24 MAY 2019

NHS
The Mid Yorkshire Hospitals
NHS Trust

Your ref: 14342
Our ref: 001.1/KS/VJ
Date: 20 May 2019

Mr J Hobson
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Coroner's Office and Court
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Medical Director
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Dear Mr Hobson

RE: Inquest touching the death of Mr Alfred Howell Regulation 28 Report

On behalf of the Trust, I am truly sorry that you identified areas of concern with regard to the timeliness of reporting in our radiology department. The Trust is committed to continuing to improve our services and the experience of patients.

The matter of concern that you raise was *"that upon the evidence given that the reporting of scans fell outwith an aimed for timescale of 5 days and could impact the treatment of patients in the future"*. Evidence at the inquest did not indicate that this had made any contribution to Mr Howell's death.

Radiology reporting turnaround time has been under pressure for some time now due to rapidly rising demand and limitations of the available trained workforce nationally to deliver the reporting workload. A variety of strategies are in place locally and nationally to manage this pressure such as radiographer reporting and outsourcing to private companies. There are no national standards for radiology reporting turnaround times.

The prioritisation of image acquisition and reporting has to be tailored for different pathways, for example whilst it may be acceptable that outpatient reports are not provided on the day of acquisition this is clearly not acceptable for emergency department patients. As there is no nationally mandated standard for the reporting turnaround of examinations at Mid Yorkshire NHS Hospitals we apply our own guidance on the expected reporting turnaround times of radiology examinations. Different priority is given to different examinations depending on the modality (Xray, CT, MRI, Ultrasound), urgency of the request (as indicated by the referrer) and the referral source e.g. Emergency Department, Inpatient vs outpatient & GP referral. We are also asked to prioritise patients on fast track cancer pathways meaning

patients not on these pathways will wait longer. Clinical teams can contact the radiology department when, due to a deterioration in the clinical condition of a patient, a report becomes more urgent to have it expedited.

The Regulation 28 report indicated an expected report turnaround of 5 days but this is an incorrect figure for the CT examinations requested. Both were requested as routine outpatient priority, to which we set a recommended reporting time of 10 days. Despite this it is acknowledged that, as in the case of Mr Howell, we do not meet this target for every patient. I have attached at appendix 1 the guidance for reporting turnaround times for the different types of examinations.

Reporting turnaround times are a key performance indicator for the radiology department. As such they are monitored internally by the radiology department, divisional management team and reported to the Trust Board. As an organisation we strive to deliver the highest quality healthcare so this focus helps us to reduce the numbers of patients who wait longer than the internal target for an examination report. Given the complexity of the workload and the challenges meeting the reporting turnaround we have a risk management approach to the outstanding reporting. Unreported examinations wait within a prioritised queue with resource prioritised to the strategic objectives of the organisation focussing on acute/clinically urgent and cancer pathways. The routine outpatient work load waits longer to be reported. This clinical stratification of the queue supports the risk management of any reporting backlogs.

The increasing focus on the need to ensure that the reporting turnaround times are not too long has gained traction nationally culminating in a recent CQC report[1] undertaken into the situation. The recommendations of the report are that:

1. *NHS trust boards should ensure that:*
    - 1.1. *they have effective oversight of any backlog of radiology reports*
    - 1.2. *risks to patients are fully assessed and managed*
    - 1.3. *staffing and other resources are used effectively to ensure examinations are reported in an appropriate timeframe.*
2. *The National Imaging Optimisation Delivery Board should advise on national standards for report turnaround times, so that trusts can monitor and benchmark their performance.*
3. *The Royal College of Radiologists and the Society and College of Radiographers should make sure that clear frameworks are developed to support trusts in managing turnaround times safely.*

Until any national standards are published by the National Imaging Optimisation Delivery Board or a clear framework is published by the RCR or SOR the radiology department will continue to work to its current standards. These will be reviewed in light of any national publications.

[1] https://www.cqc.org.uk/sites/default/files/20180718-radiology-reporting-review-report-final-for-web.pdf

I hope this provides clarity on the current situation with regards to radiology reporting turnaround at Mid Yorkshire Hospitals as well as the national context. It also outlines our approach to managing performance and the risk. If you require any further information please do not hesitate to contact me.

Yours sincerely

[redacted]

GMC No: 3455847
Medical Director

Enc. Appendices 1