Barnsley Hospital Quality in Care

Barnsley Hospital NHS
NHS Foundation Trust

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Mrs S L Slater
Assistant Coroner
South Yorkshire (West)
Medico Legal Centre
Watery Street
Sheffield
S3 7ES

Our ref: KST/ RJ
23rd June 2017

Dear Mrs Slater

Re: Mr John Higgs dob 23/5/29 (Deceased)

I am writing in response to your letter dated 10 April 2017 sent to me under the provisions of Regulation 28 of the Coroner's Investigation Regulations 2013, relating to the inquest of Mr John Higgs held on 7 April 2017.

I am grateful for your letter as this has highlighted an area within the Trust in which patient care and safety can be improved.

On 20 April 2017 a meeting took place between [redacted] Interim Medical Director, [redacted] Deputy Medical Director, [redacted] Head of Radiology, [redacted] and General Manager responsible for Radiology and [redacted] Interim Trust Solicitor to review your letter and discuss the actions and response to your concerns in Part 5 of the Regulation 28.

Taking each paragraph in turn of HM Coroner's Concerns at Part 5:

Paragraphs 1 and 2

At the meeting on 20 April 2017 it was established that there is in fact already in existence guidance which covers unexpected or urgent findings and communication of critical or urgent unexpected significant radiological findings. This is called Guidance on Communication of Critical or Urgent or

Unexpected Significant Radiological Findings ("Guidance"). It is unfortunate that this did not come to light at the recent inquest. I apologise to you and to Mr Higgs's family.

We will ensure that the Guidance is re-issued to the relevant clinical staff who have joined our organisation after 2016. We have included the Guidance as the basis of the Patient Safety Bulletin. In addition, the policy and Regulation 28 response will be reviewed and disseminated at the quarterly Quality and Governance Committee which is attended by senior medical , nursing and managerial staff.

By way of background the Guidance came in to existence on 16 January 2012 (EXH 1 and 1A) and was completely re-written and comprehensively updated in October 2015 by [redacted] In line with Trust policy review requirements, this document has been re-reviewed and minor changes made in July 2016 (EXH 3).The versions of the Guidance from January 2012 to date are enclosed and for your information and consideration.

The Guidance essentially sets out in detail how to report incidental radiological findings and in what manner this should be achieved, this local Guidance accords with the Royal College of Radiologists ("RCR") standards for fail safe alert systems documentation which was published in May 2016. HM Coroner's attention is kindly drawn to page 10, Paragraph 4(B) of the guidance.

[redacted] confirms the combination of the new Guidance, advice sought and the electronic reporting systems (ICE) now in place would significantly reduce the risk of a similar incident occurring in the future. The radiologist would be able to flag up a serious incidental finding to the treating clinician for their prompt action.

Paragraph 3

Barnsley Hospital NHS Foundation Trust has reviewed its processes for interpretation and communication of serious but incidental findings, and has considered its processes which are set out above.

It is acknowledged throughout the NHS nationally that there is a problem. We have made contact with other local NHS Trusts and been advised that the prompt review and actioning of the result by clinician's is however an area which may require improvement. The above Guidance has, in line with Royal College of Radiologist standards, improved significantly the reporting of incidental findings. We firmly believe that the measures that we have put in place will significantly reduce the likelihood of future deaths.

As a Trust we realise human error is a factor in many of our processes, we manage those by introducing policies and systems to minimise incidents of this nature occurring. It is clear following our enquires that the potential for human error remains an issue for all NHS Trusts.

Results acknowledgement and/or action is not a local problem unique to Barnsley (or is it unique to the NHS). It is a global issue for which various different methods have been used to try and resolve the problem. Such methods have spanned from using third party applications to administer the two way acknowledgement process (Christchurch Hospital, New Zealand) through to changes in

legislation making it a legal duty of the requesting clinician to acknowledge and act on test results (Ireland and the US). The NHS has neither the resource and technical uniformity to make an electronic workflow fool-proof and does not have a track record of taking action in clear failures of NPSA 16.

There is plenty of commentary online – a couple samples have been selected (and are enclosed) for HM Coroners ease of reference below:

http://www.pacsgroup.org.uk/forum/messages/2/79236.html (EXH 4)

https://www.rcr.ac.uk/posts/patients-risk-lack-systems-communicating-abnormal-imaging-test-results (EXH 5)

In addition RCR's *Standards for the communication of radiological reports and fail-safe alert notification (2016)* which contains 10 recommended standards, and which the Trust is working towards.

https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr164_failsafe.pdf

(EXH 6).

The Trust has asked the NHS Benchmarking Network to consider compliance with implementation of the standards in this year's census.

I hope that the above reassures HM Coroner and the family that whilst the communication of incidental radiological results, and those outside cancer pathologies remains a problem nationally, that the use of ICE and our Guidance will work in tandem to greatly reduce the risk of a future death like Mr Higgs' from occurring again at our hospital.

If I can be of further assistance please do not hesitate to contact me.

Yours sincerely

Rich Jl

Dr Richard Jenkins
Chief Executive

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