Referral, Justification, and Reporting of Radiological Procedures Policy

V2.0

June 2019
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1. Introduction

1.1. The Clinical Imaging Service is bound by legislation regarding the safe and appropriate use of radiation, this is alongside advisory guidance and national standards which inform patient care. The underlying principles of this policy relate to IR(ME)R but have been extended to all imaging modalities.

1.2. This version supersedes any previous versions of this document.

1.3. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net

2. Purpose of this Policy/Procedure

This policy aims to inform all those using the Clinical Imaging Service to ensure safe practice and avoid inappropriate exposure to radiation or strong magnetic fields. The Imaging modalities encompassed by this policy are:

- Plain Film
- CT
- MRI
- Fluoroscopy & Interventional
- Ultrasound
- MRI
- DEXA
- Nuclear Medicine
3. **Scope**
   This policy applies to all those who are referring to and operating within the clinical imaging service.

4. **Definitions/Glossary**
   **Referrer:** Describes the clinician who has met training and governance requirements to request clinical imaging.

   **Practitioner:** Justifies the requests by ensuring net benefit and appropriateness to clinical care.

   **Operator:** Clinician who acquires the imaging.

   **Reporting:** Reporting describes the provision of a clinical opinion through consideration of the medical history, presenting signs and symptoms declared by the referrer, the appropriateness/limitations of the imaging method, and observation and description of normal and abnormal findings to enable the referring practitioner to make an informed decision regarding patient management.

   The Royal College of Radiologists gives the following definitions:
   - **Critical Findings:** Where emergency action is required as soon as possible
   - **Urgent Findings:** Where medical evaluation is required within 24 hours
   - **Significant Unexpected Findings:** Where the reporting practitioner has concerns that the findings are significant for the patient and may be unexpected by the referrer.

5. **Ownership and Responsibilities**
   5.1. **Role of Individual Staff**

   5.1.1. **Referrer:** After a thorough clinical assessment of the patient, the clinician uses their professional judgement to decide if an imaging procedure is required. Referrers must ensure:
   - The correct patient is referred by ensuring the patient’s identification details are accurate
   - Sufficient legible clinical information is provided to enable the request to be justified (abbreviations should not be used)
   - Contraindications to the imaging procedure have been considered (e.g. some pacemakers in MRI, previous numbers of investigations involving ionising radiation especially in children)
• Pre-procedural information is supplied (e.g. eGFR for examinations requiring contrast, clotting parameters for interventional procedures)
• If the patient requires a general anaesthetic during their imaging procedure
• Any additional information or particular requirements are given
• It is the responsibility of the referrer/referring team to read and act upon the result of every investigation it generates
• Where X-rays are involved for the procedure, that the benefits and risks from the X-ray examination are weighed up when requesting the test and should have been discussed with the patient

5.1.2. Practitioner (usually within the Clinical Imaging Department): This individual evaluates the referrer’s request to ensure study is justified, i.e. potential clinical information from study outweighs any risks to demonstrate an overall ‘net benefit’. Risks include radiation, magnetic safety, and those associated with additional procedures such as contrast.

5.1.3. Operator: Undertakes procedure & ensures all clinical information is acquired for a clinical judgement to be made. This person is responsible for ensuring the safety of the patient during the examination, for example during the use of ionising radiation or strong magnetic fields.

5.1.4. Consultant In Charge of Patients Care- Must ensure:
• Any individual interpreting unreported examinations are competent to do
• Any findings of Radiological Examinations are put into the context of the patients management and acted upon
• Reports (verbal and written) are reviewed in a timely manner and where appropriate acknowledged on the maxims system

5.1.5. Reporting Staff (Radiologists & Radiographers): It is the responsibility of the reporting practitioner to ensure that the reports are timely, clear and precise; to clearly document advice on further management or action, where appropriate; and ensure the urgency for action is documented within the content of the report.

5.1.6. Non-medical Referrer’s Line Manager: is responsible for ensuring all Non-Medical referrers are acting within an approved scope of practice (which may be articulated within a protocol or as a job description).
5.1.7. Non-medical Referrer Clinical Supervisor: Is responsible for ensuring the quality of practice offered by the non-medical referrer, including evidence of:

- Competency in clinical assessment
- IRMER/MRI safety training
- Audit of referrals against this document and clinical guidance

6. Standards and Practice

6.1. Referrals to Clinical Imaging

6.1.1. Authorisation to Refer

Only appropriately qualified Health Care Professionals may request imaging procedures.

6.1.1.1. Medical/Dental Practitioner

RCHT recognises any medical or dental practitioner registered with the General Medical Council or General Dental Council as an authorised referrer, provided that practitioner has met the CPD requirements of that body with regard to imaging procedures and examinations. Within the Medical profession, the scope of requesting is as follows:

- F1 and F2 doctors may independently request X-ray examinations only.
- All more complex imaging (including US, CT, MRI and Nuclear Medicine) must be authorised by a middle grade or above. This should usually be after discussion with a named Consultant or following an agreed protocol. In out of hours situations or in an emergency, a Consultant may not be immediately on hand in which case appropriate referrals will be justified prior to Consultant review at a Registrar level. With a routine request, an F1 or F2 grade doctor may put the request on Maxims but must clearly state the name of the Consultant who has seen the patient and made the decision to request.

6.1.1.2. Non-medical/Dental Professionals

RCHT also recognises other health care professionals who are enabled to refer patients. These practitioners must demonstrate the clinical expertise to assess the need for imaging and also meet IR(ME)R training requirements. Practitioners must have imaging referral in their scope of practice/job description and be operating under a Trust approval protocol.

To gain requesting rights, the professional must contact the Imaging Department to:
• Complete a Non-Medical Referrer Application (CI.REF.FORMS.07) which is approved at the Clinical Imaging Clinical Governance Group (CICGG) Meeting
• Develop a referral protocol using a pre-set template to ensure regulatory requirements are met (CI.REF.FORMS.01) which is approved by CICGG and Care Group Governance Group meeting
• Complete IRMER training via ESR 156 Radiation Referrer Online/MRI face to face training alongside clinical training
• Complete Entitlement Form (CI.REF.FORMS.02) and Declaration Form (CI.REF.FORMS.03/04)

6.1.2. **Referral Criteria**
It is a key requirement for the referrer to make appropriate imaging requests and it is a legal requirement for RCHT to establish referral criteria to guide referrers. Further Royal College of Radiologists guidance can be accessed via i-refer, please contact the Imaging department for access information; further information can be found on [https://www.royalcornwall.nhs.uk/services/clinical-imaging/](https://www.royalcornwall.nhs.uk/services/clinical-imaging/)

All referrals should be made in accordance with this document, where there is any doubt the case should be discussed with a Radiologist.

6.1.3. **Factors to Be Considered Before Making a Referral**
Imaging will accept referrals made via:

- Electronic requesting: i.e. Maxims/ordercomms/e-mail
- RCHT request card: Original or fax of original sent directly from GP/referrer: photo/photocopies are not accepted
- RCHT dental referral form
- Letters on headed paper

Referrals made by Non-NHS providers must be on a referral form and must meet the requirements of this policy.

Following an assessment of the patient’s condition and health needs, the referrer must take the following into account when considering imaging:

- Prior imaging - has it been done before? Is an appointment for similar imaging pending?
- Will it influence the patient care? (consider timescale on which examination will be conducted).
- Are supplementary procedures required (e.g. contrast agents, anaesthetics)?
- Are there any contraindications to the procedure?
Female patients: If the imaging procedure involves radiation or strong magnetic fields, can the pregnancy status be confirmed?

MRI referrals: Is the patient safe to be in an environment which uses strong magnetic fields?

6.1.4. **Referral Information**

It will be necessary for the referrer to supply the following information on the request for imaging or an interventional procedure:

- Sufficient patient information to enable identification of the patient; this will be a minimum of 3 identifiers including name, date of birth, NHS number or for outpatients, an address
- Abbreviations should NOT be used unless the fully written version is included with the first use of the abbreviation (Trust Policy to Manage Information and Records)
- Details of the X-rays view(s)/techniques requested which are in keeping with RCR referral criteria
- Sufficient clinical information to enable the Practitioner to justify the procedure
- This must include the background information regarding clinical state and the condition/pathology about which information is sought (e.g. query fracture)
- Referrer name and contact details; it is a legal requirement that referrers are correctly identified. In addition the imaging department may need to contact the referrer urgently with critical or urgent unexpected findings
- Any other information which the referrer deems appropriate including specific needs to be addressed e.g. disability, cultural/religious

6.1.5. **Urgent Referrals**

Urgent referrals must be clearly marked as such on the referral. Time critical referrals (e.g. those requiring imaging within 24-48 hours such as suspected acute cauda equina syndrome) **must** be discussed with a Radiologist. All on-call referrals **must** be discussed with a Radiologist.

6.1.6. **Managing Referrals**

On receipt of a referral the Imaging Administration and Clerical team will process the request. A paper referral will be scanned into the CRIS system to create an
electronic record. The referral will then be managed through the CRIS system as per Imaging Procedures.

6.1.7. **Duplicate Referrals**
If the Imaging service receives duplicate requests (for example the same examination is requested by both a GP and Consultant) the GP referral is cancelled as a duplicate. A comment is added to the Consultant request to ensure a copy of the report is sent to the GP.

6.1.8. **Cancellation of Referrals**
If an examination is no longer required it is the responsibility of the Referrer to inform the Clinical Imaging Admin & Clerical team or the relevant modality. Referrals which do not meet justification criteria or which contain inadequate/ illegible information will be declined. The referrer will be informed of this decision either verbally or in writing.

6.2. **Justification**
Each referral for an imaging procedure must be justified on an individual basis by the Practitioner (usually working within the imaging department). For a request to be justified, the potential benefit from the diagnostic information obtained to assist in diagnosis or management, should outweigh the associated risks. When considering whether a referral is justified, the following factors are considered:

- The availability and findings of previous images
- The specific objectives of the procedure in relation to the history and examination of the patient
- The total potential diagnostic or therapeutic benefit to the individual
- The risks associated with the procedure (e.g. ionising radiation, magnetic field, contrast induced AKI, or specific risks of an interventional procedure.)
- The efficacy, benefits and risk of available alternative techniques having the same objective but involving no, or less risk to the patient
- Whilst requests for theatre/fluoroscopy cases do not need to be added to the electronic referral system, requests made through the theatre booking process will act as the referral/justification i.e. the theatre list will clearly identify cases that require imaging

Further Royal College of Radiologists guidance can be accessed via i-refer, please contact the Imaging department for access information; further information can be found on [https://www.royalcornwall.nhs.uk/services/clinical-imaging/](https://www.royalcornwall.nhs.uk/services/clinical-imaging/)

Justification will be performed by:
- Radiologists
- Approved Radiographers (listed on departmental IRMER register)
To ensure that the investigation has been prioritized with the appropriate urgency code in CRIS (1=routine, 5=urgent, 7=2 week wait, 9=planned)

NB. Non ED/MIU/UTC referrals for X-rays for patients known to have a mechanism of injury relating to trauma must be given a timely appointment e.g. urgency vs routine consideration

6.2.1. **Medico-Legal Exposures**
Imaging procedures purely for medico-legal purposes should be avoided whenever possible. The request should clearly identify that the procedure is requested on medico-legal grounds and provide sufficient information to allow justification.

6.2.2. **Research Trials**
Where the imaging procedure is requested as part of a research trial, this should be clearly indicated on the request accompanied by the trial name. All trials must have approval as per CI.QMS.PPG.03 Protocol for Research involving Clinical Imaging.

6.2.3. **Risks associated with Radiation**
Basic training on radiation health risks is available for referrers on the Trust’s electronic training systems and is provided for some employee groups (e.g. F1/F2 doctors in a classroom session at induction). For ease of reference, the radiation risk tables from these training packages are reproduced in appendix 1.

6.2.4. **Risks Associated with Strong Magnetic Fields**
Strong magnetic fields can pose a serious risk to health and well-being of patients. The use of magnetism in combination with powerful radiofrequencies can damage implanted devices including pacemakers; this damage can be permanent and life threatening. Referrers must ensure patients are ‘MRI Compatible’ in accordance with the MRI Screening Protocol (available on the document library) and state the exact device which is in situ, failure to supply this information will result in the referral being returned to the referrer causing a delay in patient care. The patient must also complete an MRI checklist (available on the Clinical Imaging website). All MRI safety questions in maxims, must be answered accurately at the point of referral.

6.2.5. **Risks Associated with Contrast**
Patients with pre-existing renal disease are more likely to develop complications such as acute kidney injury (AKI) and nephrogenic systemic fibrosis (NSF) as a result of contrast agents administration during some imaging techniques. All referrers must comply with RCHT Clinical Guideline for Avoiding Contrast Induced Nephropathy; further guidance is available at:
There is also a risk of reaction to the contrast agent which is more likely in patients who have had a previous reaction. Any factors which may place a patient at risk of reaction must be communicated to the Imaging team as part of the referral.

6.2.6. **Procedure change at Justification**
Occasionally the type of imaging procedure to be performed is modified or changed. When this occurs, the Practitioner will amend the procedure coding in CRIS. The referrer will not be informed of these amendments prior to the examination. The results sent to the referrer will indicate the request and the actual procedure performed.

6.2.7. **Procedure for Unjustified Referrals**
Where a request does not justify a clinical imaging examination,

- For outpatient requests, the request should be designated as ‘request unjustified’ (‘RU’) in CRIS, and a reason for declining the imaging should be entered in the appropriate box. The administrative team will generate a standard letter using the information given by the radiologist in the ‘request unjustified’ box to inform the referrer that the imaging has been declined. Requests should not be cancelled without informing the referrer. If a request is a 2WW (7) or an Urgent (5) request the referrer should be informed on the day of cancellation by email or telephone contact, in addition to the letter being sent. This task may be delegated to an administrative team member.

- For inpatient requests, the clinical team should be informed that the request has been declined with the reason for refusal, and the member of staff notified should be recorded in the CRIS comments box. This task may be delegated to an appropriate member of staff, e.g. radiographer. Only when the team have been notified and the notification recorded in the CRIS comments box may the examination be cancelled on CRIS.

6.3. **Procedure**
The clinical procedure/examination is performed by a Radiologist, Radiographer, Sonographer, or Assistant Practitioner, named dental nurse working in oral surgery at RCH as per Imaging examination procedure (CI.GEN.PPG.10), the SoR ‘Pause and Check Operator Checklist’ and the specific procedure to be undertaken. All Operators must be acting with a scope of practice which is reflect within training matrixes.
6.3.1. **Pre-Procedural Checks**
- Where there are avoidable risks to the patient, pre-procedural practises apply. These will include but are not exclusive to:
  - Correct patient identification
  - Pregnancy/breast feeding Status
  - Contrast Allergy
  - MRI safety
  - WHO Checklists

6.3.2. **Procedure Deviation**
As part of good clinical governance, most Clinical Imaging procedures have a protocol in place for the team to follow. In some cases, it may be necessary for operator to deviate from this standard, for example:
- Technique to be modified to meet the patient’s needs
- Change in procedure to reflect the patients condition
- Cancellation due to patient condition or compliance

Any deviation from the standard protocol must be recorded in the events comments in CRIS for the reporter to acknowledge within their findings.

All radiation, MRI, and Ultrasound procedures must follow the Society of Radiographers safety checklists which are clearly displayed at the control panel, or for ultrasound in the room.

6.3.3. **Post Processing**
The Operator is responsible for checking the quality of any images produced which includes correct labelling and storage of images. Only when the operator is satisfied the image meets the required standard should the image be released to PACS.

If the Reporter feels the image does not meet these standards, the Imaging quality assurance process should be followed (CI.QMS.PPG.08).

**NB: Non ED/MIU/UTC referrals where the radiographer identifies a significant abnormality that will need immediate management, e.g. Pneumothorax, # NOF or other significant #,… the radiographer must seek advice from ED/MIU/UTC. They must not allow the patient to leave the department as, more than likely; they may need to be admitted. This will need to be documented under ‘Event comment’ on CRIS.**

6.4. **Reporting**
6.4.1. **Reporting Practitioners**
- Consultant Radiologists
- Specialty Registrars at the Peninsula Postgraduate School of Radiology
- Consultant GI Radiographer acting within approved scope of practice (CI.IR.PPG.04 & CI.IR.PPG.01)
- Advanced Practitioner Radiographer. (CI.IR.PPG.02)
- Consultant Breast Imaging Radiographer acting within approved scope of practice (CI.MER.PPG.01)
- Sonographers acting in accordance with local protocols
- Advanced Practitioners (Reporting Radiographers) in X-ray reporting acting within agreed scope of practice (CI.TAG.PPG.07)
- Advanced Practitioners (Film Readers) in Breast Imaging acting within agreed scope of practice
- MRI practitioners to exclude intra orbital foreign bodies

6.4.2. **Structure and Content of Reports**

A report is an assessment of the examination/procedure and may also include advice regarding patient management. According to the Royal College of Radiologists (2006) and local standards. The usual format of reports will include:

- Clinical details
- A description of the findings
- A conclusion or interpretation of findings in the clinical context
- All complex reports should have a conclusion which answers the clinical question in the request
- If an examination is reported in conjunction with another in the same episode, the blank fields should have the following comment ‘Please see report for…’
- No examination fields should be left blank and each should be titled with the examination type
- Reports should adhere to the current trust policy ‘Policy to Manage Information and Records’ and in particular should adhere to standards for abbreviations. These should be kept to a minimum. Healthcare professionals must be aware that an accepted abbreviation within their own clinical field may have a different interpretation in the wider field of clinical care. Each report should be signed with the name of the reporter, their title and a unique professional identifier (e.g. GMC number) at the end of the body of the report

6.4.3. **Quality and Accuracy of Reports**

Each reporting practitioner is responsible for the quality and accuracy of their
work. Reports are generated using voice recognition (VR) or typed directly onto the Computer Radiology Information System (CRIS). It is the responsibility of the practitioner to check accuracy and readability before verifying the report. The report is then released to CRIS, InSight PACS (including InSight Web), MAXIMS and the patient’s GP practice.

Consultant Radiologists are viewed as the experts and all practitioners must refer to them where any doubt exists and a second opinion is needed. Any suspected discrepancy in reporting should be highlighted to the Learning from Discrepancy Lead as part of Imaging Quality Assurance Processes.

Sub-specialities exist within the reporting workforce, those evaluating imaging may seek specialist opinion from those within RCHT or from other NHS organisations.

6.4.4. Initial, Provisional and Unverified Reports

6.4.4.1. Medical/Dental Practitioner Initial Reports

The interpretation of an image by a Non-Radiology reporter whilst the full evaluation is awaited; an example of this is Emergency Department and Minor Injury centres. The individual undertaking the initial evaluation has the responsibility to check the Radiology report and act on any findings, which may include modifying the patients treatment plan. Where there is any discord, this must be discussed with the Radiology Department.

6.4.4.2. Provisional Reports

Provisional reports are provided under two circumstances:

- A critically unwell patient where an urgent report is needed, without reference to previous imaging, and where key indicators are needed to manage the patient, for example in cases of complex trauma. A full report will be issued in due course and the referrer will be informed of any discrepancies by the Reporter.
- A Radiology registrar has drafted a report following complex imaging overnight. A provisional report needs to be checked and confirmed by a Consultant Radiologist. The report will be clearly marked as provisional and an addendum will be added once the report is checked. It is the Radiology registrar and checking Consultant’s responsibility to inform the referrer of any significant changes to the report following review and the exact documentation of this discussion must be recorded on the radiology information system (see section 6.4.7).
6.4.4.3. **Unverified Reports**
Unverified reports are created on the CRIS system, visibility is controlled by permissions on the IT system. Reports will be unverified because the Reporter has not finishing collating their findings or the report requires a second check as part of competency assessment. A Consultant Radiologist has the authority to check and verify reports of all non-medical practitioners.

6.4.5. **Outsourced Reporting**
The Clinical Imaging Service will use 3rd party companies to provide imaging reports where there may be significant delays in patient care. Only UK based companies which hold an agreement with RCHT will be used and a specific reporting list will be created on CRIS. Paediatric imaging must not be outsourced from RCHT.

Outsourcing companies are expected to provide assurance audits on an annual basis.

Any discrepancies in reports will be raised through the datix system and managed accordingly.

6.4.6. **Images Which Do Not Receive Clinical Evaluation by the Imaging Department**
It is a statutory requirement of IR(ME)R that all examinations involving ionising radiation are evaluated in the clinical record, either in the form of a report by a Radiologist or an opinion by another clinician.

6.4.6.1. **Reporting Arrangements in Other Specialities**
By agreement with the relevant clinical specialities the following examinations will not be routinely reported by the clinical imaging department and the clinician's evaluation of the examination will be documented in the patient's clinical record:

- Non-paediatric orthopaedic plain radiographs from Orthopaedic wards, theatres and outpatient clinics including fracture clinic. 
  EXCEPTIONS: chest and abdominal radiographs, requests from Physiotherapist and other non-medical practitioners
- Orthodontic examinations (OPG and occlusal views) requested by the orthodontic department
- All work undertaken in the cardiac cath lab
The referring team can specifically request a Radiologist report on any examination. If this is made at the time of request the examination should be allocated to REFHOT.

6.4.7. **Communication of Findings & Safety Net Procedures**
Each referrer/referring team is responsible for reading and acting upon the result of every investigation they generate (RCR, 2012 & NPSA 2007). It is the responsibility of the Reporter to ensure that the referring clinician or another appropriate member of the clinical team is contacted if they consider that there is any likelihood of unexpected relevant information contained in the report not being acted upon (RCR, 2012).

All reports are constructed in CRIS and once verified, are automatically communicated to the referrer electronically, via the InSight Web, Clinical Care, CRIS and MAXIMS systems; electronic reports are also sent to GPs via the GP link. Paper copies (known as white copies) are currently sent to Consultants based outside of Cornwall and Military Services; however this practice is reducing due to electronic systems.

For reports which contain critical, urgent, or unexpected significant findings, the following additional safety net procedures should be followed, the documentation of these is described in 6.4.8.

6.4.7.1. **Critical Findings**
For immediately life-threatening conditions (e.g. life-threatening intracranial haemorrhage, tension pneumothorax), where emergency action is required as soon as possible, the referring clinician or an appropriate member of their team should be notified directly by telephone or in person.

6.4.7.2. **Urgent Findings**
For true on call/emergency cases the referring doctor has a responsibility to pursue and review the result, given that by definition the patient’s acute management will be determined by the result of the scan e.g. head injury scan from A&E. Nevertheless, for urgent conditions where medical evaluation is required within 24 hours, and, in the clinical judgement of the reporter, there is a concern that the report will not be viewed in a timely manner (e.g. incidental pulmonary embolus discovered on an inpatient CT before a weekend, or on an outpatient referral) the reporter or delegated deputy should notify the referrer/referring team of the report.

6.4.7.3. **Unexpected Significant Findings**
For unexpected findings which do not require an urgent change in management but which are very important for the future care of the
patient. (e.g. incidental lung cancer on CXR performed for an unrelated indication), it is the responsibility of the reporting practitioner or their nominated deputy to bring the report to the referrer/referring team’s attention if, in their clinical judgement, there is a danger that the report will not be viewed in a timely manner. The reporter may recommend the next actions following such a finding (i.e. in this example referral to a chest physician) but must not take responsibility for such referrals or the ordering of further examinations; the accountability lies with the team managing the patient’s care.

The communication of unexpected significant results may be delegated to a member of the Clinical Imaging Administration Team at the judgement of the reporter.

For all MIU referrals with unexpected significant findings, the reporting clinician should take appropriate measures in order to ensure that the patient’s GP is notified.

6.4.8. **Recording Communication Of Results.**
Where results are communicated verbally to the referrer or an appropriate member of their team by the reporter, the telephoned result should be recorded on the report as an addendum, giving the date, time, name and role of the person who received the report.

Where communication of results is delegated to the Clinical Imaging Administration Team, the report should be placed in the ‘Admin Action’ folder on InSight Web, along with a brief description of the action required. The Administration Team log the following details from these actions in an Excel database:

- Patient name
- CR number
- Procedure
- Reporter
- GP/Consultant’s Team/Ward contact details
- Date & time of communication
- PA who made the telephone call
- Any additional comments

A note of the telephone communication is also made in the comments box on the patient’s CRIS record.

6.4.9. **Communicating Findings Directly with the Patient**
The communication of results with the patient must be sensitive and honest.
Results should only be discussed if the images have been fully reviewed and the individual feels competent and it is appropriate to inform the patient including answering any questions regarding on-going care/management.

6.4.9.1. **Copy of Letters to Patients**
All patients letter are on the maxims system which will automatically send a copy to the Patient.

6.4.10. **Reporting Images of the Deceased**
Deceased paediatric patients (17 years and under): investigations must be reported.

Deceased adult patients (aged 18 and over): the investigations will not be analysed. The following statement will be placed with the image(s):

‘*Patient deceased at the time of reporting; if you require these images to be reported please contact the X-ray dept.*’

The department will review images by request.

6.5. **Location and Storage**
All Clinical Imaging reports are held on the Computer Radiology Information System (CRIS) and are available to view on the InSight Web system with the exception of NHS Foetal Anomaly Screening.

6.6. **Adverse Events**
All near miss or adverse events will be reported through the datix system and managed in accordance to Trust processes. Any reports where there is a suspected breach of regulations involve the relevant expert and will be reported to the regulator as appropriate

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6.7. **References**


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7. **Dissemination and Implementation**

The document will be shared via the Documents library and the Clinical Imaging Q Pulse system.

8. **Monitoring compliance and effectiveness**

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9. **Updating and Review**

9.1. All policy documents should be reviewed no less than every three years. Where appropriate, the author may set a shorter review date.
9.2. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.

9.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

9.4. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Referral, Justification, and Reporting of Radiological Procedures Policy V2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>April 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>June 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>June 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Glenda Shaw Imaging Quality &amp; Service Improvement Lead</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 255086</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Policy which describes how referrals are made, imaging is justified, and findings communicated.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Imaging, X-ray, Radiology, MRI, CT, Ultrasound, Interventional, Radiography</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>March 2019</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Policy for the Referral, Justification, and Reporting of Radiological Procedures V1.0’</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>CICGG</td>
</tr>
<tr>
<td></td>
<td>CS Care Group Governance</td>
</tr>
<tr>
<td>Care Group General Manager confirming approval processes</td>
<td>Robin Jones, Clinical Support Care Group Manager</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>N/A</td>
</tr>
<tr>
<td>Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>Kevin Wright</td>
</tr>
<tr>
<td></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical/Clinical Imaging</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>IRMER</td>
</tr>
<tr>
<td>Related Documents:</td>
<td>See reference section</td>
</tr>
<tr>
<td>Training Need Identified?</td>
<td>No</td>
</tr>
</tbody>
</table>
Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2016</td>
<td>1.0</td>
<td>Initial Issue</td>
<td>Naomi Burden Governance &amp; Quality Radiographer</td>
</tr>
<tr>
<td>March 2019</td>
<td>2.0</td>
<td>Amendments to document. Updated IR(ME)R and IRR information</td>
<td>Glenda Shaw Imaging QSI Lead</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy/policy/proposal/service function to be assessed</th>
<th>Referral, Justification, and Reporting of Radiological Procedures Policy V2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Clinical Imaging</td>
</tr>
<tr>
<td><strong>New or existing document:</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>Glenda Shaw</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 252285</td>
</tr>
</tbody>
</table>

1. **Policy Aim***

Who is the strategy/policy/proposal/service function aimed at?

To provide a clear framework to ensure Clinical Imaging processes to comply with IR(ME)R 2017 regulations

2. **Policy Objectives***

As per Policy Aim

3. **Policy – intended Outcomes***

Ensure radiation and other imaging techniques are used to the greatest benefit and the least harm possible through good governance processes

4. **How will you measure the outcome**

Compliance is measured through Imaging governance and audit processes

5. **Who is intended to benefit from the policy**

Staff and patients

6a **Who did you consult with**

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

b). Please identify the groups who have been consulted about this procedure.

None

What was the outcome of the consultation?

N/A
7. The Impact
Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step**

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment/Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td>Adjustments for children included throughout</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male, female, transgender/gender reassignment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Race/ethnic communities/groups</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td>The referrer is asked to relay any information which may affect care in imaging. The staff in imaging are expected to safely adjust procedures to meet patients needs</td>
</tr>
<tr>
<td>Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Religion/other beliefs</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, Heterosexual, Lesbian</strong></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**You will need to continue to a full Equality Impact Assessment if the following have been highlighted:**
• You have ticked “Yes” in any column above and
• No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
• Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  Yes  No  ✓

9. If you are not recommending a Full Impact assessment please explain why.

Not indicated

<table>
<thead>
<tr>
<th>Date of completion and submission</th>
<th>Members approving screening assessment</th>
<th>Policy Review Group (PRG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-05-2019</td>
<td>PRG APPROVED</td>
<td></td>
</tr>
</tbody>
</table>

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust’s web site.