

Worcestershire Acute Hospitals NHS Trust

Quality Report

Worcestershire Royal Hospital
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Date of inspection visit: 27 July 2016
Date of publication: 24/11/2016

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Are services at this trust safe?

Are services at this trust effective?

Are services at this trust caring?

Are services at this trust responsive?

Are services at this trust well-led?

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out an unannounced inspection at Worcestershire Royal Hospital on 27 July 2016. The purpose was to look at specific aspects of the care provided by radiology services at Worcestershire Acute Hospitals NHS Trust.

Concerns were initially raised by a member of the public, and the trust was given the opportunity to respond to these, however when satisfactory assurances were not received, the local inspection team decided to conduct an unannounced inspection.

In particular we looked at the time that it took to report on routine and urgent plain film x-ray examinations, and the governance processes in place to ensure that any backlog in reporting was managed escalated and resolved. We also looked at staffing within the department.

Worcestershire Acute Hospitals NHS Trust provides radiology services at Worcestershire Royal Hospital, Alexandra Hospital, Redditch, and Kidderminster Hospital and Treatment Centre. The service is managed by one management team based at Worcestershire Royal Hospital where Information technology systems (IT) that support the radiology services across all three sites are also based.

Worcestershire Acute Hospitals NHS Trust was rated inadequate overall at our last inspection in 2015. The outpatients and diagnostic imaging departments were rated requires improvement for all three sites, with leadership at Worcestershire Royal Hospital and Kidderminster Hospital and Treatment Centre rated as inadequate. A comprehensive inspection of all services across three sites is planned for November 2016.

A rating is not provided for this inspection. The reason for not providing a rating is because this was a very focused inspection, focusing on specific key questions and key lines of enquiry. It was carried out to assess whether there was significant risk of patient harm arising from the concerns raised.

In radiology services our key findings were:

- There was a significant backlog in the reporting of plain film x-rays dating back to 2013 which the trust

could not provide us with evidence of board oversight or knowledge of. This meant we were not assured that there were suitable governance and escalation processes in place to protect patients from actual or potential harm and trust could not provide evidence to demonstrate that the board were aware of the reporting backlog.

- Lessons were not being learnt from incidents and safety goals had not been set. An audit of 4160 films, which was one months' volume of unreported plain films from the backlog, was conducted in July 2013. This audit demonstrated that 46 films required follow up imaging, alternative imaging or clinical follow up by the patients' specialist consultant. In the course of the audit 16 patients were identified where some delay in providing a radiology report may have resulted in avoidable harm to the patient. There had been some limited follow up of these patients, but no record of the definitive outcome or conclusion of any harm review.
- The length of time for the reporting of diagnostic imaging tests had been on the trust risk register since 2003 and we saw no evidence of a review of the situation and clear actions to reduce the backlog
- During our inspection, we found that from 1 January 2016 to 26 July 2016, 10,442 plain film x-ray examinations remained unreported. The number of potentially unreported diagnostic imaging tests prior to January 2016 was undeterminable on the day of inspection. Subsequent to our inspection, the trust submitted data demonstrating that the total number of unreported images from 2013 to 2015 was 25,622.
- There were no procedures in place to trigger the escalation of risk caused by lengthy delays in reporting.
- Reports for patients referred into the departments for urgent images were not always prioritised, meaning there was a significant delay with some reports taking up to 21 days from when the image was taken before they were reported to GP referrers.
- There were 11 whole time equivalent radiographer vacancies within the department at the time of our inspection and reporting radiographers were not being released from clinical duties to undertake reporting sessions due to these vacancies. There had been six

Summary of findings

radiologist vacancies within the department since 2014. Workforce capacity therefore was not meeting the demands of the service and the clinical director told us that job plans were not reviewed regularly.

- The department was fragmented with radiologists and radiographers working separately. Radiologists were attending multidisciplinary meetings; however reporting radiographers said they would like to attend these meetings as a learning opportunity, but were not able to do so due to their clinical workload. Discrepancy meetings were being held separately which meant that there was not a cohesive approach to patient care. A discrepancy meeting is a meeting whereby results of an audit of a locally agreed number of x-ray examinations (as laid down in the Royal College of Radiologists guidelines), are presented and discussed. The audit is used to discuss cases where two radiologists have disagreed over the interpretation of an image. There is a general acceptance of a 2-5% discrepancy rate for all radiologists
- There was a comprehensive policy to support non-medical referrers requesting examinations and radiographers were following this policy and checking the database when they did not recognise the referrer's name.

Action the hospital MUST take to improve

- Take appropriate steps to resolve the backlog of radiology reporting. This must include a clinical review and prioritisation of the current backlog of unreported images, (including those taken before January 2016); assess impact of harm to patients, and apply Duty of Candour to any patient adversely affected
- Ensure that they have robust processes to ensure any images taken are reported and risk assessed in line with trust policy

Based on the findings of this inspection I authorised conditions to be imposed on the trust's registration as a service provider as I believed that patients may have been exposed to the risk of harm if I did not impose these conditions urgently.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Worcestershire Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS trust was established on 1 April 2000. The trust provides all acute services to a population of around 570,000 in Worcestershire as well as the surrounding counties and further afield. It has approximately 900 beds.

Radiology services provided by the trust are located on seven sites: Worcestershire Royal Hospital, Alexandra Hospital, Redditch, Kidderminster Hospital and Treatment Centre, Princess of Wales Community Hospital (Bromsgrove), Evesham Community Hospital, Malvern Community Hospital and Tenbury Hospital. The service is

managed by one management team based across the sites. Information technology systems (IT) that support the radiology services across all sites are based at the Worcestershire Royal Hospital site.

Radiology procedures are undertaken at all sites including: CT Scans, MRI, obstetric ultrasounds, general ultrasounds, nuclear medicine studies, plain film x-ray, mammography and breast screening, angiography, fluoroscopy and DEXA scans. The community sites providing limited procedures in plain film and ultrasound

Our inspection team

Our inspection team was led by:

Inspection Lead – Jo Naylor Smith, Inspection Manager, Care Quality Commission.

The inspection was attended by an inspection manager, one inspector and two clinical specialist IR(ME)R inspectors who provided radiology specific clinical knowledge

How we carried out this inspection

We undertook an unannounced inspection at Worcestershire Royal Hospital, radiology department on 27 July 2016. The purpose was to look at specific aspects of the radiology service which had been highlighted as a patient safety risk by a member of the public. In particular we looked at the time that it took to report on routine and urgent plain film x-ray examinations, and the governance processes in place to ensure that any backlog in reporting was escalated and resolved. We also looked at staffing within the department.

We spoke to a range of staff within the department, which included, radiographers, a radiologist, superintendent radiographers, the radiology support manager, the picture archiving and communication systems (PACS) team, and the clinical lead for the department who was a consultant radiologist.

We would like to thank all staff, members of the public and stakeholders for sharing their views and knowledge of the quality of care and treatment in the radiology departments at Worcestershire Acute Hospitals NHS trust.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We have not rated this key question because this was undertaken as a focused inspection to assess whether diagnostic imaging tests were being reported in a timely manner to ensure patients using the service were not at risk at harm :</p> <p>We found that :</p> <p>There was a significant backlog in the reporting of plain film x-rays dating back to 2013 which the trust could not provide us with evidence of board oversight or knowledge of. This meant we were not assured that there were suitable governance and escalation processes in place to protect patients from actual or potential harm and that the board were getting regular reports on progress in clearing this backlog.</p> <p>Lessons were not being learnt from incidents and safety goals had not been set. An audit of 4160 films, which was one months' volume of unreported plain films from the backlog, was conducted in July 2013. This audit demonstrated that 46 films required follow up imaging, alternative imaging or clinical correlation. In the course of the audit 16 patients were identified where some delay in providing a radiology report may have resulted in avoidable harm to the patient. There had been some limited follow up of these patients, but no record of the definitive outcome or conclusion of any harm review.</p> <p>The length of time for the reporting of diagnostic imaging tests had been on the trust risk register since 2003 and we saw no evidence of a review of the situation and clear actions to reduce the backlog.</p> <p>During our inspection, we found that from 1 January 2016 to 26 July 2016, 10,442 plain film x-ray examinations remained unreported. The number of potentially unreported diagnostic imaging tests prior to January 2016 was undeterminable on the day of inspection. Subsequent to our inspection, the trust submitted data demonstrating that the total number of unreported images from 2013 to 2015 was 25,622.</p> <p>There were no procedures in place to trigger the escalation of risk caused by lengthy delays in reporting</p> <p>Reports for patients referred into the departments for urgent images were not always prioritised, meaning there was a significant delay with some reports taking up to 21 days from when the image was taken before they were reported to GP referrers.</p>	

Summary of findings

A number of images undertaken at the trust were not routinely reported on by a radiology professional, however there were not robust arrangements surrounding this. This was because there was local agreements (often verbal) between the radiology and other departments, that some images were 'auto reported' meaning that they were only clinically evaluated by the referrer and not subsequently reported by a radiographer or radiologist. A standard operating procedure to formalise this process was reviewed after our inspection.

There were 11 whole time equivalent radiographer vacancies within the department at the time of our inspection and reporting radiographers were not being released from clinical duties to undertake reporting sessions due to these vacancies. There had been recent recruitment of eight radiographers; however only four had commenced employment and had not completed their induction period at the time of our inspection therefore they did not have significant impact on the capacity issues the trust was experiencing.

There had been six radiologist vacancies within the department since 2014.

Workforce capacity was not meeting the demands of the service.

Incidents.

- During our inspection, we were told that in 2013 the trust identified a 'huge backlog of many thousands of unreported images going back many years'. An audit of 4160 films, which was one months' volume of unreported plain films from the backlog, was conducted in July 2013.
- We were provided with the audit report from July 2013 subsequent to our inspection. It demonstrated that 46 films required follow up imaging, alternative imaging, or clinical follow up by the patients' specialist consultant, and that this had not been done in every case.
- 16 patients were identified where some delay in providing a radiology report may have resulted in avoidable harm. There had been some limited follow up of these patients, but no record of the definitive outcome or conclusion of any harm review. Subsequent to our inspection, the current clinical director for radiology led a review of the 16 patient's records and the outcome of their care. This concluded that no harm had been identified to any patient as a result of the delay in the radiology report.
- Following the audit of unreported films in 2013 the radiology directorate recommended that adequate resources were put in

Summary of findings

place to ensure that all imaging investigations were reported by trained radiology staff in a timely manner and that all chest x-rays should be reported contemporaneously. By the end of 2013 a substantial number of images (including chest x-rays taken before May 2013) remained unreported.

- The contemporaneous reporting of chest X-rays was instigated in late 2013 and improved the overall situation reducing unreported X-rays in 2014 and 2015. However a substantial backlog had been allowed to accumulate again in late 2015 and early 2016. This demonstrates that lessons were not being learnt from incidents and safety goals had not been set.

Records

- Radiology reports were generated electronically and stored using the Radiology Information System (RIS) and Picture Archiving and Communication Systems (PACS).
- A plain film is a two dimensional radiograph. During our inspection we saw that a number of plain film examinations were being 'auto-reported' this meant there was an expectation that the referring doctor requesting the x-ray would interpret the images and record a written clinical evaluation in the patients notes.
- Subsequent to our inspection, the trust provided a copy of the revised auto reporting policy to better reflect radiology's responsibilities for auto reporting. The policy was in draft form and was not fit for purpose in that it was not clear whose responsibility it was to audit compliance and ensure all films were reported.

Assessing and responding to patient risk

- During our inspection we saw that the trust risk register highlighted that there were delays in the reporting of plain film x-rays. This had been entered onto the risk register in 2003 and had not been regularly reviewed or prioritised. We found that there were 10,442 unreported plain film images since January 2016.
- The total number of unreported plain film images prior to January 2016 was undeterminable at the time of our inspection, as we were told that the data set would be so large it would crash the IT system. Subsequently the trust submitted data demonstrating there was an additional 25,622 unreported images from 2013 to 2015, broken down as:
 - 18,636 images from 2013
 - 3,455 images from 2014
 - 3,531 images from 2015

Summary of findings

- There had been no audit or risk assessment of the potential harm that could have been caused by this group of patients experiencing significant delays in receiving their imaging reports. The backlog of unreported diagnostic imaging tests had been increasing and there was significant potential risk to patients from undetected findings.
- Data provided prior to the inspection demonstrated that there was a lack of reporting capacity around cross sectional imaging (computerised tomography (CT) and magnetic resonance imaging (MRI)), and it appeared that routine image reporting was being undertaken across all modalities before urgent image reporting. We queried this during the inspection but staff were unable to explain the anomaly. This meant that there was no clear understanding and oversight of reporting timeframes and that urgent imaging was not being consistently prioritised.
- Data supplied by the trust prior to and during our inspection suggested that there was significant risk to patients around unreported chest and abdominal imaging. The data supplied prior to the inspection was not consistent with the data supplied during the inspection, which indicated that the trust were unclear as to the actual numbers of unreported images.
- When patients have diagnostic imaging tests to detect a suspected cancer or for specific diagnostic purposes, there should be clear reporting timeframes within referral to treatment pathways as indicated by the Royal College of Radiologists: Standards for the Reporting and interpretation of imaging investigation (2015). The RIS system had a facility to flag when examinations required an urgent report. Once flagged the reporting list reflected that the image needed urgently reporting. However during our inspection we saw evidence of x-rays on the urgent reporting list that remained unreported to the referrer for up to 17 days after the image had been taken. This meant that there could be a delay in the patient receiving treatment, thus causing potential harm.
- Radiographers we spoke with told us that when they saw an abnormality on an image they would escalate to the designated radiologist for urgent reporting. There was no evidence of this system working consistently as there were outstanding urgent x-rays on the RIS worklist. This meant that there was a delay in the escalation and reporting of identified potential anomalies, which could delay the patient commencing treatment thus causing potential harm.
- Prior to our inspection, the trust informed us that there was an escalation policy within the department that was triggered if an x-ray had not been reported ten days post exposure. However,

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during our inspection we found that there was a manual process in place managed by clerical staff who reassigned images between radiologists for reporting on an ad-hoc basis with no clinical risk assessment. This was not a formalised escalation policy and procedure, which was not in line with best practice as recommended by the RCR. Following our inspection, the trust implemented an escalation policy, which triggered when a diagnostic imaging test was unreported 13 days after exposure.

- GP referred imaging requests are considered a priority for reporting. This is because unlike other images requested within the hospital which are initially reviewed by non-radiology clinicians as part of the patients' diagnosis and treatment during their admission or attendance to an outpatient clinic appointment, images requested by GP's are not reviewed by any clinician until they are formally reported. During our inspection, we saw evidence that GP patients were waiting between 14 and 21 days for their radiology report. During our inspection, we saw that radiographers were advising patients' that the waiting time was 17 days. Therefore, there was a potential risk to GP patients of delay in diagnosis and treatment thus causing potential harm.
- A number of images undertaken at the trust were not routinely reported on by a radiology professional. Local agreements were in place to ensure that these images were clinically evaluated by the referrer. There was also an agreement whereby any x-ray that was referrer evaluated could be reported by a radiologist when requested. There was insufficient audit of these referrer-evaluated images to ensure that all images had been reviewed and had a clinical evaluation associated with each medical exposure. This agreement was not in place for some outpatient imaging or within the emergency department. Due to delays in formal reporting this demonstrated that there was a risk in the detection of subtle pathologies, particularly in chest imaging.
- Following our inspection, and as part of the radiology action plan, a clinical audit was to be undertaken to ensure images clinically evaluated outside of radiology were appropriately reported by referring teams, as per the auto reporting policy (detailed above). The reporting agreement had been recirculated to clearly indicate to staff which plain films are reported by radiology and which are the responsibility of referring teams. As this was a new audit process, we had no indication of audit findings and resulting learning.
- Assessing the appropriateness of an imaging request is called justification. All inpatient CT and MRI requests were justified by radiologists. GP and outpatient's requests were justified by a

Summary of findings

mixture of radiographers and radiologists. The hospital had recently implemented guidelines enabling radiographers to justify out of hours CT requests. This had previously been carried out by the requesting consultant discussing with the teleradiographer company that covered the hospital reporting and justification services out of hours. This meant that there was a more streamlined out of hours cross sectional service for patients.

- Radiologists justified all MRI requests and all inpatient scans received an instant report from the radiologist supporting the session. However, the MRI department was only open from 9am to 5pm seven days a week therefore urgently requested scans out of these hours could not be undertaken or reported upon until the next day.
- Following our inspection, the trust conducted a clinical assessment and quality impact assessment on the plain film backlog identified by our inspection that dated back to 2013. This was to identify any harm caused to patients due to delays in formal reporting of the images in the backlog. Radiology and respiratory consultants determined that images from the previous two years should be audited and agreed quality indicators. Images dating back to January 2016 were to be audited first then images dating back to 2014/2015. There had been initial validation of a sample of 259 chest x-rays however the trust cited the sample size was small in comparison to the backlog size. This meant that the results from the audit were not proportionate compared to the size of the backlog.
- We saw a range of printed reports from diagnostic imaging tests taken from patients who had attended the emergency department (ED). Radiographers we spoke with stated that they were required to separate the paper ED results from films that had been reported the day before into normal and abnormal results. The normal results were shredded and the abnormal results were then crosschecked against the patient's discharge summary. If discrepancies were found the ED consultant was informed. This meant that any pathologies found during the reporting of the images that were not picked up by the referrer at the time of the patients attendance in ED were followed up and patients would be recalled for either further diagnostic tests or treatment where discrepancies were found. However, because of the long delay in the reporting of images discrepancies had the possibility of taking months to be detected, meaning a delay of further tests or treatment.
- During the inspection, we reviewed some of these printed ED results awaiting radiographers to cross check against the discharge summaries. We saw that some of the chest x-rays

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taken on 31 May 2016 were not reported until 27 July 2016. However, we saw that other examinations for example ankle x-rays, hand x-rays and CT scans had been reported within 24 hours of being taken.

- There were not sufficient processes in place to ensure that patients who had chest and abdomen x-rays received timely reports due to the skill mix in the department. Radiographers were mostly trained to report plain film extremities, such as ankle and hand x-rays, whilst radiologist's capacity meant that cross sectional imaging took priority, as it required an expert review and report.
- Reporting on routine imaging was at times being undertaken before urgent imaging due to the gap in capacity for chest x-ray reporting and routine extremity imaging was found to be reported before urgent chest x-rays. Reporting radiographers were being reallocated to clinical work and radiologists were being reallocated to cross sectional reporting. This meant that the service was not always prioritising patients with the most urgent needs outside of cross sectional imaging.

Staffing

- Seven radiographers were qualified to report on x-rays. We saw that the reporting rota for the week was fully staffed; however radiographers we spoke with informed us that due to the vacancies in the radiography workforce they were not being released from clinical duties (conducting x-ray examinations) to undertake reporting sessions. This meant that reports allocated to the radiographer for reporting were being delayed. Eight radiographers had been recently recruited, four of which had commenced working within the department. When the remaining four commenced employment there would be two radiographer vacancies remaining. At the time of our inspection, four of the newly appointed radiographers were on their induction. There were two locum radiographers on duty in the department covering vacancies in plain film, and CT.
- There were six radiologist vacancies within the department; although the trust had been successful in recruiting to some of these posts, other radiologists had left the trust so the number of vacancies was the same as it had been two years previously. Staff we spoke with felt that recruitment into these posts had been affected by reputational damage caused to the trust by being in special measures. The recent Department of Health caps placed on locum rates of pay meant that the trust had found difficulties in obtaining locum cover.
- There was no workforce plan including calculations based on national workforce standards in place, to ensure that the trust

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employed or recruited the correct amount of staff to ensure that all new diagnostic imaging tests were reported according to trust policy. The clinical director felt that there was not enough current workforce capacity to support the demands of the service in particular the reporting of x-rays.

- The clinical director told us that radiologist job plans had not been reviewed annually which impacted on reporting capacity and had a direct effect on the ability to reduce reporting backlog.

Are services at this trust effective?

We have not rated this key question because this was a focused inspection to assess if there was a safe policy to ensure that all staff requesting x-ray examinations were qualified to do so, and that there was multidisciplinary working within the department.

We found that :

There was a comprehensive policy to support non-medical referrers requesting examinations and radiographers were following this policy and checking the database when they did not recognise the referrer's name. Radiologists and radiographers appeared to be working very separately.

Radiologists were attending multidisciplinary meetings, however reporting radiographers said they would like to attend these meetings as a learning opportunity but were not able to do so due to their clinical workload. Discrepancy meetings were being held separately which meant that there was not a cohesive approach to patient care. A discrepancy meeting is a meeting whereby results of an audit of a locally agreed number of x-ray examinations (as laid down in the Royal College of Radiologists guidelines), are presented and discussed. The audit is used to discuss cases where two radiologists have disagreed over the interpretation of an image. There is a general acceptance of a 2-5% discrepancy rate for all radiologists

Competent staff

- Health care professionals who are not medically qualified could undertake local training to enable them to request x-ray examinations under an agreed scope of practice and entitlement. We saw that there was a list of 333 members of staff across the trust that acted as non- medical referrers for x-ray examinations which was kept in a database. Whilst the list was too extensive to enable radiographers to remember each

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name personally, radiographers we spoke with told us that they would recognise the names of usual referrers in each location and if they did not recognise a referrer's name, they confirmed that they were aware of the database and would access this.

- We saw a comprehensive standard operating procedure to support non- medical referring.
- The trust did not appear to be fully utilising the reporting skills of radiographers within the department to reduce reporting delays. Radiographers we spoke with were keen to undertake additional reporting sessions

Multidisciplinary working

- Radiologists were attending multidisciplinary (MDT) meetings however although invited, reporting radiographers we spoke with told us that they were unable to attend these meetings due to clinical workload. These meetings were cancer review meetings where all clinicians, nurse specialists and reporting radiographers and radiologists meet to review the care of patients on the cancer pathway. They were held for each speciality for example, head and neck, and upper gastrointestinal.
- The Royal College of Radiologists (RCR) has clear guidance around peer review and discrepancy meetings whereby a routine review of a locally agreed number of reported images are reviewed by a second radiologist. The data from these meetings should be reported to the RCR if there are concerns, for example, about a particular radiologist performance. Separate discrepancy meetings for radiologists and radiographers were taking place. Best practice is to have a single discrepancy meeting where shared learning took place, hence establishing a multidisciplinary, cohesive approach to patient care.
- The trust aimed to hold radiologist discrepancy meetings monthly which lasted between 45 minutes and one hour. Staff told us that this was often impractical due to staff shortages. However it was not clear how often these meetings were actually taking place.
- Some staff we spoke with felt that all plain films should be reported on by radiographers and that this would improve the service within the department, however there was some resistance to this proposal from some radiologists.
- The trust had recently outsourced some reporting to a private tele-radiology reporting company. The company did not supply the trust with their discrepancy figures. However, the company performed its own discrepancy audits in line with RCR guidelines and this formed part of the contract with the trust.

Summary of findings

Access to information

- There were no measures in place to ensure that diagnostic imaging results were always available in a timely manner. This meant that the information necessary to provide effective care and treatment was not always available to medical staff.

Are services at this trust responsive?

We have not rated this key question because this was a focused inspection to assess if people have timely access to initial assessment, diagnosis, and urgent treatment, and if the service prioritises care and treatment for people with the most urgent needs.

We found that:

Reporting on diagnostic imaging tests were not completed in a timely manner with routine examinations being reported before urgent examinations which meant that patients in the most urgent clinical need were not always being prioritised.

Access and flow

- Patients did not have timely access to initial assessment, diagnosis and urgent treatment as plain x-ray reporting was not conducted in a timely manner.
- After our inspection the trust were asked for evidence of how they intended to manage the backlog of reporting within the radiology department. An action plan was produced which included a clear escalation process for unreported images. The threshold for escalation had been set by the trust at 13 days. The escalation process had an associated standard operating procedure, which reflected professional standards of radiology reporting timeframes.
- Internal standards for reporting were set subsequent to our inspection. The standard for the reporting of urgently requested x-rays was within an hour, and x-rays requested on patients in ED on the same day they are requested. The standard for x-ray requests for patients in hospital was 24 to 48 hours, GP x-ray requests within five working days, and outpatient x-rays within 10 working days.
- The trust had been outsourcing 500 films weekly to for external radiology reporting for three weeks prior to our inspection. Following our inspection, the trust increased the amount of films outsourced, to 1000 films per week to reduce the backlog. The 2016 backlog was cleared by 23 September 2016, with a planned trajectory to clear the 2015/2014 backlog by 21 October 2016

Summary of findings

Learning from complaints

- Staff we spoke to told us that incidents and complaints were discussed at staff meetings and those minutes of the meetings were circulated to all staff. The Patient Advice and Liaison service had received two enquiries relating to delays in X-ray reporting. There had been no complaints received from patients or clinicians.

Are services at this trust well-led?

We did not rate the service for this question as the inspection was focused to assess if the service had an effective governance framework and strong leadership and culture to support the delivery of good quality care.

The trust did not provide any evidence to demonstrate that the board were aware of the reporting backlog.

There was no effective governance framework to support the delivery of good quality care around reporting times.

It was unclear whether the senior management team were fully aware of the reporting backlog. There were no key performance indicators (KPI'S) set for turnaround times for diagnostic imaging test reporting and no escalation policy relating to unreported films at the time of inspection.

A number of management posts within the radiology department were new and roles and responsibilities were not clearly defined.

The department was fragmented with radiologists and radiographers working separately. There was a lack of communication and cohesion between them.

Governance risk management and quality measurement.

- The clinical director had been in post for 12 months and was aware of concerns around reporting times. The clinical director said he had told to the trusts executive team that the demand on radiology was in excess of the workforce and there was an inability to resolve the backlog of plain film reporting, although it is unclear whether this was formalised.
- During and subsequent to the inspection, the trust was not able to provide evidence that that the executive team had clear oversight of the outstanding unreported imaging backlog.
- Outsourcing of the unreported images to an external reporting company had commenced three weeks prior to the unannounced inspection, and after the Care Quality Commission had begun to ask for evidence of turnaround times for images and details of any backlog. There were mixed views

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within the radiology management team of how aware they and senior managers including the board were of the backlog and delays in the reporting of images. We were told by one middle manager that they and the radiology management team had been shocked by data produced in response to our queries and had instructed the team to begin to look at their systems and processes and to take action to reduce the backlog.

- At the time of inspection there were no KPI'S set for report turnaround times and no escalation policy for unreported images. This meant that the visibility of the imaging backlog was insufficient at local and senior management and board level.
- Following our inspection, we requested an action plan from the trust to deliver the required improvements. Within this action plan, there was a radiology directorate escalation policy and internal standards for the reporting of plain film images. Performance targets were to be reviewed through divisional operations meetings and directorate meetings.
- Data received after our inspection, showed that in 2012 there was also an issue with a large amount of images left unreported. Whilst this had improved again in 2013 and 2014, the measures that would have been put in place to mitigate future risk to the patients were clearly not robust enough or not monitored.
- There are clear national two and six week referral to treatment pathways for patients having a diagnostic imaging test where cancer is suspected or for specific diagnostic purposes. We saw that data analysis of diagnostic reporting timeframes were produced for the board review to review progress against these standards which was generated by the main IT department. However, this only took account of the reporting timeframes for patients in these two and six week pathways and did not provide oversight of all unreported images within the trust. This meant that data presented to the trust board did not reflect the overall performance of the radiology department and there were not sufficient governance processes in place to protect patients whose diagnostic imaging test remained unreported from actual or potential harm.

Leadership of the service

- There had been recent restructuring of the directorate that radiology belonged to. A number of management posts within radiology were new, and roles and responsibilities were not clearly defined. However, staff we spoke with had confidence in the new management team.

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- One of the new posts that had been created was that of a radiology support manager. We spoke with the radiology support manager who explained their key responsibilities which included, service improvement, and support of clinical teams to encourage new learning. They were also involved with business planning and would be involved in setting the strategy for reducing the backlog of reporting and with audit around unreported imaging.

Culture of the service

- The department was fragmented; radiologists and radiographers did not appear to be working collaboratively. It was clear that they worked independently and there was a lack of communication and cohesion.
- Radiographers we spoke with told us that they felt radiologists had little interest in reporting plain film images.
- Reporting radiographers we spoke with told us that they did not feel supported by radiologists, because although invited as a learning opportunity, they were not able to attend multi-disciplinary meetings due to their clinical workload and discrepancy meetings were held separately. One radiographer described a 'them and us' culture.
- Some members of staff that we spoke with felt that there was a lack of responsibility taken around unreported diagnostic imaging tests and that the problem had been allowed to escalate.

Innovation, improvement and sustainability

- The PACS manager had developed an in house peer review software package used in conjunction with discrepancy meetings. This useful tool assisted the recognition of discrepancies and related learning.
- After our inspection, the trust contacted the Royal College of Radiologists to request a peer review of the service and contacted another trust for assistance in making improvements within the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Actions the hospital must take to improve:

- Take appropriate steps to resolve the backlog of radiology reporting. This must include a clinical review and prioritisation of the current backlog of

unreported images, (including those taken before January 2016); assess impact of harm to patients, and apply Duty of Candour to any patient adversely affected

- Ensure that they have robust processes to ensure any images taken are reported and risk assessed in line with trust policy

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Section 31 HSCA Urgent procedure for suspension, variation etc.</p> <p>We have exercised our powers under S. 31 of the Health and Social Care Act 2008 to impose conditions on the Trust's registration because we believe that patients in receipt of care in radiology services at Worcestershire Acute Hospital's NHS Trust will or may be exposed to the risk of harm if we did not impose these conditions urgently.</p> <p>The trust did not have effective systems in place to ensure that patients using the radiology department were protected against the risks of delay in diagnosis leading to a delay in commencing treatment.</p> <p>There was a significant number of unreported images with no risk assessment of the potential harm that could be caused by patients experiencing significant delays in receiving their imaging reports.</p> <p>The board did not have oversight of knowledge of the backlog meaning we were not assured that there were suitable governance and escalation processes in place to protect patients from actual harm.</p>