

## **HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

### **26 SEPTEMBER 2016**

## **RADIOLOGY**

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### **Summary**

1. The Health Overview and Scrutiny Committee (HOSC) has requested an update on Radiology Services at Worcestershire Acute Hospitals NHS Trust (The Trust).
2. An unannounced inspection of radiology in July, by the Care Quality Commission, found a backlog of scans had not been reported on. The Trust has since launched its own independent review of radiology, and the HOSC would like to understand the issues involved and what action is being taken.
3. Representatives from Worcestershire Acute Hospitals Trust have been invited to the meeting.

### **Background**

4. Worcestershire Acute Hospital NHS Trust's Radiology Department provides scans, X-rays and procedures to diagnose a range of conditions.
5. In July, the Care Quality Commission (the independent regulator of health and social care in England) was prompted to inspect the Trust's Radiology Departments across its three hospitals in Worcester, Redditch and Kidderminster, after concerns were raised about unreported scans and the potential impact on patients' health.
6. The Trust had a backlog of X-rays to be reported by radiology, including 5,754 from January to August 2016, and 6986 unreported films from 2015 and 2014.
7. The X-rays in the backlog are for A&E (38%), inpatients and day-cases (40%), routine GP requests (12%) and outpatients (9%). The vast majority of plain films in the backlog (88%) are therefore for patients attending hospital who have an X-ray, which are routinely reviewed by the requesting clinician, mostly on the same day, to determine a care plan. The Trust policy is to perform a second radiology review and report to check the diagnosis and pick up 'incidental' diagnoses that may have been missed by the requesting clinician, potentially speeding up and improving patient treatment.
8. An action plan has been developed to tackle the backlog in radiology, and the Trust plans to clear the backlog of higher priority X-rays by the end of August, and the remainder in the 6 month backlog by October 2016.
9. A clinically led review of the backlog in 2013 suggested no harm could be found as a result of delays in radiology reporting.

10. A formal harm review will be conducted for completeness, and as the Trust clears the backlog, any films in the backlog that have incidental findings will be logged on the Trust's incident register for further review.

11. Any potential harm to patients identified as the backlog is reported will be followed up and the outcome reviewed at the Trust's Quality & Governance Committee.

## **Purpose of the meeting**

12. HOSC members are invited to:

- consider and comment on the information provided
- determine whether any further information is required at this stage

13. In doing so, HOSC members may wish to consider

- previous and future service provision and performance
- impact on service users, including numbers affected
- the Trust's overall performance monitoring systems

## **Contact Points**

### Specific Contact Points for this report

Emma James / Jo Weston, Overview and Scrutiny Officers, Tel: 01905 844964 / 844965  
Email: [scrutiny@worcestershire.gov.uk](mailto:scrutiny@worcestershire.gov.uk)

### Worcestershire Acute Hospitals NHS Trust

Rab McKewan, Chief Operating Officer, Tel: 01905 760808  
Email: [rab.mcewan@nhs.net](mailto:rab.mcewan@nhs.net)

## **Background Papers**

In the opinion of the proper officer (in this case the Head of Legal and Democratic Services) the following are the background papers relating to the subject matter of this report:

Worcester News Press release on 10 August 2016

[http://www.worcesternews.co.uk/news/14673973.Independent\\_review\\_launched\\_into\\_X\\_ray\\_backlog\\_uncovered\\_at\\_Worcestershire\\_hospitals/](http://www.worcesternews.co.uk/news/14673973.Independent_review_launched_into_X_ray_backlog_uncovered_at_Worcestershire_hospitals/)