Routine Peer Review by Reporting Radiographers to Embed a Culture of Quality, Continuous Learning & Development at NHSL

Marie Gibson[1], Laura Huxtable[1], Silvia Garcia[2], Sarah Carrigan[3], Siobhan Hibbs[3], Kim Jameson[3], Nicola Tasker[3], Laura Wilson[3]

1 Consultant Radiographer 2 Radiology Information Officer 3 Advanced Practitioner Radiographer

Background

Providing primary diagnostic image reports by specialist trained radiographers (Radiographer Reporting) is established practice within the UK [1]. Radiology "Events" are discrepancies or errors in image reporting which are a recognised entity within reporting practice. However, such events provide valuable learning opportunities for reporters, the service and wider organisation, if captured and acted on appropriately [2]. Robust clinical governance processes are required for a high-quality imaging service [2,3]. Peer review and feedback are cited as essential components for clinical governance of reporting practice at both national and local levels [4,5,6].

Aims

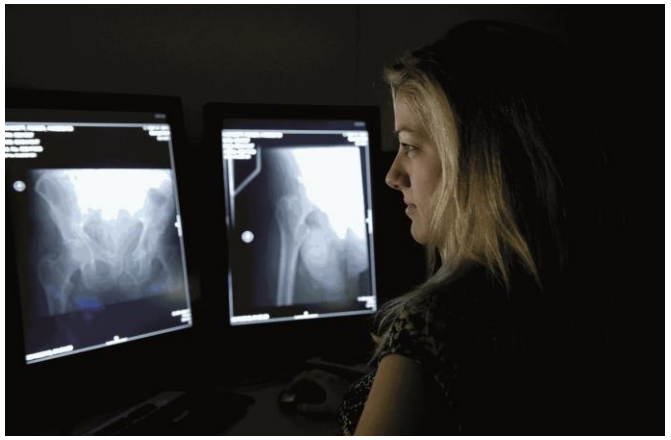
1. Introduce a new process using digital data collection methods to improve efficiency and increase volume of peer review from the baseline of 2% of annual workload
2. Embed a "Business as Usual" routine robust system to assure quality and enable regular feedback, supporting continuous professional development and learning from Radiology Events within the Radiographer Reporting team.

Method

Data reports of individual reporting radiographer (RR) workload are generated on a weekly basis by a Radiology Information Officer using Microsoft Excel. Randomisation is achieved through use of an online random number generator to identify the first report to be reviewed; with 5% of total consecutive data being selected for inclusion.

A new peer review template, introduced as part of this process, is issued to each RR Reviewer with their RR Reviewee's selected data populated into the spreadsheet. Consultant Radiographers ensure adequate time within RR Job Plans to complete peer review each week. This ensures identification of potential false negative (FN) or false positive(FP) discrepancy which may have urgent impact on patient management are discussed between the team and addressed with clinicians in a timely manner.

Weekly feedback on cases is provided to individual reporters allowing any non-urgent report addendums to be completed and communicated; and overall trends are analysed monthly along with outcome measures to inform continuing professional development needs and service planning.



Results

Since the new process was introduced in July 2024, 5% of reporting radiographer activity has been consistently peer reviewed each week, representing an increase of 3% of reports being reviewed when compared to previous years. A total of 2050 reports were reviewed across 6 reporting radiographers (4.4 WTE) who have a total reporting time within job plans equating to approx. 2.64 WTE. Outcome measures from the review demonstrate a team sensitivity of 99.2%, specificity of 99.9% and accuracy of 99.6%, above the national minimum recommendation of 95% accuracy [5}. Whilst individual data may not be reliable at the level of data collected to date, no individual outcome measure was below 97%.

Conclusion and Next Steps

Results for the first quarter show the aims have been achieved - and indicate reporting radiographers in NHS Lothian contribute to a safe, high-quality reporting service as part of a multi-disciplinary team. Despite an increase in volume of activity reviewed the process has been well received by the team due to improved efficiency, ease of use and the opportunity to evidence their impact.

Next steps are to share this project widely (AHPpreciate Event, national conferences and Specialist Interest Groups) and to collate further data each quarter to begin to evidence overall impact of Advanced and Consultant Level Radiographer Practice on Radiology Reporting in NHSL.

Key Drivers, Policy and References

1. Lockwood, P. (2017). Exploring variation and trends in adherence to national occupational standards for reporting radiographers. *Journal of Social Science & Allied Health Professions*, *1*(1), 20-27
2. NHS Lothian (2024). Radiology events and learning, discrepancy, error and candour.
3. Royal College of Radiologists (2018). Standards for interpretation and reporting of imaging investigations. 2nd ed.
4. Royal College of Radiologists and College of Radiographers (2024). Quality standard for imaging.
5. Scottish Clinical Imaging Network (2023). National framework for the musculoskeletal reporting radiographer.
6. NHS Lothian (2024).Independent reporting of radiological examinations by consultant/advanced practitioner radiographers: Policy and related procedures. V2

Team Reflections:

"Routine peer audit allows demonstration of our continued competence. It has also allowed peer learning from feedback and development of report styles across referral sources."

"The peer review audit system has proven a really useful tool for learning, gaining confidence. Overall, a really positive experience, creating a safe space for discussion."