

**A comparison of the technical merit and quality of the reports of magnetic resonance (MR) imaging examinations performed by an independent sector provider using mobile MR systems with those from standard NHS MR services.**

**A report prepared by the Royal College of Radiologists, in conjunction with the Department of Health  
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**Summary**

1. There was a longer interval between the examination being performed and the report issued by the Independent sector provider than in the two NHS centres reviewed.
2. There was little difference in the technical quality of the MR examinations between the two services.
3. The language of the reports was better in most NHS generated reports.
4. The clinical opinion was judged slightly better in NHS reports. But amongst 349 observations there was only one discrepancy that might have approached a General Medical Council Grade 4 error.
5. There is evidence that the service has improved since informal audits of the service performed in 2004.
6. It is recognised that this audit only looked at a small number of MR examinations demonstrating a limited range of lesions

**INTRODUCTION**

In 2004 the Department of Health announced that, in order to reduce waiting times for magnetic resonance imaging, they were purchasing over 500,000 MR examinations from the independent health sector over the subsequent five years. Following a National advertisement and tender process, a single supplier (Alliance Medical Limited) was awarded the contract. Under the strict terms of the contract, this MR service based on mobile MR machines had to be initiated 16 weeks later. Radiographers and radiologists providing the services had to be outwith the NHS in order to provide “additionality” to the health service within the UK.

In the first few months both the service and the NHS had to overcome numerous teething problems which ranged from the physical difficulties of establishing suitable sites for the mobile MRI vans to link to existing hospital services down to the administrative problems of identifying suitable patients for this service. The independent provider also had to identify radiologists who were on the UK General Medical Council Specialist Register of Radiologists – European Radiologists can gain ready access to this list but others have to have their training approved as equivalent.

Perhaps the most crucial aspect of any MR service is the quality of the images and the quality of the reports. Local NHS radiologists and referring clinicians get used to certain sequences with images presented in a certain way and reports issued using certain phraseology. At the outset of the new service there were considerable delays

in producing the reports, problems with the interpretation of some reports issued by radiologists for whom English was a second language and some problems with reports issued by generalist rather than specialist radiologists. Several unpublished local audits analyzing the service and the quality of the reports were performed. The results of these informal audits helped the independent provider to make several changes to the service, chiefly to identify more English speaking radiologists with MR experience and to provide a faster turnaround of reports. Thus it was deemed appropriate by the Royal College of Radiologists, supported by the Department of Health, to audit various aspects of the new service at a point in mid-January 2005. In particular it was considered appropriate to compare the performance from the Independent Sector provider (ISP) with contemporary performance within the NHS.

## **MATERIALS AND METHODS**

At a meeting of many of those concerned with the service, it was announced that a small audit of the quality of the images and reports would be carried out on MR examinations that had been performed in the previous week. 60 MR examinations (20 cranial, 20 spine, 20 knees/shoulders) performed by the independent sector along with 60 from two NHS hospitals (District General Hospital A; Teaching Hospital B: 10 cranial, 10 spine and 10 knees/shoulders each) were sought. The request form, the hard copy images and the issued report were collected and made available for review at a central site.

The examinations were analysed by for experienced radiologists – Radiologist W had particular Neuroradiological expertise and analysed all the cranial cases; Radiologist X, a musculoskeletal radiologist, analysed the knee/shoulder examinations and spinal examinations; a District General Hospital (DGH) radiologist (Y) with several years of MR experience, analysed all examinations as did an MR radiologist (Z).

The date of the examination was recorded along with the date of the issued report – the interval being defined as the reporting time (days).

The technical merit of the examination (quality of the images, completeness of the examination, etc) was recorded on a 5-point scale (1 – uninterpretable, 3 considerable artefacts, 5 perfect).

The language, grammar, style and context of the report were also scored on a five-point scale (1- uninterpretable, 3 considerable ambiguity, 5 perfect).

The clinical opinion of the report was also scored on a 5 point scale:

1. Major disagreement – report needs a complete rewrite – clinician to be informed.
2. Moderate disagreement - report needs to be amended – send to clinician.
3. Minor disagreement – report needs to be amended for completeness.
4. Trivial disagreement – no need to amend report
5. Complete agreement with report.

The proforma used to analyse the examinations is enclosed as Appendix 1.

The mean scores for each radiologist were calculated and the results for independent sector and conventional NHS compared. Comparisons of the means were made by appropriate t tests.

## **RESULTS**

After the images and reports were sent in, it transpired that some of the examinations from the DGH site had been, unknowingly, been performed by the Independent Sector provider (ISP). Through efficient clerical work, the images and reports had been married into the NHS folder so that the use of the new service was not immediately identifiable. This left a total of 23 examinations from that centre available for further analysis. Furthermore some of the examinations from the Teaching centre were double examinations – eg head and spine; therefore a total of 34 examinations from the Teaching Centre were analysed along with 60 from the Independent Sector provider.

Because some of the observers were experienced in certain areas (eg head), only three of the four observers reviewed every examination.

As regards objective measures, there was a statistically significant difference ( $P < 0.001$ ) in the mean time between the date of the MR examination and the date of the typed report between the two MR Services. In the standard NHS Service this was 4.8 days for the DGH and 5.3 days for the Teaching Centre with an overall mean for NHS centres of 5.2 days (SD 5.06), as against 9.5 days (SD 6.24) for the Independent Sector provider (Table 1).

The main results of the subjective scores are shown in Table 2 a- e.

There was little overall difference in the quality of the images and overall technical merit between examinations performed by the ISP and the NHS. Two observers scored the images from the ISP slightly better, two rather worse; only in one of the latter individual analyses did the difference reach statistical significance. However when all the results were pooled, the quality of the images was deemed slightly better in the routine NHS centres than the ISP (overall mean 3.86 versus 3.69); this difference only just reached statistical significance ( $P=0.0457$ ).

The language of the reports was deemed better in the examinations provided by the standard NHS centres than by the ISP by all four observers (reaching statistical significance in all 4). When the results were pooled, the mean scores were 4.57 for the NHS versus 3.88 for the ISP. This difference was highly significant ( $P<0.0001$ ).

The clinical opinions given in the reports were judged better in the examinations provided by the standard NHS centres than by the ISP by 3 of the 4 observers, and better by the ISP by one. For two observers the reports were deemed significantly better in the NHS; the differences for the other two observers did not reach statistical significance. When the results for all four observers were pooled, the mean of the scores for the NHS was 4.30 versus 3.79 for the ISP (highly significant  $P<0.0001$ ).

## DISCUSSION

The reporting time for the Independent Sector was longer than that provided by the Standard NHS Service – approximately twice as slow. Theoretically the suppliers of reporting to the ISP are contracted to provide a prompt turnaround of reports. However, because the contract was instituted so quickly, the provider had some initial difficulties in finding radiologists who, under the terms of the contract, had to be outwith the UK NHS. There were also interesting variations within the service provided by the NHS: for some services (eg Neuroradiology at a Teaching Centre) a radiologist was probably present on site and reported on the same day; for other services, non-urgent cases were gathered and reported at the end of a week (eg musculoskeletal).

Despite the long turnaround time for the ISP reporting, a mean time of 9.5 days represents a substantial improvement to the Service since its inception in 2004 as can be seen by reference to an unpublished audit of the service as detailed in Appendix 2. That audit shows that, in early November 2004, there was a delay of nearly 15 days before the report was typed; this was fairly representative of the service provided at numerous centres at that time.

It is reassuring that the image quality of the two Services is broadly similar. Of course it could be argued that the image quality should be better in the patients referred to the Independent Sector as the patients referred to the mobile systems tended to be ambulant and thus less likely to be frail, in pain, etc than some of the more complex procedures/patients performed on the NHS systems. However this aspect was not measured in this audit. Interestingly it proved difficult to identify patients being examined for simple musculoskeletal conditions at the NHS Centres as so many had been diverted to the Independent Sector. Furthermore the Independent Sector Service is based on modern 1.5T equipment, all using standard sequences whereas the NHS Service was provided by a variety of MR systems using somewhat different protocols.

There has been much discussion as to what the optimal protocols for some of the routine MR examinations should be. These do vary from manufacturer to manufacturer. Personal preferences also come into play. This study has highlighted the need for a consensus on a realistic set of sequences for routine examinations which would be acceptable to all centres within the UK. There is some evidence that if the initial sequence(s) is chosen carefully, there is ever diminishing return from subsequent sequences. On a mobile system designed to provide maximal throughput, a certain fixed protocol has to be adopted – these may not always be to everyone's personal preference. On a static system, with radiologists in close proximity, additional sequences might be employed to answer certain ambiguities discovered after routine sequences; this is not so easy on a system remote from radiologists and also interferes with the high volume approach. Such an approach makes some recalls inevitable. In this relatively small series, none were scored as requiring re-examination.

Although the language in the reports from the Independent Sector was not as clear (mean score 4.33 as against 4.89), this was not perceived to be a major problem. This again represents an improvement in the Service as more use is made of English native

speaking (often UK trained) radiologists working abroad. In the initial stages of the service all reports had to be provided from within the EU and low scores were common (the mean score in 2004 was 3.2 - see Appendix 2). Subsequent advice allowed the use of radiologists from other countries, provided that the patient consented to their images being transmitted beyond the EU. As stated in the introduction, all radiologists participating in the Independent Sector service had to be on the GMC Specialist Register as a radiologist. Nevertheless terminology is often used differently: for example 'coxofemoral' when describing the hip joint and a 'dislocated' rather than herniated lumbar disc.

It is perhaps not surprising that the clinical opinions provided by the local radiologist in the conventional NHS system were judged better by three of the four observers. The local radiologist would know more about the patient and any previous imaging; they work closely with the referring clinician and would be more likely to be able to decipher the request forms. This study has certainly highlighted the need for request forms to be typed and filled in adequately. Hopefully the National Programme for Information Technology (NHS Connecting for Health) and the widespread installation of Radiological Information Systems will mean that hand written requests will be consigned to history. Another aspect is that, even within most DGH settings, there is a degree of subspecialisation; certain radiologists have particular skills (eg musculoskeletal). The service provided by the ISP does not necessarily provide subspecialty reporting, although this is attempted wherever possible. On this point it is worth noting that many radiologists in the NHS are experienced in cross-sectional imaging rather than necessarily being system-based specialists.

The real question is whether the slight reduction in the scores of the clinical opinion has a negative impact on patient care. In this small series nearly all the cranial examinations were normal or nearly normal; the spinal studies showed a range of degenerative changes – as did most of the musculoskeletal examinations. No life-threatening lesion was seen within the series apart from one patient in the Teaching Centre where the radiographer had spotted a chest lesion on the pilot images before a spinal examination and extended the examination accordingly. On review of the perceived errors in the reports, only six out of the 349 evaluations were ranked as a major disagreement and achieved the lowest score (1/5). Two of these related to the same patient in whom a tear of the anterior third of the lateral meniscus (a notoriously difficult area) was probably missed (rated 1/5 - major disagreement - by two observers and 4/5 – trivial – by the third). In all the other four examples where a major disagreement by one observer, the other two observers ranked it minor or trivial.

This limited survey yet again highlights the difficulties of establishing standards for radiological reporting. Discrepancies in reporting are common and many RCR Members and Fellows and other workers have written extensively on this topic. It also highlights the difficulties of comparing discrepancy rates between single practitioners and different centres. There was considerable inter-observer variation between the reviewers. The samples are small and alternative statistical methodology could have been employed. Several other potential areas of bias should be aired. Only 2 NHS centres were sampled; it is not known how far these are representative of other NHS centres. Likewise it is assumed that the examinations from AML are representative of all their examinations. It is also assumed that the radiologists who

reviewed the examinations were unbiased. However by seeking examinations that had been performed in the immediate recent past, a fair snapshot of both services has probably been obtained.

This small audit suggests that the service from the Independent Sector provider has improved since earlier unpublished local audits that were performed soon after the rapid introduction of this initiative. Nevertheless, further work and continued audit needs to be done to further improve quality and to provide an integrated high quality service for all patients, whether they are imaged in the standard NHS or by an Independent Provider.

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**TABLE 1**  
**Time to report (days) Mean scores and (Standard Deviation)**

<b>Total</b> <b>n = 116</b>	Spine n = 42	Musculoskeletal n = 39	Head n = 35
<b>7.4 (6.07)</b>	5.4 (2.87)	11.5 (8.26)	5.2 (3.05)
<b>Independent Sector</b> <b>n = 60</b>	Head n = 20	Spine n = 20	Musculoskeletal n = 20
<b>9.5 (6.24)</b>	7.3 (1.25)	7.5 (1.00)	13.7 (9.49)
<b>NHS overall</b> <b>n = 56</b>	Head n = 15	Spine n = 22	Musculoskeletal n = 19
<b>5.2 (5.06)</b>	2.4 (2.47)	3.6 (2.79)	9.2 (6.17)

Student's t-Test results:

t = 6.18

sdev = 7.44

Degrees of freedom = 346.

The probability of this result, assuming the null hypothesis, is less than 0.0001.

**TABLE 2a**

**Mean Score and (Standard Deviations) for MRI Audit**

All Scores from all observers summated

<b>Independent Sector</b> <b>n = 178</b>	Head n = 59	Spine n = 60	Musculoskeletal n = 59	TOTAL
Technical merit	3.81 (0.68)	3.88 (0.69)	3.37 (0.69)	3.69 (0.72)
Language of report	3.84 (1.01)	4.06 (0.66)	3.72 (0.84)	3.88 (0.85)
Opinion of report	4.00 (1.28)	3.86 (1.01)	3.53 (1.17)	3.79 (1.17)
				<b>3.79 (0.93)</b>

<b>NHS centre A</b> <b>n = 69</b>	Head n = 12	Spine n = 30	Musculoskeletal n = 27	TOTAL
Technical merit	4.08 (0.66)	4.00 (0.58)	3.70 (1.06)	3.89 (0.82)
Language of report	4.33 (0.77)	4.80 (0.40)	4.63 (0.56)	4.65 (0.56)
Opinion of report	4.83 (0.38)	4.30 (0.79)	3.63 (1.11)	4.13 (0.98)
				<b>4.22 (0.86)</b>

<b>NHS centre B</b> <b>n = 102</b>	Head n = 33	Spine n = 39	Musculoskeletal n = 30	TOTAL
Technical merit	3.97 (0.88)	3.84 (0.87)	3.66 (0.95)	3.83 (0.90)
Language of report	4.69 (0.52)	4.61 (0.59)	4.23 (0.85)	4.52 (0.68)
Opinion of report	4.78 (0.41)	4.38 (0.84)	4.06 (0.98)	4.42 (0.82)
				<b>4.26 (0.86)</b>

<b>NHS overall</b> <b>n = 171</b>	Head n = 45	Spine n = 69	Musculoskeletal n = 57	TOTAL
Technical merit	4.00 (0.82)	3.91 (0.76)	3.68 (1.00)	3.86 (0.86)
Language of report	4.60 (0.61)	4.69 (0.52)	4.42 (0.75)	4.57 (0.64)
Opinion of report	4.80 (0.40)	4.34 (0.81)	3.86 (1.05)	4.30 (0.90)
				<b>4.25 (0.86)</b>

**TABLE 2b**  
**Consultant W**

<b>Independent Sector</b>	Head n = 20	Spine	Musculoskeletal	TOTAL
Technical merit	3.55 (0.82)			
Language of report	3.65 (0.74)			
Opinion of report	4.20 (1.19)			
				<b>3.80 (0.97)</b>

<b>NHS centre A</b>	Head n = 4	Spine	Musculoskeletal	TOTAL
Technical merit	4.25 (0.50)			
Language of report	4.75 (0.50)			
Opinion of report	5 (-)			
				<b>4.66 (0.49)</b>

<b>NHS centre B</b>	Head n = 11	Spine	Musculoskeletal	TOTAL
Technical merit	3.18 (0.60)			
Language of report	4.18 (0.60)			
Opinion of report	4.90 (0.30)			
				<b>4.09 (0.87)</b>

<b>NHS overall</b>	Head n = 15	Spine	Musculoskeletal	TOTAL
Technical merit	3.46 (0.74)			
Language of report	4.33 (0.61)			
Opinion of report	4.93 (0.25)			
				<b>4.24 (0.83)</b>

**TABLE 2c**  
**Consultant X**

<b>Independent Sector n = 40</b>	Head	Spine n = 20	Musculoskeletal n = 20	TOTAL
Technical merit		3.85 (0.36)	3.55 (0.68)	3.70 (0.56)
Language of report		4.05 (0.22)	3.55 (0.60)	3.80 (0.51)
Opinion of report		4.45 (0.51)	4.25 (0.55)	4.35 (0.53)
				<b>3.95 (0.60)</b>

<b>NHS centre A n = 19</b>	Head	Spine n = 10	Musculoskeletal n = 9	TOTAL
Technical merit		4.00 (0.47)	3.66 (0.50)	3.84 (0.50)
Language of report		4.60 (0.51)	4.33 (0.50)	4.47 (0.51)
Opinion of report		4.40 (0.51)	4.11 (0.92)	4.26 (0.73)
				<b>4.19 (0.63)</b>

<b>NHS centre B n = 23</b>	Head	Spine n = 13	Musculoskeletal n = 10	TOTAL
Technical merit		3.53 (0.51)	3.00 (0.81)	3.30 (0.70)
Language of report		3.84 (0.37)	3.60 (0.51)	3.73 (0.44)
Opinion of report		4.23 (0.72)	3.90 (0.87)	4.08 (0.79)
				<b>3.71 (0.72)</b>

<b>NHS overall n = 42</b>	Head	Spine n = 23	Musculoskeletal n = 19	TOTAL
Technical merit		3.73 (0.54)	3.31 (0.74)	3.54 (0.67)
Language of report		4.17 (0.57)	3.94 (0.62)	4.07 (0.60)
Opinion of report		4.30 (0.63)	4.00 (0.88)	4.16 (0.76)
				<b>3.92 (0.72)</b>

**TABLE 2d**  
**Consultant Y**

<b>Independent Sector n = 58</b>	Head n = 19	Spine n = 20	Musculoskeletal n = 19	TOTAL
Technical merit	3.73 (0.45)	3.45 (0.68)	3.10 (0.56)	3.43 (0.62)
Language of report	3.05 (0.91)	3.95 (0.60)	3.63 (0.89)	3.55 (0.88)
Opinion of report	3.10 (1.41)	3.25 (1.06)	2.55 (1.09)	2.96 (1.21)
				<b>3.31 (0.97)</b>

<b>NHS centre A n = 23</b>	Head n = 4	Spine n = 10	Musculoskeletal n = 9	TOTAL
Technical merit	3.75 (0.50)	3.80 (0.42)	2.66 (0.86)	3.34 (0.83)
Language of report	3.50 (0.57)	4.80 (0.42)	4.55 (0.72)	4.47 (0.73)
Opinion of report	4.50 (0.57)	4.00 (0.94)	2.66 (1.00)	3.56 (1.16)
				<b>3.79 (1.03)</b>

<b>NHS centre B n = 34</b>	Head n = 11	Spine n = 13	Musculoskeletal n = 10	TOTAL
Technical merit	4.45 (0.52)	3.53 (0.96)	3.30 (0.48)	3.76 (0.85)
Language of report	5 (-)	5 (-)	4.50 (0.97)	4.85 (0.55)
Opinion of report	4.63 (4.63)	4.15 (1.14)	3.70 (1.15)	4.17 (1.02)
				<b>4.26 (0.88)</b>

<b>NHS overall n = 57</b>	Head N = 15	Spine n = 23	Musculoskeletal n = 19	TOTAL
Technical merit	4.26 (0.59)	3.65 (0.77)	3.00 (0.74)	3.59 (0.86)
Language of report	4.60 (0.73)	4.91 (0.28)	4.52 (0.84)	4.70 (0.65)
Opinion of report	4.60 (0.50)	4.08 (1.04)	3.21 (1.18)	3.93 (1.11)
				<b>4.07 (1.00)</b>

**TABLE 2**  
**Consultant Z**

<b>Independent Sector n = 60</b>	Head n = 20	Spine n = 20	Musculoskeletal n = 20	TOTAL
Technical merit	4.15 (0.58)	4.35 (0.67)	3.45 (0.75)	3.98 (0.77)
Language of report	4.80 (0.41)	4.20 (0.95)	4.00 (0.97)	4.33 (0.87)
Opinion of report	4.65 (0.67)	3.90 (1.02)	3.80 (1.05)	4.33 (0.87)
				<b>4.14 (0.89)</b>

<b>NHS centre A n = 23</b>	Head n = 4	Spine n = 10	Musculoskeletal n = 9	TOTAL
Technical merit	4.25 (0.95)	4.20 (0.78)	4.77 (0.44)	4.43 (0.72)
Language of report	4.75 (0.50)	5 (-)	5 (-)	4.95 (0.20)
Opinion of report	5 (-)	4.50 (0.84)	4.11 (0.78)	4.43 (0.78)
				<b>4.60 (0.66)</b>

<b>NHS centre B n = 34</b>	Head n = 11	Spine n = 13	Musculoskeletal n = 10	TOTAL
Technical merit	4.27 (0.90)	4.46 (0.77)	4.70 (0.48)	4.47 (0.74)
Language of report	4.90 (0.30)	5 (-)	4.60 (0.69)	4.85 (0.43)
Opinion of report	4.81 (0.40)	4.76 (0.43)	4.60 (0.69)	4.73 (0.51)
				<b>4.68 (0.59)</b>

<b>NHS overall n = 57</b>	Head n = 15	Spine n = 23	Musculoskeletal n = 19	TOTAL
Technical merit	4.26 (0.88)	4.34 (0.77)	4.73 (0.45)	4.45 (0.73)
Language of report	4.86 (0.35)	5 (-)	4.78 (0.53)	4.89 (0.36)
Opinion of report	4.86 (0.35)	4.65 (0.64)	4.36 (0.76)	4.61 (0.64)
				<b>4.65 (0.62)</b>

**APPENDIX 1**

The proforma used for the evaluation

**RCR/DoH Audit of MRI**

**Date of Audit:**                    \_\_\_\_/\_\_\_\_/\_\_\_\_

**Radiologist:**                    \_\_\_\_\_

**Site:**                                **Teaching Hospital**   
**District General Hospital**   
**Independent Sector Provider**

**Image site:**                    **Head**   
**Spine**   
**Extremities**

**Image number:**                \_\_\_\_\_

**Date of MR:**                    \_\_\_\_/\_\_\_\_/\_\_\_\_

**Date of report:**                \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Technical merit of image</b>	1	2	3	4	5
	artefact +++	poor	adequate	good	perfect
<b>Language of report</b>	1		3		5
	major ambiguity		adequate		perfect
<b>Opinion of report</b>	1	2	3	4	5
	major disagreement	moderate disagreement	minor disagreement	trivial difference of opinion	full agreement
	1-3 Requiring amendment of report				

**Further comments:**

**RE: Experience of the Mobile MRI Initiative November 2004  
(Extracts from a formal report to the Department of Health and AML)**

This centre hosted the van week beginning 8<sup>th</sup> November 2004. We have audited the results as follows:

During this period approximately 85 patients were examined. As of 29/12/04 only around 49 reports had been received. We received these 49 reports on average 28 days after the examination had been performed. The rest will presumably be returned even later.

As stated on the typed report, the mean interval between the examination and radiologist actually undertaking the report was 14.1 days. In 22 patients the report indicated a further mean delay of 8.9 days (mean overall for 49, 3.9 days) between the radiologist's report being dictated and a typed report being issued. There seemed to be yet further delay in the report and images reaching us (mean 10 days).

Report of images that have been received have been analysed by our radiologists listed below according to the proforma attached.

The quality of the images was generally favourable scoring a mean of 4.1 out of 5.

The language of the report was sometimes confusing. In UK radiology, the concept of a 'rough vertebra' is not widely appreciated – I imagine the radiologists meant that the vertebral body had irregular margins. Similarly I am not quite sure what the term 'no comparison' means – does this mean that there were no plain radiographs or CT for comparison? Some of the language difficulties were typographical. On occasions the precise question on the request form was not answered – e.g. query spinal stenosis on the request form – no mention of this in the report. The language of the report was scored at a mean of 3.2/5 – only just adequate - with several major ambiguities.

We noted several discrepancies within the reports. There was one major discrepancy where a cervical spine report (whose?) had been issued for a patient whose lumbar spine was apparently examined and filmed. This lumbar spine study has since been re-reported. Such an error would initiate an incident form and governance trail in an NHS hospital. We informed the Alliance help desk about this and we await further information.

There were 9 further discrepancies requiring amendments to the report – all these amended reports have been sent back to the Alliance Medical reporting team in accordance with our normal clinical governance procedures. An example was a missed synovial cyst in an exit foramen. Another involved nomenclature difficulties around a transitional lumbosacral vertebra, compounded by typographical problems (at the level L/L S1?). The overall mean score was of the clinical opinion given in the reports was 3.6/5 (ie between minor and trivial disagreement).

December 2004