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Discrepancies in discrepancy meetings: Results of the UK national discrepancy meeting survey

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AIM: To present the findings of the UK national discrepancy meeting survey of radiology departments across England, Wales, Scotland, and Northern Ireland regarding the way in which discrepancy meetings are currently conducted. This is in the setting of impending changes required for revalidation.

MATERIALS AND METHODS: One hundred and fourteen (114) out of 195 (55%) of departments surveyed replied to an anonymous survey of 10 questions requesting information regarding the proportion of departments adopting a regular meeting, the consultant hours spent at the meeting, the system used and people involved in the identification of discrepancies, whether a grading system was used, and whether discrepancies were recorded on consultants appraisals.

RESULTS: Ninety-seven percent of responders reported that their department has a regular discrepancy meeting. Among the responders, the average consultant attendance was 68%. Seven percent of departments did not record attendance. In departments that conduct discrepancy meetings, the number of cases discussed per month averaged 10. The average time spent per case was 6 min. Seventeen percent of departments ensure discrepancies form part of a consultant's appraisal. Twenty-seven percent reported not having a grading system, whereas those that do, use varying systems. Ninety-four percent reported that the majority of errors were identified by radiologists. Ten percent of departments undertake a systematic consultant review of random reported cases.

CONCLUSION: Discrepancy meetings provide a crucial role in clinical governance by facilitating an improvement in the quality of service provided by the radiology department. After more than a decade since the introduction of discrepancy meetings in the UK, there remains a great variety in implementation across the country, and important considerations, such as the need for grading and recording discrepancies in consultant appraisals. Reflection on discrepancies and also attendance at discrepancy meetings is required for impending revalidation.

Introduction

Radiological discrepancy occurs "when a retrospective review, or subsequent information about patient outcome, leads to an opinion different from that expressed in the original report".[1] The rate of radiological discrepancy and error varies widely in the literature—the only constant is its existence.

Discrepancy meetings to analyse potential discrepancies have been advocated by the Royal College of Radiologists (RCR) for over 10 years. The key purpose of the discrepancy meeting is to improve patient care, both in the short term,

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on a case-by-case basis, and also in the longer term through educating ourselves. It has been well described that discrepancy meetings can stimulate greater knowledge sharing, provide targeted instruction, and also have the potential to promote teamwork amongst radiologists.[2] Learning is not achieved if errors are not identified. However, to achieve this, robust systems must be put in place.

In response to a Department of Health document entitled *An organisation with a memory*, which stated that "increasing patient safety by reducing error is a key priority of major health services",[3] the RCR first proposed discrepancy meetings (2001),[4] and have since produced guidelines, outlined in Box 1 below, on how to set up and conduct these meetings to achieve their "educational and governance objectives" (2007).[1] Despite these guidelines, anecdotally there is a wide spectrum of implementation of discrepancy meetings in the UK. These significant differences, even among hospitals within the same region, prompted the authors to survey all radiology departments in the UK about their practices.

Materials and methods

An anonymous survey comprising 10 questions was emailed to one radiologist (preferably the Discrepancy Meeting Lead) from each NHS radiology department across the UK. The survey comprised 10 questions, which looked at the proportion of departments adopting a regular meeting, the consultant hours spent at the meeting, the system used and people involved in the identification of discrepancies, whether a grading system was used, and whether discrepancies were recorded on consultants appraisals. The survey is included in full in Appendix A.

One hundred and ninety-five departments were surveyed: 13 from Northern Ireland, 17 from Scotland, 15 from Wales, and 150 from England, with a total of 114 responses, which constituted 55%. Each department was individually phoned and the most appropriate responder was emailed up to three times in an attempt to maximize the response rate. The responders included 26 "large teaching hospitals", 74 district general hospitals (DGH), and 14 specialist centres (such as neurological, paediatric, orthopaedic or heart and chest hospitals). The size of the departments surveyed ranged from "between one and three consultants" to departments with over 25 whole-time equivalent radiology consultants (Fig 1).

Box 1. RCR guidelines for discrepancy meetings

- All radiologists should regularly attend, with a minimum 50% attendance of meetings
- Occur at least every 2 months
- Attendance should be recorded
- Formal process of recording outcome for each case
- Formal process of confidential feedback
- Convener should produce annual report document with key learning points and any recurrent patterns
- Formal process of electing a convener for a fixed term

Adapted from RCR Guidelines 2007.[1]

Results

Only three out of 114 (<3%) departments did not run a regular discrepancy meeting: one was at a specialist centre and the other two at DGHs.

Attendance/frequency meetings

Eight out of the 111 (7%) did not record attendance. On average 68% of consultants attended each meeting. Ninety-three out of the 111 (84%) departments had a meeting at least every 2 months and 50% departments met at least monthly (Fig 2).

Length/number cases

Fifty-five percent of meetings lasted 1 h in length. Forty-six percent of meetings discussed 5–10 cases; 36% discussed 11–15 cases. Six minutes was the average, and 8 min was the median, length of time spent on each case. The range was 1.7–16 min per case (Fig 3 and 4).

Grading systems

Eighty-one of the 111 (73%) departments had a grading system: 12/81 (15%) graded error solely on the implication to the patient; 11/81 (14%) graded error solely on the severity of the "miss"; 24/81 (30%) used a system that graded a discrepancy solely on the type of error (i.e., interpretation, observational, or technical). Eight of the 81 (10%) departments used an alternative grading system. Ten of the 81 (12%) departments used a two-system and 16/81 (20%) departments used a three-system grading approach, which considered severity, risk to patient, and type of miss. Ninety-four percent of responders thought that radiologists were the most likely source of discrepancy submissions.

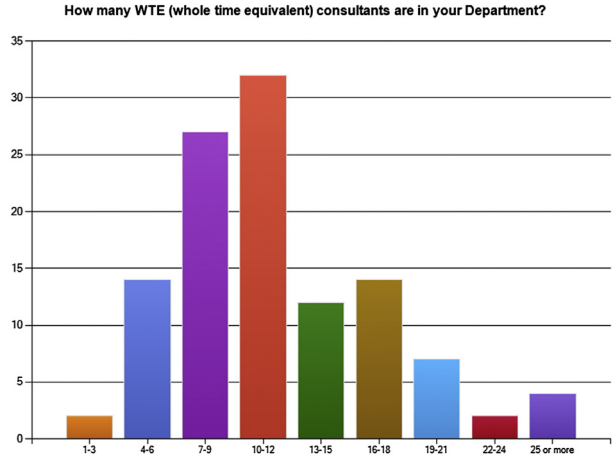

Figure 1 Size of department by number of consultants.