

Medica Reporting Limited

Medica Operational HQ - Havelock

Inspection report

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Date of inspection visit: 21 June 2022
Date of publication: 22/07/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Inspected but not rated



Are services responsive to people's needs?

Good



Are services well-led?

Outstanding



Summary of findings

Overall summary

This is the first time we have inspected this location. We rated it as good because:

Contracted reporters had training in key skills, understood how to identify abuse, and managed safety well. The service managed safety incidents well and learned lessons from them.

Managers monitored the effectiveness of the service and made sure staff and contracted reporters were competent. The service undertook audits and used the results to improve the service.

There were effective systems to ensure contracted reporters had appropriate equipment installed.

Referring organisations could access the service when they needed it. There were effective escalation processes for unexpected and significant findings. Staff and contracted reporters worked well together for the benefit of patients and had access to good information.

The leadership, governance and culture were used to drive and improve the delivery of the service. Staff understood the service's vision and values, and how to apply them in their work.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities.

The service engaged well with clients and all staff were committed to improving services continually.

However:

The service was not meeting all its contractual turnaround times with clients due to the unprecedented demand for elective reporting services. The service did however agree clinically led turnaround times with individual hospitals and radiology departments to ensure reports were delivered back to referrers in an appropriate timeframe where possible.

Operational staff were not completing level one safeguarding training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	This is the first time we have rated this service. We rated it as good. See the summary above for details. We rated this service as good overall, as we found it good in safe and responsive and outstanding in well led. We do not rate effective for diagnostic imaging services. Caring was not inspected during this inspection as it was a teleradiology service. The service did not see patients and patients did not visit the premises.

Summary of findings

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Summary of this inspection

Background to Medica Operational HQ - Havelock

Medica Operational HQ – Havelock is operated by Medica Reporting Limited, providing teleradiology reporting services including, plain x-ray films, computerised tomography (CT) and magnetic resonance imaging (MRI). Teleradiology is the transmission and display of radiological images, such as CT scans and X-Rays, in a location independent of the location the patient is imaged. It allows specialist doctors and reporting radiographers to provide an expert and timely report to allow clinicians to decide on the best treatment for their patients. Radiologists, rheumatologists and reporting radiographers will be referred to as contracted reporters throughout this report. The service has no direct contact with patients and does not provide direct patient care. Contracted reporters report on both images of adults and children.

Medica Operational HQ held contracts with NHS hospital trusts and independent healthcare providers providing remote reading and analysis of images. A team of staff are based at the registered location who provide operational support.

The NHS hospital trusts, and independent healthcare providers will be referred to as clients or referrers in this report.

This is the first time we have inspected this service. We inspected the service using the teleradiology framework.

The service is registered to carry out the following regulated activities:

Diagnostic and screening procedures

The service has a registered manager in post.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out a short notice inspection on 21 June 2022. During the inspection we visited the registered office location and met with the medical director, the registered manager, the group head of clinical quality and governance, the group head of head of resources, the clinical governance manager, the head of operations for UK and members of the operation's team.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Outstanding practice

The seminar series were a series of evening educational webinars run monthly to internal and external stakeholders and created to raise important clinical and organisational topics and provided the opportunity for operational staff and contracted reporters to remotely meet, discuss interesting cases, learn from incidents and discrepancies and receive service updates. These sessions were able to be validated and put towards a clinician's continuing professional development.

The provider's software development team created bespoke client applications to increase efficiency and client and reporter experience. The Nighthawk portal was for clients and reporters to communicate and collaborate on urgent out of hours examinations.

Summary of this inspection

The portal was created for clients and reporters to raise discrepancies, queries and learning points. It also contained valuable access to a second opinion service for use by reporters where they could gain access to support from a radiologist.

During the COVID-19 pandemic the service was proactive in support of clients and reporters and created a pass-through service to allow reporters working for the NHS to access their NHS worklists using the provider's infrastructure, this was done to reduce delays in patient management and at no cost to the client. Data showed a good uptake in clients using this service for their reporters to continue to work.

For faster detection of intracranial (within the skull) haemorrhage (bleeding), the service used a form of artificial intelligence. A decision support tool analysed non-contrast (without dye) images, flagging up possible abnormalities allowing prioritisation of reporting based on clinical priority as opposed to being reported depending on the time the scans were undertaken. The provider won two Association of Project Management awards for 'Best Technology Project of the Year' and 'Overall Project of the Year' for this innovation.

Areas for improvement

Action the service **SHOULD** take to improve:

The service should ensure that operational staff competency training for safeguarding is compliant with the Safeguarding Children and Young People: Roles and competencies for Healthcare Staff, Fourth Edition 2019 Intercollegiate Document, to ensure children and young people are protected from abuse. The training should be delivered at the level according to the job role. Regulation 13 (2)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Not inspected	Good	 Outstanding	Good
Overall	Good	Inspected but not rated	Not inspected	Good	 Outstanding	Good

Diagnostic imaging

Safe	Good 
Effective	Inspected but not rated 
Responsive	Good 
Well-led	Outstanding 

Are Diagnostic imaging safe?

Good 

This is the first time we have rated safe. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

My Compliance was an online portal used for the delivery and monitoring of training amongst operational staff and contracted reporters who did not have a substantive role within the NHS. The portal started off as a tool for deploying information security and data protection training, however had developed into a portal to deploy bespoke in-house training. The service used another tool to create content based on the service need and have to date created new content for example, complaints handling, dignity and respect, Caldicott principles, health and safety and fire safety. We reviewed the portal and saw it included videos and links to relevant policies and procedures.

The service monitored mandatory training as part of the radiologists and reporting radiographers and annual appraisal. The senior governance administrator informed us that the service requested contracted reporters to provide them with evidence of training compliance from their substantive roles in the NHS. There were some contracted reporters who did not have substantive roles in the NHS and mandatory training was provided by the service.

Data provided showed compliance of over 93% completion of mandatory training for operational staff and contracted reporters. Data showed 97% compliance amongst operational staff and 76% for contracted reporters. The provider's target for mandatory training compliance was 100%. Data for contracted reporters was inclusive of staff undergoing the onboarding process who have a three month period to submit all the required information.

Contracted reporters were provided with picture archiving and communication system (PACS) training. PACS is a medical imaging technology system which allows organisation to securely store and digitally transmit electronic images and clinical-relevant reports.

The mandatory training was comprehensive, and operational staff confirmed it met their needs. Topics included in mandatory training were flexible and were influenced by any themes and trends in incidents or complaints. For example, a module was included this year on email etiquette.

Managers monitored mandatory training and alerted operational staff and contracted reporters when they needed to update their training.

Diagnostic imaging

Safeguarding

Contracted reporters understood how to protect patients from abuse and the service worked well with other agencies to do so. However, operational had not received training on how to recognise and report abuse.

Contracted reporters had an established process if they identified or suspected non-accidental injuries in a scan, including an urgent notification to the referrer and escalation through the local procedure. We were given an example of this on inspection, when the radiologist was not happy with the response from the referrer and escalated it to the medical director and a referral was made to the local authority.

Not all staff had received training specific for their role on how to recognise and report abuse. Operational staff had not received level one adults and children safeguarding training in line with the Royal College of Nursing intercollegiate document on safeguarding. Contracted reporters completed as a minimum level one adults and children safeguarding training. Data showed 78% compliance amongst contracted reporters for adults and children safeguarding training. The provider's target was 100%. Data for contracted reporters was inclusive of reporters undergoing the onboarding process who have a three month period to submit all the required information.

Staff knew how to access information on safeguarding and who to contact if they needed advice or support if they had concerns.

Cleanliness, infection control and hygiene

The service did not provide any onsite reporting services and did not work directly with patients. All reporting was done within the contracted reporters home location.

The service had a service level agreement with a third party to provide cleaning at the office location. All areas were visibly clean and there were alcohol hand gel available on entry and hand washing facilities.

The service had an up to date infection control policy which referenced national guidelines, for example hand hygiene. The service had a COVID-19 policy and had completed risk assessments for all operational staff.

Environment and equipment

The environment was suitable for the reporting of imaging services and there were processes in place to maintain its equipment both locally and remotely.

The service leased the office location, within the terms of the lease was maintaining the building and furnishings.

The service provided contracted reporters with suitable equipment to work remotely from home. All contracted reporters received information technology (IT) equipment supplied by the provider. The provider used an external provider to install and set up equipment and office furniture. Part of the onboarding process of contracted reporters included an assessment to assess the suitability of the environment to be used for reporting.

Operational staff and contracted reporters completed a visual display unit equipment risk assessment as part of the mandatory training which covered workstation set up. We saw records which confirmed these were completed.

Contracted reporters were provided with monitors in line with recommendations from the Royal College of Radiologists. There were effective processes to ensure that the equipment used by the service was safe for use. The service had a

Diagnostic imaging

diagnostic display quality control policy which outlined the processes and procedures to ensure they were safe and high quality. The service used an external company for the checking and calibration of reporter's screens. We saw records which confirmed these were undertaken and monitored. The technical support team explained how they have oversight of the monitors and how many hours they had been used for as they had to be replaced after 20,000 hours of use.

Contracted reporters were provided with a dedicated internet connection or they could choose to "piggyback" off their own internet.

The service provided 24-hour IT support and to resolve any equipment faults.

The service had an equipment replacement policy which outlined the schedule for the replacement of old equipment in a timely way for equipment that was no longer "fit for purpose". In addition, the service maintained an inventory of assets and equipment, which showed when regular maintenance and checks were scheduled.

The design, maintenance and use of facilities, premises and equipment at the head office met the needs of staff. The office was located on the sixth floor and was accessible by lifts, there was an accessible toilet and a wheelchair available for staff use. There were dedicated fire marshals and fire evacuation plans. Staff had access to a kitchen and "pods" which were comfortable seating areas which were partially enclosed where staff could meet and have conversations together.

Assessing and responding to patient risk

Contracted reporters identified and quickly acted upon risks identified when reviewing patient scans.

The service did not provide direct scanning or diagnostic services to patients. The service had a contracts with NHS hospitals and private healthcare organisations and only completed part of the medical pathway for the patient.

The office building had an automated external defibrillator and dedicated first aiders, there was also first aid kits to deal with minor injuries.

Contracted reporters responded promptly to any significant and critical results. The service had three set pathways staff followed, one for significant findings, one for critical findings and one for incidental findings. The criteria for each was defined in the critical and significant findings alert pathways which also included the actions specific staff should take and the timeframe for these actions to be completed.

Referrals were triaged by the service's administrative team using a tool developed by the service that allowed staff to easily see what contracted reporters were working and their areas of expertise before assigning scans for review.

The service had experienced difficulty with complying with all key performance indicators (turnaround times for reports) outlined in contracts with clients. All referrers were kept informed and worked in partnership with them to develop solutions. All clinically urgent scans were reported within the national guidelines and therefore there was no harm to patients. The leadership team had developed plans to address the shortfall in reporting staff, as this was the reason not all key performance indicators were met.

The service used a software system that managed the process of obtaining, storing and sharing of medical images. This system was shared across all the referring sites meaning that contracted reporters could easily access previous images of patients and relevant medical history.

Diagnostic imaging

The service had a client escalation policy which outlined how clients could discuss or escalate any report findings or queries when required. The policy included how to contact the service.

The service had a process for the secure transfer and review of images and where necessary, storage of patient data. The data transfer was encrypted to maintain security and patient confidentiality. Operational staff and contracted reporters were trained to ensure patient information was protected.

The service had an IT system where they kept a record of any administrative errors of their referees or reporting errors by the reporting staff. This enabled the service to monitor and follow up on any errors and any learning.

The service did not provide direct scanning or diagnostic services to patients. The service had contracts with NHS hospitals and private healthcare organisations who undertook the scans. These organisations were responsible for compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 17). However, contracted reporters who provided the justification CT scans on their behalf had the relevant radiation protection training and were all UK registered healthcare professionals. The IRMER 2017 is a legislative framework intended to protect patients from the harm associated with ionising radiation.

Staffing

The service had enough contracted reporters with the right skills and experience to meet the imaging reporting needs of patients.

The service had enough contracted reporters to keep patients safe. The provider's reporters comprised of consultant radiologists, reporting radiographers and rheumatologists, all specialising in their relevant field, who typically reported on the images from their own home.

The contracted reporters were divided into different categories. Connected reporters (approximately 40) who did not hold a substantive position within the NHS but worked for the service on a contract, not connected reporters (approximately 400) who held a substantive position within the NHS and worked for the service on a contract and employed reporters (approximately six) who did not have a substantive position within the NHS and were employed by the service. All reporting staff worked under a mutually agreed contract.

The service had a reporting radiographer and radiologist job planning and workload management policy. This outlined what hours they could work and included the length of rest time they should have before and after a shift with the service. This ensured they were not working excessive hours.

The number of contracted reporters the service had on their reporting panel was based on estimated volume of scans expected based on previous weeks against each modality (type of images). This could be flexed during peak times with additional staff available. However, there was not always enough contracted reporters to meet the increased elective reporting activity, which had increased since the COVID-19 pandemic and this was a nationwide challenge. The senior leadership team had several different initiatives to employ additional contracted reporters to meet the needs of the service.

The service had a rostering management system that ensured the contracted reporters availability in advance. Work was allocated to the contracted reporters via a work list.

Diagnostic imaging

The staff who worked in the office were made up of: the recruitment team, project management, clinical governance team, IT support, finance and accounts team, client service team, scheduling team, service delivery team, managers and the senior leadership team. All of these staff were directly employed by the service and worked a mixture of working in the office and working from home.

The service had low sickness and turnover rates.

Records

Contracted reporters kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing the report.

The service had a data protection policy which assured confidentiality from initial enquiry to final review. All contracted reporters used a three-tier remote login system to access patient information and images to read and report scans. Reports were stored in the picture archiving and communication system (PACS) system. PACS is a medical imaging technology system to securely store and digitally transmit electronic images and clinically relevant reports.

The reporting system included a facility for contracted reporters to attach an addendum. An addendum is a description of revisions made to an earlier signed report or record. There was a clear process and audit trail if an addendum was added to a report.

The service maintained records which complied with The Royal College of Radiologist standards. There was a clear and transparent system for rapid, secure transfer and review of images and where necessary storage of patient data. For example, contracted reporters could only access images assigned to them to maintain patient confidentiality

There was a protocol which defined clear responsibilities and requirements of reporting which formed part of the induction process for new contracted reporters.

All reports were transmitted back to the client's radiology information system securely. The results and reports were communicated and integrated into the referring radiology IT systems in a timely manner. The service operated a virtual data system which meant that no images were retained on local computers or servers for longer than 30 days. Images could be accessed again for up to 90 days for audit purposes, but only certain staff had access to do this. Longer retention periods may be required if subject to a legal claim or discrepancy.

IT systems were secure, they were password protected and fingerprint recognition technology was also used for extra security. The IT systems used joined up with the referring organisations meaning information was easily accessible including previous images and relevant past medical history.

We saw that office computers were locked when not in use. This prevented unauthorised access and protected patients' confidential information.

Medicines

The service did not store or administer medicines.

The service did not store or administer medicines as it did not have any direct face to face contact with patients.

Diagnostic imaging

The service provided a service to clients to justify the use on contrast in CT scans as part of the Nighthawk service. Contrast is special dye injected into a vein for a CT scan to improve the quality of the images. However, it can be harmful to patients with impaired kidney function, therefore a radiologist only authorised the use of the contrast after reviewing a patient's blood results which showed their kidney function.

The service had a policy for administration of IV contrast as part of the Nighthawk service. The policy clearly defined the key considerations and responsibilities for the safe and appropriate administration of intravenous contrast.

Incidents

The service managed patient safety incidents well. Operational staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There was a system and process to report, investigate, and learn from incidents. The service used an electronic reporting system which all staff had access to. Operational staff we spoke with knew what incidents to report and how to report them. Operational staff told us they were encouraged to report incidents and felt confident to do so.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service reported 121 incidents between May 2021 and May 2022, which included complaints and discrepancies. Of these 8% had a root cause analysis completed, the majority (86%) related to service delivery, 10% were clinical and 3% were reporter liaison. Of the service delivery incidents 78% related to delayed reports, 16% were Technical/ Workflow, 4% were communications, 2% were reported behaviours and 1% related to report quality. Significant findings and improvement actions were discussed at complaint handling performance meetings.

In the event of a discrepancy with a report being identified by the referrer, the service had a policy and process to investigate any identified discrepancy and if appropriate an addendum to the original report could be issued. A reporting discrepancy occurred when a retrospective review, or subsequent information about a patient outcome, led to an opinion different from that expressed in the original report.

The seminar series were a series of evening educational webinars run monthly to internal and external stakeholders and created to raise important clinical and organisational topics and provided the opportunity for operational staff and contracted reporters to remotely meet, discuss interesting cases, learn from incidents and discrepancies and receive service updates. Learning and any associated actions were shared in monthly newsletters which were sent to all staff.

Managers investigated incidents thoroughly and monitored for themes. For example, a theme was identified when internal emails had been sent to the wrong recipients. As a result of this the clinical governance team created a training video which all staff were required to watch, this led to a reduction in similar incidents.

Weekly root cause analysis meetings were held to discuss progress with any incidents requiring an in-depth investigation. In addition, there was a monthly meeting to track actions from root cause analysis reports and we reviewed meeting minutes which confirmed this. Root cause analysis investigation reports were shared with the client involved in the incident once completed.

Operational staff understood the duty of candour. They were open and transparent and gave clients a full explanation if and when things went wrong.

Diagnostic imaging

Operational staff and contracted reporters received feedback from investigation of incidents, both internal and external to the service. Learning was shared through closed social media groups, emails, newsletters and meetings.

Are Diagnostic imaging effective?

Inspected but not rated 

We currently do not rate effective for teleradiology services.

Evidence-based care and treatment

The service provided diagnostic reporting services based on national guidance.

Policies referenced appropriate national guidance to ensure they were in line with current legislation, standards and evidence-based guidance. Policies and procedures were within the e learning platform and were accessible to all, operational staff and contracted reporters had to sign to confirm they had read and understood them and compliance with this was monitored. Updates to policies and national guidance was shared through team meetings and reporter bulletins we saw evidence which confirmed this.

Policies and procedures were reviewed and updated in line with best practice. For example, new guidance implemented within the last 12 months included: guidance issued by The British Society of Cardiovascular Imaging and British Society of Cardiac Computed Tomography on reporting of the incidentally recognised coronary artery (arteries in the heart) calcification (hardening caused by calcium build up).

Diagnostic reports followed the Royal College of Radiologist standards for interpretation and reporting of imaging investigations.

The service had a clinical audit committee (CAC) who was the decision-making group responsible for the governance of clinical audit. Its remit included review and maintenance of the quality of the clinical audit process including routine, entry, background and targeted audits. The CAC reported via the Medical Advisory Board to the company board.

The service had a clinical audit policy. Clinical audit within the service was the review of radiological reporting by selected peer group radiologists (auditors/arbitrators) who applied standards set by the service and used a scoring framework. The aims of clinical audit were twofold. Firstly, to provide quality assurance to the service, its clients and reporting staff, secondly, to use the data to improve the quality of clinical reporting.

The clinical audit policy detailed the quality assurance methods. The key aims of quality assurance were to provide a 'measure' of the radiological competence using simple metrics to record the auditor's assessment of key competencies: observation, interpretation and communication of images. The auditor also assessed the potential risk to the patient.

Nutrition and hydration

Due to the nature of the service, this key line of enquiry was not inspected as it was not applicable to the service.

Pain relief

Due to the nature of the service, this key line of enquiry was not inspected as it was not applicable to the service.

Diagnostic imaging

Patient outcomes

Managers monitored the effectiveness of reporting used the findings to improve the service.

The service had an effective system to regularly assess and monitor the quality of its services, ensuring patient outcomes were monitored and measured, through audits.

The provider had the Quality Standard for Imaging (QSI) accreditation. The QSI sets national quality criteria for imaging services. The QSI is a collaboration between The Royal College of Radiologists (RCR) and the College of Radiographers (CoR). The accreditation means the provider contributes to improving the quality of reporting services in the UK. The provider was regularly audited and assessed to ensure that the quality and best practice of the service improved patient care and outcomes. QSI accreditation meant that the provider was independently assessed every year.

The service held monthly seminars for operational staff and contracted reporters to attend where discrepancy reporting errors were discussed, these were well attended by all and formed part of contracted reporters continual professional development. External speakers also presented at these webinars a recent one was titled “how did I miss that” which provided hints and tips for reviewing a certain type of CT scan.

Each individual providers’ protocols were included in each radiology request assigned to contracted reporters this meant they knew the individual requirements for each provider. There was an established process if providers wanted to make a change to their protocol.

The service demonstrated a continuous, proactive approach to improving the standards of radiology reporting. It had a clinical audit policy and process to investigate any discrepancy identified. Named clinical auditors undertook audits of up to of 5% of cross-sectional image reporting and 2% of plain film work. Cross sectional imaging techniques view the body in cross-sections for example computed tomography (CT) scans and Magnetic resonance imaging (MRI).

Any reporting discrepancies were fed-back to the reporting consultant and to the referring organisation. Discrepancy reports were considered at monthly clinical governance meetings, we reviewed meeting minutes which confirmed this. Where themes in discrepancy report errors amongst individuals were identified, the medical director facilitated developmental and supportive management sessions with the individual. There was an established policy which was could be followed if there was no improvement despite support and education. Clients could also request a peer review. This system ensured discrepancies and learning opportunities were identified.

The service monitored discrepancy rates and took action to address any themes is discrepancies provider’s clinical quality report for May 2022 showed an overall elective discrepancy rate of 2.2% overall x-ray plain film, CT and MRI rates were at 1%, 3.4% and 3.5% respectively. Overall acute discrepancy rate is was 1.8% The are no objective benchmarks for discrepancy rates.

The service provided reporting on patients who had undergone imaging after severe injury. The Royal College of Radiologists standards of practice and guidance for trauma radiology in severely injured patients state that the radiologist should provide the final report within one hour. Data showed for the previous 12 months (4,233 scans reported) on average compliance was 85% within one hour.

Diagnostic imaging

The service provided reporting on patients who had suffered an expected stroke. The National Institute for Health and Care Excellence guideline on the diagnosis and initial management of stroke recommends brain imaging should be performed immediately (defined as within one hour) for people with acute stroke if indicated although it does not define time taken to provide a final report. Data showed for the previous 12 months (1,362 scans reported) on average compliance was 90% within 30 minutes.

There was a radiologist second opinion process this allowed contracted reporters to request a second opinion or other support from peer radiologists. All support requests were raised via the service delivery team and were logged and monitored, to ensure there was an audit trail.

Managers shared and made sure operational staff and contracted reporters understood information from the audits. Audit findings were shared via email, newsletters, seminars and meetings. Staff we spoke to confirmed this.

The provider has ISO 9001 accreditation which is defined as the international standard that specifies requirements for a quality management system (QMS). Organisations with accreditation use the standard to demonstrate the ability to consistently provide products and services that meet customer and regulatory requirements. A quality management system QMS defined is a formalised system that documents processes, procedures, and responsibilities for achieving quality policies and objectives.

Competent staff

The service made sure both operational staff and contracted reporters were competent for their roles. Managers appraised performance to provide support and development.

Contracted reporters were experienced, qualified and had the right skills and knowledge to meet the needs of the service. All radiologists who provided “justification for CT scans” were registered with the General Medical Council (GMC) and had obtained The Fellowship of the Royal College of Radiologists (FRCR) qualification. The service reviewed each radiologist’s license to practice annually. Contracted reporters based outside of the UK had to demonstrate the experience, qualification, skills and knowledge equivalent to that of reporting staff based in the UK. At the time of our inspection, the service demonstrated 100% compliance with employment and qualification checks for all contracted reporters.

All new operational staff had a full induction tailored to their role. We spoke to two members of staff who worked in the operations team and both said the induction and associated training was comprehensive and thorough.

The service had a reporter recruitment selection policy and guidance all elements had to be completed before they were able to undertake any reporting duties.

A new reporter to the service, or a reporter who was extending their scope of practice had an initial audit of 100% of each modality (type of images) they would be reporting. The aim of the audit was to provide assurance that new reporting staff reached an acceptable standard of reporting of routine work within their scope of practice.

Managers supported operations staff to develop through yearly, constructive appraisals of their work. Contracted reporters who did not hold a substantive role in the NHS were not able to work unless they had completed an annual appraisal. The service was a Designated Body for this group which meant the organisation provided a regular appraisal and supported revalidation. The medical director facilitated these and was also their Responsible Officer (RO). A RO is a senior clinician in a Designated Body who ensures that the doctors for whom they act in this nominated capacity, continue to practice safely and are properly supported and managed in maintaining their professional standards.

Diagnostic imaging

Contracted reporters working under practicing privileges who held substantive roles within the NHS were required to provide evidence of an external appraisal. Practicing privileges authorise medical practitioners for a specific practice of patient care in a specified healthcare facility. Practicing privileges were granted based on their current medical credentials and previous performance.

There was a clinical appraisal and revalidation committee who met and monitored compliance with appraisal and revalidation of radiologists. The committee reported to the Medical Advisory Board.

Managers identified any training needs their operational staff had and gave them the time and opportunity to develop their skills and knowledge. Staff within the operational team told us that they were supported to undertake additional training and qualifications.

Managers made sure operational staff received any specialist training for their role. For example, a member of staff within the finance team had undertaken an accountancy qualification.

Managers identified poor performance promptly and supported operational staff to improve, we were given an example on inspection which confirmed this.

There was evidence of Disclosure and Barring Service (DBS) checks for operational staff and contracted reporters in line with the provider's policy. In addition, each contracted reporters was required to submit evidence of indemnity cover.

Managers made sure operational staff attended team meetings or had access to full notes or recordings when they could not attend. Staff we spoke to confirmed this.

Multidisciplinary working

Operational staff and contracted reporters worked together and supported each other as a team to provide good care.

The service provided radiologist attendance at oncology multidisciplinary team meetings (MDT) for the referring organisation. A MDT is a weekly or monthly meeting that takes place between health care professionals, to discuss individual patient cases. Every patient with a new diagnosis of cancer was discussed and their scans and biopsies are reviewed by the team.

Due to the nature of the service, and contracted reporters working remotely, there was very limited contact with each other.

There was an in-house service delivery team which operated during normal working hours. If referring centres wished to discuss reports directly with reporting staff, the helpdesk could facilitate such requests.

Seven-day services

The service provided a 24-hours a day seven-day teleradiology service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service did not see patients and they did not visit the premises due to the nature of the service provided. The service did not see patients directly therefore consent was initiated at the referring hospital or clinic.

Diagnostic imaging

Are Diagnostic imaging responsive?

Good 

This is the first time we have rated responsive. We rated it as good.

Service delivery to meet the needs of local people

The service did not see patients and patients did not visit the premises due to the nature of the service provided.

The service provided tendered contract work to NHS trusts and independent healthcare providers across the country. However, the service could not always meet the needs of their clients as were not always able to meet the agreed key performance indicators (turnaround times for reporting) within agreed contracts.

Teleradiology enabled reporters to provide the services remotely, thereby facilitating the rapid availability of trained specialists 24 hours a day, 365 days a year. This minimised delays in reporting of images and treatment for patients. The administration service worked Monday to Friday 9am to 5pm.

The service provided hospital radiology departments with independent support to address capacity issues in both urgent and non-urgent reporting pathways.

The service relieved pressure on other organisations by providing a radiologist attendance at oncology multidisciplinary team meetings (MDT).

Meeting people's individual needs

Due to the nature of the service, this key line of enquiry was not inspected as it was not applicable to the service.

Access and flow

Clients could access the service when clinically urgent. However, contractual turnaround times were not always met.

Patients were imaged in healthcare facility, the images transmitted to the services 24 hours a day seven days a week support team, who send them on to a specialist from a team of global reporters. The expert reporter reviews the images and the patient's clinical history and creates a report detailing what the images show. The report is then sent back to clinician to inform patient treatment in an average of 24 minutes for the emergency service.

The provider's IT platform had the ability to access the requesting hospitals radiological information system so they could review previous reports and images which saved time.

The service had four main pathways; acute, elective, specialist and the Nighthawk service and dedicated contracted reporters were allocated to each pathway. The Nighthawk service provided and 24 hour a day seven day a week reporting service for emergency imaging. The Nighthawk service provided contracted reporters to provide justification of CT scans out of hours following an agreed protocol for referring clients. There were dedicated pathways for stroke and major trauma.

Diagnostic imaging

Data showed for the Nighthawk service between 01 May 2022 and 31 May 2022, 94% compliance with contracted turnaround times for reporting. Data showed for the elective service between 01 January 2022 and 31 May 2022, 87% compliance for plain x-ray films and 66% compliance for CT and MRI scans against contracted turnaround times.

The service had a client liaison capacity management role, it was their responsibility to identify areas in which expected capacity was not reached, organise short term capacity uplifts, respond to capacity related queries and liaise with account managers and the capacity and demand team.

The allocation team allocated specific work to contracted reporters based on their speciality by the daily allocation process. Morning session worklists were usually allocated the night before so contracted reporters had all information to hand at the start of their session.

The service had a 'One More Thing' (OMT) log process. This was a tool used for contracted reporters to notify operational staff of issues with exams in their worklist. These were updated at regular intervals throughout the day and sent to the allocation team inbox for actioning.

The provider held monthly performance review meetings during which key performance indicators including report-turnaround times were discussed. Deep dive analysis was completed to establish if any changes to practice were required when turnaround times were missed.

The service had a business continuity plan in place should their IT infrastructure fail. The plan was supported by a number of standard operating procedures for each different IT system and detailed action to be taken in the event of failure. There were a number of different safeguards in place to prevent an IT failure or cyber-attack. Operational staff had access to a point of contact for each referring organisation who they would call in the event of disruption to the service.

Learning from complaints and concerns

The service had processes in place to treat concerns and complaints seriously, investigated them and learned lessons from the results.

The provider had a complaints handling policy which set out the principles and process that enabled clients to give feedback or make formal complaints about any aspect of the service supplied by the provider. The policy included response times for acknowledging receipt of complaints and how to handle complaints with clients. Department Managers/Team Leads were responsible for the management of complaint cases, remedial actions and learning points in their area. They assigned case owners and investigators where necessary. The complaints co-ordinator was responsible for overseeing the day-to-day administration of complaints and providing status and compliance reports for management and executive review.

The service monitored complaints and themes and trends through the complaint handling performance review meetings. Between 01 January 2022 and May 2022 the service had received 124 complaints from clients, these included discrepancy reports. The majority of complaints (86%) related to service delivery, 10% were clinical and 4% were reporter liaison related. Of the service delivery complaints, the majority (78%) related to delayed reports.

The service set an objective that 90% of all complaints are closed within 28 days within the same time period 99% compliance was achieved with the objective.

Diagnostic imaging

The complaint handling performance review meetings reviewed the outcomes of complaints identifying learning, training and development opportunities for operational staff which were discussed at team meetings.

We reviewed three complaints and found them to be comprehensive and identified the root cause. We saw evidence of a change to a protocol as the result of learning from a complaint.

The service clearly displayed information about how to raise a concern or give feedback on their website.

Are Diagnostic imaging well-led?

Outstanding



This is the first time we have rated well-led. We rated it as outstanding.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for staff. They supported operational staff to develop their skills and take on more senior roles.

The executive team of Medica Reporting Limited consisted of a group chief executive officer, group chief financial officer, group medical director, clinical lead for education and reporter welfare, clinical lead – audit, governance lead – appraisal, group director of corporate development, chief information officer and a managing director. They were supported by 17 different group function committees all of which had an overarching lead.

The registered manager of the service was also the managing director and had a radiology background. They understood the challenges in the wider healthcare system and how their service could help improve access to timely reporting of scans.

Senior leaders understood the challenges the service was facing with regards to meeting all their contractual turnaround times with clients. They acknowledged maintaining quality attracting and retaining contracted reporters was a concern, as it was nationally across the sector. However, they had a number of different initiatives to try and address these challenges.

Operational staff we spoke with were positive about the senior leaders, stating they were available and approachable. Leaders and the team met regularly to maintain good working relationships, share learning and ensure effective lines of communication. One new member of operational staff told us how the chief executive officer had taken the time to introduce themselves and welcome them.

Operational staff told us they found leaders responsive to their requests for development. Staff gave examples of when additional training had been identified and provided to assist them to develop in their role.

There was an embedded system of leadership development to ensure leaders represented a diverse workforce.

Vision and Strategy

The service had a vision, mission, strategy and values for what it wanted to achieve.

Diagnostic imaging

The providers mission was: “To lead the way in delivering collaborative and responsive telemedicine solutions that put patient outcomes at the heart of what they do. We will achieve this through technical innovation underpinned by the highest standards of clinical excellence”.

The providers vision was: “To provide market leading diagnostic services by connecting healthcare professionals and organisations with talent and technology. A trusted partner, we will be pioneering in adapting our offering to deliver sustainable and scalable services for customers and their patients”.

The providers values were: “Patient first and truly collaborative, Adaptive and pioneering, Responsive and accountable and Excellence in our DNA. All staff we spoke to could describe what the values were.

All operational staff we spoke with knew the vision and values of the service and told us how the service was patient centred and that “every scan was a patient”

The service had a five-year plan which was monitored and regularly reviewed, The five year plan centred around enhanced patient outcomes, which encompassed; an engaged and motivated team, increased reporter capacity, expanded core offering, diversified service offering and driving profitable growth. Staff told us that they were regularly updated on progress against the strategy.

Operational staff and contracted reporters used closed social media groups to communicate with each other and message groups included the senior leaders. This was for communication only and did not include patient identifiable information.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The service had an open culture where staff could raise concerns without fear.

There were high levels of satisfaction across all operational staff, there was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce.

Operational staff were proud of the organisation as a place to work and spoke highly of the culture which valued their input. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process. The service used a range of strategies to drive a positive culture in which senior leaders wanted the team to feel proud to work for the organisation. This included an environment in which staff were encouraged to openly suggest improved or new ways of working.

The medical director described a supportive culture in which mistakes or discrepancies were used as opportunities for learning.

Operational staff felt respected, supported and valued. The culture encouraged openness and honesty at all levels. Staff were encouraged to provide feedback and raise concerns without fear of reprisal and knew their concerns would be taken seriously.

The service promoted inclusion and diversity it celebrated different, cultures, religious and other events advertising these on social media groups.

Diagnostic imaging

There were compassionate, inclusive and effective leadership at all levels. Leaders demonstrated high levels of experience, capacity and capability needed to deliver the service. There was a strong focus on the well-being of operational staff and managers demonstrated a commitment to the health and wellbeing of all staff. All operational staff were given the option to work either from home or flexibly with some time spent in the office and some working from home.

The service provided opportunities for operational staff career development. There were a number of different courses and qualifications that staff could access.

Staff worked in collaboration with each other as part of a team to ensure their part of a patient journey was as smooth as possible. We saw friendly interactions and banter amongst staff.

Governance

The service operated effective governance processes. Staff were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

There was an effective governance structure, processes and systems of accountability to support the delivery of good quality service. Medica Reporting Limited had a dedicated clinical governance team. The clinical governance team was led by the group head of clinical quality and governance, who was supported by a clinical governance manager, three senior clinical governance administrators and five clinical governance administrators.

The service had a clear management structure with defined roles and responsibilities. Staff we spoke with knew who leads of services were and how to escalate matters when needed.

The systems to monitor contracted reporters training, appraisals, indemnity insurance and revalidation were effective.

The service audited all discrepancies, turnaround times, incidents and complaints as part of the governance process.

Policies and procedures were reviewed and updated, in line with national guidance, and were carried out in a timely manner.

The service met regularly with referring clients with whom they held contracts. They reviewed turnaround times, complaints, discrepancies and any incidents.

The clinical governance committee (CGC) was a decision making group responsible for reviewing the quality and practice of reporters to ensure high professional standards were maintained. It was the committee which gave oversight to any concerns raised regarding contracted reporters.

Clinical governance meetings took place monthly chaired by the medical director and were structured around set agenda items including actions from the last meeting; reporters' entry audits, recent investigations, notifications to CQC, weekly discrepancy reports and review of client activity.

The clinical quality and governance committee was a sub-committee of the Public Limited Company (PLC) board chaired by the non-executive director with responsibility for governance, risk and quality. The purpose of the committee was to provide oversight and reassurance of the governance processes and governance management within the service to the PLC board. The committee met biannually three weeks prior to PLC board, output from the meetings presented at PLC board the following month.

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The root cause analysis meeting (RCA) met weekly with a monthly meeting to monitor and track any actions from root cause analysis investigations.

The medical advisory board (MAB) ensured the delivery of high clinical standards and quality. The MAB ensured recruitment process and appraisal processes were fit for purpose, oversaw and managed all activities related to: clinical governance, clinical policies, quality assurance, appraisal and revalidation, risk management, information governance and client clinical issues. The MAB also monitored consultant practice to ensure high professional standards were maintained. The MAB met biannually and reported to the company board.

We reviewed meeting minutes from the MAB, RCA, clinical quality and governance committee and clinical governance meetings, we found they were well attended, followed a set agenda, followed up on previous actions and all actions had a nominated person assigned to them.

Operational staff confirmed they received any clinical and business updates relevant to them via email and meetings.

The service had an effective system to ensure it complied with the requirements as set out by Schedule 3 of Health and Social Care Act 2008 Regulations 2014. We reviewed the database which confirmed this.

Management of risk, issues and performance

Leaders and teams worked to use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had a business continuity plan in place should their IT infrastructure fail. The plan was supported by several standard operating procedures for each different IT system and detailed action to be taken in the event of failure. There were a number of different safeguards in place to prevent an IT failure or cyber-attack. Staff had access to a point of contact for each referring organisation who they would call in the event of disruption to the service.

There was a clear and effective process for identifying, recording and managing risk supported by a risk management policy. We reviewed the clinical risk register which showed it was reviewed and updated regularly and each risk had an assigned owner. All risks had control measures in place to help reduce any risk and review dates.

A systematic approach was taken to working with clients to improve patient outcomes. The service had a process to manage and widely share learning from adverse events, incidents, discrepancies or errors that might have or had occurred.

The service invested in innovative and best practice information systems and processes. The provider's software development team created bespoke client applications to increase efficiency and client and reporter experience. The Nighthawk portal was for clients and reporters to communicate and collaborate on urgent out of hours examinations.

The portal was created for clients and reporters to raise discrepancies, queries and learning points. It also contained valuable access to a second opinion service for use by reporters where they could gain access to support from a radiologist.

Clinical governance systems were focused on identifying and managing risk and performance. The service had a comprehensive audit programme as part of this structure, which involved named clinical auditors completing audits of up to 5% of cross-sectional image reporting and 2% of plain film work.

Diagnostic imaging

The service had processes to manage and widely share learning from adverse events, incidents, discrepancies or errors that might occur. The seminar series were held monthly operational staff and contracted reporters were encouraged to attend, and the recordings were available for anyone who were not available. The service based the risk management and discrepancy review system on Royal College of Radiologists (RCR) guidance. For example, the service regularly engaged with clients and contracted reporters where discrepancies arose to foster a culture of continuous learning and improvement.

The service provided reports in line with the RCR guidance: Standards for the provision of teleradiology within the United Kingdom' (December 2016), which meant that patients could be confident that even though their examinations were not being reported within the base hospital, it was being completed to the same standard and with comparable security.

The service monitored turnaround times and query and discrepancy reports for any themes and trends. Any themes and trends identified in discrepancy reports fed into the seminar series.

Problems were identified and addressed quickly and openly. The organisation reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Data collection using dashboards was used to monitor performance and identify areas of improvement. Areas monitored included the number of discrepancies identified and missed key performance, incidents, complaints and incidents. Performance was monitored at the various weekly and monthly governance meetings.

The service had appropriate insurance in place to cover all relevant insurable risks to ensure it was protected from financial loss, equipment failure or malfunction.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The providers IT system enabled the secure electronic transmission of radiological patient images from one location to another, for the purposes of diagnostic interpretation and reporting by qualified radiologist experts.

The provider was assessed and certified against the Cyber Essentials standard. The standard is a government backed scheme that helps to ensure that organisations are protected against cyber security risks. Whilst Cyber Essentials focuses on common IT security risks the provider also holds ISO 27001 accreditation which is an international standard on how to manage information security.

Strategies and plans were aligned with demands in the wider health economy, and there was a commitment to system-wide collaboration and leadership. During the COVID-19 pandemic the service was proactive in support of clients and reporters and created a pass-through service to allow reporters working for the NHS to access their NHS worklists using the provider's infrastructure, this was done to reduce delays in patient management and at no cost to the client. Data showed a good uptake in clients using this service for their reporters to continue to work.

The data protection policy referred to current legislation outlining everyone's responsibility and procedures to follow to keep personal data safe. The service was compliant with the "General Data Protection Regulations(GDPR) 2016/679". All transfer of data was encrypted or on a secure network between the referrer and service. Referring clinicians received reports by a secure system which ensured that all data was encrypted.

Diagnostic imaging

The training platform required operational staff and contracted reporters to confirm they had read and understood policies including information governance policy, secure transfer and receipt of information, guidelines on identifying and reporting information incidents and emergency and business continuity response arrangements.

Appropriate access and security safeguards protected the provider's radiology information system and picture archiving and communication system.

The service had a retention policy which outlined how records were stored and managed in a safe and legal manner. The chief executive officer retained ultimate responsibility for determining whether to keep or dispose of specific documents. Day to day responsibility for adherence to this policy was with individual directors and designated senior managers. The service had an information security and risk team (IS&R) who were consulted if there was any query as to retention or deletion.

The service submitted statutory notifications to the Care Quality Commission as required.

Engagement

Leaders and staff actively and openly engaged with staff and external organisations and had a process in place to receive feedback.

There was strong collaboration, team-working and support across all functions improving the quality and sustainability of the service. Medica Reporting limited held quarterly town hall meetings all staff were invited to attend. Town hall meetings are a type of meeting that brings everyone in an organisation together to discuss important topics. The meetings provided an opportunity for managers to present new information, learning, updates on performance and progress against the strategy. In addition, they provided all staff and opportunity to contribute to the conversation.

Services were developed with the full participation of those who used them, operational staff and external partners as equal partners. The service held formal monthly or quarterly meetings as outlined in the referring organisations contract. Operational staff engaged with referring organisations frequently about operational issues. There was an effective referrer feedback process that enabled each referrer to feedback on discrepancies.

The seminar series were a series of evening educational webinars run monthly to internal and external stakeholders and created to raise important clinical and organisational topics and provided the opportunity for all to remotely meet, discuss interesting cases, learn from incidents and discrepancies and receive service updates.

Lunch and learn sessions were set up by the provider to provide be short bite size sessions (30 mins) during the lunchbreak so people could drop-in whilst they were having their lunch and learn a new topic regarding the company. Many of these sessions were run for the introduction on the integrated IT system in the latter half of 2021 to give updates on the status of the project.

During the early stages of the COVID-19 pandemic the internal communications team deployed a weekly newsletter for staff to cope with the change to working from home and the challenges of the pandemic. This included recipes, TV Suggestions, and quizzes. This was well received by the team. The service also put together a video for contracted reporters , many of whom returned to their trust to work front line in the pandemic, to say thank you – this was recorded by the whole team and put on the provider's website and social media sites.

Diagnostic imaging

The service had a strong focus, since the COVID-19 pandemic, on wellbeing. This was evidenced through the introduction of the employee assistance programme, which was a free service where staff could access confidential counselling over the phone.

The provider ran a series of internal awareness training sessions and seminars on mental health and wellbeing in the workplace. These sessions were free to attend.

The service hosted a virtual coffee morning, to support the integration of operational staff and to get an understanding of the opinion on home working post pandemic. This was an opportunity for operational staff to meet new colleagues, socialise and discuss the way the pandemic affected their approach to work.

The service undertook a wellbeing survey in June 2021. This allowed staff to provide feedback on the proposed home working policy. The survey also explored ways to support employees through mental health initiatives. Results of the survey had been implemented for example, the introduction of plants within the office and protected wellness time within the working week.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The seminar series, root cause analysis meetings and research committee meetings had a structured agendas which allowed the whole team to share from learning from events and incidents, present interesting cases or good spots, offer ongoing training and discuss new innovations or techniques.

There was a fully embedded and systematic approach to improvement. The service had invested in a programme assurance team (PAR) led by a project manager who worked together projects to achieve its objectives. The team was currently working on the 'Future Tech Programme', which had multiple projects sitting within it. The aim was to deliver significant improvements for three primary stakeholder groups –reporters, clients, staff and ultimately improve patient outcomes. Due to this significant investment has been made. The team commissioned a programme assurance review who comprised of internal stakeholders outside of the programme team who utilised a framework to review evidence and interview members of project teams to establish a red, amber or green rating for successful delivery. The PAR presented their findings to the programme board noting areas of commendation and recommendations for improvement. This was started in 2020 and was continuing into Future Tech Stage 2.

Managers used audit results to improve patients' outcomes. For example, a pilot was underway using dedicated reporting staff providing the "justification" for CT scans as part of the Nighthawk service to improve reporting times.

The service used data generated by the quality assurance process to facilitate quality improvement. Review of discrepancies by reporting staff involved reflective practice and learning.

The service had a quality assurance to provide reassurance to the organisation, clients and the reporting staff that the radiological reporting met an acceptable standard. It provided a guide to the level of performance of individuals and of the reporting group as a whole.

Diagnostic imaging

For faster detection of intracranial (within the skull) haemorrhage (bleeding), the service used a form of artificial intelligence. A decision support tool analysed non-contrast (without dye) images, flagging up possible abnormalities allowing prioritisation of reporting based on clinical priority as opposed to being reported depending on the time the scans were undertaken. The provider won two Association of Project Management awards for 'Best Technology Project of the Year' and 'Overall Project of the Year' for this innovation.