EMBARGO: 10am on Thursday 18 July 2019
Issued by the Healthcare Safety Investigation Branch (HSIB)

HSIB latest report focuses on technology to reduce risk of x-ray findings getting lost

A report published today by HSIB showcases where technology could play a pivotal role in reducing harm caused by failures in communication or follow-up of unexpected significant radiological findings.

The lack of follow-up or communication of unexpected significant findings can have a serious or life-threatening impact on patients. This was seen in the reference case that informed the investigation. In that event, a 76-year old woman had a chest x-ray showing a possible lung cancer which was not followed up and resulted in a delayed diagnosis. The patient died just over two months after her diagnosis.

The investigation identified that there are multiple opportunities for error in the processes used to communicate unexpected findings; that there are many steps that have to be completed successfully before the patient is informed; and that there is variance in how clinicians receive findings and how they acknowledge receipt of them.

One of the recommendations has been made to **NHSX** to work in conjunction with the **Royal College of Radiologists** to develop an automated, digital notification to inform patients of a significant result to be discussed with them. The notification would be sent within an agreed timeframe to ensure that the vast majority of patients would have received the information by a clinician. However, if the result had become lost in the system for any reason, the notification would provide a vital safety net and ensure the most important person – the patient – was made aware of the result.

Keith Conradi, Chief Investigator commented:

"In this investigation, we recognised the shift in culture towards people having full access to their health information but also the need to balance the personal approach with technological solutions, especially when findings are unexpected.

"In our reference case, the patient's husband expressed his regret at the missed opportunities for his wife. He wanted to be part of our investigation to help prevent the same thing happening again. The organisations and individuals we have worked with on this investigation are all committed to reduce the identified risks, and we are confident our safety recommendations will make a difference for patients across the country."

The investigation also makes three other recommendations in relation to following up unexpected significant radiological findings.

Recommendations in full

- **The Royal College of Radiologists**, working with the Society and College of Radiographers and other relevant specialties through the Academy of Royal Medical Colleges, develops:

- principles upon which findings should be reported as ‘unexpected significant’, ‘critical’ and ‘urgent’,
- a simplified national framework for the coding of alerts
- a list of conditions for which an alert should always be triggered, where appropriate and feasible to do so.

- **NHS England and NHS Improvement’s** patient safety team takes steps to ensure providers are aware of the safety recommendations in this report and act to implement the key findings regarding risk controls such as a monitored acknowledgement system for critical, urgent and unexpected significant findings.
- **NHSX** develops a method of digitally notifying patients of results. This should be used to inform patients of unexpected significant radiological findings after an agreed timeframe. It should be developed in conjunction with the Royal College of Radiologists. The notification system should be tested and evaluated.
- **The Care Quality Commission** amend all appropriate core service frameworks to include risk controls identified in this report to mitigate the risk of significant abnormal findings not being followed up.

The responses to the recommendations will be published on the HSIB website later this year.

ENDS

Media contacts

Please contact media@hsib.org.uk or phone 07710 114191 for interview requests and other queries.

About HSIB

The formation of HSIB is a world-first and represents a landmark moment for the NHS in England. HSIB’s purpose is to help improve safety in the healthcare system by developing recommendations and sharing lessons from investigations. HSIB will improve patient safety through effective and independent investigations that do not apportion blame or liability. More details can be found at www.hsib.org.uk