Radiographer Reporting of Chest X-Rays: the benefits of radiographer reporting and a toolkit for its introduction

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1. ACE Context

The ACE programme was established to Accelerate, Coordinate and Evaluate local projects as they implement service improvements aimed at achieving earlier diagnosis of cancers. One cluster of projects within the ACE programme has focussed on streamlining lung cancer pathways from referral to diagnosis. In addition to its Final Report (www.cancer.org/ACE) the ACE Lung Cancer Pathway Cluster has produced a number of associated documents, including this report on radiographer reporting.

ACE has found that the use of radiographer reporting of CXRs can add capacity and quality to an important stage of the lung cancer diagnostic process. This paper demonstrates that the addition of reporting radiographers, as part of the reporting team can improve CXR turn-around times while also maintaining, if not enhancing, the quality of the reporting. The appendices to this paper include practical advice on introducing radiographer reporting and a case study which demonstrates how radiographer reporting can reduce turn-around times and increase the volume of reported examinations.

2. Introduction

The Chest X-Ray (CXR) is normally the first diagnostic test in a lung cancer pathway. It is relatively inexpensive and is only a first step in the process, but it is an important stage nevertheless and requires specialist skills. Approximately 20% of lung cancers are not detected on the initial CXR, partly because of the nature and position of the cancer, but it can also be due to lack of expertise of those reporting the CXR. Thoracic radiologists have the most specialist skills for reporting CXRs but there is a national shortage of radiologists, including thoracic radiologists.

The 2018 radiology benchmarking findings\(^1\) showed a 14% vacancy rate for consultant radiologists and imaging activity has been growing at nearly 6% per annum over the last ten years and will continue to grow according to Horizon Scanning: An evaluation of imaging capacity across the NHS in England, a recent report on imaging capacity commissioned by CRUK.\(^2\)

The shortage of radiologists has a significant impact on lung cancer pathways. A report from the Royal College of Radiologists identified that 230,000 patients were waiting too long for their CXR results and, in February 2016, over 175,000 plain films (CXR) were still

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\(^1\) [http://www.nhsbenchmarking.nhs.uk](http://www.nhsbenchmarking.nhs.uk)

\(^2\) Horizon Scanning: An evaluation of imaging capacity across the NHS in England, 2015
unreported after 31 days. In order to improve outcomes for lung cancer patients the National Optimal Lung Cancer Pathway was developed. Rapid imaging, ideally within a single attendance facilitated by immediate reporting, is recommended as best practice. Diagnostic capacity continues to make these goals challenging.

CXR need to be reported quickly to ensure any patients with worrying results can be followed up quickly. Evidence also shows that delays within the diagnostic pathway can result in poorer outcomes for patients. If the CXR report is delayed, this will then delay the diagnostic process and could have a detrimental impact on the patient’s outcome.

It is also important that those reporting the CXRs have sufficient skill and expertise to pick up anything of concern. In some lung cancer services, the task of reporting CXRs is undertaken by a large number of people which can mean that each reporter is not seeing enough CXRs to maintain their expertise. A recommendation in the full ACE report is that anyone reporting CXRs should report a minimum of 2,000 per annum.

This paper proposes that one way of addressing this staffing challenge is by training and employing more radiographers to report CXRs and including them as key members of the lung cancer team. Fully trained reporting radiographers can add considerable value to an overstretched lung cancer team and increase valuable capacity. This in turn relieves waiting times pressures and achieves earlier diagnosis of lung cancer.

This role should only be undertaken by radiographers who have undergone the necessary academic and clinical training and who then work within a team that includes sufficient skill mix to offer an appropriate level of support. Within this context, radiographer reporting can add a very valuable resource to lung cancer teams.

The focus of this paper is on radiographer reporting of chest X-rays as part of the lung cancer pathway. This is already in place in some parts of England, but ACE believes there is scope for radiographer reporting to be used more widely. The attached papers are intended to provide local lung cancer teams with practical information and guidance about radiographer reporting so they can consider whether it could be useful to progress in their locality. The appendices give information about developing a local business case and include a case study which illustrates the benefits achieved by introducing radiographer reporting at one Trust.

### 3. Important considerations

**Skill Mix and Team Working**

The concept of widening the skill mix of teams is well established in the NHS. Where radiographer reporting has been most successful is in organisations that fully embrace the concept of team working, with radiologists supporting the radiographers, often providing their initial training, contributing to their education and development and providing continuing...

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3 The Royal College of Radiologists. *Diagnostic radiology: Our patients are still waiting ...* London: The Royal College of Radiologists, 2016.
6 [https://www.clinicalradiologyonline.net/article/S0009-9260(17)30536-6/pdf](https://www.clinicalradiologyonline.net/article/S0009-9260(17)30536-6/pdf)
7 Radiologists Royal College of, Radiographers Society and College of. Team working in clinical imaging. 2012 London: Royal College of Radiologists and the Society and College of Radiographers
support and expert opinion. Reporting Radiographer engagement with the respiratory/lung cancer MDTs ensures recognition and acceptance of their role within the team.

A chronic shortage of radiologists, coupled with sustained increases in imaging workload has seen a substantial reporting backlog emerge. Diagnostic capacity is frequently cited as a barrier to improved patient outcomes and streamlined patient pathways, and limits ambitious plans for cancer diagnosis, compounds unrelenting pressures in emergency medicine and hinders improvements in neonatal care. Radiographer reporting has shown to be an effective, efficient and safe way of meeting rising demands. 8

Quality
More research studies would be welcome but those that have been conducted show that fully trained reporting radiographers produce reports that are comparable in quality to those produced by radiologists. 9

A growing body of evidence10,11,12 suggests that radiographer chest X-ray reporting can be successfully implemented in accordance with the joint position of the Royal College of Radiologists and College of Radiographers, with radiographer performance comparable to that of consultant radiologists.13 14

How widespread is radiographer reporting?
Since the 1990s, an increasing number of trained radiographers have been successfully undertaking clinical reporting15,16 including the reporting of CXRs. Current evidence shows significant variability between Trusts, with radiographer providing 3 out of every 4 X-ray reports in some departments and a significant minority where no radiographer reporting occurs17 making a significant contribution to effective and patient-focused service delivery, but this is by no means universal across the NHS.

A survey undertaken by two consultant radiographers estimates that there are between 100 to 150 chest reporting radiographers working across 9 of the 10 English regions 18,19

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9 https://create.canterbury.ac.uk/15847/2/Woznitza.pdf
12 https://www.radiographyonline.com/article/S1078-8174(18)30013-0/abstract
14 https://www.academicradiology.org/article/S1076-6332(18)30177-6/fulltext
16 Price R., Miller L. An evaluation of the impact of implementation of consultant practitioners in clinical imaging. 2010 London: College of Radiographers
17 https://improvement.nhs.uk/resources/model-hospital/
(Appendix a). Of the trusts involved with NHS Benchmarking, 18% of all CXRs were reported by radiographers, again with significant variation between 86% - 0%.20

Commitment to earlier diagnosis
The risk of a delay in diagnosis due to lengthy waiting times from examination to reporting; or worse, failure to diagnose due to no radiology report being undertaken; requires a strategy that will mitigate the risk that is effective and sustainable for the future in the face of increasing demands.

Networking imaging
Networked imaging services can increase the capacity for complex reporting by radiologists without compromising the capacity for reporting plain films by the wider use of reporting radiographers. This will ensure best practice and better outcomes for cancer patients by standardising turn-around times across a wide geographical area, reducing unwarranted variation in practice.

Radiographer curriculum
Education of the radiographers at undergraduate level should include more image interpretation to prepare radiographers for their future career. There needs to be greater access to accredited post-graduate programmes for chest X-ray reporting.

Quality Assurance
The Society and College of Radiographers should work with the Royal College of Radiologists to determine a standard for reporting volumes for radiographers to ensure they are given sufficient time for reporting to maintain their competence.

20 http://www.nhsbenchmarking.nhs.uk
Appendix 1
Implementing Radiographer Reporting

Introduction
This document provides practical information to help providers who want to develop a business case for implementing radiographer reporting.

Understanding demand
Toolkits
This is aimed primarily at demand and capacity modelling for image acquisition but can be used for modelling reporting requirements.

Radiology Imaging System (RIS)
Measuring demand for plain film reporting, however, can be undertaken by specific interrogation of the Radiology Information System (RIS). RIS captures image acquisition activity, which is also representative of the demand for reporting.

To offer a timely report, understanding and quantifying demand on a weekly and daily basis is essential. Analysing monthly or annual demand is useful for retrospective monitoring of activity levels but it is not sensitive enough to plan proactive responsive capacity.

Retrospective analysis of RIS activity can be useful to determine likely future average and maximum demand (allowing for projected annual growth) and identify predictable seasonal variations such as increased demand for CXRs over the winter months and for the increased demand that is generated because of symptom awareness campaigns.

Turn-around Times
It is important to set local standards for reporting turn-around times, although analysis undertaken by the Care Quality Commission found significant variation between Trusts23. These must be realistic and recognise the need to meet national standards24 even if initially these can’t be met.

NHS England Diagnostic Imaging Board suggested standards:

- Urgent cases - Immediate (within 30 minutes)
- Inpatients and A&E - Same working day
- All other cases - By next working day

21 NHS IMAS IST Diagnostic Imaging Model tool-kit Updated 06.07.2015
22 NHS IMAS IST Diagnostic Imaging Demand and Capacity User Guide (Final) G-116 V1.00
All examinations that are unreported outside of the local standard for reporting are defined as the “backlog”. This should not be considered as part of the daily or weekly demand and needs additional resource to be redressed separately.

**Defining the existing capacity.**

There are several stages to understanding the existing capacity for plain film reporting and, more especially, for chest X-ray reporting,

**Job Plans**

Looking at the job plans for each radiologist will help determine if there are specific sessions identified for plain film reporting. If a department has specialist thoracic radiologists their output for reporting chest X-rays might be far greater than a non-chest radiologist and therefore it is incorrect to assume the same level of output for chest reporting for each radiologist; each one must be reviewed individually. Job planning is also an effective way to maximise the contribution of reporting radiographers\(^\text{25}\).

**Outputs**

The RCR have published guidelines\(^\text{26}\) suggesting hourly reporting output but these assume protected/uninterrupted reporting sessions. Using RIS data retrospectively will give a more “real world” idea of what is achievable in a reporting session and will consider other radiologist activity such as checking trainees’ reports, supporting the reporting radiographers etc. which impacts on the radiologist’s productivity.

The capacity gap can then be calculated by subtracting the weekly capacity from the weekly demand data.

**Quantifying the workforce required.**

To ensure a sustainable and reliable service there should be sufficient numbers of reporting radiographers to allow confidence that a consistent service can be delivered without relying on radiologists to cover at short notice. Equally Radiographer Advanced Practitioners, including reporting radiographers, should have an agreed flexible job plan. They should be an addition to the overall radiographic workforce and not used to backfill in the absence of band 5 or band 6 radiographers.

**Productivity**

Some assumptions need to be made regarding productivity. There is currently no professional standard for the expected productivity of reporting radiographers. Experience from sites where radiographer reporting is well established indicates that each reporting radiographer, when fully trained and experienced, will report between 60 and 80 chest examinations per four-hour session.

In addition to time spend reporting, radiographers also need to have time allocated to other activities such as audit, education, image acquisition, attending MDTs, management and leadership. All of these activities are also important to enable them to develop and maintain

\(^{25}\) [https://improvement.nhs.uk/documents/919/Final_AHP_job_planning_FINAL_3a.pdf](https://improvement.nhs.uk/documents/919/Final_AHP_job_planning_FINAL_3a.pdf)

\(^{26}\) RCR Clinical radiology workload: guidance on radiologists’ reporting figures. Royal College of Radiologists; October 2012.
their professional competencies. Annual leave and an allowance for possible sick leave must also be factored in when determining an individual’s likely reporting capacity.

<table>
<thead>
<tr>
<th>Example.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity gap per week</td>
</tr>
<tr>
<td>Number of reports predicted per session</td>
</tr>
<tr>
<td>Number of reporting sessions per rad/week</td>
</tr>
<tr>
<td>The percentage for AL/Sickness cover</td>
</tr>
<tr>
<td>Number of reporting radiographers required.</td>
</tr>
</tbody>
</table>

**Education and Training.**

Developing the radiographer’s skills and knowledge for reporting chest x-rays requires academic underpinning knowledge as well as clinical education and training. This needs to be carried out with a partnership between the clinical department and a university which provides post graduate education accredited by the College of Radiographers. There are currently only four such programmes in England and one in Wales:

- Canterbury Christ Church University (South East)
- Birmingham City University (Midlands)
- University of Bradford (Yorkshire and North East)
- University of Salford (North West)
- Cardiff University (Wales)

Within the clinical department, it is essential that a radiologist mentor is identified to support the radiographers through their training, to be actively engaged in their clinical education and reporting practice. This will include tutorials, observation of practice, report checking, competency assessments and audit of their work. Once the appropriate competencies and governance are in place, experienced reporting radiographers could act in the role of either a mentor or auditor. If there is a lack of radiologist capacity or support within the local department, linking with a Trust where radiographer chest reporting is already established can be very effective.

It is important that reporting radiographers engage in the same Quality Assurance activities as radiologists so their involvement in specialist multidisciplinary meetings, radiology discrepancy processes and routine audit of practice should be established.

There should be a clear policy setting out the scope of practice of the reporting radiographer during training and when independent, this should be underwritten by the organisation to demonstrate that this is accepted practice. The policy should specify any restrictions to practice e.g. particular patient age groups, referral sources etc. that are out of scope. The policy must also include the standard protocols for recalling the patient for further imaging, which may be for technical or clinical reasons. Protocols are also needed for escalating reports where there are urgent or unexpected findings. If the reporting radiographer acts as a Referrer under the Ionising Radiation (Medical Examinations) Regulations 2017 this must be documented in the protocol and in the Employers IR(ME)R 2017 procedures.


28 Department Health; Ionising Radiation (Medical Examination) Regulations 2017
On-going support by the radiologists is vital for discussion and consultation of difficult cases and for continuing professional development.

**Governance and risk management**

The introduction of new roles requires a robust clinical governance process to ensure that any potential risks are understood by the Executive Management Team and that the mitigation of risk is managed effectively both for the benefit of the patient and the organisation. For such change to become sustainable, senior leaders need to support and promote initiatives in new ways of working. Any potential reticence amongst members of the radiology workforce should be alleviated by the Trust taking on the vicarious risk at corporate level, allaying fears at departmental level that any perceived risk resides with them.

**Developing a business case**

Implementing a sustainable reporting radiographer workforce requires investment. Developing the existing team without back-fill will just exacerbate any vacancy situation and result in increased waiting times for examinations or unrealistic work-loads for the radiographers and is therefore counter-productive. The worst-case scenario is that the highly skilled reporting radiographer is then pulled out of reporting to backfill the role of a band 5 radiographer.

Developing the business case for reporting radiographers requires some basic information on the *why, what and how* this will benefit the organisation and the patient.

**Why?**
- Strategic Drivers.
- Examination to report turnaround times (particularly for cancer)
- Risk Management
- 7 day working (diagnostic access is a priority area)
- Evidence base

**What?**
- Data
- Demand, Capacity and Gap
- Support from the wider MDT
- Governance and assurances
- Resources required:
  - Number and grade of staff
  - Additional resources such as workstations and office space, training etc
  - Cost

**Benefits?**
- Improving outcomes for patients
- Avoiding litigation
- Extending 7 day services
- Achieving accreditation; The ISAS standards
- Recruitment and retention of radiographers
- Cost avoidance – out-sourcing, premium rate costs, 7 day/ extended day working to minimise investment in workstations etc.
Bridging the gap

There will be a significant lead-in time between identifying your needs and training the radiographers to full competence, during this time the gap will still exist. Having established the clinical governance and assurances for safe implementation of radiographer reporting through the business case, the use of locum reporting radiographers or for engaging a managed service for radiographer reporting, or for setting up a networked approach, can help with implementation and managing the gap. This should be included in any business case if additional resources are required in the interim. It is unlikely that any single strategy will provide the solution to the short to medium term problem, therefore a combination of strategies will be required.

Networks and Hubs.

Growing your own reporting radiography workforce may not be practical for many reasons: this may be due to the demographics of the department or size of the workload. As the staff-base of reporting radiographers continues to grow in the NHS, the establishment of Hubs or Networks could increase capacity and improve turn-around times for all modalities. An example of where this has been shown to work well is in the East Midlands with an initiative called EMRAD https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/acute-care-collaboration/emrad/

A group of hospitals working together to deliver radiographer reporting across a wide geographical area has the potential to release radiology time from reporting of plain films in their own organisation for reporting CT and MRI studies for a neighbouring Trust. The advances in Picture Archiving and Communications Systems (PACS) and Image Sharing make this approach to fully utilising the skills of the workforce more achievable now than in the past. This could be particularly useful to smaller departments that would struggle to support more than one reporting radiographer. This would lead to a more uniform approach to CXR reporting, and therefore access to lung cancer pathways, within adjacent CCGs regardless of capacity variations within individual hospitals.

Monitoring

Having identified and addressed the capacity gap, there needs to be a system for routine monitoring of the worklist. Based on the reporting turnaround standards, daily reports are needed to along with a standard operating procedure or departmental policy to ensure “report in line” for each of the standards. Beware of carve-out and prioritisation for any individual group of patients: for example, A&E and GP referrals may have a turnaround target of within 24 hours but in-patient and out-patient referrals are within 48 hours which may lead to the risk that the latter will fall behind as the former are prioritised. This needs careful management and a consistent approach by all reporters to prevent “cherry-picking” at the detriment of some patients as this introduces the risk of delayed diagnosis.

As demand for imaging continues to grow, it is essential that the demand/capacity analysis is undertaken regularly at every 12 to 24 months to assess for impact against key metrics; Demand, Reporting Turnaround times, Plain film/chest reporting volumes per session.
Adjustment of radiology job plans to meet the turnaround times for CT and MRI may leave a capacity gap for plain films, plan for this by projecting the increase in demand across all modalities before it happens and increase the workforce before crisis point.

As well as meeting the reporting demand, it is essential that sufficient time is built into job plans for audit. The RCR recommends all departments aim to provide feedback when reviewing previous examinations as part of routine reporting and MDT preparation, this will increase the time required to if this audit standard is to be achieved. Capturing this data can reduce the burden on specific audit sessions. Audit should be part of the reporting radiographers’ role as well as the role of the radiologist.\textsuperscript{14 15}.
Appendix 2

A Case Study:
University Hospitals of North Midlands NHS Trust.

Background
The University Hospital of North Midlands (UHMN) is a large teaching hospital which was created following the merger of the University Hospital of North Staffordshire and Stafford Hospital in 2015. The Imaging Directorate is one of the largest in the UK.

UNNM Imaging Directorate Activity

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Activity</strong></td>
<td>404,904</td>
<td>443,733</td>
<td>476,116</td>
<td>621,835</td>
</tr>
<tr>
<td><strong>Plain Film Activity</strong></td>
<td>202,701</td>
<td>209,915</td>
<td>222,624</td>
<td>292,664</td>
</tr>
</tbody>
</table>

The workforce for reporting activity that was in place in 2012/13 comprised of
- 22 Consultant Radiologists in post
- 2 MSk Reporting Radiographers

Challenges
In 2013 the capacity for reporting was inadequate to meet the demands and recruitment to vacant radiology posts was proving very difficult. The turn-around times from examination to report were very variable with a significant backlog that was over 6 months old.

To manage the demand for reporting general radiographs there was a variety of strategies:
- In-patient general radiographs interpreted by referring clinicians
- A&E general radiographs interpreted by referring clinicians initially with radiology report if the patient was not referred to fracture clinic or admitted to the wards.
- Out-patient reporting was done as and when time allowed, or when requested specifically immediately prior to the patient returning to clinic, or when they were in clinic for their follow-up appointment.
- GP referrals were all reported by a radiologist but could take up to two weeks.

To ensure that the IR(ME)R 2000 regulations were adhered to, the Imaging Directorate undertook and audit of the in-patient reviews and found that not examinations all had formal documentation in the notes; where there was documentation these were variable in accuracy but mainly correct.
There had been some adverse incidents reports of missed diagnosis from A&E and in-patient referrals, these were reviewed by Trust Risk Management Panel where there was a recognition of the lack of capacity in Imaging.

**The Business Case**
The Imaging Directorate undertook a demand and capacity review and quantified the gap in reporting capacity. The Trust had already introduced reporting radiographers but they only undertook a limit scope of musculo-skeletal reporting.

A business case was written for the introduction of more reporting radiographers and to increase the scope of practice to include Chest Reporting Radiographers.

A strategy for dealing with the demand and the backlog in the interim whilst the radiographers were in training was included in the business case.

The benefits that would be realised from the investment were clearly defined and were measurable.

The business case was approved with two separate funds, one for the managing the backlog and interim solution, one for recruiting and training the radiographers. A regular report was requested by the Trust to demonstrate the benefits of radiographer reporting, for both cost efficiency and improved performance in reporting turn-around times.

**Clinical Governance**
The lead thoracic radiologist led the selection of the trainee chest reporting radiographers and worked with Canterbury Christ Church University, to ensure there was a robust clinical education and training programme to support the academic education. The same radiologist acted as mentor, educator and clinical champion for the radiographers. A second thoracic radiologist was identified to carry out the audit of clinical practice before the radiographers were signed off for independent practice.

A policy document was submitted to the Trust Clinical Governance team, this set out the scope of practice for the radiographers and the governance arrangements during training and for when independent practice was achieved.

In addition to introducing Chest Reporting Radiographers, efforts continued to recruit to vacant radiology posts. The directorate also engaged with a Managed Service to bring fully trained reporting radiographers on to site to report on the full range of general radiographic examinations to prevent the backlog increasing whilst the reporting radiographers were in training.

To manage the backlog, significant volumes of general radiographs were sent to two outsourcing reporting companies.

**Outcomes**
The backlog of unreported examinations was managed within the predicted time frame but outsourcing the reporting continued during the training period of the first cohort of chest reporting radiographers (see Chart 1).

The volume of general radiography reporting in-house increased due to the contribution of the reporting radiographers. This was further increased with the development of a second business case to introduce consultant Radiographers who can undertake the entire range of
general radiographer reporting, thus better able to manage the referrals for patients who required examinations of several anatomical areas (see Chart 2).

Chart 1. Managing the backlog.

![Chart 1. Managing the backlog.](image1)

Chart 2. Reporting activity by job role.

![Chart 2. Reporting activity by job role.](image2)
A standard was set for the reporting turn-around times (chart 3) and a monthly statistical report was produced to demonstrate compliance with the standard (chart 4).

**Chart 3. Reporting turn-around standard.**

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Urgency</th>
<th>Request to Exam TAT Target</th>
<th>Exam to Report TAT Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E Attender</td>
<td>3</td>
<td>1 hour (1 Day)</td>
<td>2 Days</td>
</tr>
<tr>
<td>Out Patient (Routine)</td>
<td>1</td>
<td>6 Weeks (42 Days)</td>
<td>7 Days</td>
</tr>
<tr>
<td>Out Patient (Urgent)</td>
<td>3, 7</td>
<td>4 Weeks (28 Days)</td>
<td>3 Days</td>
</tr>
<tr>
<td>In Patient</td>
<td>1 Day (If requestTime &gt; 3pm, 2 Days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Case</td>
<td>1</td>
<td>6 Weeks (42 Days)</td>
<td>7 Days</td>
</tr>
<tr>
<td>Day Case</td>
<td>3, 7</td>
<td>4 Weeks (28 Days)</td>
<td>3 Days</td>
</tr>
<tr>
<td>GP</td>
<td>3, 7</td>
<td>4 Weeks (28 Days)</td>
<td>5 Days</td>
</tr>
<tr>
<td>GP</td>
<td>1</td>
<td>6 Weeks (42 Days)</td>
<td>5 Days</td>
</tr>
</tbody>
</table>

**Chart 4. Turn-around times as at October 2016.**

<table>
<thead>
<tr>
<th>PatientTypeName</th>
<th>TargetTAT</th>
<th>ModalityName</th>
<th>Reported Events</th>
<th>Avg. TAT (Days)</th>
<th>%</th>
<th>Reported Events</th>
<th>Avg. TAT (Days)</th>
<th>%</th>
<th>Total Reported Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E Attender</td>
<td>5</td>
<td>CT</td>
<td>1,354</td>
<td>0</td>
<td>99%</td>
<td>11</td>
<td>11</td>
<td>1%</td>
<td>1,365</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MRI</td>
<td>56</td>
<td>0</td>
<td>95%</td>
<td>3</td>
<td>14</td>
<td>5%</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plain Film</td>
<td>7,014</td>
<td>1</td>
<td>99%</td>
<td>40</td>
<td>7</td>
<td>1%</td>
<td>7,054</td>
</tr>
<tr>
<td>A &amp; E Attender Total</td>
<td></td>
<td></td>
<td>8,424</td>
<td>1</td>
<td>99%</td>
<td>54</td>
<td>8</td>
<td>1%</td>
<td>8,478</td>
</tr>
<tr>
<td>GP Direct Access Patient</td>
<td>5</td>
<td>CT</td>
<td>61</td>
<td>1</td>
<td>28%</td>
<td>157</td>
<td>13</td>
<td>72%</td>
<td>218</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MRI</td>
<td>57</td>
<td>1</td>
<td>29%</td>
<td>133</td>
<td>12</td>
<td>73%</td>
<td>190</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plain Film</td>
<td>4,438</td>
<td>3</td>
<td>94%</td>
<td>264</td>
<td>6</td>
<td>6%</td>
<td>4,702</td>
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<tr>
<td>GP Direct Access Patient Total</td>
<td></td>
<td></td>
<td>4,556</td>
<td>3</td>
<td>89%</td>
<td>554</td>
<td>9</td>
<td>11%</td>
<td>5,110</td>
</tr>
<tr>
<td>In Patient</td>
<td>3</td>
<td>CT</td>
<td>1,494</td>
<td>0</td>
<td>99%</td>
<td>18</td>
<td>7</td>
<td>1%</td>
<td>1,512</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MRI</td>
<td>323</td>
<td>0</td>
<td>93%</td>
<td>23</td>
<td>10</td>
<td>7%</td>
<td>346</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plain Film</td>
<td>3,270</td>
<td>2</td>
<td>78%</td>
<td>914</td>
<td>5</td>
<td>22%</td>
<td>4,184</td>
</tr>
<tr>
<td>In Patient Total</td>
<td></td>
<td></td>
<td>5,087</td>
<td>1</td>
<td>84%</td>
<td>955</td>
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<td>21</td>
<td>CT</td>
<td>883</td>
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<td>75%</td>
<td>297</td>
<td>31</td>
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<tr>
<td>Out Patient (Urgent)</td>
<td>21</td>
<td>CT</td>
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<td>81%</td>
<td>87</td>
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<td>MRI</td>
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<td>0%</td>
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</tr>
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<td></td>
<td></td>
<td>MRI</td>
<td>39</td>
<td>1</td>
<td>10%</td>
<td>374</td>
<td>10</td>
<td>90%</td>
<td>413</td>
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<td>203</td>
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<td>23%</td>
<td>684</td>
<td>17</td>
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<td>2</td>
<td>93%</td>
<td>1</td>
<td>11</td>
<td>7%</td>
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<td>2WW Patients Total</td>
<td></td>
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<td>32%</td>
<td>806</td>
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</table>
The number and scope of reporting radiographers has increased to keep pace with the demand as shown in chart 2. The reporting radiographers work to a standard that prioritises GP chest referrals to report these on the same day as the examination whenever possible. The performance shown in chart 4 demonstrates that the average turn-round times for general radiographs reduced to between 0-2 days. There was no backlog of general radiographs awaiting reporting.