Patient safety incident investigation (PSII) report

Incident ID number:	W290270
Date incident occurred:	22nd of September 2023
Report approved date:	25th of January 2024
Approved by:	Debbie Lowe, Director of Nursing – Hull & East Riding 

Distribution list

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About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability, or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks, and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers, and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement

We would like to thank the following primary care colleagues who took the time to explain their systems, processes, and experience of the Radiology reporting system specifically:

- Karen Andrews at James Alexander Family Practice in Hull
- Nicki Dunlop at Marmot Primary Care Network in Hull
- Rebecca Rowe at The Ridings Medical Group in the East Riding of Yorkshire
- Amanda Edwards at Willerby & Swanland Surgery in the East Riding of Yorkshire
- Helen Thompson and Karen Boileau at Modality Hull Division

We also thank Stephen Miller and Barry Fitzsimons at Hull University Hospitals NHS Trust (HUTH) for taking the time to explain how the reporting process works from their perspective and widen this thanks to the staff in the radiology department at Castle Hill Hospital who were present during this visit.

Thanks also to Emma Couch from N3i for providing specialist advice about managing results within the EMIS clinical system.

We are also grateful to Simon Nichols, the Interface Officer at the Humberside Local Medical Committees (LMC) for collecting and sharing feedback from other practices.

Executive summary

Incident overview

On Friday the 22nd of September 2023, an email was sent from the Radiology Department at Hull University Teaching Hospitals NHS Trust to Primary Care GP Practices including Hull, East Riding, North and Northeast Lincolnshire. The email read:

We are aware that notification about the radiology reports being available for these patients has not been sent previously. Please accept this email as notification of this. You are advised to review the report asap via GP browser.

Attached to the email was a file that contained those patients' details. No further information, guidance or context was included. Each practice received the same email however the number of patients within the attached documents varied and were bespoke to the practice involved.

A revised communication was sent by the Trust at the request of the Integrated Care Board (ICB) offering greater context and to confirm that the reports did not contain any urgent significant findings.

This communication resulted in the LMC being inundated by concerns about clinical risk and impact on workload from GP practices. No patient harm has been identified to date.

Summary of key findings

- The non-sending of the radiology notifications was due to a technical issue with the integration between the new radiology system and that used by outsourcing providers IT systems when the HUTH system was implemented in September 2022.
- There was a lack of communication and engagement with primary care from HUTH about the change to the radiology system in September 2022.
- There was a lack of communication from HUTH to primary care that the problem with not sending report notifications was both known and subsequently resolved.
- The radiology system change was an enhancement, pushing reports / results out in real time.
- There is different process for the managing of radiology reports within primary care depending on the clinical system used.
- Some GP practices had not notified HUTH that email addresses had changed to send radiology reports to.
- Some GP practices were not aware of the functionality within their clinical systems to make the process for managing radiology reports as efficient as possible.
- The current process for reporting radiology results works and is in line with national guidance to protect patient safety.
- If the practice has referred the patient to another provider, who have then requested a test, those radiology reports are not shared with the GP practice as they are not the referrer.
- There was a lack of awareness by HUTH about the lack of access to and appropriateness of use of the GP browser portal for accessing radiology results.

Summary of areas for improvement and safety actions

Areas for improvement

- GP Practices to review current processes, including governance, in terms of how radiology results are received to ensure they are safe and as efficient as they can be optimising the functionality within their respective clinical systems.
- GP Practices to review all generic emails / mailboxes to ensure they are monitored or deleted if not required.
- GP Practices to be aware that if a clinician refers to another service who then requests a radiology test, the results will not be received by the practice as they are not the referring clinician for the test. The Result will therefore need accessing via GP Browser by the Practice.
- HUTH to review wording and format of notification emails to ensure wording is suitable and appropriate for Primary Care.
- HUTH To explore an alternative to the Critical Findings emails for patients who do not attend or for rejected referrals.
- For the LMC to share the improvement and safety actions that relate to primary care from the perspective of learning and improvement.
- ICB to develop a summary of the process, including the requirement to acknowledge the critical finding alerts and rational for this, to share with GP practices.

Safety Actions

- For HUTH to explore an integrated system that allows radiology results to be sent directly into primary care clinical systems, whilst still notifying of any critical findings via an alert email requiring acknowledgement.
- For HUTH to ensure it communicates and engages with primary care via the LMC where there are changes to systems that may impact primary care processes and ensure there are robust systems in place.
- Practices to review the contact details, inclusive of email addresses and circulation lists supplied to HUTH for initial and escalation emails and develop a robust process to ensure any changes, including practice mergers, are communicated timely to HUTH.
- To ensure other Trusts and GP practices within the Integrated Care System and wider who are adopting the same process are made aware of the findings from this investigation to allow for safe, robust systems and processes to be put in place.
- To create a collaborative forum, inclusive of HUTH, primary care, the LMC and the ICB and other relevant system partners to enable discussion and work towards solutions of existing and emerging issues.

Contents

Background and context

In October 2022, the Academy of Medical Royal Colleges published the Alerts and Notification of Imaging Reports Recommendations. This had been developed following the publication of the Healthcare Safety Investigation Branch (HSIB) report (2019) - *Failures in communication or follow-up of unexpected significant radiological findings* that highlighted the case of a patient with lung cancer on a chest radiograph that was not reported and acted upon promptly by several different clinical teams leading to delayed diagnosis and poor outcome. The report identified a clear need to address some of the areas of concern regarding the existing result notification system to ensure there are no opportunities for missed or delayed communication and action. To achieve this, the process, and the responsibility to act on abnormal radiology findings needs to be clearly defined and standardised across multiple specialties.

The Academy of Medical Royal Colleges Alerts and Notification of Imaging Reports Recommendations identified the need for a prompt and effective imaging result notification system, in combination with robust audit and governance procedures, is essential to minimise patient harm and improve outcomes. It stated that the system should be practical, sustainable, and reliable and that this requires a collaborative approach among healthcare organisations, the availability and functionality of information technology, funding support, and human oversight. By the adoption of the recommendations outlined in this document will protect patient safety, reduce variations, and move towards a nationally recognised system achievable by all involved.

The principles and recommendations of a Fail-Safe Result Notification System are:

1. Prompt notification of all imaging reports by the Imaging department.
2. Prompt review, acknowledgement, and action on all imaging reports by the referrers.
3. A system to facilitate identification and action of reports which have not been read,acknowledged and acted upon.

Hull University Teaching Hospitals NHS Trust implemented a new Radiology Information System (RIS) in September 2022. It was acknowledged that the Trusts current radiology system was beginning to fail, and the radiology team deployed a solution within six months to ensure that a safe system was in place to protect patient safety.

HUTH outsource radiology reporting to external reporting providers to help support with the increased demand on radiology services and to reduce the reporting time. The outsourcing company have their own radiology reporting systems but communicate the results as per national guidance.

The new RIS resulted in some changes to the old system with some enhanced functionality. The main one being that it replaced a manual batch process for the sending of radiology reports and allowed HUTH to perform this task in real time. The reports are pushed out as soon as they are ready to an email address that is supplied by the GP practice. They are sent as an email with the radiology results included within the body of the email in a report type format. This enabled the prompt notification of all imaging reports by the Imaging department.

The requirement to acknowledge receipt of all urgent significant findings, known as Critical Findings, was seen as a burden on Primary Care. It is perceived as "Secondary to Primary Care work shift" with some practices stating that they will not do it. The Royal College of GP's are part of the AOMRC and should have been aware of the impact and actions in relation to the guidance but as this system change was not communicated effectively locally to primary care, it was not fully understood why practices were then being requested to acknowledge the Critical Finding alert emails. This was a source of frustration for GP practices and seen as an interface issue between the acute trust and general practice. It is best practice to acknowledge the Critical Finding alert emails, from a patient safety and audit perspective, as per national guidance, but it is not enforced by HUTH.

The radiology reports are sent based on the findings:

No significant findings – referred to as 'green' notifications.
The RIS generates a notification, known as a 'green' notification for non-critical findings. This is in the form of an email with the report findings included within the body of the email. These do not need to be acknowledged by the referrer and its purpose is solely to alert a referrer that a report has been completed and is available to view.

Critical findings – referred to and known locally as 'Yellow, Red, Cancer.'
These are known as 'Critical Findings' to notify the referrer that there is something that has been found on the imaging exam that requires immediate attention by the referrer and the need for action by the referring clinician. The referrer is asked to acknowledge receipt of such findings to demonstrate to the Radiology team that the urgency of the report has been understood and that the necessary action will be taken as part of the patient pathway. There is a requirement to acknowledge receipt of the Critical Findings, as per the recommendations from Academy of Medical Royal Colleges (2022) Recommendations, and this is achieved by GP practices sending a 'Reply' email. If the alert is not acknowledged, emails continue to be sent by the RIS. If, after 20 days, the report is not acknowledged, an email is sent to a separate "Escalation email" provided by the GP practice.

As well as sending radiology results via email, all radiology reports once complete are available on "GP Browser" a web-based portal accessed via a smartcard. This gives access to information from HUTH's Patient Administration system "Lorenzo," allowing GP practices to review and download results including as a PDF document should they wish. From a HUTH perspective this provided additional patient safety assurance and resilience regarding abnormal results.

HUTH felt that the Radiology reporting system was a safe and effective way of delivering radiology results to Primary Care in accordance with the Academy of Medical Royal Colleges (2022) Recommendations.

The LMC, on behalf of GP Practices, advised that this incident was a further example of failings with the system adopted by HUTH in September 2022 for communicating Radiology results to GP Practices. Practices had reported continued failings with the system in the form of reports not being received resulting in angry patients and frustrated Primary Care Clinicians. In addition, GP practices observed that the change was introduced without the required consultation.

In July 2019, GP practices formed Primary Care Networks (PCNs), and this resulted in several practices merging and / or working together to manage demand in Primary Care. Other practices merged after this date also. As a result, some of the email addresses associated with GP practices changed.

Description of the patient safety incident

On Friday the 22nd of September 2023, an email was sent from the Radiology Department at Hull University Teaching Hospitals NHS Trust to Primary Care GP Practices including Hull, East Riding, North and Northeast Lincolnshire. The email read:

We are aware that notification about the radiology reports being available for these patients has not been sent previously. Please accept this email as notification of this. You are advised to review the report asap via GP browser.

Attached to the email was a file that contained those patients' details. No further information, guidance or context was included. Each practice received the same email however the number of patients within the attached documents varied.

The LMC Interface Officer contacted the ICB Hull Place Senior Quality & Patient Safety Manager to advise of this communication and that the LMC were being inundated with concerns from practices due to the poor communication that had been received without any prior notice.

The Senior Quality and Patient Safety Manager contacted the Assistant Director of Quality at HUTH to raise the concern and potential risk to patient safety, as it was unclear at that time if any of the reports contained significant clinical findings. HUTH confirmed that none of the reports contained significant findings. No Critical Findings were impacted.

Whilst assurance was provided that the notifications did not contain any Critical Findings, they may still include advice or directives for Primary Care clinicians which had not been received via email and would only be available on GP Browser. For example, to refer to physiotherapy or advice to prescribe medication.

The Hull Place Senior Quality and Patient Safety Manager requested that a revised communication was sent as soon as possible to provide assurance that the notifications did not contain any urgent findings and to be clear what GP practices were required to do. This communication was distributed on the 25th of September 2023 to all GP practices affected. The communication also included an apology for the lack of context and clarity of the original email.

HUTH confirmed that during the period 5th of September 2022 and the 21st of June 2023 9,869 radiology result notification emails had not been sent to practices. A full list of affected patients was sent to every practice with the option of reviewing on GP browser or having the emails pushed out to them. During this same period, a total of 83,019 GP referrals for radiology testing were reported, meaning 11.89% result notifications were affected.

The three GP Practice Groups most affected were:

Practice	Total Number of Results Reported	Number of Reports Not Sent	% Not sent
Holderness Health	6,887	931	13.52%
Modality Hull	7,387	721	12.60%
Ridings Medical Group	4,850	450	19.20%

GP practices expressed concern about the additional workload and resource required to review the list of patients affected and the processing of these. This was raised via the LMC, who requested on behalf of practices for some additional monies / resource to support with this. In addition, concern was also raised by GP practices that this was a 'pull down' and not a 'push out' system potentially increasing the chance of missing patient results.

When the new RIS was implemented, there was an unforeseen gap in the integration between the systems that HUTH and Tele-radiology providers use as part of the outsourcing process. The gap was that the system used by the outsourcing company, the main outsource provider, did not push out the 'green' notification radiology report emails.

There was an expectation by HUTH that even though the radiology report notifications had not been sent, the results were available to review on GP Browser and Practices would do this. The ICB Senior Quality and Patient Safety Manager explained that not all practices have chosen to sign up to request access to GP browser, particularly in North Lincolnshire and North East Lincolnshire and would not know the reports were available to view via GP Browser without the radiology report notification emails.

This issue had first been noted in October 2022, when a GP practice had raised a concern. The issue was resolved by the RIS provider, using HL7 integration, which is a complex integration language, to push the 'green' radiology reports out in the same way as if they had been reported internally. HUTH had not acknowledged the issue or communicated that the issue had been resolved to Primary Care as intended. This had resulted in several Datix incident reports being submitted by primary care detailing the non-receipt of radiology reports following referrals.

The Radiology team had drafted a communication in June 2023 in response to the concerns the LMC had raised with HUTH Contracting Team and were asked to review this by HUTH. The communication outlined the new system and why it was implemented but didn't mention missing radiology results. Because of these factors, the LMC didn't believe the communication contained an appropriate response. The LMC requested a meeting with HUTH to discuss the problems before communication went out. An initial meeting was planned for July 2023 to explore some of the problems as a group, and to gather more information.

The Place Nurse Director and Medical Director from Humber and North Yorkshire ICB Hull & East Riding of Yorkshire Place instructed the Senior Quality and Patient Safety Managers from Hull & the East Riding of Yorkshire to investigate the issue.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:	DL	Place Nurse Director	North Yorkshire & Humber ICB – Hull & East Riding Place
Investigation leads:	LS	Senior Quality & Patient Safety Manager	North Yorkshire & Humber ICB – Hull Place
Investigation leads:	RT	Senior Quality & Patient Safety Manager	North Yorkshire & Humber ICB – East Riding of Yorkshire Place

Summary of investigation process

Following the initial email from HUTH on the 22nd of September 2023 and conversations with Hull Place and the LMC, HUTH reported the incident onto their DATIX risk management system.

The Senior Quality and Patient Safety Managers at Hull & East Riding of Yorkshire place were asked to investigate the incident.

The draft report was shared with key stakeholders for review and comment prior to final sign off by the Place Nurse Director for Hull and East Riding Place, Humber and North Yorkshire ICB.

The safety actions will be monitored via a new forum that is in development as a direct result of this incident. Members include the LMC, Primary care, HUTH and ICB place representatives. The forum will discuss any existing and emerging issues and enable collaborative working towards solutions.

Terms or reference

This investigation will

ToR 1	Determine if the current system of reporting Radiology results to Primary Care by HUTH is safe and reliable?
Key Questions	1. How does the reporting system work? 2. Are results “pushed out” or do practices have to “pull them down”? 3. Are suitable safeguards in place to ensure urgent findings are not missed and acknowledged?
Healthcare Settings	How does the system / process work from a HUTH perspective? How does the system / process work from a Primary care perspective?
ToR 2	Determine if the reporting mechanism can be improved to increase efficiency and effectiveness.

Key Questions	1. Are GP practices managing the reports in the most effective and efficient way? 2. Are there technical or IT solutions to improve the way practices manage the receipt of Radiology results? 3. Could HUTH send the Radiology reports in another format? 4. Could assurance about receipt of urgent findings by Primary Care be done in another way?
Healthcare Settings	SystmOne and EMIS patient administration systems in General Practice Radiology Information System at HUTH
ToR 3	To identify areas for improvement
Key Questions	• What work systems were involved in this incident? • What is the gap between work as imagined / prescribed and work as done? • What were the areas of good practice?
Healthcare Settings	HUTH GP Practices

Information gathering

The ICB Senior Quality and Patient Safety Managers, Hull and the East Riding of Yorkshire Place arranged to visit GP practices to observe their processes in terms of how radiology results are received and processed. Visits were undertaken to both Hull and the East Riding of Yorkshire practices and included practices that used both SystmOne and EMIS clinical systems, as it was acknowledged that the process would differ due to the different system functionality. These visits occurred on the 5th and the 6th of October 2023.

A visit was also arranged to the radiology department at Castle Hill Hospital to understand how the process worked from a HUTH perspective. This visit included primary care, the LMC and ICB representation. The visit took place on the 10th of November 2023.

The visits allowed the opportunity to observe the processes from both an acute and primary care perspective, speak to the staff who manage the processes daily and to see work as done.

HUTH also supplied a list of email addresses they used to send radiology reports for both initial emails and the “Escalation Emails” for review by the Investigators.

Findings

Summary of findings, areas for improvement and safety actions

In this section we will outline the findings based on the Terms of Reference for this investigation.

Is the current radiology reporting system safe & reliable?

The HUTH Radiology reporting system to GP Practices as designed works from a HUTH perspective as it meets the AOMRC guidance requirements in a way that the system it replaced did not because of the ability to send results in real time and it being fully auditable.

The radiology reports are reviewed and reported upon by the radiology team. These are then completed, detailing the findings and any other relevant information and are then “pushed out” in real time by the system to the GP Practices. The reports are sent to the email address supplied to HUTH by GP Practices.

There is a system in place for the RIS to alert GP practices to urgent findings via “Critical Findings” emails which continues to notify the practice until the alert is acknowledged by a reply email. There can, on occasion, be more than one ‘green’ or ‘Critical Findings’ sent for a patient if they have been referred for multiple studies as these are reported separately and this could mistakenly be seen as duplicate reports being received.

If the reply to Critical Findings is not received after 20 days a further email is sent to an “Escalation Email” supplied by the practice flagging up that the urgent result has not been acknowledged. Assuming that the emails are reaching the correct address at the practice, the system is effective from a patient safety perspective.

HUTH had not communicated that there was a problem with the green notifications and that it had been resolved when the issue was first raised in October 2022. This resulted in Datix incidents being reported by primary care for missing reports and triggered the sending of the email and the lists of patients affected.

Some of the missing report notifications that were reported by primary care were from the cohort of the ones affected by this incident. Others were found to be ones that had been referred by another provider, who the primary care clinician had referred the patient to and therefore the reports were sent back to them as the referrer and not the GP practice. Others were found to have gone into GP practice mailbox’s that were not monitored effectively.

Appendix One outlines how the process is designed to work.

Management of radiology results in primary care

From the practices observed as part of the investigation, GP Practices have different ways of handling the radiology report emails depending on practice preference and clinical system in use.

SystmOne has the ability to automate some aspects of the handling via an NHS.net email downloading facility which pulls emails and their attachments into SystmOne workflow for attaching to patient records, coding, and forwarding to clinicians. Some SystmOne practices have supplied the

email address attached to SystmOne for HUTH to send the Radiology reports to take advantage of this facility.

The EMIS system does not have such a NHS.net download facility and GP Practice staff must manually save the Radiology results from NHS.net emails and import them into EMIS before attaching, coding, and forwarding to clinicians. The EMIS practices seemed to be using all the solutions available to them to make the process efficient.

Appendices Two and Three outline the processes for both SystmOne and EMIS systems.

It was identified that some practices were not aware of the ability to save emails as PDF files and instead were printing off the radiology report emails and scanning them before attaching them to clinical records which was time consuming and unnecessary. This observation was linked to one of the concerns raised via the LMC that referenced the need to undertake this process and the additional resource it would require to process the backlog of results. When the paper-based radiology system was replaced by the electronic system in 2016, Hull and East Riding Clinical Commissioning Groups and the LMC distributed detailed information and guidance to GP practices including the requirement to provide correct email addresses to HUTH, how to set up rules in nhs.net emails, and save documents as PDF files to make the new process as efficient as possible.

Some SystmOne practices were not using the rules functionality available within NHS.net emails which would automatically send clinical information from other providers to the NHS email download facility in SystmOne. This meant that the processes were not as efficient as they could be.

Critical Findings

All results that contain a 'Critical Findings' must be acknowledged by replying to the alert email. This demonstrates that urgency of the alert has been recognised by the referrer and necessary action taken.

Both SystmOne and EMIS Practices must manually acknowledge receipt of the "Critical Findings" emails within NHS.net. EMIS Practices can do this as they download and save the results.

SystmOne Practices have different workarounds for this using rules in NHS.net email to forward emails to Admin staff to review and acknowledge if required. It is impossible for SystmOne to automatically "reply" to the emails from HUTH.

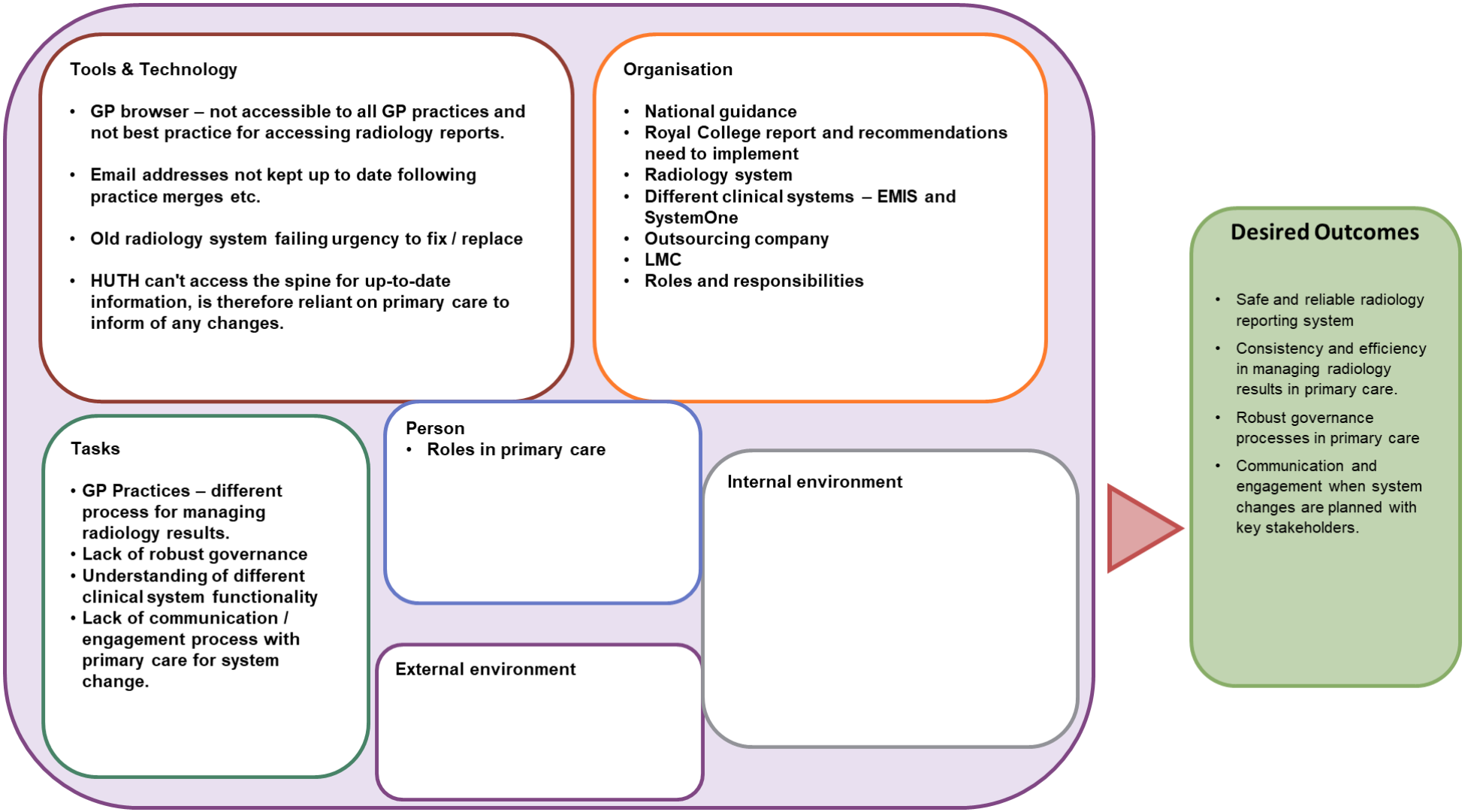
There is no other way at present time of acknowledging receipt of the Critical Findings emails. The system is designed to maximise patient safety with regards to urgent results and this is in line with national guidance.

It was identified that Critical Findings are also sent for patients who do not attend or have had the referral rejected. This has caused confusion for GP practices as they look the same as the Critical Findings for urgent findings. It only becomes clear when reading the notification narrative what it is for. The Critical Findings alert is used to notify practices of a patient who did not attend or that a referral has been rejected to alert the referrer that something needs to be done / action needs to be taken. The patient is passed back to primary care in this way, to ensure acknowledgement and to allow for the appropriate action to be taken to protect patient safety.

Some of the wording within the radiology reports appeared to be written for internal Trust processes and this caused some confusion. For example reference to accessing the Lorenzo system that primary care, do not have access to.

One Practice that was visited stated that prior to September 2022 Radiology results were sent as an attachment and were not included as narrative in the body of the email. This made the results easier to read in SystmOne. It was identified that by including the results in the body of the email was a more efficient process.

Clinical systems are not currently integrated, radiology results cannot be sent direct to SystmOne or EMIS. Although such systems exist for example the Message Exchange for Social Care and Health (MESH) system, and are used in other departments at HUTH, the current process is as effective as it can be now until such that systems are fully integrated. We also acknowledge that some practices have indicated that requesting Radiology tests via the existing ICE system currently used for pathology would be a superior way of managing the Radiology requests from primary care. HUTH have indicated that this is not currently possible, but it has been included as a safety improvement action.


Tools & Technology
• GP browser – not accessible to all GP practices and not best practice for accessing radiology reports.
• Email addresses not kept up to date following practice merges etc.
• Old radiology system failing urgency to fix / replace
• HUTH can't access the spine for up-to-date information, is therefore reliant on primary care to inform of any changes.
Organisation
• National guidance
• Royal College report and recommendations need to implement
• Radiology system
• Different clinical systems – EMIS and SystemOne
• Outsourcing company
• LMC
• Roles and responsibilities
Tasks
• GP Practices – different process for managing radiology results.
• Lack of robust governance
• Understanding of different clinical system functionality
• Lack of communication / engagement process with primary care for system change.
Person
• Roles in primary care
External environment
Internal environment
Desired Outcomes
• Safe and reliable radiology reporting system
• Consistency and efficiency in managing radiology results in primary care.
• Robust governance processes in primary care
• Communication and engagement when system changes are planned with key stakeholders.

Safety action summary table

Area for improvement: Primary Care – Governance / Process / Communication								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.	GP Practices to review the contact details, inclusive of email addresses and circulation lists supplied to HUTH for initial and escalation emails and develop a robust process to ensure any changes, including practice merges, are communicated timely to HUTH.	Practice Manager	April 2024			Annually	Practice	Annually

2.	GP practices to review current processes, including governance, in terms of how radiology results are received to ensure they are safe and as efficient as they can be optimising the functionality within their respective clinical systems.	Practice Manager	April 2024			Annually	Practice	Annually
3.	GP Practices to review all generic emails / mailboxes to ensure they are monitored or deleted if not required	Practice Manager	March 2024					
4.	GP Practices to be aware that if a clinician refers to another service who then requests a radiology test, the results will	Practice Manager	March 2024			Annually	Practice	Annually

	not be received by the practice as they are not the referring clinician for the test. The Result will therefore need accessing via GP Browser by the Practice.							

Area for Improvement: HUTH – Communication / Engagement / Process								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
5.	For an integrated system that allows radiology results to be sent directly into primary care clinical systems, whilst still notifying of any critical findings via an alert email requiring acknowledgement.	Stephen Miller	June 2024					

6.	To review wording and format of notification emails to ensure wording is suitable and appropriate for Primary Care	Stephen Miller	March 2024				HUTH	Annually
7.	To explore an alternative to the Critical Findings emails for patients who do not attend or for rejected referrals	Stephen Miller	March 2024				HUTH	Annually
8.	For the Trust to ensure it communicates and engages with primary care via the LMC where there are changes to systems that may impact primary care processes and ensure there are robust systems in place.	Stephen Miller	March 2024				HUTH	Annually

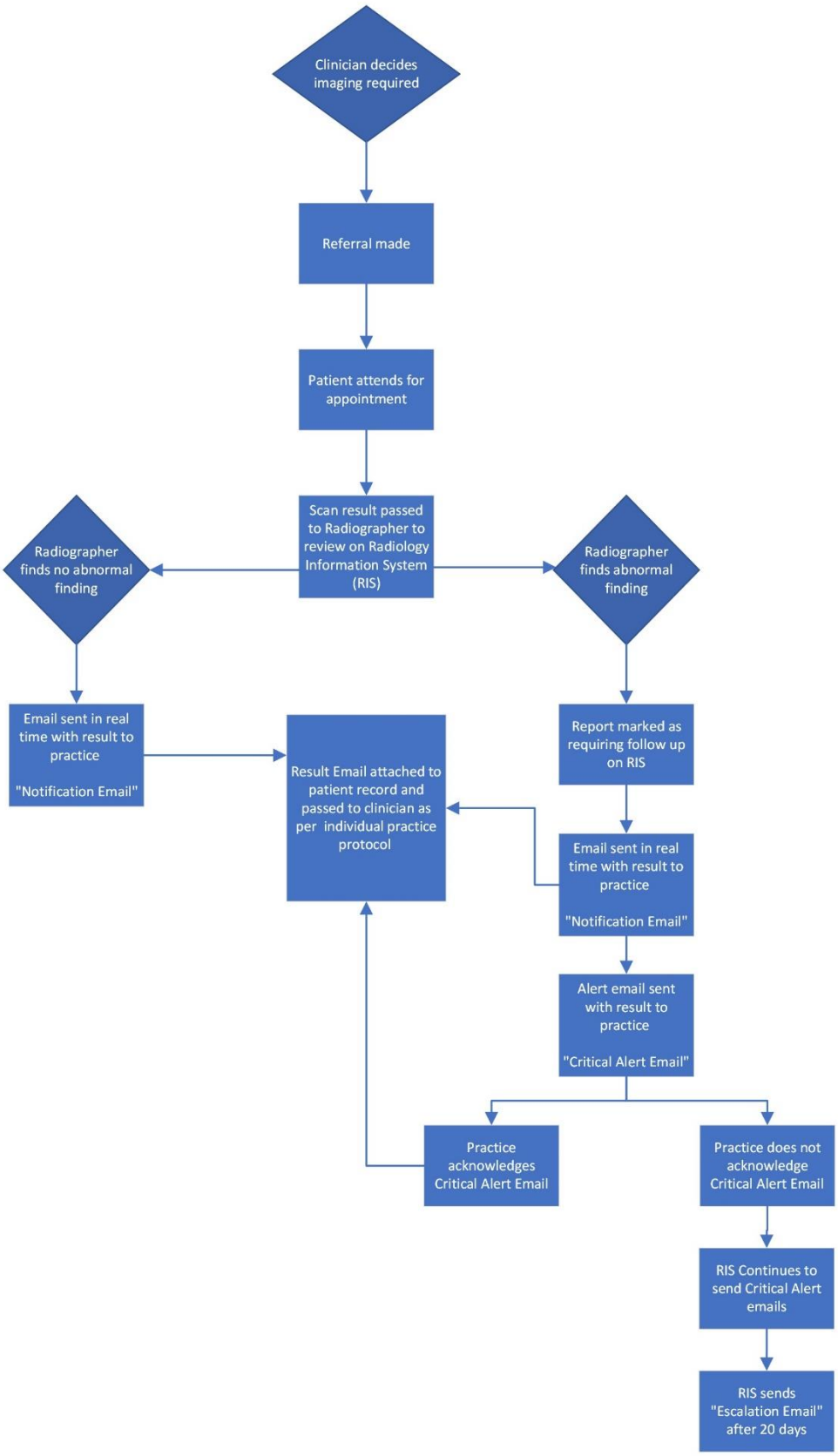
Area for Improvement: ICB - Share Learning / Safety Improvements								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
9.	To ensure other Trusts and GP practices within the Integrated Care System and wider who are adopting the same process are made aware of the findings from this investigation to allow for safe, robust systems and processes to be put in place.	ICB	March 2024				ICB	Annually
10.	To create a collaborative forum, inclusive of HUTH, primary care, the LMC and the ICB and other relevant system partners to enable discussion and	HUTH / ICB	January 2024		Increased awareness	Annually	ICB / HUTH	Annually

	work towards solutions of existing and emerging issues.							
11.	To develop a summary of the process, including the requirement to acknowledge the critical finding alerts and rational for this, to share with GP practices.	ICB Senior Quality and Patient Safety Manager	January 2024		Increased awareness		ICB	N/A

Area for Improvement: LMC - Share Learning / Safety Improvements								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(eg daily, monthly)***	**Responsibility for monitoring/ oversight** ***(eg specific group/ individual, etc)***	**Planned review date** ***(eg annually)***
12.	For the LMC to share the findings, improvement, and safety actions with primary care	LMC	April 2024				LMC	

	from the perspective of learning and improvement.							

Appendix One – Process as Designed to Work



Appendix Two – Importing Results into SystmOne

There is an automated NHS Mail facility on S1 if configured but practices can, if they wish, manage the process manually as per EMIS WEB

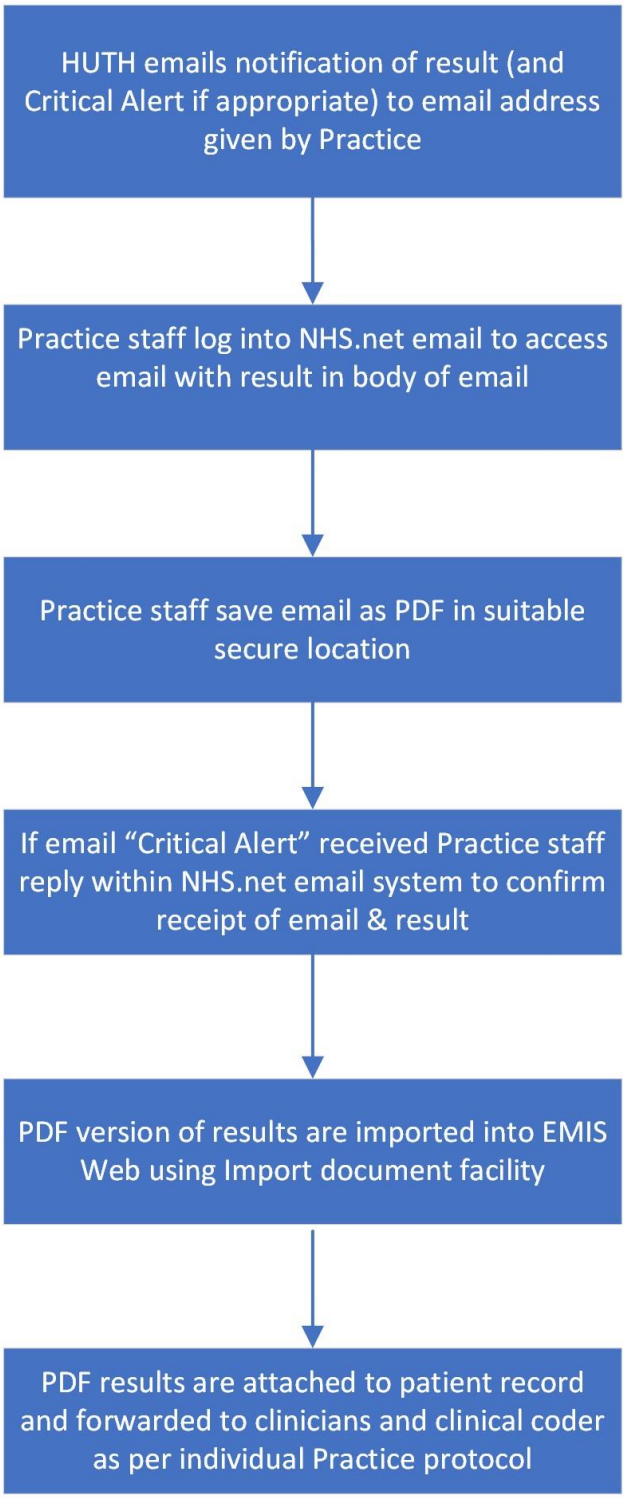
Note Re NHS Mail

There is no function within SystmOne to acknowldge receipt of Critical Alert emails

S1 have either supplied additional email addresses for staff to check receipt and reply to HUTH. Alternatively the "Rules" functionality in NHS.net emails is used to forward the email to another inbox so that the Critical Alerts can be acknowledged

Appendix Three – Importing Results into EMIS Web

There is no automated bulk upload facility – confirmed by two EMIS Web Practices & N3I System Specialist



References

Academy of Royal Medical Colleges (2022) Alerts and Notification of Images: Recommendations. Academy of Medical Royal Colleges. London.

Alerts_notification_imaging_reports_recommendations_1022.pdf (aomrc.org.uk)

Failures in communication or follow-up of unexpected significant radiological findings (hssib.org.uk)

NHS England » Patient Safety Incident Response Framework