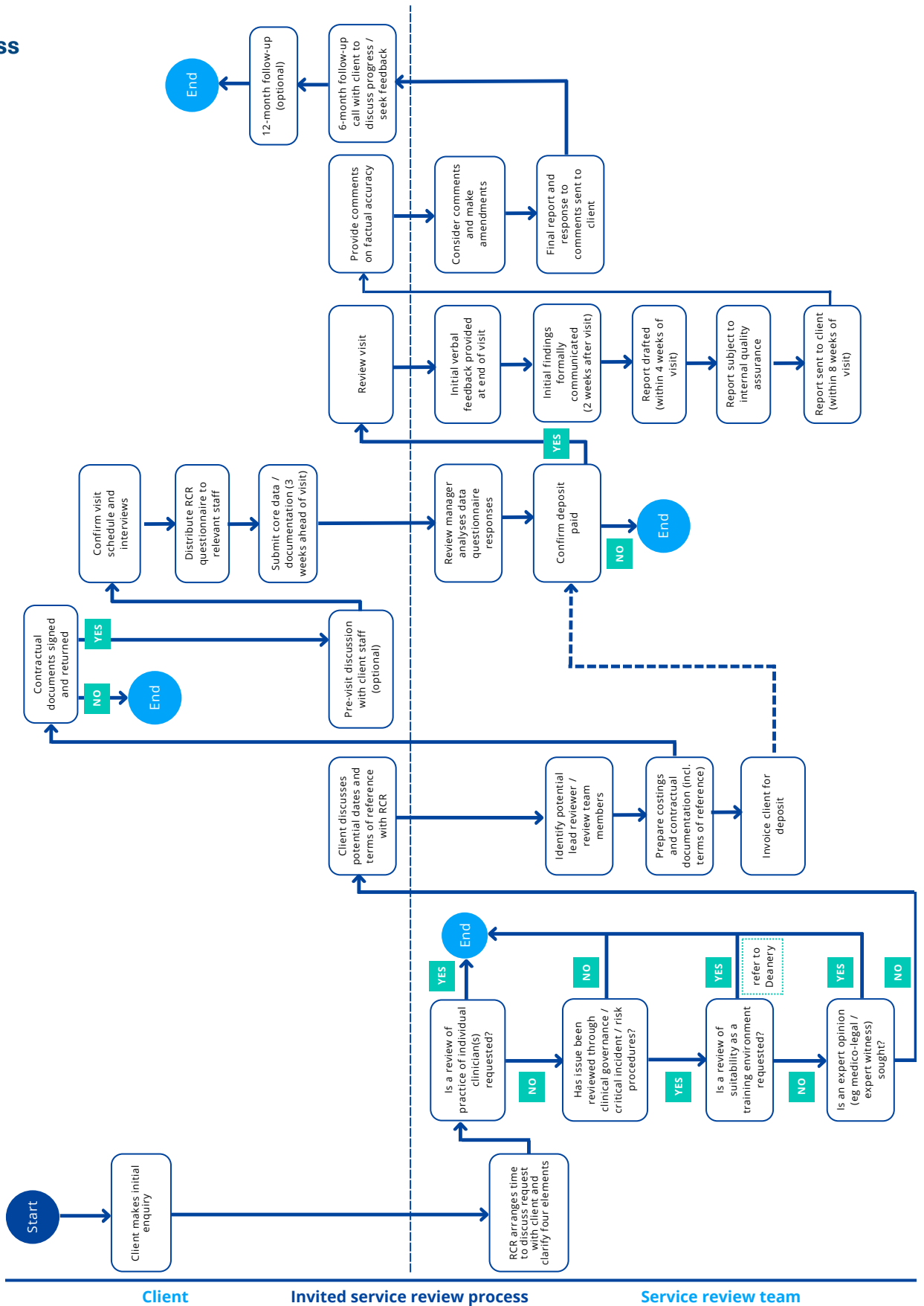
Comments and complaints

- 6.21 Inevitably there will be individuals or groups who are anxious about the process of undergoing a review or are unhappy with the analysis, conclusions or recommendations in the report. Throughout the whole review process, the lead reviewer and review manager endeavour to hear all views and conduct the review in as open, transparent and objective a manner as possible. Where concerns are expressed or appear to be forming, they will be discussed and addressed as soon as is practicable, acknowledging where changes may be needed or explaining the process, approach and rationale.
- 6.22 Where this informal process does not resolve the issue, the RCR offers a more formal complaints process which can be accessed by anyone wishing to register their concerns for investigation. Details are available from the RCR website: www.rcr.ac.uk/college/council-governance/policies/rcr-complaints-procedure.

References

1. The Royal College of Radiologists and the College of Radiographers. *Quality Standard for Imaging*. London: The Royal College of Radiologists, 2021. Available from: www.rcr.ac.uk/clinical-radiology/service-delivery/quality-standard-imaging-qs.
 2. Diagnostic Imaging Dataset: www.england.nhs.uk/statistics/statistical-work-areas/diagnostic-imaging-dataset/.
 3. Getting It Right First Time: www.gettingitrightfirsttime.co.uk/clinical-work-stream/radiology/.
 4. National Radiotherapy Data Set: www.cancerdata.nhs.uk/radiotherapy.
 5. Clinical Radiology publications: www.rcr.ac.uk/clinical-radiology/publications-and-standards.
 6. Clinical Oncology publications: www.rcr.ac.uk/clinical-oncology/publications.
 7. Maintaining high professional standards in the NHS: resolution.nhs.uk/practitioner-performance-advice/maintaining-high-professional-standards-in-the-nhs/.
 8. NHS case investigator advice: www.england.nhs.uk/professional-standards/medical-revalidation/ro/resp-con/cit/reading/.
 9. NHS practitioner performance advice: resolution.nhs.uk/services/practitioner-performance-advice/.
 10. GMC employer liaison: www.gmc-uk.org/about/how-we-work/outreach/employer-liaison-service.
 11. Academy of Medical Royal Colleges. *A framework of operating principles for managing invited reviews within healthcare*. London: Academy of Medical Royal Colleges, 2022. Available from: www.aomrc.org.uk/invited-reviews/.
 12. UK Government. *Equality Act 2010*. London: The Stationery Office, 2010.
 13. UK Government. *Freedom of Information Act 2000*. London: The Stationery Office, 2000.
 14. General Data Protection Regulation: <https://gdpr-info.eu/>.
 15. UK Government. *Data Protection Act 2018*. London: The Stationery Office, 2018.
 16. Department of Health. *Confidentiality: NHS Code of Practice*. London: Department of Health, 2003. Available from: www.gov.uk/government/publications/confidentiality-nhs-code-of-practice.
 17. The Royal College of Radiologists. *Continuing Professional Development (CPD) Scheme (4th edition)*. London: The Royal College of Radiologists, 2016. Available from: www.rcr.ac.uk/college/cpd-and-revalidation/rcr-cpd-scheme.
 18. NHS England Friends and Family Test: www.england.nhs.uk/fft/.
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Appendix 1
Review process



Appendix 2 Information management protocol

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

The RCR accepts that the service 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 imaging and cancer care services for the benefit of patients and may assist oncology and radiology departments to perform better and avoid or overcome problems. It is recognised that the service 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 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 wherever possible, and therefore needs to guarantee that the service will ensure that such assurances are respected.

The following principles apply 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, 'service' will be used for ease of reference to refer to the different types of health organisations providing imaging and cancer care services across the UK.

1. Confidentiality

- a. All service reviews will be conducted confidentially and all information or documentation generated by reviews shall be confidential to the service 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 (GMC) or, as appropriate to the location of the service, to the Care Quality Commission (CQC), Healthcare Improvement Scotland, Healthcare Inspectorate Wales (HIW), or The Regulation and Quality Improvement Authority (RQIA).
- b. In relation to personal data, the RCR, the client and the service will act in accordance with the Data Protection Act 2018.

2. Disclosure

- a. The RCR has no general objection to disclosure within the service of certain information arising from reviews such as:
 - i. 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
 - ii. Core data about the department provided by the service for the review team

- iii. Administrative data such as records of contacts, visits and dates of meetings, again provided that any reference to the names of individual participants or means of identifying them are removed
 - iv. The contractual arrangements between the RCR and the client, including fees.
 - b. By their very nature, service reviews inevitably deal with inherently sensitive information which might be contained in a variety of documentation including but not limited to:
 - i. All comments given to the review team, whether in documents or verbally, or at interviews or recorded in meeting notes
 - ii. Details of and/or comments about the service's individual practitioners or managers who may be under scrutiny during a review
 - iii. Minutes of team meetings
 - iv. Personal notes kept by review team members
 - v. The draft and final reports
 - vi. Communication with the RCR about specific issues discussed during reviews and records of discussion of those matters within the RCR.
 - c. If any request under the Freedom of Information Act 2000 received by a service is found to cover information of this sort, or if there are any enquiries or requests from third parties [this includes individual oncologists or radiologists or their advisers who may be thinking of litigating against the service] concerning such information, the service 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

- a. The RCR will only hold personal information for as long as necessary. For the purpose of the review process the RCR will keep written records of all contacts during the service review (including any summaries of telephone calls) for a maximum period of 12 months from the date on which the review visit concluded. This will allow time for the RCR's follow-up letter to be sent and the delivery of the final report, regardless of whether the service responds. After this point 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

- a. Information about any individual cases that may have been mentioned over the course of the review will not be recorded and will not form part of the review documentation or report.

5. External statements

- a. 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 service should ensure there is express agreement with the review team leader and the MDPP about any statement concerning the review given to an external agency. Similarly, the RCR will ensure that the service is content with any statement about a review that it might make.

6. The service's use of the review report

- a. The service accepts that the transcripts of any interviews, the draft report and the final report will remain the property of the RCR.
- b. In using the report for its purposes, it is recognised that the service must take all appropriate steps to ensure that the report is considered as necessary to ensure that recommendations contained therein are acted upon. However, the service should ensure that all individuals who receive the full report are aware of and respect its confidentiality.
- c. In confirming that a review should proceed, the service 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 service should advise the RCR.
- d. The service is encouraged to share the report with all participants in the review and the wider team being reviewed.
- e. The service will be responsible for any and all interaction with the media in relation to the report and its outcomes. The RCR will forward any and all requests for information to the service's appointed officers.

Appendix 3

Example core data questionnaire

The following information is required in support of an RCR invited service review.

Service and management

1. Brief description of hospital, including size of population served, number of beds and so on, and the department of clinical oncology/radiology including number of rooms, equipment available and so on. (This information may be contained in your most recent oncology/radiology appointment job description).
 - a. Include standard trust activity template.
 - b. Include CQC compliance statement.
2. Diagram showing the management structure of the client and oncology/radiology service (medical and non-medical), clearly identifying those with a management role in the service.
3. Service level agreements (SLAs) or commissioning service contracts if any, with oncology/radiology components.
4. *Radiology only*: If the radiology service has been visited by GIRFT, a copy of the submission.
5. Links to or copies of reports from regulators or any external review/inspections/serious incidents (last 12 months) together with action plans and progress.
6. Details of any strategic planning or network reviews (internal or external) including service redesign for the last three years.
7. Minutes of divisional and/or governance meetings (last 12 months) where pertinent issues were discussed.

Workforce

8. Names of oncologists/radiologists (consultants and staff, associate specialist or specialist [SAS] doctors) in post indicating grade, nature of appointment (permanent, fixed-term, locum), sessions worked and agreed job plans.
9. Details of any oncologist/radiologist (consultant and staff, associate specialist or specialist [SAS] doctor) vacancies and of any consultant and SAS staff turnover in the past three years.
10. Model Hospital datasets for workforce.
11. Provide establishment, vacancy and turnover data, as appropriate to the service, for:
 - Diagnostic and/or therapy radiographers and other support staff
 - Physicists
 - Nurses
 - Other relevant health professionals
 - Administrative staff
 - IT support.
12. Statutory and mandatory training programme and record of completion.
13. Deanery/GMC trainee survey reports.

Workload and service delivery

14. The most recent consultant departmental timetable.
15. Agreed reporting protocols and turnaround times.
16. *Radiology only*: Current waiting times for examinations, such as abdominal ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), mammography, interventional procedures and plain films and so on.
17. *Oncology only*: Current waiting times to start of treatment, benchmarked against standard national targets (for example, NHS England).
18. Level of regular outsourcing and any SLAs in place with partner/supplier organisations.
19. Processes in place to manage workflow.
20. Any current external reports, including:
 - CQC inspection
 - Any serious incidents, especially those reported under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)
 - *Radiology only*: GIRFT
 - *Radiology only*: QSI

Benchmarking from NHS England or devolved nation equivalents

21. The most recent oncology/radiology report.
22. Number of examinations performed with specialty breakdown (last three fiscal years).
23. Individual consultant reporting figures with specialty breakdown (last three fiscal years).
24. What and how many examinations are conducted/reported by extended role radiographers?
25. *Radiology only*: What examinations are available to general practitioners (GPs) on direct access?

Governance

26. List of department policies/standard operating procedures (SOPs); (team may request individual ones).
27. List of relevant accreditation statuses and checklists/reports where appropriate. This should include IR(ME)R for relevant duty holders, and may also include, for example, QSI accreditation, British Society of Interventional Radiology (BSIR) exemplar status or International Accreditation System for Interventional Oncology Services (IASIOS) accreditation.
28. Details of audit activity performed during the last 12 months.
29. *Radiology only*: Evidence of discrepancy or errors meetings held in the past year (including attendance records and minutes).
30. *Oncology only*: 30-day and 60-day mortality rates.
31. Evidence of continuing professional development (CPD) undertaken by oncologists/radiologists, in line with The Royal College of Radiologists' CPD requirements.¹⁷
32. Consultant appraisal completion, other staff individual peer review (IPR) completion rates.

33. Sickness absence for the whole workforce, by professional group, during the last 12 months.
34. The reporting structure and governance arrangements for the client.
35. A recent governance report and any business unit/directorate reports.
36. A copy of the risk register – detailing any risks that are red rated (or equivalent, for example, those rated 12 or above) according to the risk assessment methodology in use.
37. Copies of or links to any recent local and national clinical audits and action plans.

Referrer/organisation-wide relationships

38. Range of sample communications with referrers.
39. *Radiology only*: Services offered to primary care and services off limits to primary care.
40. *Radiology only*: Feedback from referrers within the client and from other sources.
41. *Radiology only*: Processes used to highlight to referrers the following: rejected requests; fail safes; unexpected findings; cancer and non-cancer alerts.

Patient-centred care

42. Processes in place to ensure that patients are kept safe and are empowered to keep their dignity.
43. Examples of patient leaflets/information including for children and young people.
44. Details of any complaints and their outcomes, other sources of patient/carer experience data such as surveys, informal feedback, clinical incidents or plaudits in the last three years.
45. Details of any reported serious incidents involving the service in the last three years.
46. Friends and family test (FFT) or equivalent survey results;¹⁸ audits of patient experience and feedback.

Note: This list is not exhaustive and other documentation may be considered appropriate for inclusion by the lead reviewer. Additionally, if there is information not listed that the service would like to share with the review team, please do include this.

Appendix 4 Example terms of reference

Review of oncology/radiology at [client]

- [Client] is seeking an independent external review of its [imaging/oncology] service(s).
- The [client] comprises [details of sites and facilities].
- The issues of concern are [outline including any major challenges].
- The purpose of the review is to [agree plan/strategies to address the concerns above].
- Assessment will be based upon RCR guidance, recognising best practice and benchmarks.
- The themes agreed with the client are listed below.

Clinical governance and safety

- Review of wider [client]/departmental governance procedures and alignment.
- Quality assurance processes.
- Policies for discrepancies and the effectiveness of their application within the service.
- Picture archiving and communication systems (PACS)/radiotherapy planning systems and information technology (IT) infrastructure in and between hospital sites and remote (home) access.
- Patient experience: information, engagement and acting on feedback.

Operational leadership and effectiveness

- The operational, clinical and professional leadership of the oncology/radiology service.
- Team structure and team-working notably across and between sites.
- Representation of oncology/radiology within the client's management structure.
- Systems and processes in the oncology/radiology service.
- Communication strategies within and beyond the department(s).
- Lines of responsibility internally between oncologists/radiologists, (therapy) radiographers, physicists and management.

Service sustainability and strategic development

- Strategies for development of the service including workforce planning.
- Recruitment and retention.
- Service accreditation.

Exclusions

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

Appendix 5 Reference standards and other documents

Guidance published by The Royal College of Radiologists

Clinical Radiology

1. The Royal College of Radiologists. *Clinical radiology job planning guidance for consultant and SAS doctors 2022*. London: The Royal College of Radiologists, 2022.
2. The Royal College of Radiologists. *Professional Duty of Candour: Guidance for Radiologists*. London: The Royal College of Radiologists, 2022
3. The Royal College of Radiologists. *Implementing Ordercomms (electronic requesting) in radiology*. London: The Royal College of Radiologists, 2022
4. The Royal College of Radiologists. *Radiology Reporting Networks: Understanding the technical options*. London: The Royal College of Radiologists, 2022
5. The Royal College of Radiologists and the College of Radiographers. *Quality Standard for Imaging Networks*. London: The Royal College of Radiologists, 2022.
6. The Royal College of Radiologists and the College of Radiographers. *Quality Standard for Imaging version 1.1*. London: The Royal College of Radiologists, 2022.
7. The Royal College of Radiologists. *Integrating artificial intelligence with the radiology reporting workflows (RIS and PACS)*. London: The Royal College of Radiologists, 2021.
8. The Royal College of Radiologists. *Vetting (triaging) and cancellation of inappropriate radiology requests*. London: The Royal College of Radiologists, 2021.
9. The Royal College of Radiologists. *Standards for radiology events and learning meetings*. London: The Royal College of Radiologists, 2020.
10. The Royal College of Radiologists. *Guidance on maintaining patient confidentiality when using radiology department information systems, second edition*. London: The Royal College of Radiologists, 2019.
11. The Royal College of Radiologists and the British Society of Interventional Radiology. *Provision of interventional radiology, second edition*. London: The Royal College of Radiologists, 2019.
12. The Royal College of Radiologists. *Standards for interpretation and reporting of imaging investigations, second edition*. London: The Royal College of Radiologists, 2018.
13. The Royal College of Radiologists. *Interventional oncology: guidance for service delivery, second edition*. London: The Royal College of Radiologists, 2017.
14. The Royal College of Radiologists. *Standards for providing a 24-hour interventional radiology service, second edition*. London: The Royal College of Radiologists, 2017.
15. The Royal College of Radiologists. *Standards for providing a seven day acute care diagnostic radiology service*. London: The Royal College of Radiologists, 2016.
16. The Royal College of Radiologists. *Standards for the communication of radiological reports and fail-safe alert notification*. London: The Royal College of Radiologists, 2016.
17. The Royal College of Radiologists. *Standards for the provision of teleradiology within the United Kingdom, second edition*. London: The Royal College of Radiologists, 2016.
18. Royal College of Physicians, British Society of Cardiovascular Imaging and The Royal College of Radiologists (RCR). *Standards of practice of computed tomography coronary angiography (CTCA) in adult patients*. London: The Royal College of Radiologists, 2016.
19. The Royal College of Radiologists. *Standards of practice for trauma radiology in severely injured patients, second edition*. London: The Royal College of Radiologists, 2015.
20. The Royal College of Radiologists. *Cancer MDT meetings – standards for clinical radiologists, second edition*. London: The Royal College of Radiologists, 2014.
21. The Royal College of Radiologists. *Standards for the provision of an ultrasound service*. London: The Royal College of Radiologists, 2014.

Other RCR guidance of relevance to the delivery of imaging and diagnostic services is available from www.rcr.ac.uk/clinical-radiology/publications-and-standards.

Clinical Oncology

1. The Royal College of Radiologists. *Clinical oncology job planning guidance for consultant and SAS doctors 2022*. London: The Royal College of Radiologists, 2022.
2. The Royal College of Radiologists. *Head and neck cancer: RCR consensus statements*. London: The Royal College of Radiologists, 2022.
3. The Royal College of Radiologists. *Postoperative radiotherapy for breast cancer: hypofractionation. RCR consensus statements*. London: The Royal College of Radiologists, 2021.
4. The British Nuclear Medicine Society, the Royal College of Radiologists, the Royal College of Physicians, the Institute of Physics and Engineering in Medicine. *Review of molecular radiotherapy services in the UK*. London: The Royal College of Radiologists, 2021.
5. The Royal College of Radiologists. *Radiotherapy for lung cancer: RCR consensus statements*. London: The Royal College of Radiologists, 2020.
6. The Royal College of Radiologists. *Radiotherapy dose fractionation, third edition*. London: The Royal College of Radiologists, 2019.
7. The Royal College of Radiologists. *Timely delivery of radical radiotherapy: guidelines for the management of unscheduled treatment interruptions, fourth edition*. London: The Royal College of Radiologists, 2019.
8. The Royal College of Radiologists. *Interventional oncology: guidance for service delivery, second edition*. London: The Royal College of Radiologists, 2017.
9. The Royal College of Radiologists. *Radiotherapy target volume definition and peer review – RCR guidance*. London: The Royal College of Radiologists, 2017.
10. The Royal College of Radiologists. *Towards safer radiotherapy*. London: The Royal College of Radiologists, 2008.

Other RCR guidance of relevance to the delivery of oncology services is available from www.rcr.ac.uk/clinical-oncology/publications.

Other national guidance

1. General Medical Council. *Good medical practice*. London: General Medical Council, 2013. *Note: a revised edition is under development at the time of publication of this guidance.*
2. General Medical Council. *Decision making and consent*. London: General Medical Council, 2020.
3. Academy of Medical Royal Colleges. *A framework of operating principles for managing invited reviews within healthcare*. London: Academy of Medical Royal Colleges, 2022.
4. NHS England and NHS Improvement. *Streamlining multi-disciplinary team meetings (Gateway Reference 000590)*. London: NHS England and NHS Improvement, 2020.
5. NHS England and NHS Improvement: www.england.nhs.uk/transforming-imaging-services-in-england/.
6. Welsh Government. *National diagnostic imaging framework*. Cardiff: NHS Wales, 2009.
7. Department of Health. *Strategic Framework for Imaging Services in Health and Social Care*. Belfast: Department of Health, 2018.
8. Department of Health, Social Services and Public Safety. *Framework document*. Belfast: Department of Health, Social Services and Public Safety, 2011.

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