LONDON CANCER ALLIANCE

Unexpected Significant Radiological, Endoscopy and Histological Findings

Colorectal Protocol for Reporting

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Contents

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1 Rationale

The Model of Care [1] reported that the majority of newly diagnosed cancers are not found through the two-week referral route, and so there is a need for an appropriate and clear protocol for diagnosticians to act on the receipt of abnormal results when patients have little or no suspicion of cancer. In light of this it recommended that a clear protocol for acting on the receipt of abnormal results in secondary care should be established to reduce delays.

2 Aim

The protocol is aimed at radiology, endoscopy and pathology departments and the colorectal MDTs within each Trust. However, the principles could equally apply to other cancer MDTs with links to these services and should be considered for implementation.

The protocol for reporting of unexpected significant results to the colorectal MDT is illustrated in Appendix 1.

For those patients whose symptoms of cancer are identified in other care pathways, or for those already on the suspected cancer pathway for a particular cancer tumour who are found to have a different or additional cancer tumour(s); early communication of abnormal results or findings of an unexpected suspected cancer to the referring clinician/MDT ensures further required diagnostics are undertaken in a timely manner. It will reduce time taken to treatment and encourage robust communication systems between GPs, patients, their carers and members of the MDT.

Across the LCA cancer patients are monitored via patient tracking lists (PTL) and results are actively sought. The aim is to ensure speedy onward referral by the referring clinician to the colorectal MDT in order to minimise the risk of serious harm to patients resulting from significant imaging, endoscopy or histology findings being overlooked even though they have been correctly reported.

3 Background to Improving Radiology Reporting

The National Patient Safety Agency (NPSA) published the 'safer practice notice 16' in 2007 following receipt of 22 reports where failure to follow up radiological imaging reports led to patient safety incidents, most of which involved fatalities or significant long-term harm. This included recommendations for action by radiology departments and the individual reporting the findings.

The NPSA notice also incorporated recommendations for referrers to:

> *'Ensure systems are in place to provide assurance that requested images are performed… and the results of these are viewed, acted upon accordingly and recorded. It is the referring registered health professional's responsibility to ensure this is followed.'*

4 Definitions

4.1 Definitions of findings from an examination/investigation

If an examination/investigation reveals an abnormality which requires urgent further evaluation or treatment, the radiologist, endoscopist or histopathologist has a duty of care to communicate this to the referring clinician. The date, time and person notified and the means of notification should be clearly stated in the report.

A situation may occur where the results of a test do not constitute an emergency but where there may be adverse consequences for the patient if a significant unexpected finding is not subsequently acted upon. The Royal College of Radiologists[2] categorises these unexpected findings into three groups; critical, urgent and significant unexpected findings with guidance on recommended actions for each. However, it will be a matter of professional judgement on the part of the reporter (which is equally applicable to radiologists, endoscopists and pathologists) when additional steps need to be taken to supplement the normal systems of reporting to referrers.

4.1.1 **Critical findings:** Where emergency action is required as soon as possible

An example of this would be:

- The radiologist/endoscopist/histopathologist contacts the referring clinician/team and informs them of the report findings.
- Out of hours, where the requesting clinician/team is not available, the appropriate on call team should be contacted, who should document the findings and manage the situation appropriately.
- The above communication/action should also be documented in the radiology/endoscopy/histopathology report and include date, time and to whom information was conveyed to.

4.1.2 **Urgent findings:** Where medical evaluation is required within 24 hours

The above example of communication for critical findings would also be applicable in this situation.

4.1.3 **Significant unexpected findings:** Cases where the reporting clinician has concerns that the findings are significant for the patient and are unexpected.

In this group of patients a clear communication protocol to expedite their onward referral/further investigations and definite treatment pathway is recommended (section 5) given newly diagnosed cancer patients are often identified whilst undergoing investigations where there is little or no suspicion of cancer.

5 Protocol for Communication of Unexpected Significant Radiological, Histological and Endoscopy Findings

The LCA Colorectal Pathway Group developed this communication protocol for unexpected significant radiological, histological and endoscopy using findings from an LCA-wide audit in July 2015 of local Trust policy/protocols regarding receipt of abnormal results; and with reference to the Royal College of Radiologists[2] report on standards for the communication of critical, urgent and unexpected significant radiological findings.

5.1 Protocol compliance

This protocol is aimed at radiology, endoscopy and pathology departments and the colorectal MDTs within each Trust. They form part of the LCA Colorectal Cancer Clinical Guidelines and will also form part of the LCA colorectal accreditation scheme upon its completion. Trusts should make available the protocol to all staff involved and put in place a compliance work programme.

5.2 Protocol

The protocol for reporting of unexpected significant results to the colorectal MDT is illustrated in Appendix 1. This is underpinned by the following process:

1. Each clinician or consultant led team referring to diagnostics is responsible for reading and acting on the result of every investigation it generates within 24-48 hours of receipt in the office to ensure treatment plans can be optimally determined.
2. Each NHS Trust should have a clear policy for hospital wide tracking processes of radiology, endoscopy and histopathology reports which are auditable and transparent.
3. Each NHS Trust should have hospital-wide alert systems to highlight or code reports so that they are specifically drawn to the attention of the clinical team and expedite the referral of patients through colorectal cancer pathways. The Royal College of Pathologists[4] recommends this principle, and each NHS Trust should have a clear policy with regards to the above.

6 References

1. NHS Commissioning Support for London, *A model of care for cancer services clinical paper*, 2010
2. Royal College of Radiologists, *Standards for the communication of critical, urgent and unexpected significant radiological findings Second Edition*, 2012
3. Royal College of Pathologists, *Communication of unexpected findings, urgent reports, delayed reports and the use of Alert systems in diagnostic cellular pathology: Guidance from the Royal College of Pathologists*, 2013
4. NPSA Safer Practice Notice 16, *Early identification of failure to act on radiological imaging reports*, 2007

Appendix 1: Protocol for Reporting of Unexpected/Clinically Significant Results to Colorectal MDT