Tameside Hospital NHS
NHS Foundation Trust

Chief Executive Office
Silver Springs
Tameside General Hospital
Ashton-Under-Lyne
OL6 9RW

Our ref: [redacted]
Your ref: [redacted]

Date: 16 January 2015

Private & Confidential
Mr J S Pollard
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Pollard

Harold Penny (Deceased)

I write further to your letter dated 24 November 2014 enclosing a Regulation 28 Report issued at the conclusion of the inquest touching the death of Harold Penny, which took place on 21 November 2014. I am, of course, very sorry that you felt the need to issue this Report. I hope to be able to address the concern, as set out in Section 5 of the report, to your satisfaction in this letter.

1 **There seems to be no system in place to require the Radiology Department either to rectify the situation themselves if that is possible, or to urgently report back to the treating clinicians in a case where, for example, they find that a urinary catheter has become displaced and is causing a blockage.**

The Trust recognises that in a large number of patients radiological imaging plays a pivotal role in both diagnosis and treatment. I entirely agree that it is essential that there is a robust system in place at the Trust which confirms the responsibilities of the referring clinician, the radiologist and the radiology department.

Work is being undertaken in this area at the Trust as part of the Sign up to Safety campaign which was launched by the Secretary of State for Health on 24 June 2014 with a mission to strengthen patient safety in the NHS. A draft 'Radiology Requesting and Reporting Policy' has been produced by the Trust and is currently going through our governance procedures.

A Results Governance Steering Group (RGSG) was also developed in October 2013 and is one of ten project teams that report to the Tameside Hospital Patient Safety Programme Board (PSPB) as part of the 'Keeping patients safe and reducing harm' programme. The RGSG met for the first time on 4 November 2014 and is concerned with ensuring that the Trust has clinical and operational processes to adequately support effective results governance. The scope of this group is to ensure that effective results governance processes are in place to ensure the timely recognition and escalation of abnormal clinical results. The 2014-2015 objectives of this group specifically include improving the standards of results governance from both a report and service delivery perspective. The group has completed an initial review of processes and is now meeting monthly to ensure implementation and continuous improvement.

The draft radiology policy, referred to above, will be reviewed in the Results Governance Steering Group meeting in February 2015. The finalised policy will be brought to the attention of staff by Lead Consultants and will be circulated by way of an 'all acute' email and will be available on the Trust intranet. Staff will receive notification that a new policy has been uploaded to the intranet which they will then be required to familiarise themselves with.

The radiology policy, referred to above, recognises that it is essential that radiologists and all reporting practitioners are provided with the relevant clinical information in order to prioritise and interpret radiological investigations. This, together with reliable and timely communication of results, forms the basis of an effective imaging service. The policy will reinforce the responsibilities of referring clinicians in requesting and acting upon radiological findings in a timely fashion. The purpose of the radiology policy is to provide a clear framework in which this system will operate within the Trust.

The vast majority of radiology investigations are given a formal report that is transcribed on to RIS (Radiology Information System) and, once authorised (approved by the radiologist), is held as a permanent record. Authorised reports are automatically transferred to both EPR (Electronic Patient Record, referred to as 'Lorenzo' at Mr Penny's inquest) and PACS (the Picture Archiving and Communications System) where they can be read hospital wide and acted upon.

The radiology requesting and reporting policy confirms that all radiological investigations constitute part of the permanent patient record, regardless of whether it is formally reported by Radiologists or not. It is mandatory that a record of the investigation, its findings and subsequent action is fully and consistently documented in the patient's notes. The Radiologist provides a report which forms part of the patient's health records unless there is a documented agreement that the images will be reviewed by a referring clinician and reported on by them. The policy will define that a formal radiological report will be issued for any radiological investigation, regardless of its nature, if specifically requested by the referring clinician and providing there is sufficient radiological expertise locally to do so.

I understand that one of the issues explored at Mr Penny's inquest was radiology report turnaround times. The Trust will incorporate recommendations from the RCR Guidelines to ensure robust systems and processes are incorporated into the final document. At the Trust the objective is to report GP, in-patient and Emergency

Department examinations the same day. Where there are urgent findings (where medical evaluation is needed within 24 hours) the expectation will be that these are reported within four hours, the time frame depending on the nature of the imaging findings. Priority is given to inpatients, urgent requests and unexpected significant findings. The Trust's objective is to document significant radiological findings and ensure they are communicated in a timely and unequivocal fashion. The Trust is reviewing its IT infrastructure to ensure this support is in place.

A small proportion of imaging tests will demonstrate significant findings that are unexpected or warrant early action. In Mr Penny's case, the detection of a displaced urinary catheter was unexpected and warranted early action. I confirm that it is the responsibility of the Radiologist, or the performing healthcare practitioner e.g. Consultant/Advanced Practitioner or Sonographer, to ensure that the nature and significance of abnormal findings are clearly stated in the report. I understand that in Mr Penny's case the CT scan report produced on 19 June 2014 did clearly confirm significant distension of the bladder and the misplaced catheter. Advice was given that this should be deflated and a new catheter inserted. If the radiologist recommends further investigation or action this should be communicated effectively to the referring clinician. Again, our policy will ensure that all responsibilities are clearly defined. As confirmed above, a significant unexpected finding, such as the displaced urinary catheter, will warrant specific action. The urgency of the action will depend on the nature of the abnormality. I can confirm that our radiology policy, discussed above, classifies significant findings as:-

1 Critical (red category). Life threatening abnormality where clinical assessment and action is required immediately. Immediate verbal communication with the referring clinician is mandatory at the Trust in the case of critical findings. This is the responsibility of the reporting radiologist or a designated deputy. Communication should be with the Consultant / GP in charge of the case or an alternative senior member of the team. Occasionally communication will be with a junior team member or ward nurse. The policy confirms that it is essential that the significance of the findings is clearly stated and further instruction given where relevant. A record of the communication will be recorded in the radiology report, including the name of the person receiving this information. A record of the communication in the patient's health records is also mandatory and should be dated, timed and legibly signed. This is the responsibility of the person to whom the results are communicated, i.e. the referring clinician, ward doctor or GP. In cases of critical findings the policy will specifically direct that an attempt should be made to contact a senior member of the referring team where possible.

2 Urgent (amber category). Where clinical evaluation is required within 24 hours. Radiology to be reported within 4 hours. The Trust has also recommended to the Radiology Department that where there are urgent findings that they make use of voice recognition software to ensure that the report is given priority typing. The radiologist can then verify them instantly and the report is immediately available electronically to the referring clinician.

3 Unexpected. A finding of this nature will usually not be expected by the referrer or patient. The speed of action and assessment will depend upon the nature of the finding. It may require urgent communication of the findings by the issue of a short code on CRIS (Computerised Radiologist Information System) indicating there is an unexpected finding on the report. Following that alert a medical secretary will then inform the referrer via fax. The Trust has a safe faxing protocol which will be referenced within the policy.

The Radiologists also have a responsibility to ensure that copy reports are sent, where appropriate, to GPs, MDT co-coordinators or specialist nurses, for example lung cancer nurses. This responsibility helps to minimise the risk of important findings not being followed up and acted upon.

As set out above, the policy that we are in the process of ratifying, places a great deal of responsibility with the Radiologists within the Trust. However, it is important to note the responsibilities of the referring clinicians also. It is their responsibility to ensure that they have in place a robust system to enable tracking and follow up of all radiology reports. One of the focus areas of the RSRG is to review frameworks for tracking and follow up of all radiology reports and ensure these are robust. Once received, reports should be legibly signed, dated and filed in a permanent patient record with a clear indication of any action taken following receipt of the report. It is the responsibility of the referring clinician to ensure this takes place and individual systems in place will be subject to regular audit.

Summary

The requesting practitioner has responsibility for:-

1. Ensuring that they are logged in under their name before an electronic request is made.
2. Recording the discussion of the case between a Radiologist and a referrer in the patient's record if a request for imaging is declined to ensure that the record contains a balanced summary of the discussion. This will include the name of the Radiologist, the reason for declining the investigation and any other recommendations offered.
3. Ensuring that the minimum data set for radiology referrals is included on requests.
4. Responding promptly to a request for further information regarding a request for radiological investigation.
5. Discussing the case with a Radiologist if asked to do so by the on call Radiographer.
6. Ensuring the investigation, findings and subsequent action is recorded in the patient record.
7. Reading the report of every radiological investigation they generate.
8. Ensuring that the patient is aware of the follow up arrangements so that results are communicated in a timely fashion.
9. Ensuring that they have in place a robust system to enable tracking and follow up of all outstanding radiological reports.
10. Signing and dating a radiology report and ensuring it is filed in the permanent patient's record with a clear indication of any action taken.

11. Recording the result of an 'out of hours' investigation in the patient record when the on call Radiologist communicates this verbally.

The Consultant in charge of the patient is responsible for:-

1. Ensuring that the person interpreting an unreported radiological investigation is qualified to do so.

The Radiologist involved has the responsibility for:-

1. Ensuring that the referrer is informed that a request for imaging has been declined.
2. Ensuring that the reason for declining a request is documented in the common section of CRIS with the appropriate attendance number.
3. Ensuring the nature and significance of abnormal findings are clearly stated in the report, and any recommendations are clear and unequivocal.
4. Immediate verbal communication of critical findings to the Consultant/GP in charge of the case or an alternative senior member of the team/practice and ensuring a record of the communication is recorded in the radiology report, including the name of the person receiving the information.
5. Recording the result of an out of hours investigation in the patient record wherever possible or communicating the result to a member of the referring team.

The Radiology Department has responsibility for:-

1. Ensuring a robust system for the communication of significant radiological findings using the specified communication process as described above.

I do hope that I have addressed your concern and that I have reassured you of the work that the Trust is currently undertaking in relation to the requesting and reporting of radiology at the Trust in order to prevent the recurrence of a similar set of circumstances in the future.

Should you have any further questions arising from the contents of this letter, please do not hesitate to contact me. I am again sorry that your investigation into this death caused you such significant concern to issue a Regulation 28 Report but I hope that you are now reassured.

Yours sincerely

[redacted]

Karen James
Chief Executive