CL1 – The service implements and monitors systems to ensure delivery of the service from referral to discharge from the service.

a. Delivery of an effective imaging service requires collaboration with referrers and others to ensure appropriate imaging and reporting is undertaken within specified timescales. The delivery of imaging pathways should be grounded in current best practice and reflect relevant professional guidance and statutory requirements.

b. Each imaging pathway should outline the processes and procedures necessary for effective delivery, and with clear lines of management and accountability for each stage of the pathway. The pathways should be monitored and regularly reviewed to ensure they are as streamlined and effective as possible. Responsibilities should be communicated to all those involved, both inside and outside the service, and details should be kept up to date.

c. Imaging may be delivered within and outside a radiology service. Wherever the service is delivered, the same requirements apply for patient safety, clinical competence and regulatory compliance. The use of radionuclide pharmaceuticals for therapeutic purposes is beyond the scope of this accreditation scheme.

d. The service should have robust systems in place to ensure that the imaging pathway for all patient groups (including children and vulnerable adults) are actively managed from referral through to discharge from the service, with careful attention to specified, national or locally agreed timescales.

e. Children have clinical needs and priorities which are different from those of adults, and services that image children should ensure that those needs are adequately met. Staff involved in the imaging of children should be aware of any special approaches that may be required and be appropriately trained to recognise and handle these. (See also standard statements CL2, PE4c4, FR2c2 and FR4)

f. Imaging pathways are usually delivered by multidisciplinary teams. The service should participate in multidisciplinary team meetings and care pathway mapping. Input from all staff involved in delivering the pathway, inside and outside the service, should be sought for the development of imaging pathways including that of: medical staff; allied health professionals; nurses; administrative staff; porters; and others. Pathways should adhere to national guidelines and frameworks. Process mapping may be useful in developing pathways co-operatively.

g. An agreed process should be in place to ensure all relevant information is supplied within each referral, including: the patient's name; contact details; date of birth; NHS number; all clinically relevant information; and full contact details for the referrer. An agreed template would be helpful. This may include a registration number or PIN unique to the referrer. Acquiring clinically relevant information from patients should be done in a sensitive manner and in an appropriate environment. Staff should respect patients' knowledge and understanding of their own experience, their own clinical condition, their experience of their illness and how it impacts on their life (see also standard statement PE4).

h. All referrals should be vetted, justified, authorised and prioritised. Vetting ensures that the patient receives the right examination or procedure, with the correct imaging protocols, in the right circumstances. Each referral should be subject to a justification process taking account of clinical indications and the requested imaging modality. Where the examination involves ionising radiation, it must be justified by an entitled IR(ME)R Practitioner or authorised under guidelines issued by the Practitioner, to ensure that the benefits to the patient of each examination or procedure outweigh the risks associated with ionising radiation. The process

must include consideration of alternative modes of imaging and should be in consultation with the referrer and patient. A procedure should be in place for documenting the process in the patient's record and include dealing with requests that are not justified, or for recommending alternative examinations or procedures where appropriate. Referrals should be prioritised to ensure the most urgent cases are dealt with first, to meet specified timescales. Procedures should be regularly reviewed in the light of audit information, safety notifications and developments in clinical practice.

i. Processes should be in place and monitored to ensure that reports, particularly those with critical, urgent or unexpected findings, are communicated to the referrer and patients in accordance with agreed protocols, which should include reporting timescales. Protocols should suggest the most appropriate forms of communication in various situations, and how to respond to patients asking for findings during their examination, particularly if the diagnosis is likely to be bad news. Processes should be in place for prompt referral to a clinician for formal counselling and management following discovery of any unexpected untoward findings.

j. Alterations or amendments to reports should be carried out in accordance with a documented procedure, and should be recorded. Reports should be checked for clinical and grammatical accuracy before authorisation and release.

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