

Everlight Radiology Limited

Everlight Radiology Limited (London - Head Office)

Inspection report

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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?

Good 

Summary of findings

Overall summary

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

- The service had enough staff to provide a safe service. Staff understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learnt lessons from them. Staff collected safety information and used it to improve the service.
- The provider had systems to ensure reporting radiologists had appropriate equipment provided.
- The provider monitored the effectiveness of the service. There were effective systems to act on urgent and emergency referrals. There were escalation processes for reporting radiologists in the event of a significant finding. Staff worked well together for the benefit of patients and had access to good information.
- Referrers could access the service when they needed it and received the report within agreed timeframes.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's strategy and vision, and how to apply them in their work. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well with their referring organisations and all staff were committed to improving services.

However:

- The service's did not undertake Disclosure and Barring Service (DBS) checks for non clinical staff who had access to patient identifiable information.
- Non-clinical staff did not undertake safeguarding level one training in line with the intercollegiate document.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	

Summary of findings

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Summary of this inspection

Background to Everlight Radiology Limited (London - Head Office)

Everlight Radiology Reporting Limited, (London Head Office) provides teleradiology reporting services to NHS hospitals across the United Kingdom (UK), including plain film, computerised tomography (CT) and magnetic resonance imaging (MRI), as well as quality assurance monitoring for ultrasound screening. The service operates 24-hours, seven days a week and 365 days a year. Reporting is available for urgent daytime and out of hours cases, in addition to routine and backlog reporting. The service provides audit and second opinion reporting for both adults and children.

The provider has other offices in the UK that are registered with CQC and international offices that do not fall under our regulatory powers. While this inspection did not include the provider's other UK locations, and international offices are outside of our scope, we reference them in some contexts as a number of teams and services are shared with the head office location.

This service employs 38 radiologists who are registered with the General Medical Council as specialists or with the Royal College of Radiologists. Radiologists can work from home using equipment approved and maintained by the provider or from the nine fully equipped reporting rooms on site.

The service provides diagnostic imaging services on a remote basis, which means patients do not attend the location and staff have no contact with patients. All patient care and contact is made by the NHS trust responsible for their treatment.

The location had not been inspected since its registration on 3 February 2022. This was the first time the service had been inspected and rated. We inspected the service using the Teleradiology core service framework.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out a short notice inspection on 7 September 2022. During the inspection we visited the registered office location and met with nine directors, including the registered manager and chief executive officer. Following the inspection, on 12 and 13 September 2022 we conducted telephone calls with staff. We spoke with three reporting radiologists and the responsible officer.

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>.

Areas for improvement

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

- Non clinical staff who have access to patient records should be subjected to DBS checks
- All staff including non-clinical staff should complete level one safeguarding in line with the intercollegiate document.

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	Good	Good
Overall	Good	Inspected but not rated	Not inspected	Good	Good	Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good 

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training programme was undertaken through e-learning to staff who were permanently employed by the service. We were provided with evidence, which stated as of 22 August 2022, the overall mandatory training completion rate for the service was 99.5%.

Mandatory training for contracted radiologists was monitored through their annual appraisal. Radiologists were required to provide evidence of training compliance from their substantive roles in the NHS. The service had added four internal mandatory training courses required to be undertaken by all radiologists. These were ionising radiation (medical exposure) regulations (IRMER), equality and diversity and human rights – Level 1, safeguarding children & young people – Level 2 and data security and protection training – Level 1.

The service monitored completion of mandatory training using a dashboard which automatically flagged modules that were about to or had expired. The dashboard was reviewed regularly, by the registered manager, and a reminder was sent to staff when their renewal date was near. Staff told us they could also check the dates of when their training was due to expire on the internal training site.

Staff we spoke with understood their responsibility in relation to completing their mandatory training and told us the training they received was relevant to their roles.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Employed radiologists had training on how to recognise and report abuse and they knew how to apply it.

The radiologists employed by the service undertook safeguarding children and adults' level 2 training as part of their mandatory training. This was in line with the Royal College of Nursing intercollegiate document on safeguarding. We

Diagnostic imaging

saw records that completions rates were 100% as of August 2022. We did not see safeguarding training data for other staff groups. Following the inspection, the service provided feedback which confirmed that non-clinical staff did not undertake safeguarding level one training which is not in line with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff - intercollegiate document.

Radiologists contracted to the service completed mandatory training at their substantive employer in the NHS but also undertook safeguarding children & young people – Level 2 training provided by the service. Evidence of training was provided to the service for sign off during their induction and was reviewed annually as part of their appraisal. This information was included on the training dashboard and monitored.

Radiologists had an established process if they identified or suspected non-accidental injuries on a scan, including an urgent notification to the referrer and escalation through the local procedure.

The service had a safeguarding policy, which covered children, young people and adults. The policy was version controlled and in date. All staff we spoke with knew how to access the safeguarding policy and the procedure to follow. They were aware of who the service's safeguarding lead was.

The service ensured that safety was promoted through recruitment procedures and employment checks. Clinical staff had enhanced Disclosure and Barring Service (DBS) checks completed before they could work. However, non-clinical staff were not required to undertake DBS checks. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

There had been no safeguarding concerns reported to the care quality commission (CQC) in the reporting period, from September 2021 to August 2022.

Cleanliness, infection control and hygiene

The provider did not see patients and patients did not visit the premises due to the nature of the service provided. The service provided the facilities for remote reporting to take place in the head office as well as in the reporter's own home.

At the office location, COVID 19 guidelines were followed, and hand sanitiser was available.

Environment and equipment

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

The service provided staff with suitable equipment to work remotely from home. All staff received IT equipment. The service provided evidence that all electrical equipment in the head office location had received electrical safety testing in the last year.

The location had nine radiology reporting rooms that were available 24-hours, seven days a week.

Radiologists booked reporting rooms using the provider's electronic system.

The service had established systems which ensured radiologists had access to reliable, standardised reporting and communication equipment regardless of whether they worked from the office suite or remotely.

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A dedicated radiologist deployment team worked across multiple geographical locations to install the hardware needed for radiologists to work from home and provided a 24-hour on-call support service. Where radiologists worked outside of the UK and reported for UK-based hospitals, the IT team shipped medical grade equipment to them, and an approved third-party organisation installed it. Remote radiologists based overseas were required to send photographs of their home workstation reporting area to the IT team to ensure the environment was appropriate and fit for purpose. The radiologists we spoke with said this system worked well, and one commented that when they had had an issue with an item of hardware a replacement was provided within 24 hours.

Assessing and responding to patient risk

The service did not provide direct scanning or diagnostic services to patients and compliance with medical exposure of ionising radiation regulations was the responsibility of the referring hospital. The service only provided the diagnostic report of patients' images and therefore only completed part of the medical pathway for the patient.

Radiologists used internal professional standards and advisory guidelines to alert the referring provider of unexpected or significant discoveries from diagnostic reports. Each referring provider set their own preferred alert phrase for reports. This acted as a trigger for the referrer to act on results immediately. Radiologists inserted a standard 'RED ALERT' phrase in the conclusion of the report as internal assurance that a significant finding had been noted. The administration team then sent out an e-mail to the trust's nominated distribution group to ensure they acted on the findings promptly.

Where radiologists found significant or life-threatening results during a routine review, they contacted the referrer directly by telephone through their reporting system and provided a verbal report in addition to the written report. The operational co-ordinator maintained oversight of all significant findings communications, which ensured the service maintained a continual audit trail.

The service had a dedicated urgent findings team which was always available. Radiologists had instant online messaging access to this team regardless of where in the world they were working from. A coordinator in this team ensured referring doctors were contacted immediately with the results. Staff used established processes to ensure trusts with manual records systems received results at the same speed as those with fully automated systems.

The service had an established process to request previous imaging or additional relevant clinical history for the patient from the referrer, if the reporting radiologist required further information prior to reporting the images.

The service ensured reporting radiologists were only given referrals in modalities that they were qualified to report and within their field of expertise.

Staffing

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

The service had both employed radiologist and contracted radiologists who worked for the service alongside their substantive NHS role. As part of their contracted radiologist contracts with the service radiologists were not allowed to work during rostered NHS hours and working hours must include rest breaks. Radiologists were required to declare what work they did elsewhere so the service could monitor individual's capacity to carry out their agreed work. Employed radiologists were contracted to work for specific hours for the service.

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The scheduling team planned staffing levels in advance based on known trends and predicted changes in demand. The team provided cover 24-hours, seven days a week and could increase the number of radiologists available at short notice during surge periods.

The scheduling team monitored the number of radiologists working remotely from their homes and from the service's own reporting rooms, including who were based in the UK and those overseas. This meant services were continually coordinated to take into account time differences between the location of the radiologists and the time in the UK, where referrals came from.

The service had a protocolling radiologist always on shift, who triaged referrals from NHS trusts before the operations team assigned these to a reporting radiologist.

An operations team worked across the service to coordinate planned work. Team leaders supported administration staff, operations coordinators and the medical editing team. Teams provided 24-hour cover and the senior team had developed staffing principles based on trends in demand on the service.

Records

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

The service received, stored and handled referrals from NHS trusts in line with its data protection policy and NHS number protocol. A digital, centralised system tracked all patient information in real time so that there was a continuous audit trail. Meaning staff had assurance that all information relating to a patient was updated immediately on receipt of any follow-up from the trust.

Radiologists had access to the same patient information as they would in the referring hospital and had access to previous imaging or reports if required. The radiologists we spoke to confirmed that this process was effective.

The reporting system included a facility for radiologists to attach an addendum. An addendum is a description of revisions made to an earlier signed report or record. The referrer would be informed by the operation's team if an addendum was added to a report.

Radiologists could only access images assigned to them to maintain patient confidentiality. All the information the radiologist needed was included in a single module, including the request card, scan images and prior images and reports. Opening this module automatically launched the dictation system, which transcribed reports. This system facilitated radiologists having straightforward access to the case at hand and reduced time spent searching for documents or other information.

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 as it did not have any direct face to face contact with patients.

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Incidents

The service managed patient safety incidents well. 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 in place to report, investigate, and learn from incidents. The service had a version controlled and in date incident reporting policy which clearly defined incidents and the reporting process.

The provider used an incident tracking system which provided a chronological process from incident reporting through to completion of the investigation, all documents were stored within the tracking system, including coroner reports and police statements. The senior team also tracked incidents relating to information governance, health and safety and personal data.

The provider did not provide direct care to patients and had no contact with patients. However, where referrer trusts reported a serious incident (SI), the service worked with them during the investigation. We saw examples of this through the service's contract monitoring minutes.

The service had not evoked duty of candour for any incident. However, there was a duty of candour policy and staff we spoke with could explain what duty of candour was.

In line with the RCR guidance, "Standards for radiology events and learning meetings", the service held monthly meetings which promoted a culture of respectful sharing of knowledge with no blame or shame. These meetings were also an opportunity for the radiologists to present interesting cases and for the team to discuss other incidents.

The service had a business continuity plan to ensure there were processes to continue to operate its service with minimum disruption.

Are Diagnostic imaging effective?

Inspected but not rated 

We do not currently rate effective for teleradiology services.

Evidence-based care and treatment

The service provided diagnostic reporting services based on national guidance.

Staff followed up-to-date policies to plan and deliver a high-quality service according to best practice and national guidance. The ten policies reviewed during our inspection all referenced national guidance and legislation. The service used referral protocols based on national standards. For example, radiologists used National Institute for Health and Care Excellence (NICE) guidance for head trauma and the Royal college of radiologists (RCR) guidance for trauma patients who experienced a severe injury.

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All staff, including reporting radiologists had digital access to procedures, standard operating processes (SOP) and organisational policies remotely from wherever they were working. This promoted adherence to consistent, standardised reporting processes. The provider required all staff to read relevant policies annually and staff had to sign to document they had read the policies. All staff we spoke with knew how to access policies and procedures. All policies we reviewed were in date at the time of our inspection

The diagnostic reports followed the RCR standards for interpretation and reporting of imaging investigations. The quality and standard of the reports was confirmed by the radiologists we spoke with.

The service achieved certification for the ISO9001:2015 for the delivery of diagnostic imaging reports in July 2019.

Nutrition and hydration

The service did not have any direct face to face contact with patients.

Pain relief

The service did not have any direct face to face contact with patients.

Patient outcomes

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

The service had key performance indicators (KPIs) in place for each referring organisation which were audited regularly at either monthly or quarterly contract monitoring meetings. The KPI for turnaround times for urgent CT stroke and trauma reports being completed was within 30 minutes of receipt of the scan. Between February and July 2022, the service reported 96% compliance with this KPI. For urgent CT reports completed within 60 minutes for the same time period, the service reported a compliance rate of 91%. The service met their 90% compliance for both these KPIs.

Due to the increase demand for scans post COVID-19 the service were working with their referrers to meet the increased demand being put on the service. The service was recruiting more radiologists to support this work.

The service monitored discrepancies as part of a quality assurance (QA) review, which staff used to detect significant discrepancies. The QA review could be triggered by the routine peer review audit or at the request of the referring client. This facilitated discrepancies being identified and monitored, and opportunities for learning highlighted. We saw evidence of the discrepancy process being used which the reporting radiologists were made aware of as part of their induction process.

The service was accredited by United Kingdom Accreditation Service (UKAS) achieving accreditation in Quality Standard for Imaging (QSI) 2019.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of the service. All radiologists who reported for the service were registered with the General Medical Council (GMC) and had submitted evidence of indemnity cover.

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Radiologists were not able to work unless they had completed an annual appraisal. The radiologists provided evidence of their external appraisal undertaken by the NHS trust they work for. The radiologists we spoke with confirmed that the service annually requested a copy of their appraisal. For radiologists who did not work for an NHS trust, the service provided the required appraisal process.

Non-clinical staff had quarterly one on one meetings and annual appraisals. Staff we spoke with told us they felt well supported by their managers and they found the appraisal process to be a positive experience.

The service gave all new staff a full induction tailored to their role before they started work.

The service had a Disclosure and Barring Service (DBS) policy in place. There was evidence of DBS checks for all staff employed by the service.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The radiologists we spoke with confirmed the service provided update and continuous development training on a monthly basis.

Multidisciplinary working

Due to the nature of the service staff worked remotely with limited contact with each other and radiologist were not expected to join referring clinician's multidisciplinary team meetings (MDT).

Currently, radiologists spoke with the referring clinician on an ad hoc basis if requested by the referring organisation.

Seven-day services

Services were available seven days a week to support timely patient care.

The provider operated services 24-hours a day, 365 days a year. The international model of the organisation meant staff were utilised based on the local time in their location. This approach aimed to reduce the risk of service interruption, facilitate a continuous service with no reduction in service overnight and staff not working during hours usually classed as out of hours.

Non-clinical services, such as scheduling and operations administrative staff, provided advanced coordination and planning services that ensured unexpected increased demands or shortfalls in planned staffing levels did not affect service standards.

Health promotion

The service did not have any direct face to face contact with patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service did not have any direct face to face contact or deliver any direct patient care.

Are Diagnostic imaging responsive?

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

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Service delivery to meet the needs of local people

The provider planned and delivered services in a way that met the needs of referring organisations.

The provider planned and delivered a service that met the needs of the referring organisation. Reporting radiologists were available to speak with referring clinicians on request to discuss reporting requirements or complex needs. Reporting radiologists were able to request previous relevant imaging or further clinical information from the referring clinicians.

A dedicated member of staff provided a single point of contact for each NHS trust and liaised daily to maintain continuous oversight of their needs. This enabled the service to be responsive to changing needs and demands, including to short notice changes.

The service provided out of hours reporting and rapid reporting on trauma scans, some scans were reported by radiologists who were based overseas, but if issues were identified, they were reported directly to the referring organisation through the service's reporting system, followed up by a telephone call to the referrer.

Meeting people's individual needs

The service did not have any direct face to face contact with patients.

Access and flow

Referring organisations could access the service when they needed it as outlined in their individual contract.

The provider had service level agreements (SLAs) in place with agreed key performance indicators (KPIs) for each referring organisation, which included turnaround times (TATs). The service monitored TATs for each of the referring organisations and used the data to identify themes across specialities. The TATs were individual to each referring organisation.

Radiologists were based in all major time zones, using the provider's 'follow the sun' model. This meant various time zones were utilised to the advantage of referring organisations and radiologists. At any given time at least one of the provider's global offices was fully operational, which supported the 24-hour service.

The service had a business continuity plan in place should their IT infrastructure fail. The service 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 service had a complaint's management procedure which was in date at the time of the inspection. This procedure included response times for acknowledging receipt of complaints and investigation of the complaint. The procedure also detailed how to handle both clinical and operational complaints.

There had been 31 complaints recorded by the service during the 12 months prior to the inspection. Most complaints about the service were made by referring organisations regarding discrepancies. There were also complaints from

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referring organisations regarding addendums added to reports post patients leaving the service, reporting outside TATs and patients seeking a second opinion on their scan result. All complaints were reviewed by the medical leadership council and investigated by the service. All radiologists were informed about complaints and learning was shared during monthly meetings.

All complaints or concerns were discussed with the referring organisation who raised the matter with the service, issues were identified, and action taken to resolve it.

Are Diagnostic imaging well-led?

Good 

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

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 the staff.

The service had a clear management structure with defined lines of responsibility and accountability. A team of senior managers and directors were responsible for the provider's functions, with oversight from the chief executive officer. They led on specific functions, such as operations, business development, and finance. Senior leaders had a good understanding of the service's priorities, challenges and issues it faced and managed these.

The structure of the leadership team was based on the demands on the business and staff we spoke with were positive about leadership access and support. All operational staff we spoke with told us senior leaders were available and approachable. They gave examples of when they had needed support or advice and they found the senior leaders to be welcoming, open and supportive.

The radiologists we spoke with said management communicated well with them and were always approachable, efficient and provided support when needed

Vision and Strategy

The service had a vision and strategy for what it wanted to achieve developed with involvement from staff.

The provider had a vision and strategy for the service, developed with involvement of staff. The provider's vision was to make the most of international time zones and provide 24 hour, seven days a week radiology reporting, while ensuring the team of radiologists worked only in daylight hours.

The provider had a written five-year strategy dated 2022 and a one-year plan which outlined the priorities and goals for 2022/23. Senior leaders demonstrated a clear understanding of the strategy and how to achieve it. Radiologists and staff, we spoke with understood the vision and strategy and their role in achieving the service's strategy and vision.

The strategy included a focus on attracting and retaining the best radiologists, creating an environment which allowed them opportunities to develop in their careers. It also included having technology that optimised staff's on-shift experience and future proofed the service's technology infrastructure, while increasing the service's relevance and key impact to their clients.

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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.

All staff we spoke with were positive about working for the service. They described good relationships with the management team and a working culture that valued the input of each individual. Radiologists we spoke with described a supportive culture in which mistakes or discrepancies were used as opportunities for learning.

The service had an online forum where radiologists could post interesting cases or discussion topics to ensure all remote working staff could interact with each other.

The service had a freedom to speak up (FTSU) policy and FTSU guardian to support staff raising concerns.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and high standards of care. The committee structure was used to monitor performance and provide assurance of safe practice. The service had a clinical governance committee, medical leadership council, global information governance forum and information governance committee meetings which fed into the board.

The clinical governance committee provided feedback about the business, discussed peer review and provided general updates and reminders. The second part of the meeting reviewed interesting or unusual scans, providing an opportunity for learning.

The medical leadership council met monthly and reviewed the quality assurance data and discrepancies review findings. The council also monitored turnaround times, incidents and complaints as part of the governance process.

The service had a quarterly information governance meeting which discussed information governance issues and incidents. The global information governance forum reviewed policies and procedures annually ensuring they reflected the last national guidance. The quality management forum which met quarterly to review sales, quality, recruitment and workforce planning.

The service audited all outputs, discrepancies, turnaround times, declined scans, incidents and complaints as part of the governance process. Account managers and other senior staff shared governance data with NHS trusts as part of their relationship to monitor and improve services.

Management of risk, issues and performance

The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were clear and effective processes for identifying, recording and managing risks. Clinical governance systems were focused on identifying and managing risk and performance.

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The service had both a corporate and clinical risk register. The corporate risk register provided during our inspection, described the identified risk, mitigating actions and controls in place, however there was no identified risk owner accountable for managing the risk and ongoing actions. The clinical risk register we were provided with when requested during inspection did not include mitigating actions or identify the risk owner. There were no dates listed in either document of when the risk had been identified or of any subsequent updates to the risk. However, following the inspection, the service sent us further risk registered which detailed risk owner accountable for managing the risk and ongoing actions.

The service had a rolling internal peer review of 5% of all scans using a predefined review tool. Peer review and discrepancies were a standing item on the monthly clinical governance meeting agenda. The minutes we reviewed for four of these meetings, included discussions about review of discrepancies and significant peer review findings.

The service had a process to manage and widely share learning from adverse events, incidents, discrepancies or errors that had occurred. Radiologists are encouraged to attend or later view half of all Clinical meetings in line with the Royal College of Radiologists (RCR). Attendance was logged and monitored, and action taken if individuals failed to attend the required number of meetings.

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 hospital where they had received their scan, it was being completed to the same standard and with comparable security.

The service planned for emergencies and staff understood their role if one should occur. Policies, such as business continuity, were accessible and detailed what action staff should take in the event of a major incident such as a system failure.

Staff we spoke with told us they received feedback on risk, incidents, performance and complaints in a variety of ways, such as regular team meetings and emails.

The service had a team of contract co-ordinators who produced performance reports for each contract monitoring meeting they had with the refereeing trust. These reports were discussed at monthly or quarterly contract and performance review meetings which the service had with each of its contracted trusts.

Information Management

The service managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service had a Caldicott guardian in place and identified lead for information governance providing staff with a point of escalation. A Caldicott guardian is a person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

There was a data protection policy in place, last reviewed in June 2021, which was aligned with relevant legislation, including General Data Protection Regulations (GDPR) 2016/679. This covered a wide variety of topics including data breaches. The service was compliant with GDPR 2016/679.

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All data transferred was encrypted or sent via a secure network between the referrer and the service. The nature of the service meant most key risks related to information security and data protection. Risk management systems were focused on this area and staff used a risk treatment plan to address existing and emerging risks. The risk treatment plan was the service's internal tool developed to address risks.

Staff adhered to an identity verification process when accepting, reviewing and processing scans. Each referral was identified by an NHS patient number or other unique identifier to ensure reports were produced for the correct patient. The service had an established NHS number protocol to ensure staff followed standards consistently.

Unexpected, significant or urgent findings identified by the radiologist were notified to the referring organisation through the service's IT system by an e-mail and followed up with a telephone call with the referring clinician if required.

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

The service had also re-certified for the ISO/IEC 27001 :2013 for processing, storage and transmission of personal data and, supporting technical processes was re-issued in February 2022.

Engagement

The provider engaged well with staff and client organisations to plan and manage services.

The provider used a wide range of methods, including emails and bulletins to ensure all staff, including those working remotely, received consistent, up to date information. Staff told us they were kept updated through regular team meetings and email communication.

The provider had dedicated account managers who engaged with referring organisations quarterly, throughout their contract to obtain feedback on the service and identify opportunities for improvement.

Staff told us they felt engaged with plans for the future of the service and that they were listened to. Managers and their teams met regularly to maintain good working relationships and effective lines of communication.

Learning, continuous improvement and innovation

The provider was committed to improving services by learning from when things went well and when they went wrong, promoting training and innovation.

There was a focus within the service on continuous improvement and quality. Leaders were responsive to any concerns raised, including performance issues and sought to learn from them and improve services.

The provider had completed various improvement projects that reflected the growing needs of the provider and increased demands on its services. For example, the service had developed an integration model which meant that radiologists did not need to connect directly to the referring hospital's systems to access images that needed reporting. The new system did not require any changes to existing infrastructure on the referring hospital's site, everything was handled securely from the systems the referrers had already.

The service had developed dedicated shift notes to be displayed every time a radiologist logged on the system at the beginning of their shift, which required active acknowledgement before their reporting session could begin. This had enabled confidence that information on mandatory training or other crucial communications were read and understood.

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An externally led review of over 100,000 Everlight cases, found that the implementation of an intracranial haemorrhage (ICH) and pulmonary emboli (PE) artificial intelligence algorithm had reduced the number of unreported ICH, without seeing an increase in the number of false positives. We were told this algorithm was now used globally to increase patient safety and reduce potential for poor outcomes.