Royal Devon University Healthcare NHS Foundation Trust

Unexpected Significant Radiological Findings

Reference Number: F4678
Date of Response: 29th June 2022

Further to your Freedom of Information Act request, please find the Trust's response, in **blue bold text** below:

Royal Devon's Eastern FOI Office Response

1) I would be most grateful if you would please supply me with the RD&E hospital policy regarding unexpected significant radiological findings.

   Please see the attached policy.

Royal Devon and Exeter NHS Foundation Trust

COMMUNICATION AND ACTIONING OF MEDICAL IMAGING RESULTS POLICY

Post holder responsible for Procedural Document	Medical Director
Author of Policy	Radiology Services Manager
Division/ Department responsible for Procedural Document	Specialist Services/Medical Imaging
Contact details	[redacted]
Date of original document	October 2008
Impact Assessment performed	**Yes**/ No
Ratifying body and date ratified	Safety and Risk Committee May 2021
Review date	November 2023 (every 2 ½ years)
Expiry date	May 2024
Date document becomes live	May 2021

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience	✓	Maintain Operational Service Delivery	
Assurance Framework	✓	Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation**:**		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Draft	
Version	**Date**	**Author**	**Reason**
1.0	September 2008	Ris / Pacs Manager	New Policy, to meet NHSLA Standards
1.1	September 2014	Radiology Services Manager	Revision to reflect changes in Radiology practices
2.0	August 2015	Radiology Services Manager	Revision to reflect responsibility changed to Medical Director for this policy
3.0	September 2016	Radiology Services Manager	Revision to reflect change in Author, turnaround time for Radiology reporting, and timeframe for running verified reports for the Emergency Department as a result of incident investigation findings.
4.0	November 2018	Radiology Services Manager, Diagnostics Cluster Manager, Clinical Lead for Radiology, Governance Manager for Diagnostics	New template. Review to align with associated SOPs for consistency of practice. Minor amends to content for clarity.
4.1	June 2019	Governance Manager for Diagnostics	Updated hyperlinks to reviewed associated SOPs.
5.0	May 2021	Radiology Services Manager	Revision to reflect introduction of Electronic Patient Record

Associated Trust Policies/ Procedural documents:	• SOP for the Requesting of a radiological procedure *(RADP0042)* • SOP for Communication of critical, urgent or unexpected and significant results following reporting *(RADP0051)* • SOP for Medical Imaging reporting *(RADP0029)* • SOP for Performing an X-ray examination *(RAGN0006)* *(Q-Pulse reference numbers for associated documents)*
Key Words	Medical Imaging, X-ray, Communication, Results, Radiology
In consultation with and date: Governance Managers (by email): 30/01/2019 Associate Medical Directors (by email): 30/01/2019 Assistant Directors of Nursing (by email): 30/01/2019 Diagnostics Governance Group: 11/05/2021	
Contact for Review:	Radiology Services Manager
Executive Lead Signature:	**To be added by Policies Administrator when uploading to Intranet**

CONTENTS

KEY POINTS OF THIS POLICY:

THE MEDICAL IMAGING DEPARTMENT WILL

- Ensure Critical and Significant Unexpected results are communicated following reporting, are emphasised in reports and that the degree of urgency for the referrer is clear as defined in Section 3, as described in SOP for Communication of critical, urgent or significant unexpected results following reporting, to alert the Radiology secretaries of the need to contact the requester with the report. As per this SOP, only GP and outpatient imaging reports will be flagged with significant unexpected findings.

- Have agreed policies and Service Level Agreement for the management of those images that will not, by mutual agreement, receive a report (i.e. referrer evaluated), as described in SOP for Radiological Reporting.

- Ensure the 'red dot' system, as described in the SOP for Performing an X-ray examination, is used where ever appropriate.

- Define and communicate Key Performance Indicators (KPIs) for Reporting Turnaround Times.

- Advise patients through leaflets, posters and during attendance, to encourage them to actively seek results and/or to know when and how their results will be communicated to them.

This does not replace the requirement for each referrer to be responsible for reading the result of every investigation they request, and have a robust process in place to ensure the result is received.

Non-communication should not lead to an assumption that the report does not contain findings which may be critical or significant unexpected.

1. INTRODUCTION

1.1 The National Patient Safety Agency issued a notice in 2007 (NPSA16) recommending Trusts set up the policies and procedures required to ensure medical imaging results are communicated and acted upon appropriately.

1.2 This policy describes the standard operational procedures and policies required to ensure that the medical imaging reports of all patients are communicated to and received by the appropriate registered health professional and, where necessary, action is taken in a manner appropriate to their clinical urgency.

1.3 **Failure to comply with this policy could result in disciplinary action.**

2. PURPOSE

2.1 To define the roles and responsibilities when medical imaging is requested and subsequently reported.

2.2 To acknowledge the shared responsibility between referring clinicians and reporters for continuity of care.

2.3 To minimise the risk to patients by significant imaging findings being overlooked although correctly reported.

2.4 To reiterate to referring healthcare professionals the requirement to have in place 'safety net' procedures to ensure a report is received for each request, and that the result/report receives appropriate action.

2.5 To ensure it is clear to patients how and when they should expect to receive the results of a diagnostic test.

3. DEFINITIONS

3.1 **Critical findings:** Where emergency action is required.

3.2 **Urgent findings:** Where medical evaluation is required within 24 hours.

3.3 **Significant Unexpected:** Cases where the reporter has concerns that the findings are important, not expected or cause significant clinical implication and a fail-safe alert should be added to the normal communication method to ensure that they are acted upon urgently.

3.4 **Reporter:** A suitably trained and qualified professional who evaluates an image and provides a written evaluation in the patient record. This may be the Referrer where an agreed Referrer Evaluate Protocol exists.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The **Medical Director** is responsible for:

Ensuring arrangements are in place for the implementation and governance of this policy. The Medical Director is responsible for providing clinical advice on Trust arrangements for radiological report receiving and subsequent actions.

With agreement, setting explicit timeframes for reporting events.

Ensuring each healthcare professional is adequately trained in the use of the systems they are required to use.

Ensuring existing policies and procedures are in place and 'safety net' mechanisms for the management of radiological imaging reports are reviewed and developed, where necessary, to meet the requirements of the safer practice notice.

Considering mandatory use of systems functionality to record such actions where such functionality exists.

4.2 **Entitled Referring Healthcare Professionals** are responsible for:

Having robust systems in place to ensure a report is received for all requested events unless there is a Trust wide agreement of referral evaluation.

Ensuring compliance with the SOP for the Requesting of a radiological procedure. This SOP is available on the Medical Imaging page on the Trust Intranet (HUB).

Ensuring all tests requested are followed up, actioned and filed in the patient's notes. If there is any terminology not understood within the report, referrers must contact the reporter for clarification.

Acknowledging results electronically where such functionality exists. Where the functionality does not exist, the action of having seen the result and responsibility taken for that result should be recorded in the patients' notes.

Considering the ability of clinical systems to 'filter' their patients to aid report tracking.

Using system functionality to record such actions, where such functionality exists.

4.3 The **Medical Imaging department** is responsible for:

Having a clearly defined SOP in place for ensuring the communication of Critical and Significant Unexpected findings to the referring team. Where this is deemed necessary, the communication should be documented.

Ensuring patients are advised of when and how their results will be communicated to them.

4.4 **Reporters** are responsible for ensuring that they comply with, and champion, these procedures.

4.5 **Radiographers/Operators** are responsible for escalating concerns identified at image acquisition.

Radiographers are bound by a Code of Practice that states they should 'communicate appropriately, co-operate and share knowledge and expertise with other practitioners for the benefit of service users'.

4.6 The **Medical Imaging Secretaries** are responsible for communicating the findings to the referring healthcare professional and/or the clinical nurse specialist / MDT co-ordinator as indicated by the reporter, as described in SOP for Communication of critical, urgent or significant unexpected results following reporting

5. THE MEDICAL IMAGING DEPARTMENT

The Medical Imaging Department will:

5.1 Ensure Critical and significant unexpected results are communicated following reporting, are emphasised in reports and that the degree of urgency for the referrer is clear as defined in Section 3, as described in SOP for Communication of critical, urgent or significant unexpected results following reporting, to alert the Radiology secretaries of the need to contact the requester with the report.

5.2 Have agreed policies and Service Level Agreement for the management of those images that will not, by mutual agreement, receive a report (i.e. referrer evaluated), as described in SOP for Medical Imaging Reporting.

5.3 Ensure the 'red dot' system, as described in the SOP for Performing an X-ray examination, is used where ever appropriate.

5.4 Define and communicate Key Performance Indicators (KPIs) for Reporting Turnaround Times.

5.5 Advise patients through leaflets, posters and during attendance, to encourage them to actively seek results and/or to know when and how their results will be communicated to them.

Section 5.0 does not replace the requirement for each referrer to be responsible for reading the result of every investigation they request, and have a robust process in place to ensure the result is received. Non-communication should not lead to an assumption that the report does not contain findings which may be critical or significant unexpected.

6. IT DEVELOPMENT

The implementation of My Care will greatly assist referring clinicians with having the ability to electronically monitor, and acknowledge, imaging results / reports.

7. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the Radiology Services Manager, Medical Imaging. An electronic copy will be maintained on the Trust Intranet, P → Policies → C → Communication. Archived copies will be stored on the Trust's "archived policies" shared drive and will be held indefinitely.

8. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

8.1 To evidence compliance with this policy, the following elements will be monitored:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
Referrer Evaluated Images.	Annual 'Reporting by Other Referrers' audit report	Allocated Registrar will conduct the audit and report through the Radiologist Audit meeting. Non-compliance will be escalated and monitored through Speciality/Divisional Governance Groups.

Reporting Turnaround Times	Annual 'Reporting Turnaround Times' audit report	Allocated Registrar will conduct the audit and report through the Radiologist Audit meeting. Non-compliance will be escalated and monitored through Speciality/Divisional Governance Groups.
Communication of Critical and Significant and unexpected results	Annual 'Significant Findings' audit report	Administrative Line manager will conduct the audit and report to the Diagnostics Speciality Governance Group.

9. ASSOCIATED DEPARMENTAL DOCUMENTS

SOP for the Requesting of a radiological procedure

SOP for Communication of critical, urgent or significant unexpected results following reporting

SOP for Medical Imaging Reporting

SOP for Performing an X-ray examination

APPENDIX 1: COMMUNICATION PLAN

Royal Devon and Exeter NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the ~~strategy~~/policy	All clinical staff who request and undertake radiological imaging
The key changes if a revised policy/~~strategy~~	Revision to reflect changes in Medical Imaging practice. Aligned with SOPs for consistency.
The key objectives	To define the roles and responsibilities when a medical imaging event is requested and subsequently reported. To acknowledge the shared responsibility between clinicians and reporters for continuity of care. To minimise the risk to patients by significant imaging findings being overlooked although correctly reported. To ensure health professionals have in place 'safety net' procedures to ensure a report is received for each request and that result / report receives appropriate action To ensure it is clear to patients how and when they should expect to receive the results of a diagnostic test.
How new staff will be made aware of the policy and manager action	New staff on induction. Current staff ; cascade by email from manager, Trust Intranet 'Must Reads'
Specific Issues to be raised with staff	All Entitled Referring Healthcare Professionals should be made aware of the policy.
Training available to staff	My Care training is delivered centrally via an E Learning package which can be accessed via the Electronic Staff Record (ESR) link on the Trusts Intranet Site. Completion of the E Learning package automatically updates the Trusts ESR.
Any other requirements	None
Issues following Equality Impact Assessment (if any)	No negative impacts, 2 positive impacts
Location of hard / electronic copy of the document etc.	The original of this policy will remain with the Radiology Services Manager, Medical Imaging. An electronic copy will be maintained on the Trust Intranet, P → Policies → C → Communication. Archived copies will be stored on the Trust's "archived policies" shared drive and will be held indefinitely.

APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Communication and Actioning of Radiology Imaging Results Policy
Division/Directorate and service area	Specialist Services/ Medical Imaging
Name, job title and contact details of person completing the assessment	[redacted], Radiology Services Manager
Date completed:	10/05/2021

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

To define the roles and responsibilities when a medical imaging event is requested and subsequently reported.

To acknowledge the shared responsibility between clinicians and reporters for continuity of care.

To minimise the risk to patients by significant imaging findings being overlooked although correctly reported.

To ensure health professionals have in place 'safety net' procedures to ensure a report is received for each request and that result / report receives appropriate action

To ensure it is clear to patients how and when they should expect to receive the results of a diagnostic test.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☐	☒
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☒	☐

Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

None

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it treat everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Age: Elderly patients may assume 'no news is good news' and not want to bother professionals for a result Race: Patients whose first language is not English may struggle to understand how or when they will receive their results if they do not understand what is being explained to them. The Trust has a range of support throughout the Trust for such patients, such as translation services & some patient information leaflets in other languages and there is a willingness to develop more patient information leaflets in different languages

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	None
Issue:	None
How is this going to be monitored/ addressed in the future:	N/A
Group that will be responsible for ensuring this carried out:	N/A