Good Hope Hospital

Quality Report

Good Hope Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection at Good Hope Hospital on 22 August 2019. The purpose was to look at specific aspects of the care provided by radiology services at Good Hope Hospital, which was run by University Hospitals Birmingham NHS Foundation Trust.

Concerns were initially raised following a serious incident which occurred in the diagnostic imaging service which included the time taken to report on routine and urgent computerised tomography (CT) examinations, and the governance processes to ensure any backlog or delay in reporting was managed, escalated and resolved. 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.

Good Hope Hospital was previously managed by Heart of England NHS Foundation Trust. On 1 April 2018, a merger by acquisition took place of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust. Consequently, Good Hope Hospital is now part of University Hospitals of Birmingham NHS Foundation Trust.

A rating has not been provided for this inspection as it focused on specific key questions and key lines of enquiry. It was carried out to assess whether there was significant risk of patient harm resulting from the concerns raised.

In diagnostic imaging services our key findings were:

- There was no escalation of unreported scans due to lengthy delays, or a risk assessment process for patients waiting for their scan to be reported. We found no evidence of completed harm reviews for patients who had experienced lengthy delays in their scan being reported. However, staff responded to and acted quickly if patients deteriorated within the department. Patient records were not always up-to-date, or easily available to all staff providing care. Processes used by staff created a risk that scans could go unreported, and there was no appropriate risk assessment following the decision to migrate to a new patient records system. However, staff kept detailed records of patients' care and treatment, which were stored securely.
- Staff did not always recognise and report incidents and near misses, with variability in staff understanding around raising incidents related to delays in reporting diagnostic scans. While managers investigated incidents, local leaders were not always included throughout the entire process, and recommendations following investigations were not always implemented effectively. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.
- There were significant delays in images being reported for several diagnostic investigations, with limited action taken to address performance issues. Waiting times from referral to scan were generally in line with national standards and most people could access the service when they needed it.
- The leadership team was not yet fully established or embedded within the service, and priorities and issues faced were not well managed. However, they had the skills and abilities to run the service. Leaders were visible and approachable in the service for patients and staff.
- There were ineffective governance processes within the service. Staff at all levels were unclear about their roles and accountabilities. While staff had regular opportunities to meet and discuss the performance of the service, limited action was taken to address issues.
- Leaders and teams did not always identify and escalate relevant risks and issues and did not implement actions to mitigate their impact. Risks were not always graded appropriately.
- There were no clear responsibilities or robust arrangements for data management and audit across radiology information systems. While the service collected data, it was not analysed and no actions were taken to address concerns or improve performance. However, staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations to help the service improve. We also authorised conditions to be imposed on the trust's registration, as we believed patients may have been exposed to the risk of harm if they were not imposed urgently. Details are included at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals (Midlands Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging		We carried out an unannounced focused inspection of the diagnostic imaging service at Good Hope Hospital on 22 August 2019, in response to concerning information we had received in relation to a serious incident. We did not inspect any other core services, or any other locations provided by University Hospitals Birmingham NHS Foundation Trust. We did not cover all key questions or lines of enquiry and we did not rate this service at this inspection. We inspected elements of safe, responsive and well led.

Summary of findings

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Services we looked at:
Diagnostic imaging

Summary of this inspection

Background to Good Hope Hospital

Good Hope Hospital is operated by University Hospitals Birmingham NHS Foundation Trust.

The diagnostic imaging service at the trust provides care and treatment across four sites; Queen Elizabeth Hospital Birmingham, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. The trust had 2,477 inpatient medical beds across the four sites, with 485 of these beds based at Good Hope Hospital.

We carried out an unannounced focused inspection of the diagnostic imaging department at Good Hope Hospital on 22 August 2019. This was in response to concerns which were initially raised following a serious incident. The trust was given the opportunity to respond but when satisfactory assurances were not received, the local inspection team decided to conduct an unannounced inspection. We looked at the time taken to report on routine and urgent computerised tomography (CT) examinations. We also looked at the governance processes to ensure any backlog or delay in reporting was managed, escalated and resolved. We also looked at standard operating procedures within the department.

Our inspection team

The team who inspected the service comprised a CQC inspection manager, a CQC inspector, and two clinical specialist IR(ME)R inspectors, who provided diagnostic imaging specific clinical knowledge. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Good Hope Hospital

Diagnostic imaging services provided by the trust are located at four sites: Queen Elizabeth Hospital, Good Hope Hospital, Solihull Hospital and Heartlands Hospital. Services provided at Good Hope, Solihull and Heartlands Hospitals are managed by one management team predominantly based at the Queen Elizabeth Hospital.

The diagnostic imaging service forms part of the Clinical Support Services division (CSS). The current structure includes a divisional director, divisional head of nursing and a divisional director of operations. This team is supported by speciality leads and a general manager across all sites. Radiology services at Good Hope Hospital are led by a site head of imaging, who is supported by department/service leads.

The diagnostic imaging department at Good Hope Hospital offers a wide range of diagnostic imaging services including; ultrasound, magnetic resonance imaging (MRI), plain film X-ray, fluoroscopy, nuclear medicine, computed tomography (CT), mammography, bone densitometry (DEXA) and interventional radiology.

Diagnostic imaging also occurs in the clinical investigations department. These investigations included non-radiological investigations, such as electrocardiograms, heart monitoring, respiratory function testing and echocardiograms. These were performed by specialist technicians within an outpatient's clinic.

During the inspection, we visited all areas providing diagnostic imaging services at the hospital, observed patient care and treatment and looked at four patient care records. We spoke with eight members of staff, including radiographers, radiologists, ultra-sonographers, nurses, healthcare support workers, administrators, unit managers and senior managers. We also considered the environment and reviewed the trust's diagnostic imaging performance data.

Diagnostic imaging

Safe	
Responsive	
Well-led	

Are diagnostic imaging services safe?

We inspected but did not rate safe

Assessing and responding to patient risk

There was no escalation of unreported scans due to lengthy delays, or a risk assessment process for patients waiting for their scan to be reported. We found no evidence of completed harm reviews for patients who had experienced lengthy delays in their scan being reported. However, staff responded to and acted quickly if patients deteriorated within the department.

There was no clear pathway or process to assess patients who deteriorated while waiting for their scan to be taken or reported, with no clear lines of accountability for the monitoring and escalation of imaging reports. During our inspection, we spoke with staff, in various roles, across the service and there was confusion around who was responsible for escalating delays in reporting scans. While the service produced a range of performance reports, including lists of unreported scans, we found little evidence actions were taken to address issues identified.

Following investigation into a serious incident (SI) which occurred in October 2018, one of the recommendations was for all unallocated images to be immediately added to a shared reporting pot, from which scans could be reviewed by clinicians to ensure they were not missed. However, during our inspection we found the diagnostic imaging service did not have a report and were unable to monitor the number of scans which were not assigned a reporting pot. We also found 445 scans which fell outside of the trust's performance targets and were assigned to a 'blank radiologist'. This presented a risk as patients' images could go unreported due to not being assigned to a reporting pot, with clinicians unable to monitor and report on scans not assigned to pooled reporting pots.

Following our inspection, the trust provided evidence of 1056 unreported scans which were outside of the hospital's key performance targets. The number of unreported scans presented a risk to patients due to the potential delay in treatment. We found no evidence of audits or risk assessments relating to the potential patient harm caused by delays in image reporting. Therefore, we were not assured that patients had not been harmed due to delays.

Referrals to the imaging service were received via several methods, including patients GPs and consultants. The service maintained an up-to-date master copy of staff who were eligible to refer patients for investigations according to the staff members competency and training, including non-medical referrers. On receipt of the referral, the investigation was screened against set criteria for appropriateness, to ensure the right investigation was being requested according to the patient's complaint. If there were any concerns, the screening radiographer or radiologist would contact the referrer to discuss alternatives.

Staff used a nationally recognised tool to identify deteriorating patients within the department and escalated them appropriately. There were clear pathways and processes for the assessment of patients who became unwell within the radiology department. Staff told us what action they would take if a patient became unwell or distressed while waiting for or having a scan. They said this depended on the specific situation and gave us examples which indicated they would take appropriate action.

Emergency equipment such as a resuscitation trolley located within the department, were in date and available to staff in a medical emergency. They were well equipped and maintained, with daily and weekly checks recorded. We found no issues or concerns with the recordings.

Anaphylaxis emergency boxes were also accessible and located throughout the department to respond to deteriorating patients. For example, the anaphylaxis box was used for patients requiring contrast media prior to an MRI scan should they experience a reaction. Contrast

media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations. Anaphylaxis is a serious, life threatening allergic reaction which can be triggered by medicines.

Emergency pull cords were available in areas where patients were left alone, such as toilets, and emergency call buzzers were available within the MRI and CT scanning rooms to alert staff. There was an emergency 'stop' switch located in the MRI imaging suite, which staff could activate if they needed to urgently stop the scan, for example to access the room in an emergency. The radiographers could confidently describe the process to quench the magnet.

Staff completed risk assessments for each patient on arrival and updated them when necessary and used recognised tools and staff knew about and dealt with any specific risk issues. There were processes to ensure women, who were or may be pregnant, always informed a member of staff before they were exposed to any radiation, in accordance with Ionising Radiation (Medical Exposure) Regulations IR(ME)R. Processes were in place to identify any pre-existing clinical conditions a patient may have which could impact on the ability to perform the investigation. For example, patients with an impaired kidney function received a different dose of contrast media. Staff checked patients, who required a contrast media, were not allergic to any substances prior to administering the medicine. An anaphylaxis box was available in scanning rooms if patients were to react to any substance.

The Society of Radiographers "pause and check" system was used across all areas with posters displayed. Pause and check refers to the Society of Radiographers operator checklist which prompts radiographers to confirm the patient and the investigation using set prompts. Patients when called into the department should always be asked to confirm their identity, by giving their full name, date of birth and address.

The diagnostics service appointed radiation protection supervisors (RPS), whose role was to ensure staff followed the hospital and trust standard operating procedures and adhered to the radiation protection procedures. The was in line with Ionising Radiation Regulations 2017 (IRR17) guidance. IRR17 guidance states the number of RPS' should be determined by the number of different locations, the range and complexity of radiation work undertaken, and factors, such as shift work, and any planned/ unplanned staff absence. IRR17 also requires employers to keep exposure to ionising radiations as low as reasonably practicable. The role of the radiation protection advisor (RPA) and medical physics expert (MPE) were fulfilled internally by the trust, and staff described them as readily accessible and there was a good working relationship.

Local rules were available in all imaging suites. Local rules identified risks, including steps taken by staff to ensure scanning procedures were completed safely. For example, the service had local rules and employers' procedures (IR(ME)R) in place to protect staff and patients from ionising radiation. The service had a health and safety executive registration certificate for use of ionising radiation, which they provided us following the inspection.

Records showed radiographers had been inducted and trained on the imaging equipment they used. Data provided by the service showed all staff working as operators under IR(ME)R had undertaken a recognised academic course of training and were registered with the Health & Care Professions Council. We observed records indicating staff had read the local IR(ME)R procedures.

The diagnostic service used World Health Organisation (WHO) safety checklists, and we saw completed checklists were used when appropriate. An audit of the WHO safety checklists was completed to ensure appropriate safety checks had been completed and documented before, during and after a scan. Audits from April to July 2019 demonstrated 94% compliance across all diagnostic investigations. Service leads told us the service aimed to be 100% compliant in the completion of WHO safety checklists. The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health), and staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Staff told us they could access the psychology team who could assess and support patients' mental health when required.

Records

Diagnostic imaging

Patient records were not always up-to-date, or easily available to all staff providing care. Processes used by staff created a risk that scans could go unreported, and there was no appropriate risks assessment following the decision to migrate to a new records system. However, staff records of patients' care and treatment, were stored securely.

The service used two electronic patient record systems. The Radiology Information System (RIS) and the Picture Archiving and Communication System (PACS). RIS was a password protected record of patient's demographics and was used to book patients into vacant investigation slots. PACS was used for storing completed images and the associated reports. It was password protected and accessible to radiology staff for reporting and clinicians who had requested the image. The trust was in the process of moving all hospital sites, including Good Hope Hospital, to one system, as different systems were used across the different sites. During our inspection, staff at Good Hope Hospital, were unable to view information held in each of the separate RISs across the trust, which included vacant investigation slots leading to delays. Despite the risk of data quality and integrity issues, associated with migration to a new electronic records system, we found there was no effective system to identify and assess the risk.

During our inspection, we observed the use of the RIS by staff and identified there was a risk patients' images could go unreported due to the filters applied to the view used by clinicians and radiographers. The standard filter used to view images for reporting showed only those within predefined time frames. However, scans which were outside of this range were not displayed and this could lead to delays in them being reported. Due to our concerns in relation to the performance reports and escalation of delays, we were not assured patients would not be missed and lead to delays in image reporting and potential harm.

Patient notes were not always comprehensive, with access to up-to-date, accurate and comprehensive information on patients' care and treatment not always possible. Staff told us clinical history for some patients was not always shared with radiology when scan results were received from other hospitals or providers and was not available in the patients record. When patients transferred to a new team, there were no delays in staff accessing their records. The radiology team received patient referrals through a secure email, by telephone or post from the referring consultant or hospital. Appointments were booked in advance, and patients were sent letters to confirm their appointment details. If appointments were booked at short notice, staff would telephone patients to ensure they were aware of the appointment. The hospital provided referrers with electronic diagnostic imaging reports which were encrypted. Staff told us there were no issues with delays in receiving scan results from other hospitals or providers.

Records were stored securely. Throughout the radiology department, care was taken to ensure computer screens were not accessible or in view of unauthorised persons. Computers were locked when not in use. There was a clear standard operating procedure for staff to follow in the event of IT failure. Computer access was password protected and staff used individual log-ins. Paper documentation such as referral requests were stored securely and destroyed in line with trust policy. Staff received training on information governance as part of their mandatory training programme which was up to date.

Incidents

Staff did not always recognise and report incidents and near misses, with variability in understanding around raising incidents related to delays in reporting diagnostic scans. While managers investigated incidents, local leaders were not always included throughout the entire process, and recommendations following investigations were not always implemented effectively. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff generally knew what incidents to report and how to report them. Staff generally reported all incidents that they should report. While staff understood their responsibilities to raise concerns and to report safety incidents internally and externally, some staff were unaware of the types of issues they should report and record as incidents. There was variable understanding

among staff of raising incidents related to delays in reporting diagnostic scans, despite significant numbers of scans reported outside of the hospital's key performance target.

The hospital used an electronic online system for reporting incidents. Incidents were categorised according to the severity of harm. Most incidents resulted in no harm. Staff throughout the radiology department described the process for reporting incidents and were confident in using the system. All staff we spoke with had received training and were encouraged to report incidents, including near-miss situations. Staff understood their responsibilities to report incidents.

During the reporting period from February 2019 to August 2019, there were 71 incidents reported across diagnostic imaging services at Good Hope Hospital. Of these, 21 were non-radiation, and 49 were radiation related incidents. The incidents were categorised into those that resulted in near miss (five), no harm (34), and low (10). The most frequently reported themes for incidents included procedure stopped/abandoned (24), operator error (14) and delay in scan/x-ray at attendance (nine). The remaining 23 incidents related to topics which included operator error (e.g. wrong exposure set, wrong radioactive medicinal set) and referrer error (e.g. wrong anatomy or modality, unnecessary request). There were eight incidents reported during the reporting period which related to a delay in clinical diagnosis due to timeliness of reports. Due to staff awareness of what types of incidents to report, we were not assured that these represented all incidences of patient harm due to reporting delays.

The trust also provided evidence of 15 IR(ME)R reportable imaging incidents. Staff could describe how they would manage and report IR(ME)R incidents. Managers told us all incidents would be reported following the incident reporting procedure and escalated to the radiation protection advisor (RPA) and radiation protection committee meeting. There was a medical physics expert available for advice when needed. All radiation incidents had a completed root cause analysis (RCA) which included action plans.

Managers debriefed and supported staff after any serious incident. Staff told us when they reported an incident, they discussed it with their manager and when feedback was returned they had further discussions about what improvements could be made to prevent it from reoccurring.

The service had one serious incident (SIs) during the reporting period. Staff were aware of the serious incident which was raised in October 2018 related to a delay in reporting of a CT scan and subsequent missed diagnosis.

The service had no never events, however managers shared learning with their staff about never events that happened elsewhere if applicable. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. From April 2015, healthcare providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and give reasonable support to the person. Staff said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. Staff were familiar with the terminology used to describe their responsibilities regarding the duty of candour regulation. Staff described a working environment in which any errors in a patient's care or treatment were investigated and discussed with the patient and their relatives, however there was a lack of awareness around the impact of reporting delays on patient care. Following our inspection, we identified two urgent images which had waited over eight weeks to reach the referrer which had not been incident reported. This posed a risk due to timeliness of associated treatment.

Managers investigated incidents thoroughly, however local leaders in the department were not always involved in the investigation from the beginning of the process. Patients and their families were involved in these

investigations. During our inspection, we reviewed a serious incident report which occurred in the diagnostic imaging service and found comprehensive investigations were completed, with lessons learned and arrangements for shared learning. We saw evidence of action plans to reduce recurrence and that duty of candour was applied to incidents where appropriate. However, we also found that local managers within the service had not been involved in the investigation or report until towards the end of the process and investigation. Reports were not always written by a member of staff from the service and managers had little input into the development of the report. This could lead to inaccuracies in the report due to potential confusion of how the service operates. The service held discussions with patients and their families who were invited to discuss the outcome of the investigation.

There was evidence that some changes had been made as a result of feedback, however recommendations were not always followed or implemented. Following the SI investigation in October 2018, one of the recommendations was for a robust system to be implemented to check for unallocated scans. During our inspection, we found 433 plain film x-ray scans which fell outside of the trust's performance targets which were assigned a 'blank' radiologist on the radiologist imaging system. Of these 148 were two weeks past the trust's performance target. This presented a risk as patients' images could go unreported due to not being assigned a reporting pot, which had previously been raised as an issue during the SI review.

Following learning from incidents, staff attended Continuing Professional Development (CPD) lectures to highlight and demonstrate how to spot pulmonary embolism (PE), and a process was changed to ensure CT pulmonary angiogram (CTPA) scans were reviewed within four hours.

Staff received feedback from the investigation of incidents, both internal and external to the service, and staff met to discuss the feedback and look at improvements to patient care. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas at staff team meetings and by a global email. During team meetings improvements were discussed and learning shared, with administration staff also invited to clinical team meetings to ensure they are included in the learning from all incidents.

Are diagnostic imaging services responsive?

We inspected but did not rate responsive.

Access and flow

There were significant delays in images being reported for several diagnostic investigations, with limited action taken to address performance issues. Waiting times from referral to scan were generally in line with national standards and most people could access the service when they needed it.

While managers monitored waiting times, we found little evidence action was taken to address delays in scans being reported. While most patients could access services when needed and received treatment within agreed timeframes and national targets, a significant number of patients experienced delays due to their scans being unreported. The diagnostic imaging service aimed to ensure all appointments met the six-week diagnostic target. This target meant less than 1% of patients should wait six weeks or more for a diagnostic test. Any patient with a suspected cancer diagnosis should also be seen within two weeks of referral as part of the cancer pathway national target. Following our inspection, the trust provided us with the waiting times for four of the national reported diagnostic tests. This showed that of July 2019, the six-week standard was met for one of the four reported diagnostic tests, 100% of patients received their investigation within six weeks of referral for Dual-energy X-ray absorptiometry (DEXA) scans. However, 1.42% of MRI, 2.32% of CT and 3.95% of non-obstetric ultrasound patients waited over six weeks for a scan. Across all diagnostic investigations, data provided showed that 1.92% of patients waited six weeks or more for a diagnostic test.

Following our inspection, we also asked the trust to provide information on image reporting. There are two waiting periods for imaging investigations. The waiting time between referral and the image being taken and the time for the image to be interpreted by a radiologist

Diagnostic imaging

(termed reported). Patients' treatment often relies on the reporting of an image to their clinician. Evidence provided by the trust showed as of 27 August 2019 there were 2380 unreported MRI (magnetic resonance imaging), CT (computerised tomography) and plain film images, relating to patients who had attended Good Hope Hospital. Of these, 533 MRI, 238 CT and 265 plain film scans, were outside of the providers key performance target, which required GP and outpatient scans to be reported in less than 10 working days. The longest delay reported was 71 days for an MRI scan. The average number of days waited across the three diagnostic investigations was 21.

We found there were no processes or procedures to trigger the escalation of risk caused by lengthy delays in image reporting, and there were no clear lines of accountability for the monitoring and escalation of imaging reports. The performance reports sent by the trust showed little evidence of actions taken to address issues identities.

The performance reports that were run were generally assigned to administrative members of the team, rather than clinicians. As such there was limited clinical oversight of the data in the reports, which led to incidences of missed unreported images. For example, performance reports for computerised tomography (CT) were sent and assigned to administrative staff and service leads rather than clinicians. During our inspection we identified an MRI scan which was unreported from 26 May 2019 which we raised with the service. The scan was reported on the same day with no harm identified due to the delay in reporting. However, staff were unable to say why the report had been delayed, or why it had not been escalated for reporting urgently.

The trust also provided evidence demonstrating a further 445 images fell outside of trust performance targets which were assigned a 'blank' radiologist' on the providers radiology imaging system (RIS). Of which 148 were delayed two weeks past the trust's performance target. This presented a risk as patients' images could go unreported due to not being assigned to a reporting silo, with clinicians unable to monitor and report on scans not assigned to pooled reporting silo.

We found reports for patients referred into the departments for urgent images were not always prioritised, meaning there was a delay with 112 urgent reports taking over four weeks. This fell significantly outside of the providers performance targets of two weeks from when the image was taken to the report reaching the referrer. Of these, two urgent images waited over eight weeks to reach the referrer and posed a risk due to timeliness of associated treatment.

There were delays in patients having CT coronary angiogram scans performed due to patients first requiring an EGFR blood test. These delays were caused by referrers not requesting them when submitting the imaging request, and limited engagement with pathology to get the patients seen in a timely manner. This led to delays in patients having their scan. Staff told us it had been raised as an issue at divisional level meetings, however there had been no improvement or changes made as a result. During our inspection we saw a patient had been waiting for a CT for 20 weeks but was unable to have their scan until the blood test had been completed.

There was also a risk patients' images could go unreported due to the filters applied to the RIS view used by clinicians and radiographers. The standard filter applied to view images for reporting only showed those within the national target (e.g. six weeks). Staff applied date filters due to speed limitations with the RIS and to ensure it was functional. However, scans which fell outside of this range, were not displayed and would not be reported on. Due to our concerns related to the performance reports and the escalation of these, we were not assured patients would not be missed and could lead to delays in image reporting.

Managers and staff worked to make sure patients did not stay longer than they needed to. Appointments generally ran to time; reception staff would advise patients of any delays as they signed in. Staff told us they would keep patients informed of any ongoing delays.

Are diagnostic imaging services well-led?

We inspected but did not rate well led.

Leadership

The leadership team was not yet fully established or embedded within the service, and priorities and

issues faced were not well managed. However, they had the skills and abilities to run the service. Leaders were visible and approachable in the service for patients and staff.

The management and reporting structure across the diagnostic service was unclear, with leaders unsure who they should report to and who was responsible for areas of concern. The diagnostic imaging service was part of the Clinical Support Services division (CSS). The directorate was led by a divisional director, divisional head of nursing and a divisional director of operations. While there was a clear management structure at a senior and divisional level, with clear lines of accountability, it appeared disorganised at a local level within the department.

The service was managed by a general manager who worked across all sites for the trust, a site head of imaging, supported by a deputy head of imaging and dedicated modality leads. The service had undergone a significant amount of change among its senior leaders, with three general managers in the past 12 months. During our inspection, the head of imaging was unavailable and had been since August 2018. In the head of imaging's absence, the daily management of the service was performed by the deputy head of imaging, who stepped up into the management role from a previously operational position. There were also vacancies in service leads. For example, staff told us the lead for ultrasound left due to a high workload and was not replaced as the service were not recruiting to that position. The ultrasound service was now managed by two lead sonographers.

We spoke with senior members within the team and found they were all aware of the plans for the service. They did not fully understand the challenge to quality and sustainability the service faced, including significant delays in reporting. We recognised the vision and strategy presented by the new general manager was a positive step towards making improvements and would take time to fully embed.

Across the service, staff told us they could approach immediate managers and senior managers, with any concerns or queries. Most staff throughout the diagnostic service told us they felt supported, respected and valued by their immediate line manager.

Governance

Leaders did not operate effective governance processes, throughout the service. Staff at all levels were unclear about their roles and accountabilities. While staff had regular opportunities to meet and discuss the performance of the service, limited action was taken to address issues.

The diagnostic imaging service did not have governance systems that ensured there were structures and processes of accountability in all areas to support the delivery of good quality services. There was a disorganised management and reporting structure throughout the department and staff were often unclear about their roles. Staff we spoke to said there was confusion and a lack of understanding about what they were accountable for. While clinical staff told us they were professionally accountable for the service and care that was delivered within the department, when there were issues which affected patient care, staff were unsure who they should report to and who was responsible for areas of concern.

During our inspection we identified scans which had not been reported for a significant period, had fallen outside of the trusts performance targets and presented a risk to patients due to a delay in diagnosis and treatment. We found no evidence of governance arrangements to support the escalation and resolution of delays in scans being reported. There were no standard operating procedures around who was responsible for what processes need to be followed for unreported or unallocated images. Following a serious incident in October 2018, a recommendation from the subsequent coroner's report was for updated standard operating procedures to include guidance for staff on what to do with diagnostic images and scans. During the inspection we found no improvement and remained concerned as the risks were not mitigated with the new procedures.

Staff told us modality leads attended a weekly meeting to discuss topics including training compliance, recent incidents, changes to processes and procedures and imaging performance. Modality leads produced performance reports, however we found little evidence that staff who reviewed these reports had taken any action to address issues identified.

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There was a radiation protection committee meeting which was held annually as well as monthly meetings between modality leads and the radiation protection supervisors. The radiation protection committee met to discuss any issues relating to radiation protection, and they followed a set agenda with items covering; updates on trust policies, validation of key documents, changes to the Ionising Radiation Regulations 1999 to the Ionising Radiation Regulations 2017 (IRR17) and regulations with the Health and safety Executive.

Managing risks, issues and performance

Leaders and teams did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Risks were not always graded appropriately.

The service had arrangements for identifying, recording and manging risks, however there was no clear management of the risk register. The radiology service had a divisional risk register which identified key risks at the Good Hope Hospital. The risk register included 12 radiology specific risks which included, 10 risks rated as moderate and two risks rated as high. Risks were categorised as, high, moderate or low risk and scored accordingly.

The two high risks included:

- Sustainability and safety of the provision of the interventional radiology service.
- Age profile of imaging equipment due to lack of investment.

Moderate risks included areas like, obsolete equipment leading to poor image quality, unreliability of equipment due to age, and potential delay in treatment for patients due to imaging reports not available or highlighted to clinicians. No mitigating actions were included on the risk register.

During the inspection, staff were unable to say what their top three risks were and were unaware of recent changes made to the online portal for viewing their risks. Staff told us it was a recent change made by IT, however we noted the update occurred in April 2019, suggesting that they had not reviewed their risk register for some time. There were also concerns around the grading of incidents and risks. We saw the serious incident related to a patient death was recorded on the incident report as a 'low risk', despite resulting in the patient's death. Despite the risk and danger posed by the planned migration of data to the new radiology information system (RIS) of unreported images, this was not recorded on the risk register as a concern.

When risks were identified and escalated, leaders did not always attempt to mitigate them. Staff told us of delays in patients having CT angiogram scans due to waiting for an EGFR blood test. Staff told us it had been raised as an issue at divisional level meetings, however there had been no improvement or changes made as a result.

Local risk assessments for all modalities and imaging suites were in place and were overseen by the modality leads and the general manager and deputy head of imaging. Risks regarding radiation were monitored through the local radiation protection committee.

Managing information

There were no clear responsibilities or robust arrangements for data management and audit across radiology information systems. While the service collected data, it was not analysed and action was not taken to address concerns or improve performance. However, staff could find the data they needed, in easily accessible formats, to understand performance and make decisions and. The information systems were integrated and secure.

Electronic systems were used to monitor quality of care and performance measures and the service had a range of performance measures which were regularly captured and reported. For example, these included referral to scan times and scan to report times. However, the service did not effectively review the data collected as it was not used to drive forward changes and improvements. For example, we saw delays in scans being reported with little evidence staff who reviewed performance reports had taken any action to address. During our inspection, we found the service carried out few audits of performance reports that were produced and did not monitor some key performance indicators. For example, they did not monitor the number of scans which were not assigned a 'reporting pot, which was raised as a recommendation following a review of a serious incident which occurred October 2018.

Diagnostic imaging

The service was aware of the requirements of managing a patient's personal information in accordance with relevant legislation and regulations. General Data Protection Regulations (GDPR) had been reviewed to ensure the service was operating within the regulations. Staff had completed General Data Protection Regulation (GDPR) training and understood their responsibilities. Staff were encouraged to report any potential data breaches, and the hospital had a procedure for reporting breaches to the Information Commissioner's Office (ICO).

During the inspection, we saw appropriate use of computers with no screens detailing patient information left unattended. There were enough computers available to enable staff to access the system when they needed to. Computers were available in all the areas we visited. All staff had secure, personal login details and had access to email and all hospital information technology systems.

Policies were stored on the hospital's intranet and were easily accessible. Staff we spoke with could locate and access relevant polices and key records easily. All staff had access to the hospital's intranet to gain information on policies and national guidance, and to access online e-learning training. Staff told us when documents were updated they received an email informing them of the changes, which were also discussed at team meetings. This process was used to cascade new standard operating procedures, key documents and policies. We saw there was a form for staff to sign to confirm they had received and reviewed updated documents.

There was a risk management system where incidents and complaints were recorded. There were also systems to ensure that data and notifications were submitted to external bodies as required.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is a process to manage the reporting of images including escalation for unreported images. (Regulation 12.2 (a) (b) Safe care and treatment).
- The provider must ensure there are clear responsibilities and effective arrangements for data management and audit across radiology information systems. (Regulation 12.2 (a) (b) Safe care and treatment).
- The provider must implement effective approaches to ensure the identification and prioritisation of appointing and reporting of urgent examinations. (Regulation 12.2 (a) (b) Safe care and treatment).
- The provider must ensure there is an effective system to identify and assess the risk posed by the migration of data to the new RIS system of unreported images. (Regulation 17.2 (b) Good governance).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Section 31 HSCA Urgent procedure for suspension, variation etc. We have exercised our powers under Section 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 of radiology services at Good Hope Hospital will or may be exposed to the risk of harm if we did not impose these conditions urgently. 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. A number of images fell outside of trust performance targets which were assigned a 'blank' radiologist' on the providers radiology imaging system. This presented a risk patients' images could go unreported due to not being assigned to a reporting silo, with clinicians unable to monitor and report on scans not assigned to pooled reporting pot. Reports for patients referred into the departments for urgent images were not always prioritised, meaning there was a delay with a number of urgent reports taking over four weeks. There were no procedures in place to trigger the escalation of risk caused by lengthy delays in image reporting, and there were no clear lines of accountability for the monitoring and escalation of imaging reports. The performance reports sent by the provider following our inspection showed little evidence actions were taken to address issues identified. The performance reports were generally assigned to administrative members of the team with no clear clinical oversight of the output of these reports. This led to incidences of unreported images being missed.