2023

National Radiology Quality Improvement (NRQI) Programme

SUMMARY REPORT

What is the NRQI Programme?

The NRQI Programme was established in 2009 in response to cancer misdiagnosis reports to enhance quality improvements in local hospitals and nationally within radiology.

Reporting Timeline

1st January - 31st December **2023**

Key Quality Indicators

CLICK HERE FOR DETAILED DESCRIPTIONS AND TARGETS

- Peer Review
- Radiology Alerts
- Radiology Quality Improvement (RQI) Meetings
- Report Turnaround Time (TAT)

48 Public and Voluntary Hospitals

68 Clinicians Involved

(Out of a possible 51. Private hospitals are due to start joining the Programme in the near future)

How is information collected and used by the Programme?

CLICK HERE FOR DETAILS

Words and Phrases to Help You Understand Report Findings

- Radiologist
- Radiology
- Emergency Department
- GP Referral
- Inpatient Referral
- Outpatient Referral
- Outcomes (Peer Review)
- Key Quality Indicator
- Target
- Recommendation

RCSI FACULTY of RADIOLOGISTS and RADIATION ONCOLOGISTS

HSE

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

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Report Turnaround Time (TAT)

Referral Source	CT	MRI	US	XR
Emergency Department	12 hours			48 hours
Inpatient	24 hours			72 hours
Outpatient	10 days			
General Practitioner	10 days			

19 out of 41 radiology departments met the 90% report turnaround time target
(Note: some smaller radiology departments upload their data under bigger radiology department accounts This is why you will see 41 accounts in the report findings).

GP REFERRALS
The national average of CT, MRI and Ultrasound cases met their targets in 2023. No change from 2022 findings.

X-ray cases met the target, with a 5% increase from 2022.

INPATIENT REFERRALS
The national average of CT, MRI and Ultrasound cases met their targets in 2023. No change from 2022.

X-ray cases did not meet target. No change from 2022.

EMERGENCY DEPARTMENT
The national average of CT and Ultrasound cases met their targets in 2023, similar to 2022.

MRI and X-ray cases did not meet their targets, similar to findings in 2022.

OUTPATIENTS REFERRALS
In 2023, the national average of CT, MRI and Ultrasound cases met their targets. X-ray cases did not meet the target.

No change from 2022 findings.

WHAT DOES THIS MEAN FOR PATIENTS?

Delays in report turnaround times, may lead to longer waiting times for diagnosis or results for patients. Individual radiology departments are greatly effected by growing workload and the resources that are available. Importantly, not meeting the target does not necessarily mean that these departments are underperforming, rather, it may reflect the challenges they face in managing their department workload and the available supports.

Peer Review

PROSPECTIVE PEER REVIEW
The majority of these reviews were completed for MRI cases at 79% in 2023, an increase of 20.7% from 2022.

The percentage of these reviews carried out on CT cases was 15.2%, no change from 2022.

The percentage of these reviews carried out on X-ray cases decreased from 19.3% in 2022 to 1.4% in 2023.

RETROSPECTIVE PEER REVIEW
In 2023, the highest number of these reviews took place for CT cases at 45.5%, an increase of 12.6% from 2022. Followed by X-ray at 38.2% (decrease from 2022) and MRI at 10.9% (increase from 2022).

ASSIGNED PEER REVIEW
Agreement with the initial diagnosis was recorded in the majority of these cases in 2023 at 95%.

WHAT DOES THIS MEAN FOR PATIENTS?

Peer review is an important activity because it can help to ensure high-quality patient care. Radiologists are encouraged to look for second opinions, which helps prevent errors and can ensure more accurate reporting of patient cases. A decrease in the amount of peer reviews taking place can affect the quality of patient care.

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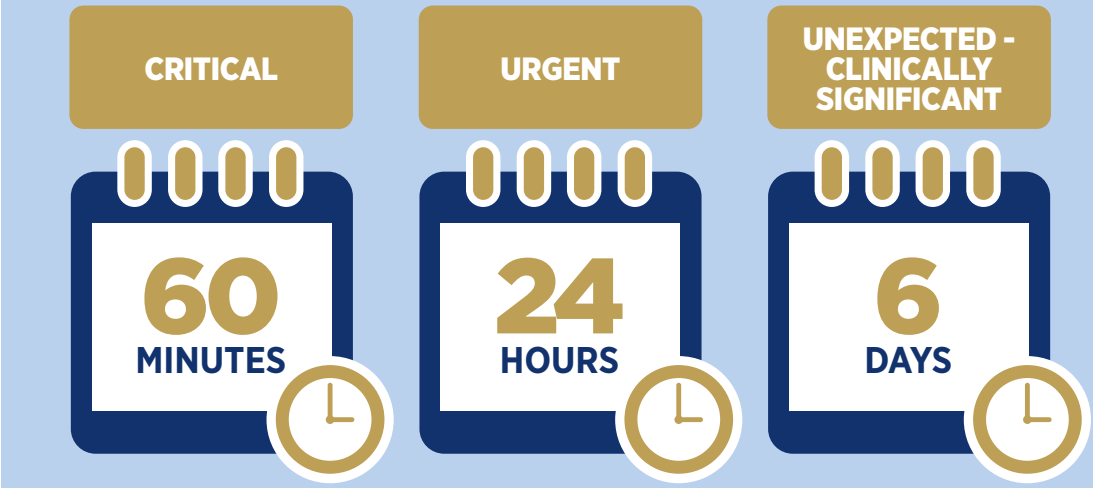
Radiology Alerts

The overall number of alerts recorded in 2023 was higher across all referrals, when compared with 2022. The Programme are aware that hospitals can use different systems to record radiology alerts, some of these systems are not compatible with the Programmes data collection tool and so not all alerts are captured in our findings.

Radiology Alerts Acknowledgement windows as defined in the Guidelines for the Implementation of a National Radiology Quality Improvement Programme - Version 3.0.



The highest percentage of alerts raised in 2023 was for Unexpected – Clinically Insignificant findings for outpatient referrals, followed by cases referred by GPs.

The percentage of urgent and critical alerts raised in 2023 was similar to 2022, these levels are considered low by the Programme.

WHAT DOES THIS MEAN FOR PATIENTS?

When a radiologist finds an urgent or critical finding on a patient's images, their priority is to inform the healthcare professional who referred them for the diagnostic imaging. This is most often done verbally as it is the quickest and safest way to share this important information. The Programme knows that a radiologist's first priority will not be to record the action on their computer but rather to get the information out as quickly as possible. As a result, we know that more critical and urgent alerts take place than we are able to report on.

Radiology Quality Improvement (RQI) Meetings

Not all departments are recording attendance and therefore accurate measurement and reporting on this key quality indicator is difficult, however an increase in attendance was seen in 2023.

WHAT DOES THIS MEAN FOR PATIENTS?

RQI meetings are a very important part of quality improvement activity in a radiology department. By discussing patients' cases, sharing learnings and expertise, radiologists are contributing to safer, more accurate care, and continuously improving radiology services, which results in better healthcare outcomes for patients.

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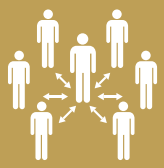
KEY RECOMMENDATIONS

→ The NRQI Programme recommends that appropriate staffing and equipment requirements are prioritised to meet the increasing demand in radiology departments. The responsibility for this recommendation should rest with the accountable management in participating public and voluntary hospitals.

→ The NRQI Programme recommends that hospital management are made aware of and acknowledge the challenges faced at a local level for radiology departments in reaching the recommended report turnaround time targets set by this programme. These targets are indicative of best practice regarding diagnostic reporting and patient care. Specifically, report turnaround times for X-ray should be a focus for root cause analysis where sites are not meeting targets. The responsibility for this recommendation lies with accountable management both in the radiology department and at senior management level in participating public and voluntary hospitals.



→ The NRQI Programme acknowledges the impact technology issues had on recording peer reviews in 2023. Given recent updates to existing associated technology, the Programme continues to recommend that radiologists record the completion of peer reviews in their local information systems. The positive impact of peer review on patient care and the time required to carry out and document this vital QI activity should be recognised by accountable management in participating public and voluntary hospitals.

MESSAGE FROM OUR PPI REPRESENTATIVE

Ms. Siobhán Freeney | **PPI Representative, NSQI Steering Committee**
Independent European Patient Advocate

Hello, I'm Siobhan Freeney, an independent European patient advocate. As a member of Irish Platform for Patient Organisations in Science and Industry (IPPOSI) and graduate of their patient education training programme, I was invited to join the RCPI NSQI steering committee in 2021 as one of two Public Patient Involvement partners.
Public Patient Involvement (PPI) is about working collaboratively with patients and the public. PPI engagement focuses on raising awareness through patient's lived experience and sharing decision making. In 2023, I was delighted when the NSQI steering committee adopted my suggestion to produce lay summaries for each of the National Specialty Quality Improvement Programme's annual data reports. The lay summaries are primarily for the public, they are written in plain English, in a concise, coherent, comprehensive manner with a clear explanation of frequently used key terminology. We hope that they will serve as useful short documents giving a flavour of what can be accessed in each of the full annual data reports.
After I was diagnosed with breast cancer in 2015, I was to become keenly aware of the importance of radiology and how it was to influence my diagnosis, treatment plan and outcomes.
Every sector within the health care field relies on radiology, including oncology, surgery, paediatrics, obstetrics, and emergency medicine. Patients, family physicians and consultants rely on radiology to find the right diagnosis and course of treatment. Without radiology they cannot effectively manage patient care, in many cases, an early diagnosis through the efficient use of quality radiological images will save lives.
Siobhán Freeney

Royal College of Physicians of Ireland
Frederick House, South Frederick St.,
Dublin 2, D02 X266.

Phone: +353 1 863 9700
Email: SQIProgrammes@rcpi.ie
www.rcpi.ie

National Radiology Quality Improvement Programme
11th National Data Report

CLICK HERE TO VIEW