University Hospitals of Derby and Burton
NHS Foundation Trust

TRUST POLICY FOR EAST MIDLANDS SPINAL NETWORK - REGIONAL EMERGENCY RADIOLOGY IMAGING POLICY

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	3	Jan 2023	Dr Michele Platt (Network Manager) and Mr Denis Calthorpe (Network Medical Lead), supported by Radiologists Dr Yuriy Arlachov	A policy to standardise practice across the EMSN in respect to emergency imaging at the three centre hospitals and their partners.
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Training and Dissemination: Policy needs to be brought to Divisional attention for dissemination and action by individuals identified.				
To be read in conjunction with: State the name(s) of any other relevant policies: / procedure				
In consultation with and Date: Mr Denis Calthorpe Lead Clinician Royal Derby Spinal Centre UHDB Chair. Clinical Steering Group. East Midlands Spinal Network. Medical Lead. East Midlands Spinal Network				
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Executive Lead Signature	(regional policy)			

NHS
Spinal Network
East Midlands

East Midlands Spinal Network

Regional Emergency Radiology Imaging Policy

January 2023

"Operational Delivery Networks - Embracing excellence, delivering quality…"

NHS Spinal Network East Midlands

Classification: General

Organisation	East Midlands Spinal Network
Document Purpose	Network Policy
Title	EMSN Regional Emergency Radiology Imaging Policy
Author	Dr Michele Platt (Network Manager) and Mr Denis Calthorpe (Network Medical Lead), supported by Radiologists Dr Yuriy Arlachov
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Description	A policy to standardise practice across the EMSN in respect to emergency imaging at the three centre hospitals and their partners.
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NHS Spinal Network East Midlands

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Introduction

This Network policy defines the principles, systems, processes and strategy for emergency radiological imaging for spinal services in the East Midlands Spinal Network (the Network). This includes referrals for all spinal patients between the three Network Specialist Spinal Centre (SSC) hospitals and their Local Partner Hospitals (LPHs).

Background and Rationale

A Network Urgent Radiological Imaging Policy is required for several different conditions and situations, for example, Metastatic Spinal Cord Compression (MSCC) and Cauda Equina Syndrome (CES).

Acute Cord Compression (ACC) and CES is a serious clinical situation which requires an urgent intervention (decompression) as any delay in management could result in long-term irreversible complications; a rapid diagnosis is therefore paramount. Radiological imaging must be performed within the first few hours of suspected ACC. Magnetic Resonance Imaging (MRI) is the gold standard for diagnosis of ACC.

In acute trauma however (e.g. Road Traffic Collision, RTC), multi-detector computed tomography (MDCT) is the most appropriate first step. If the patient demonstrates any neurological signs or symptoms, MRI should be considered as the next modality.

Availability of MRI across the Network is therefore a key element to the delivery of equitable, quality care to all spinal patients across the region, but particularly patients with suspected CES and acute oncology conditions (e.g. MSCC). It also impacts on patients from other clinical networks (i.e. neurology and stroke) and other local operational delivery networks (ODNs), including the East Midlands Major Trauma Network (EMMTN), the East Midlands Critical Care Network (EMCCN) as well as those networks on the boundaries of the East Midlands (i.e. Central England Networks).

For example, patients with suspected CES require an urgent MRI scan. A recent Getting It Right First Time (GIRFT, 2019) edict indicates that this should take place in the referral hospital. In the interim, where 24/7 provision is not available locally however, patients may have to be transferred to an alternative provider, incurring use of East Midlands Ambulance Service (EMAS) emergency resources. Furthermore, following a negative MRI scan, patients who require repatriation back to the referring hospital for ongoing care cannot be delayed while bed availability and/or appropriate Patient Transport Services (PTS) are secured. Any delay will incur unnecessary lengthy and costly stay in a specialist spinal bed, blocking the use of limited vital resources.

Member organisations across the Network use electronic referral systems (Refer-Back and Referapatient) keep track of all urgent referrals and responses, ensuring that all communications to and from the three Spinal Centre hospitals are securely documented. It provides a single platform which allows data to be uploaded manually or automatically to the Trust Electronic Patient Record system. Electronic referral systems in use across the EMSN aim to remove the inefficiencies of the previously used bleep-and-refer system within the NHS, reducing non-urgent calls, enhancing response times and improved data fidelity.

Purpose of the Policy

This policy aims to provide a regional framework for use across the Network to ensure appropriate, timely imaging examinations are performed for spinal patients, resources are used effectively, and the risks associated with requesting and reporting urgent imaging are managed.

Aim of the Policy

The aim of this policy is to ensure equity of access and timely imaging for all appropriate spinal patients across the EMSN region.

Objectives

Patients will be able to access urgent spinal radiology safely, with speed and accuracy through local networked image transfer arrangements and electronic referral, providing early diagnosis or early clearance where relevant, resulting in safe, efficient and cost-effective use of specialist beds and resources, following appropriate established COVID pathways.

Scope of the Policy

This policy relates to spinal care facilities in the East Midlands Spinal Network; all centre hospitals and their spinal/non-spinal partners. Member organisations and named radiology leads are listed in **Appendix 1**. A universal protocol for urgent spinal MRI is agreed and can be found in **Appendix 3**

This policy has been informed by a recent Network-wide survey in which all three centre hospitals identified that they provided 24/7 MRI availability. Partner hospitals indicated a service covering between 12 and 16 hours per day, as illustrated in Table 1 below. In line with the edict from GIRFT (2019) partner hospitals will be supported by the Network to develop plans to extend their MRI availability to 24/7.

Table 1. MRI Coverage across the Network

Member Organisation	MRI Coverage		
	Mon-Fri	**Saturday**	**Sunday**
Kings Mill	07:30 – 20:00	07:45 – 18:00	08:00 – 17:00
Lincoln County	07:20 – 20:30	07:20 – 20:30	07:20 -20:30
Pilgrim, Boston			
Kettering General	08:00 – 20:00 hrs *Reporting: 09:00 - 17:00hrs;*	08:00 – 20:00 *Reporting 10-16:00*	08:00 – 20:00 *Reporting 10-16:00*
Northampton General	08:00 – 20:00 hrs *Reporting: 09:00 - 17:00hrs;*	08:00 – 20:00 *Reporting 10-16:00*	08:00 – 20:00 *Reporting 10-16:00*
Queens Hospital Burton	0900-1700hrs	No service	No service
Chesterfield Royal Hospital	0730-1800hrs	0730-1800hrs	0730-1800hrs

All EMSN Spinal Centre Hospitals have equal capacity to manage patients' bariatric requirement for scanning (see **Appendix 2** for details).

This policy, a set of agreed principles, focuses on the shared, collaborative aspects of emergency radiological imaging which aims to facilitate rapid access to urgent imaging for all spinal patients anywhere in the Network, in line with the Network's vision of equitable care.

Referring consultants will take an active role in the management of patients referred from local partner hospitals to the Spinal Centre. Synchronised management of patients by the referring and receiving consultants will ensure that the patient benefits from the expertise of both and continuity of care.

Principles

1. All patients who require urgent spinal MRI radiological imaging (e.g. suspected CES) will access this investigation without undue delay via a safe COVID-status appropriate pathway

- *The investigation should be undertaken as an emergency. Waiting until the end of an elective MRI list cannot be justified. The spinal societies (BASS and SBNS) strongly recommend that MRI scanning should be undertaken urgently at the*

hospital receiving the patient in order to ensure timely diagnosis and, when appropriate, immediate referral and transfer to a spinal unit (BASS and SBNS, 2016) [1]

2. The Society of British Neurological Surgeons (SBNS, 2009) have long recommended that access to a 24-hour MRI scanning service must be available for patients with suspected CES. This standard now pertains to all hospitals (centre and partner) whereby patients with suspected CES will have a referral made by a senior decision-maker to a 24-hour scanning service performed locally in the hospital of presentation, ensuring no delay (GIRFT, 2019)[2].

- Where individual partner hospital trusts cannot resource out of hours MRI, centre hospitals will work with trusts, local infrastructure and the network to provide interim solutions.

3. Radiologists must prioritise suspected CES patients considering the severity and the time critical nature of effective treatment (GIRFT, 2019).

4. The variable spectrum and rate of development of potentially catastrophic CES symptoms conspire to confound a reliable consensus time-lined pathway. While every hour from initial symptoms to clinical presentation and definitive management may define outcome, patients with suspected CES should be scanned and reported as soon as practicably possible within an appropriate time-frame determined by the responsible Clinician

5. Where urgent MRI is available in the base local partner hospital (in-hours), when appropriate following diagnosis of CES, the patient must immediately be referred to and accepted by a Specialist Spinal Consultant at the Specialist Spinal Centre Hospital and transferred as an emergency (EMAS Priority 2 i.e. within 1 hour).

6. If radiological imaging is not available in the base local partner hospital (either out-of-hours during the period of transition to 24/7 MRI availability or through mechanical dysfunction), the patient will require emergency transfer, mandated within one hour of transfer request (EMAS Priority 2) to the nearest Specialist Spinal Centre Hospital with available facilities, regardless of their geographical location at the time of the Emergency Spinal incident (EMAS Priority 2).

- The patient must immediately be referred electronically and by telephone, senior clinician (consultant or SPR) to senior clinician to the specialist Spinal Centre Hospital prior to urgent transfer.
- The patient will remain the responsibility of the referring clinician until seen by the receiving clinician at the spinal centre hospital.

[1] https://www.sbns.org.uk/index.php/policies-and-publications/
[2] www.gettingitrightfirsttime.co.uk

- Where a patient presents at the Spinal Centre Hospital out of hours (20;00hrs or later) senior clinician judgement will determine if the scan takes place during the on-call ou of hours period or is delayed until 07:00hrs the following morning
- If the patient lacks capacity, they will ideally be accompanied by a family member or legal guardian, but where not available, the Mental Capacity Policy from the referring Trust will be invoked.

7. Access to urgent radiological facilities at both the referring Local Partner Hospital and the receiving Spinal Centre must be independent of resource limitation at both locations. Elective Imaging services at the referring Local Partner Hospital must not be spared at the expense of similar services at the Spinal Specialist Centre. Likewise, if the Specialist Spinal Centre hospital is experiencing a surge scenario, an urgent requirement for patient admission from a Local Partner Hospital cannot be refused and must be accommodated. Elective Imaging must be interrupted in accordance with clinical priority on whatever site the patient currently resides if emergency assessment and management is contemplated.

8. Clinical referrals for urgent imaging requiring transfer to an alternative facility should be made at a senior clinician level, i.e. Consultant/S.P.R. to Consultant/S.P.R. level. These do not require the involvement of the on-call radiologist. Once a clinical referral is accepted by a Specialist Spinal Consultant Radiology on-call, a Specialist Registrar/Consultant should be informed immediately in order to prevent any potential delay of urgent spinal radiological imaging.

9. Patients will be referred to the Spinal Centre hospital using an electronic referral system providing the minimum dataset required.

10. Electronic patient referrals should be followed up by a verbal telecom.

11. Where a patient presents out-of-hours at a local partner hospital requiring an urgent MRI scan, and the scanner is closed, urgent senior clinician to senior clinician electronic and telephone communication between the partner and centre hospital is essential to determine the requirement for transfer to the centre hospital for MRI. This will be a matter of joint clinical decision making. For example, if the patient presents at the partner hospital at 04:00hrs there may be little time benefit to that patient in a transfer to the centre hospital when the first scan available in the partner hospital is 07:30hrs.

12. In-hours, the radiology department should be ready to accommodate urgent requests and reschedule non-urgent and elective requests within-hours. Out-of-hours, on-call radiographers will need to be informed immediately for urgent scan requests.

13. The referring clinician must inform the on-call radiologist directly of any modification to a request for urgent radiology.

14. Where a request for urgent imaging is declined by the on-call radiologist, they should discuss this with the referring clinician by telephone to optimise onward care. The reason for imaging delay must be documented (GIRFT, 2019).

15. Once patients have completed their imaging, treatment will be managed in the most appropriate location for their spinal condition.

16. Where specialist care is no longer required, the patient will be repatriated to their referring hospital, under the terms of the *Network Transfer and Repatriation Standard Operating Procedure* (July 2019, V2.0 currently being updated) within 48 hours, immediately if possible, to protect ongoing spinal care capacity within the Specialist Spinal Centre, but always within 48 hours.

17. Images will be available for review through the local imaging transfer system, however where instant access to acquired images is not available this will require involvement of the radiology department from the referring hospital. Clinical staff will be cognisant of processes for urgent access to image viewing facilities available in each Trust and should follow local procedures.

18. On conclusion of the scan, the responsible requesting team will be notified directly by the responsible Radiology Dept. Team via the contact phone number accompanying the scan request and will act on the scan pending a timely consultant radiologist opinion. Final reporting will be by a consultant radiologist or other with requisite competencies depending on local arrangements. Pending the definitive radiology report a responsible Radiologist with requisite competencies will be available at all times should urgent consultation be required.

19. Patients requiring repatriation will be classified under the following broad headings (as per *Network Transfer and Repatriation Standard Operating Procedure.* See **Appendix 4**) and following the appropriate COVID status pathway.

20. A universal MRI protocol has been agreed for all acute cord compressions. These can be found in **Appendix 3.**

21. Any imaging request declined by the responsible Radiology Team, must be immediately communicated by telephone to the responsible requesting Senior Clinician with the reasons for request cancellation documented in the case notes.

Governance Issues

At a Network level, whilst the East Midlands Spinal Network (as a non-statutory organisation) does not have any formal responsibility for patient care, the Network does however have a responsibility for the system, so in terms of assurance and enabling standards, there is a requirement to ensure that the Network functions safely with appropriate processes in place.

At Trust level, the Executive Director with specific responsibility for Radiology will oversee implementation of this policy and investigate adverse incidents as per local protocol, supported by the Trust radiology leads.

Each Trust within the Network has an identified Clinical Governance lead who is key to ensuring clinical governance implementation. The Network Clinical Governance Framework identifies a requirement to monitor critical incidents. Critical incidents should be reported via individual Trust mechanisms. Where incidents have implications for the wider Network, they should be reported either to the Network management team as a matter of urgency where action may be needed or raised at the Network Clinical Steering Group (CSG). High-risk issues will be raised at the Board meeting following consultation with the CSG.

Clinical Governance

a) All Network member organisations will keep an accurate record of all urgent radiology referrals, whether refused, postponed or accepted for urgent imaging (this will be automated with the use of an electronic patient referral system) to facilitate regional audit and evaluation.

b) Implicit in requests for urgent and out-of-ours imaging is the requesting senior clinician opinion that time-critical diagnosis is required .

The minimum dataset required for urgent imaging referrals is as follows

- Adequate clinical information must be itemized individually, using an electronic patient referral system as appropriate, supported by telecom:
  - Symptoms and onset of symptoms
  - Results of objective neurological examination with validated tools (e.g. ASIA)
  - Previous imaging and results
  - Previous surgical intervention and date
  - Detailed relevant medical history including history of cancer and treatment
  - Patient completion of MRI questionnaire, where appropriate
  - Requesting Senior Clinician to be identified in the request – Contact details of referring clinicians for discussion of case and results
  - Requesting Senior Clinician to inform radiology department at earliest opportunity.

c) The patient will remain the responsibility of the Local Partner Hospital referring consultant during transfer to the receiving Spinal Centre Hospital.

- This will require ownership of the patient by a Trauma and Orthopaedic consultant in the referring LPH Ward or Emergency Department, who will make the referral.

- A consultant in the receiving Spinal Centre Hospital must accept all valid emergency patient referrals and will retain ownership of the patient during their stay at the Centre Hospital until repatriation
- The Local Partner Hospital will resume ownership of their referred patient on completion of Specialist Spinal Centre Hospital management as per Network Transfer and Repatriation Standard Operating Procedure (See **Appendix 4**).

d) Serious untoward incidents linked with urgent imaging will be shared with the Network members at the Clinical Steering Group for mutual learning and direction for quality service improvement.

Key Responsibilities and Duties

Key responsibilities for Network healthcare professionals across the East Midlands region can be found in **Appendix 5**.

Indicators of Success

The following key performance indicators (KPIs) will be monitored within each member organisation as indicators of success

- Total time from arrival in Emergency Department (ED)/ at GP to definitive surgery i.e.
    - Time arrived in ED / Or seen by GP
    - Time of MRI scan
    - Time of report and diagnosis
    - Time of surgery
- Number of partner hospitals offering 24/7 (or increased) MRI provision
- Reduction in number of missed CES
- Reduction in number of litigation cases
- Reduction (or increase) in transfers for patients with suspected CES (either could be an improvement depending on starting point
- Availability of sufficient clinical information on referral requests.

Summary and Conclusion

This is the current version of the Network Policy ratified by the Network Board for implementation in each Network participant member organisation with effect from December 2021

Appendix 1. Radiology Links by Member Organisation

Member Organisation	Radiology Link
Queens Medical Centre, Nottingham (NUH)	Yuriy.arlachov@nuh.nhs.uk
City Hospital, Nottingham (NUH)	
Kings Mill Hospital, Sutton in Ashfield	Ranjeet.jagdale@nhs.net
Lincoln County Hospital (ULH)	Mohammad.butt@ulh.nhs.uk
Pilgrim Hospital, Boston (ULH)	
Leicester General Hospital (UHL)	Bruno.morgan@uhl-tr.nhs.uk David.swienton@uhl-tr.nhs.uk Tanveer.butt@ulh.nhsluk
Leicester Royal Infirmary (UHL)	
Kettering General Hospital	Zoe.saunders@kgh.nhs.uk
Northampton General Hospital	Amanda.north@ngh.nhs.uk
Royal Derby Hospital (UHDB)	Smeer.aggarwal2@nhs.net
Queens Hospital Burton (UHDB)	
Chesterfield Royal Hospital	Prateek.sharma@nhs.net

Appendix 2 Weight Limits & Bore for Bariatric Scanning & Additional Resources

All Spine Centre Hospitals have the same resources for managing bariatric patients as illustrated in the table below.

	MRI		CT	
	Bore	**Weight Limit**	**Bore**	**Weight Limit**
UHL – LRI & LGH	70cm	227Kg	70cm	200kg
UHL - GH	70cm	250Kg	70cm	200-220kg
LRI (CT 2, CT3)			70cm	300kg
UHDB – Derby	70 cm	250kg	70cm	227- 306Kg
UHDB – Burton	70 cm	250kg	70 cm	227kg
UHDB – London Rd	No bariatric capability			
NUH – QMC	70cm	250kg	70cm	205-227kg
NUH- NCH	**70cm**	250kg	70cm	205-307kg

NB: For other National NHS Hospitals and their CT and MRI bore size and weight limits please refer to appendix 6 and appendix 7)

Scanning facilities are available at the following centres

Upright MRI
The Birmingham Upright MRI Centre
38 Calthorpe Road
Edgbaston
Birmingham
B15 1TS

Cheltenham Cobalt Unit
Contact - switchboard@cobalthealth.co.uk or telephone 01242 535910
1T - **Weight limit 40 stone**
Online Referral - https://secure.lohost.com/mriservice/mri_portal.php
or post to Cheltenham Imaging Centre, Linton House Clinic, Thirlestaine Road, Cheltenham, Gloucestershire, GL53 7AS or fax (01242 535919).
Referral forms, information leaflets for patients and referrers, and maps and directions from www.cobalthealth.co.uk

InHealth Croyden University Hospital
1.2T -**Weight limit 300kg**
530 London Road
Thornton Heath
Surrey
CR7 7YE

Cardiff UME Diagnostics
Weight limit 190kg
Tel: 0800 222 9048
Copse Walk
Cardiff Gate Business Park
Pontprennau
Cardiff
CF23 8RB
Katharine.norfield@umegroup.com

Bronglais Hospital in Aberystwyth (NHS)
0.4T - **Weight limit of 225kg**

The Ridgeway Hospital near Swindon
BMI hospital
0.3T - **Weight limit of 225kg**

Bolton Arena Ex-Scan UK
Open Low Field scanner E-Scan XQ - **Weight limit 30 stone**
Cannot scan spine or head
Bolton Arena
Middlebrook Retail & Leisure Park
Arena Approach
Horwich
Bolton BL6 6LB
ex-scanuk@boltonarena.com
Phone: 01204 488211
Fax: 01204 488363
Web site: www.exscanuk.co.uk

Newcastle Clinic
Weight limit 227kg/35 stone 10lbs
Depth must be under 32cm
4 Towers Avenue
Jesmond
NE2 3QE
Tel: 0191 281 2636
Fax: 0191 281 2393
Newcastle Liz Storey liz.storey@newcastleclinic.co.uk

Knowle - CMC Imaging Services Ltd.
2 Open MRI 0.35T and 1.5T, weight limit of 230kg
Heath Lodge Clinic
1357 Warwick Road
Knowle
B93 9LW
Tel: 01564 732150
www.cmcimaging.co.uk

Appendix 3. Protocol for emergency spinal MRI

(i.e. CES, MSCC or other e.g. haematoma) carried out in all Specialist Spinal Centre Hospitals

Unless otherwise specified, i.e. Lumbar Spine initially for suspected Cauda Equina Syndrome, the entire spine should be imaged at least T2 sagittal including the cranio-cervical junction as a reference point for counting vertebra

a. The minimum sufficient MRI protocol should include sagittal T2W, T1W, STIR; axial T2W, T1W

b. If full imaging of the spine is hindered due to pain or claustrophobia sagittal T1W or STIR images should be first.

c. In trauma, MDCT is the first important modality in assessing of integrity of the osseous structure.

d. Where MRI is contraindicated, CT myelogram should only be performed in clinical circumstances where there is an emergency need and intention to proceed immediately to treatment, if appropriate (and service facilities available).

e. MRI of the spine in patients with suspected MSCC should be supervised (indirectly) and reported urgently by a radiologist in order to facilitate further management of patients (NICE, 2014). The radiologist should have competence to decide on further protocol and the need for contrast administration.

Source: NICE (2014) *Metastatic Spinal Cord Compression in Adults*. Found at https://www.nice.org.uk/guidance/qs56 Last accessed 2/1/19

Appendix 4. Classification for Repatriation

Patients requiring repatriation will be classified under the following broad headings

i. Patient with complex intervention, acute care in the Specialist Spinal Centre hospital, finished but require on-going hospitalisation/rehabilitation/awaiting Spinal Cord Injury Unit bed available in local hospital. Patient gets repatriated to their LPH.

ii. Patient with complex intervention, acute care in the Spinal Centre, finished but requires on-going need for intervention (Oncology) only available in certain units. Patient gets repatriated to the nearest home/LPH with the appropriate level of care.

iii. On-going complex intervention only available in Spinal Centre (e.g. neurological/oncological). Patient stays in the Spinal Centre.

iv. Rehabilitation need only. Patient returns either home or to the partner hospital awaiting Rehabilitation Unit.

v. Patient does not get admitted to Spinal Centre due to over-triage. Patient immediately returns to nearest appropriate LPH (query CES cleared by MRI).

Source: *Network Transfer and Repatriation Standard Operating Procedure.*

Appendix 5. Key Responsibilities and Duties

Requesting Medical Practitioner

- To liaise with on-call spinal team to refer patient for urgent scanning.
- To provide appropriate clinical information, following personal examination, on the referral as above.

Consultant in charge of patient (parent consultant)

- To be aware of referral and to supervise with provision of adequate information in the clinical referral.
- To have ultimate ownership of the patient during urgent imaging requests and subsequent onward referral until arrival at Spinal Centre.
- To ensure reports for the urgent imaging requested are acted upon and should available and accessible for discussion.

Radiologist

- At the specialist spinal centre hospitals, studies will be reviewed by a radiology Specialist Registrar or Consultant on-call as soon as practicable after acquisition
- The reviewer must alert the referrer of any important findings.
- Radiography staff should ensure urgent studies are reviewed by a named individual and allocated to the correct reporting box for reporting.
- Relay findings to the referring team via phone in addition to formal report.
- An MSK radiologist should be available 24/7 for consultation.

Non-medical referral

- All referrals should be between Registrar/Consultant to Registrar/Consultant

Use of electronic patient referral systems (Referapatient or Refer-Back)

- To be used by peripheral centres in conjunction with a direct telephone call, to refer to spinal centre hospitals for urgent radiological imaging.

Appendix 6: National NHS Hospitals CT Scanner Information

Hospital Name	Bore size (cm)	Weight limit (kg)
Yeovil District Hospital	72 horizontal x 56 vertical	205
Royal United Hospital, Bath	80	227
Leeds General Infirmary & St James Hospital	79	307
Queen Alexandra hospital	78	300
University Hospitals Plymouth	70	227
Stepping Hill	70cm (FOV 55cm)	225kg
Pinderfields	78	330
Mid Yorks NHS Trust	78	330
Royal Hampshire County Hospital	70	230
Salford Royal NHS Foundation Trust	78cms	300kg
Wycombe Hospital/Stoke Mandeville Hospital	76cm	300kg
Northern devon Healthcare NHS Trust	78cm	220
Royal Albert Edward Infirmary Wigan	70	230
Royal Victoria Infirmary, Newcastle Upon Tyne	80 (patient would have to be approx 5cm smaller in diameter than this to fit through for body imaging	300
Freeman Hospital	80	200 (No bariatric facilities)
Royal Victoria Infirmary, Newcastle Upon Tyne	80	~200 (No bariatric unit in Neuroradiology)
Tameside Hospital	78	300
Spire Bristol	70cm	230kg
Blackpool Teaching Hospitals NHSFT	77	227
Kings Mill Hospital	50cm	227kg
The Royal Oldham Hospital (CT) Fairfield General Hospital (MR)	78cm	300kg
Musgrove Park Hospital, Taunton	80	227
General Hospital Jersey	70	227
Queen Elizabeth Hospital Birmingham	82	307
ST-MARY'S ISLE OF WIGHT	78	215
Queen Alexandra hospital	78	300
Basingstoke	78 (max scan FOV 70cm)	227
RHCH Winchester	70	227
Southend site- MSE	60	225kg
Barnet Hospital RFL NHS	78	307
Blackpool Victoria Hospital	78	227
University Hospital Southampton NHS FT	90cm	205kg
Royal Free Hampstead NHS Foundation Trust	72	300
Dorset County Hospital	78	300
SOUTHAMPTON GENERAL HOSPITAL	78	227

Royal Berkshire Hospital	70	224
West Berkshire community hospital	70	315
St George's Hospital	80	227
Bristol Royal Hospital for Children	78	300
East Lancashire Hospitals NHS Trust	78	227
Royal Cornwall	75cm reduced to 65cm by the table	300kg
Whittington Health	78	300
james paget	60	205
QEH Kings Lynn	78	300
Bedford Hospital NHS Trust	70cm	227kg
SALISBURY NHS FOUNDATION TRUST	70	227
Luton and Dunstable Hospital	70	305
United Hospitals of Leicester (LRI & LGH)	70cm	200kg
Uited Hospitals of Leicester GH	70cm	220-220kg
LRI CT2, CT3	70cm	300kg
United Hospitals of Derby and Burton: Derby	70cm	227-306kg
United Hospitals of Derby and Burton: Burton	70cm	227kg
United Hospitals of Derby and Burton: FN	No bariatric capacity	
Nottingham University Hospitals Trust:QMC	70cm	205-227kg
Nottingham University Hospitals Trust:NCH	70cm	205-307kg

Appendix 7: National NHS Hospitals MRI Scanner Information

Hospital Name	Bore size (cm)	Weight limit (kg)
Yeovil District Hospital	58.5 horizontal x 39.5 vertical	200
Royal United Hospital, Bath	70	250
Leeds General Infirmary & St James Hospital	70	250
Queen Alexandra hospital	70	226
University Hospitals Plymouth	70	200
Stepping Hill	60cm	250kg
Pinderfields	70	250
Mid Yorks NHS Trust	70	250
Royal Hampshire County Hospital	70	231
Salford Royal NHS Foundation Trust	70cms	227kg
Wycombe Hospital/Stoke Mandeville Hospital	70cm	250kg
Northern devon Healthcare NHS Trust	65cm	220
Royal Albert Edward Infirmary Wigan	70	250
Royal Victoria Infirmary, Newcastle Upon Tyne	70 (patient would have to be approx 5cm smaller in diameter to fit into scanner for body imaging)	250
Freeman Hospital	70cms	250kg
Royal Victoria Infirmary, Newcastle Upon Tyne	70 (patient would have to be at least 5cm smaller in diameter than this to fit through safely with coils)	250
Tameside Hospital	70	250

Spire Bristol	70cm	250kg
Blackpool Teaching Hospitals NHSFT	60	225
Kings Mill Hospital	70cm	250kg
The Royal Oldham Hospital (CT) Fairfield General Hospital (MR)	70cm	250kg
Musgrove Park Hospital, Taunton	70	250
General Hospital Jersey	70	220
Queen Elizabeth Hospital Birmingham	70	250
ST-MARY'S ISLE OF WIGHT	60	250
Queen Alexandra hospital	70	250
Basingstoke	70	160
RHCH Winchester	60	143
Southend site- MSE	70	~37 STONES
Barnet Hospital RFL NHS	60	200
Blackpool Victoria Hospital	50	220
University Hospital Southampton NHS FT	70cm	250kg
Royal Free Hampstead NHS Foundation Trust	70	250
Dorset County Hospital	62	250
SOUTHAMPTON GENERAL HOSPITAL	70	250
Royal Berkshire Hospital	70	250
West Berkshire community hospital	70	250
St George's Hospital	60	140
Bristol Royal Hospital for Children	70	250
East Lancashire Hospitals NHS Trust	70	250
Royal Cornwall	60cm reduced to 50cm by the table	250kg
Whittington Health	70	250

james paget	70	200
QEH Kings Lynn	70	225
Bedford Hospital NHS Trust	70cm	250kg
SALISBURY NHS FOUNDATION TRUST	70	250
Luton and Dunstable Hospital	70cm	200
United Hospitals of Leicester (LRI & LGH)	70cm	227kg
Uited Hospitals of Leicester GH	70cm	250kg
LRI CT2, CT3		
United Hospitals of Derby and Burton: Derby	70cm	250kg
United Hospitals of Derby and Burton: Burton	70cm	250kg
United Hospitals of Derby and Burton: FN	No bariatric capacity	
Nottingham University Hospitals Trust:QMC	70cm	250kg
Nottingham University Hospitals Trust:NCH	70cm	250kg