The Discrepancy Meeting is Dead, Long Live the Educational Cases Meeting:

How we started and ran a successful Governance meeting addressing Radiological Errors in the largest UK Hospital Trust

The Leeds Teaching Hospitals NHS
NHS Trust

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Out with the old

- × Focus on mistakes
- × Blame attributed to individuals
- × Individuals felt singled out
- × Poorly attended meetings
- × The same few people identifying cases
- × Few radiologists attending 3 meetings a year as per RCR guidelines
- × Defensive adversarial culture
- × Sub-specialities felt excluded
- × No incentive to attend and perceived value of meeting low

Background

Most UK radiology departments aim to run a regular meeting to discuss errors or discrepancies in reporting[1].
The Royal College of Radiology (RCR) first published guidance on running a discrepancy meeting in 2008[2].
Meetings throughout the UK have traditionally been of variable quality. Historically in Leeds attendance, contribution and morale were poor. Since 2012 we have tried to improve the meetings and here we share our experience.

First we rebranded it

In order to emphasise the change of culture the "errors" meeting was renamed "**The Educational Cases Meeting**".
A regular, more suitable venue was found and the timetable published in advance. A chairman organised the program and collected cases from the entire consultant body. This was a popular change; in 2014 the RCR updated their guidance suggesting a renaming of the errors meeting: "**Learning from discrepancy meeting**"[3].

Then we set standards

Colleagues were reminded of their responsibility to follow Royal College guidelines for minimum attendance of 3 meetings per year.
In addition they were encouraged to contribute a minimum of one case per year via the standard template to the chairman, present audits and organise targeted teaching on behalf of their sub-specialty.
Cases were then presented in a standard template (fig. 1) and each consultant supplied with a letter of contribution annually for their appraisal folder (fig. 2). Reflective practice is required for all UK doctors documenting learning from one's mistakes[4].

We tried to make it blame free and positive

Anonymity was the key here. All consultants are informed prior to the educational meeting if one of their cases has been sent to the Chair and is due to be discussed. This is done by a "heads up" standard letter (fig. 3). The cases are anonymised by the Chair and used for ***learning points not blame***. In addition "good spots" were introduced where examples of particularly good practice were highlighted (fig. 4). An example of the culture change this has engendered was when consultant A recently nominated a consultant colleague B for a "good spot" when he identified a discrepancy in consultant A's report. Now that's more like it!

Education, Education, Education

We wanted to emphasise the importance of education as the aim of the meeting rather than individual scrutiny. We did this by:
1. Summarising the educational points after discussing each discrepancy case
2. Linking the case with targeted teaching (fig. 5)
3. Linking the educational cases meeting with a rolling targeted teaching session run by each sub-specialty in turn (fig. 6)
4. Integration of the educational cases in the Trust PACS system after each meeting (fig. 7)

We used I.T. To make the meeting interesting and interactive

Interactive voting in 'grey' or difficult cases was very successful in keeping the audience engaged (fig. 8).

Added attractions made it worthwhile to attend

It is the responsibility of the Chair to provide a diverse and interesting program (fig. 9). Linking the educational cases meeting to other aspects of interest to the departmental staff make it a true Governance meeting (fig. 10).

We gave feedback

Every consultant who contributed a case, whose case was discussed, or who contributed an audit presentation or targeted teaching session was sent a standard document for their appraisal (fig. 11). Each year, every consultant, including the recalcitrant few who had not attended any meetings, were sent an annual statement for appraisal and revalidation purposes (fig. 11).
The aim of this was to make compliance the norm, and to recognise and reward participation.

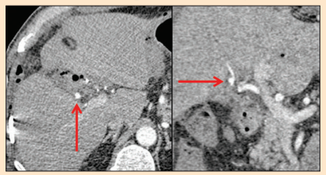
We ended up with a better meeting

Prior to 2012 only a minority of the workforce attended the meeting regularly. Now, **75% of consultants attend 3 or more meetings per year.** During the last 3 years feedback has been good and engagement has increased with more consultants contributing cases (fig. 12). Most importantly the culture has changed from "blaming for errors" to "learning from discrepancies".
This surely leads to a more open engaged consultant body sharing best practise and improved patient care.

In with the new

- ✓ Focus on education and patient safety
- ✓ Participant group encouraged to take ownership of the meeting
- ✓ Cases anonymised and used as a basis for learning points, not for blame
- ✓ All consultants required to provide one case per year democratising the process
- ✓ Feedback of attendance formalised for appraisal and revalidation documentation
- ✓ Sub-specialities encouraged to present targeted teaching sessions
- ✓ 100 educational cases per year discussed

Figure 1: An example case using the departmental standard template



Case number: 398
Scenario: Lap Chole. Bile duct injury. Open hepato-jejunostomy. 11 days post surgery. PR bleed, drop in blood count and B.P.
Report: No bleed
Diagnosis: Bleeding HA aneurysm at surgery
Educational points:
1. Complicated surgery may results in false aneurysm formation
2. Coronal thin slice reformats may aid aneurysm detection
3. Triple phase imaging should be considered plus or minus delayed imaging

Figure 2: Sample letter of contribution

Re: The Audit and Educational Cases meeting 2013-14

Dear .....

I am writing to thank you for your contribution to the Audit and Educational Cases meeting (previously called our discrepancy meeting) during the year 201.3.

Attendance and contribution to a general departmental governance meeting demonstrates good practice and is a requirement of the Royal College of Radiologists and Lunch Radiology Department.

The positive feedback we have received from colleagues about the improvements we have made to this meeting are encouraging. We have taken on board many suggestions and as a result attendance and contributions are increasing steadily.

The success of the meeting relies upon individuals being involved actively and in an equitable fashion.

We have been very impressed with the sub-specialities taking ownership of individual meetings allowing the specialists to decide on the clinically important topics to review and deliver focused targeted teaching by the experts.

The expectation is that every consultant radiologist in the Trust should:

1. Attend a minimum of 3 of the 6 meetings held per year (Royal College Standard)
2. Contribute at least one educational case per year (Departmental standard)
3. Present one audit at the meeting every 3 years (Departmental standard)

I hope that documenting individual attainment of these three standards in this standard annual letter will help colleagues produce concrete evidence demonstrating their involvement with audit, education and governance in their individual appraisals and revalidation. It will also improve the quality of the meeting and encourage inclusivity and equity.

If you feel my records are incorrect then please contact me directly.

It is important to send in your apologies if you cannot attend the meeting so the venues can be recorded.

Elective work should be cancelled to allow attendance at these meetings. If you have difficulty arranging this with your manager, please inform me so I can contact them and facilitate your attendance.

Once again thank you for your contribution and we look forward to your ongoing participation in 2014.

Yours sincerely,

Jonathan Smith, Consultant Radiologist and Audit lead for Radiology

RECORD OF CONTRIBUTION TO AUDIT AND EDUCATIONAL CASES MEETING 2013

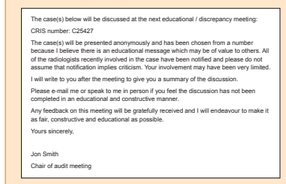
Name of Consultant:

Number of meetings with recorded attendance in 2014:

Number of educational cases contributed in 2014:

Number of audit presentations in last 5 years (starting Jan 2013):

Figure 3: 'Heads Up' Sample letter



The case(s) below will be discussed at the next educational / discrepancy meeting:

CRIS number: C25427

The case(s) will be presented anonymously and has been chosen from a number because I believe there is an educational message which may be of value to others. All of the radiologists recently involved in the case have been notified and please do not assume that notification implies criticism. Your involvement may have been very limited.

I will write to you after the meeting to give you a summary of the discussion.

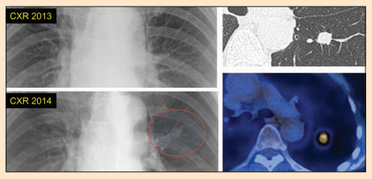
Please e-mail me or speak to me in person if you feel the discussion has not been completed in an educational and constructive manner.

Any feedback on this meeting will be gratefully received and I will endeavour to make it as fair, constructive and educational as possible.

Yours sincerely,

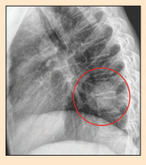
Jon Smith
Chair of audit meeting

Figure 4: This case is an example of a 'good spot' presented at the educational cases forum

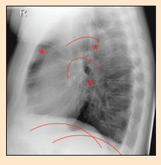


Good spot initiative. Recognise and record good radiology
Reporter: GP CXR completed and reported 2014. 'SPN'. 'Query summation shadow but given the coughing, smoking and TCC history needs a CT'
Diagnosis: T1a lung cancer at surgery
Educational points:
1. Smoking increases the risk of lung cancer and TCC
2. When reporting a CXR always compare with old films

Figure 5: Linking the case with targeted teaching



Case number: 422
Scenario: 56 years old. Fall on ward. Confused. Query fracture
Report: Normal. No fracture
Diagnosis: Lower lobe mass
Educational points: The lower lobe should be highly lucent

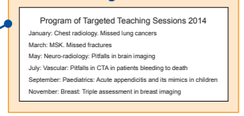


Targeted lateral teaching film.
An example of a normal film
Normal black spaces review areas include:
- Retro-tracheal. Note 2 straight lines are anterior scapula border
- Anterior mediastinal space
- Sub-carinal. No 'ring' or 'doughnut'
- Lower lobes, darker more inferiorly

Normal 2 curves / commas
- Aortic arch
- Pulmonary outflow

There should be 2 diaphragms

Figure 6



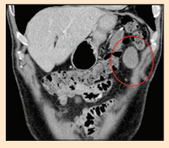
Program of Targeted Teaching Sessions 2014

January: Chest radiology. Missed lung cancers
March: MSK: Missed fractures
May: Neuro-radiology: Pitfalls in brain imaging
July: Vascular: Pitfalls in CTA in patients bleeding to death
September: Paediatrics: Acute appendicitis and its mimics in children
November: Breast: Triple assessment in breast imaging

Figure 7: Integration of educational cases

Integration of educational cases into the Trust PACS system provides an opportunity for an on-the-job learning resource

Figure 8: Using IT to improve staff engagement

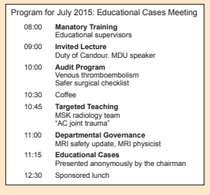


Case number: 404
Scenario: FU CT 12 months post-surgery for mixed main duct IPMN with dysplasia but no invasion
Question: Is it cancer?
Diagnosis: Biopsy proven fat necrosis mimicking peritoneal recurrence

Educational points:
1. Benign disease can mimic cancer and visa versa
2. Well circumscribed low density nodules could represent necrotic cancer or fat necrosis
3. A biopsy will differentiate benign from malignant processes in most cases

Voting results:
40% voted yes it is cancer
60% voted no it is not cancer

Figure 9



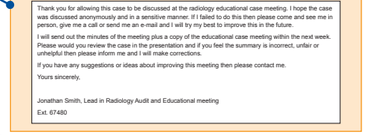
Program for July 2015: Educational Cases Meeting

08:00	**Manatory Training** Educational supervisors
09:00	**Invited Lecture** Duty of Candour. MDU speaker
10:00	**Audit Program** Venous thromboembolism Safer surgical checklist
10:30	Coffee
10:45	**Targeted Teaching** MSK radiology team "AC joint trauma"
11:00	**Departmental Governance** MRI safety update, MRI physicist
11:15	**Educational Cases** Presented anonymously by the chairman
12:30	Sponsored lunch

Figure 10: Other items of interest covered at the meeting

- Hospital Trust updates
- Mandatory training
- MDU/MPS guest speakers
- Invited RCR lectures
- Surgical/physician guest speakers
- Candour
- Pension advice

Figure 11: Standard letter of feedback following radiological educational case meeting



Thank you for allowing this case to be discussed at the radiology educational case meeting. I hope the case was discussed anonymously and in a sensitive manner. If I failed to do this then please come and see me in person, give me a call or send me an e-mail and I will try my best to improve this in the future.

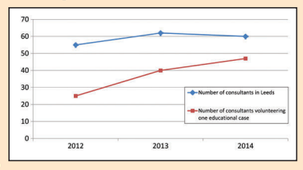
I will send out the minutes of the meeting plus a copy of the educational case meeting within the next week. Please would you review the case in the presentation and if you feel the summary is incorrect, unfair or unhelpful then please inform me and I will make corrections.

If you have any suggestions or ideas about improving this meeting then please contact me.

Yours sincerely,

Jonathan Smith, Lead in Radiology Audit and Educational meeting
Ext. 67480

Figure 12: Consultant contribution



References

1. Discrepancies in discrepancy meetings: results of the UK national discrepancy meeting survey. Prowse SJ, Pinkey B, Etherington R. Clin Radiol. 2014 Jan; 69(1):18-22.
2. Standards for Radiology Discrepancy Meetings. Royal College of Radiology. 2008
3. Standards for Learning from Discrepancies meetings. Royal College of Radiology. 2014
4. Good reflective practice. General Medical Council. 2013

Thanks to Catherine Parchment-Smith and Nicola Ruddock for help with the poster