Standards for Radiology Report Turnaround Time KPIs

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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Radiology
Target staff categories	All Radiology staff

SOP Purpose

This document outlines the internally agreed standards for the reporting of Radiology examinations

Date	Amendment	By
24.02.2023	Addition of BPP targets	Deena Smith – Directorate Manager
22.09.2023	Change of format to align to national guidelines released August 23	Andrew Joyce – Clinical Services Manager
22.02.2024	Reformatting -no change to content	Andrew Joyce - Clinical Services Manager
13.03.2024	Reformatting – National TAT's duplicated into WAHT column	Andrew Joyce - Clinical Services Manager

Aim and scope of process

Turnaround time (TAT) in imaging is the interval between an imaging examination and a verified report being made available to the referring clinician. Keeping TATs as short as possible is essential for the timely diagnosis and treatment of patients.

In 2018, the Care Quality Commission's (CQC) review of NHS radiology services in England found variation in TAT for reporting imaging examinations, and a lack of clear national guidance. The Care Quality Commission (CQC) recommended that the NHS England National Imaging Board should produce national guidance for imaging reporting turnaround times.

Since then there have been several important related developments in imaging and diagnostics, including the publication of Diagnostics: recovery and renewal, establishment of community diagnostic centres and changes to the structure of the NHS with the Health and Care Act 2022.

The TAT guidance comes into effect on 9 August 2023. NHS providers, foundation providers and imaging networks should implement reporting against them immediately thereafter.

The expected TATs will act an enabler to help providers hit 62-day and faster diagnosis standards given the clear link between reporting delays and faster diagnosis and treatment for patients.

Below is the new national TAT guidance in England for imaging reporting TATs across clinical pathways, including the maximum timeframe within which all imaging must be reported.

We have also included some additional KPIs, as already agreed and in place at Worcestershire Acute Hospital Trust (WHAT). Some of these relate to Best Practice Pathways (BPPs) and some relate to specific NICE guidance.

About the turnaround times

The guidance seeks to reflect and codify existing best practice in reporting TATs, and while they are new, the TATs should not be unfamiliar or unachievable.

The priority TAT (see below) is that no examination should take longer than 4 weeks to be reported. This maximum timeframe has been set with reference to the current workforce and capacity limitations. The current guidance is considered a stepping stone to more ambitious TATs (e.g. 2 weeks) for consideration in the future.

All imaging departments and networks should aspire to achieve faster TATs than those set in the guidance, where capacity allows. Many units are already doing so. The Diagnostic Imaging Dataset (DID) 2021/22 shows that >84–94% of imaging studies (cross modality) are reported within 2 weeks.

Where this is not currently possible, imaging departments should be improving their reporting infrastructure so that they can deliver a maximum 2-week reporting for all imaging examinations in the near future. This will be achieved through workforce planning, working across imaging networks and developing insourcing models.

The expected TATs depend on the patient's referral pathway. Please note the differential targets according to urgency and referral source set out below.

Imaging departments may have local agreements in place to manage examinations where a written formal radiology report is not required and instead provide a standard automated report. We expect all auto-reported examinations to meet the TAT guidance. Providers will need local processes in place to ensure these examinations are auto-reported without delay.

Imaging reporting TATs

Priority

No verified report should take longer than 4 weeks to be provided after image acquisition, under any circumstance

Any report at risk of taking longer than 4 weeks should be insourced or outsourced, with insourcing preferred (within the imaging department or across the imaging network).

Best practice is to continuously aim for reporting TATs that exceed the guidance through increased efficiency using measures such as:

- subspecialty reporting
- network collaboration

- ring-fenced reporting time for all professional groups who undertake reporting
- optimised digital connectivity for reporters.

Key Staff Responsibilities

Post	Responsibilities
Reporting Monitoring Officer	To ensure all available reporting options have been reviewed. Follow SOP to escalate any un-reported examinations which are likely to breach if capacity not identified
Radiology Directorate Manager	To support Report Monitoring officer and ensure all reporting capacity has been reviewed. Follow process to identify additional reporting capacity, utilising external resources.
Radiology Clinical Service Manager	To support Report Monitoring officer and ensure all reporting capacity has been reviewed. Follow process to identify additional reporting capacity, utilising external resources.
DDOPs	Escalate to Executive Level where appropriate
DM	Ensure update to Div Ops group on a weekly basis
Reporting Radiologist	Ensure that reports are reported within agreed timescales (see below)
CD / Clinical service manager/ DM	Monitor adherence to reporting targets

References

External Documents	Location
NHSE Imaging reporting turnaround times	
Internal Documents	**Location**
• Radiology Reporting Professional Standards	Acute/radiology/directorate/cqc/section 31/documents
• Escalation Process	Acute/radiology/directorate/cqc/section 31/documents
• Escalation Template	Acute/radiology/directorate/cqc/section 31/documents

Systems/ tools & equipment required

- CRIS
- PACS
- PC's

- Radiologist Specialist Reporting (High Definition) screens
- Allocated Reporting time
- Reports to show adherence to internal standards
- Internal monitoring of standards
- Escalation template

Who should use this SOP

- Consultant Radiologists
- All Reporting Radiographers
- Radiology Clinical Service manager
- Superintendent Radiographers
- Directorate Management Team
- Divisional Management Team

When should this SOP be used

This SOP should be used to identify expected reporting turnaround times and to measure reporting standards

Specific process and relevant detailed procedures – including Targets and Measures

TAT by referral category for imaging services

Imaging service	Referral category	National Maximum TAT	WAHT Max TAT
Cross-sectional imaging: – CT, including cone beam CT – MRI	Urgent Inpatients/ED	12 hours, with <4 hours post acquisition of images for ED or acutely unwell inpatients (includes radiologist trainee provisional reports)	<4 hours post acquisition of images for ED or acutely unwell inpatients (includes radiologist trainee provisional reports)

Imaging service	Referral category	National Maximum TAT	WAHT Max TAT
	CT head only for trauma as per NICE guidance for scans required within 1 hour		1 hour report for those with risk factors for an urgent scan as per NICE guidance CG176. <u>Risk Factors.</u> • GCS < 13 on initial assessment • GCS < 15 at 2 hours after injury on assessment in the emergency department • Suspected open or depressed skull fracture • Any sign of basal skull fracture • Post-traumatic seizure • Focal neurological deficit • More than 1 episode of vomiting since the head injury
	CT head for stroke/thrombolysis as directed via the stroke physician or stroke nurse		30 minutes if the patient is for thrombolysis as directed by a stroke team or stroke nurse.

Imaging service	Referral category	National Maximum TAT	WAHT Max TAT
	CT body for full trauma scan (with or without CT head and CT cervical spine) as per TARN guidance Acute Corda-Equina Syndrome (CES) MRI		1 hour (initial survey report within 15 mins – this will be a written scanned in document by in-house radiologist or in the report if a Medica radiologist report < 4 Hrs of request
	Non-urgent Inpatients 7 Day MSCC Pathway	24 hours	24 hours Within 24hrs post scan
	Outpatient faster diagnosis standard cancer pathway (eg, CT Colons, CT Chests, MRI Prostate)	3 days	3 days

Imaging service	Referral category	National Maximum TAT	WAHT Max TAT
	Urgent GP and outpatients	7 days	7 days
	All other routine outpatient and GP studies	28 days	14 days
Plain film	Acutely unwell/ED patients	12 hours, ideally <4 hours during normal working hours (includes radiologist trainee provisional reports)	12 hours, ideally <4 hours during normal working hours (includes radiologist trainee provisional reports)

Imaging service	Referral category	National Maximum TAT	WAHT Max TAT
	Outpatient faster diagnosis standard for cancer pathway	3 days	3 days
	Other inpatients	7 days (clinician should seek a formal report from the imaging department if discharge-dependent)	7 days (clinician should seek a formal report from the imaging department if discharge-dependent)
	Urgent GP/urgent outpatients	7 days	7 days
	Routine GP and outpatients	28 days	14 days
Fluoroscopy, Nuclear medicine and other DEXA	Urgent inpatients	12 hours with <4 hours post acquisition of images for ED or acutely unwell inpatients	12 hours with <4 hours post acquisition of images for ED or acutely unwell inpatients

Imaging service	Referral category	National Maximum TAT	WAHT Max TAT
		(includes radiologist trainee provisional reports)	(includes radiologist trainee provisional reports)
	Non-urgent inpatients	24 hours	24 hours
	Outpatient faster diagnosis standard for cancer pathway (based on the cancer patient tracking list)	3 days	3 days
	Urgent GP and outpatients	7 days	7 days
	All other routine outpatient and GP studies	28 days	14 Days

Imaging service	Referral category	National Maximum TAT	WAHT Max TAT
Ultrasound and Interventional Radiology	All	At the time of examination/ session	At the time of examination/ session

Monitoring

Performance against the expected TATs will form part of the regular DID reporting to NHS England, and we will use this to monitor compliance with the TAT guidance. Through 'use of resources' assessments we will consider this data when making judgements on diagnostic performance.

Where the TATs are not met due to known workforce capacity issues, we will expect providers to show that they are taking sufficient reasonable steps to confirm that available capacity is being used as productively as possible. Gaps in workforce should be addressed where possible by ensuring robust workforce plans include the number of trainee reporting posts required per year to meet demand.

Currently, reporting of most imaging tests already fall within the guidance. Based on data in the DID, which measures time to report in days, in Q4 2021/22 only 1.0% of examinations were reported outside the 4-week TATs.

Initial local monitoring

Local monitoring of compliance against the guidance will be required, with clear escalation routes in place for any reports due to fall outside the TATs (eg escalation to providers executive board and imaging network board).

Acronyms and glossary

Acronyms and glossary	Description
SOP	Standard Operating Process/Procedure
DM	Directorate Manager
CD	Clinical Director
DDOPs	Deputy Divisional Director of Operations
DOPs	Divisional Director of Operations
DMD	Divisional Medical Director

Governance

Continuous improvement and sustainability

Reports will be created and run on a monthly basis for continuous monitoring of reporting times and feedback to Divisional Management Teams via Divisional Performance and Planning meeting. This will ensure continuous sustainability of reporting times.

This document will evolve with the service