Radiology Reporting Online LLP – London Head Office

Quality Report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Radiology Reporting Online LLP – London Head Office is operated by Everlight Radiology. The service provides teleradiology reporting services to NHS hospitals across the United Kingdom, including plain film, computerised tomography (CT) and MRI, as well as quality assurance monitoring for ultrasound screening. The services 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. The service began reporting from this location in July 2018.

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 17 radiologists who are registered with the General Medical Council as specialists or with the Royal College of Radiologists. A further 181 reporting radiologists worked for the service nationally. 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 service does not store or prescribe medicines and does not monitor patient symptoms such as pain or clinical presentations.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 8 March 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. However, we did not inspect the service using the caring domain of our inspection framework because the service has no direct contact or interaction with patients.

As the service does not have direct contact with patients the provider has no areas of required compliance with the Mental Capacity Act 2005.

Reporting radiologists typically process tens of thousands of reports per month from the provider's UK locations or UK-based homeworking.

We rated the service as **Outstanding** overall:

- The service had enough staff to provide a safe service. Staff had training in key skills, understood how to identify abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- There were effective systems to act on urgent and emergency referrals. There were escalation processes for reporting radiologists to contact referring clinicians in the event of significant finding. Failsafe processes meant radiologists always had a named point of contact within each hospital in the event the referring clinician was unavailable.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. All services were available seven days a week.

Summary of findings

- The service sought accreditation by appropriate awarding bodies and had developed benchmarking and audit processes to establish consistent standards of work.
- Services were provided flexibly, provided choice and ensured continuity of care. The organisation involved NHS clients in all aspects of service provision and provided highly tailored solutions based on their needs. There were innovative approaches to providing integrated pathways of care that involved other service providers, particularly for emergency scan results. All aspects of the service were available 24-hours, seven days a week with senior clinical oversight available at all times. The senior team actively reviewed complaints within an established framework that ensured improvements were made as a result.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We found areas of outstanding practice:

- All staff had a demonstrable, driven approach to improving standards for patients and clients. This included multiple, responsive processes that senior staff continually sought to develop. Although the service did not provide direct care to patients, staff clearly had patient outcomes at the centre of their dedicated work ethos.
- The provider had effective, well-established systems to ensure reporting radiologists who provided services for UK-based hospitals had appropriate equipment installed. This included a visual check of their reporting area by the IT team and installation of equipment carried out by approved UK-qualified technicians.
- The service was highly responsive to client and patient needs and had tested and implemented solutions to issues in a timely manner.
- There was a continual, well-defined focus on improvement and innovation. Dedicated staff continually reviewed work processes and systems to identify opportunities for improvement.
- In the absence of national standards for teleradiology reporting, the provider had established an internal peer review system aimed at benchmarking reporting quality.
- The provider had developed innovative solutions to challenges relating to 24-hour working. This included scheduling work hours based on the report's location to avoid the fatigue associated with night shift.
- The senior team placed value on effective, advanced communication between staff and provided opportunities for advanced development. For example, the provider had secured training from a neuroscience specialist to help staff build strong working relationships by recognising how they perceived each person's style of communication

Nigel Acheson

Deputy Chief Inspector of Hospitals

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Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Outstanding 	We rated this service as outstanding because it was safe, effective, responsive and well-led.

Summary of findings

Contents

Outstanding ☆

Radiology Reporting Online LLP - London Head Office

Services we looked at
Diagnostic Imaging.

Summary of this inspection

Background to Radiology Reporting Online LLP – London Head Office

Radiology Reporting Online LLP – London Head Office is operated by Everlight Radiology. The service began carrying out regulated activities from this location in July 2018. The location is the provider's UK head office and includes operations, scheduling and administration teams in addition to reporting facilities for radiologists. The service has no direct contact with patients and does not provide direct patient care.

The location is registered to provide the following regulated activity:

- Diagnostic and screening procedures

The London office primarily provides routine daytime reporting and the dedicated operations team provide live monitoring and resource control based on demands on the service, including for urgent out of hours reporting. The team works with colleagues in other UK and international locations to coordinate reporting capacity.

Radiology Reporting Online LLP, London Head Office, was previously located at another address. A registered manager has been in post since the service began operating.

We have not previously inspected this service.

Our inspection team

The inspection team comprised of a CQC lead inspector and a specialist advisor with expertise in radiology. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Information about Radiology Reporting Online LLP – London Head Office

The location is the provider's head office and is equipped with nine radiology reporting rooms as well as digital resources to coordinate and manage the service globally.

During the inspection, we visited the head office and spoke with staff from each key department, including IT and human resources, as well as senior staff and two reporting radiologists. During our inspection, we reviewed four sets of radiologist reports.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has not previously been inspected.

The service employed a range of specialist non-clinical staff in addition to standard corporate functions, including for operations, urgent escalations and capacity and demand planning.

The service typically reviewed tens of thousands of scans per month nationally.

The service did not provide direct care to patients and staff had no direct patient contact. The service recorded incidents that NHS hospitals reported in relation to patients whose scans had been reviewed by the service. Senior staff proactively assisted in the investigations of serious incidents with NHS trusts as part of their role in providing services.

Services accredited by a national body

The service held two accreditations:

- ISO27001, which denotes information security standards.
- Information Governance Statement of Compliance (IGSOC), to enable them to use electronic NHS systems.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated the service as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff had training on how to recognise and report suspected abuse and they knew how to apply it. The service worked well with other agencies to escalate concerns.
- The service had suitable premises and equipment and looked after them well. There were systems to manage equipment used by staff who worked remotely.
- Established safety systems ensured only reporting radiologists qualified and experienced in specific modalities were given referrals. Equivalent systems applied to emergency referrals.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide diagnostic reporting services.
- Staff provided detailed records of patients' diagnostic assessments. Records were clear, up-to-date and easily available to all staff providing care.
- 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.
- The service used safety monitoring results well. Staff collected safety information and managers used this to improve the service.

Are services effective?

We do not currently rate effective for diagnostic imaging services.

However, we found the following areas of good practice:

- The service demonstrated a continuous, proactive approach to improving the standards of radiology reporting using the latest evidence of best practice.
- The service provided diagnostic reporting services based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Summary of this inspection

- Managers monitored the effectiveness of reporting used the findings to improve the service. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different disciplines worked together as a team to benefit patients. Clinicians and non-clinical professionals supported each other to provide good standards of reporting.

Are services responsive?

Outstanding ☆

We rated the service **Outstanding** because:

- **Services were tailored to meet the needs of each NHS trust and their patients and were delivered in a way to ensure flexibility, choice and continuity of care.**
- Client's individual needs and preferences were central to the planning and delivery of tailored services. Services were flexible, provided choice and ensured continuity of care.
- The organisation involved clients and stakeholders in service planning to ensure they continued to meet demand. There were innovative approaches to providing integrated pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- Staff were proactive in their approach to understanding the needs of different clients and to deliver care in a way that met these needs and promoted equality. This included people who had complex needs.
- Client NHS trusts could access services in a way and at a time that suited them.
- Senior staff actively reviewed and made improvements as a result across the service and involved complainants in the review.
- Between January 2018 to December 2018 the service achieved 96% compliance with turnaround targets for routine referrals and 99% compliance for urgent referrals.

Are services well-led?

Outstanding ☆

We rated the service **Outstanding** because:

- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred reporting.
- The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.

Summary of this inspection

- The provider had a systematic approach to working with other organisations to improve care outcomes.
- Senior staff proactively reviewed governance and performance management arrangements and reflect best practice,
- Leaders had an inspiring shared purpose, strived to deliver and motivated staff to succeed. Comprehensive and successful leadership strategies ensured delivery and developed the desired culture.
- There were high levels of staff satisfaction across all grades and roles we spoke with. Staff were proud of the organisation as a place to work and spoke highly of the culture. Leaders constructively engaged with staff and actively encouraged them to contribute ideas.
- There was strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences.
- Staff used innovative approaches to gather feedback from NHS trusts that used the service.
- The senior team welcomed rigorous and constructive challenge from clients and stakeholders.
- The leadership drove continuous improvement and staff were accountable for delivering change. The senior team celebrated innovation and had a proactive approach to seeking out and embedding new and more sustainable models of care.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	N/A	N/A	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	N/A	N/A	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding ☆

Diagnostic imaging

Safe	Good
Effective	
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are diagnostic imaging services safe?

Good

We rated safe as **good.**

Mandatory training

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

- Mandatory training applied to all staff, including those who worked on zero-hour contracts. It included specialist modules relevant to the services provided, with a key focus on information governance and each individual's specific role. The system was designed to ensure standards of work and practice were consistent regardless of radiologists' experience and type.
- A trained first aider was always available in the office. Modules included various stages of information governance, and General Data Protection Regulation (GDPR) 2016/679 training and knowledge tests. At the time of our inspection, the location had 100% compliance with training targets.
- Radiologists were required to complete mandatory training before they were able to begin reporting.

Safeguarding

Staff had training on how to recognise and report suspected abuse and they knew how to apply it. The service worked well with other agencies to escalate concerns.

- The provider ensured all staff, including radiologists working on zero-hour contracts, remained up to date with the principles of safeguarding. As staff did not have direct contact with patients, the service ensured training opportunities were relevant to the roles and responsibilities of radiologists. For example, in September 2018 the service arranged specialist training in imaging in cases of suspected physical abuse that referring doctors had not identified.
- All reporting radiologists and senior staff had safeguarding adults and children level two training, in line with the Royal College of Nursing intercollegiate document on safeguarding.
- Radiologists used establish processes when they identified or suspected non-accidental injuries in a scan, including an urgent notification to the referrer and escalation through the local safeguarding procedure.
- Radiologists followed national best practice guidance when identifying potential safeguarding issues, including from the General Medical Council and November 2018 guidelines issued by the Royal College of Radiologists relating to the suspected physical abuse of children.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- 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.
- Established systems ensured radiologists had access to reliable, standardised reporting and communication equipment regardless of whether they worked from the office suite or remotely.
- A dedicated radiologist deployment team worked across multiple geographic 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. This system was well established amd the provider had successfully deployed radiologists to six contients.

- Radiologists we spoke with said IT and equipment support was of a high standard and said the reporting environment in the office was readily accessible, with equipment adjustable to their needs.
- The IT team calibrated screening monitors annually and checked them for consistency monthly. This was a centralised process that included all reporting screens, regardless of location.
- The IT team carried out regular cyber-security penetration tests on the provider's equipment, including equipment used remotely. A penetration test examines a computer network for vulnerabilities so that they can be addressed to provide security protection.
- A dedicated health and safety officer maintained oversight of staff safety in the office, with support from an HR officer. All staff were required to attend an annual health and safety meeting and the senior team shared the outcomes with those unable to attend.
- The provider was based in a building with fire and evacuation procedures managed centrally by an external facilities team. A trained, designated fire warden was always on shift in the service and the facilities company carried out regular major incident and evacuation drills.

Assessing and responding to patient risk

- The reporting radiologist assigned to an emergency referral discussed this with the referring clinician to ensure they could comply with local referral protocols. The service had a 'direct to scan' protocol in place with some providers, which meant the reporting radiologist could proceed immediately without discussion. These were specific to each NHS client and ensured the provider could meet the hospital's requirements and that the radiologist had the appropriate expertise. The provider declined to accept referrals which were not compliant with the client referral protocols.
- 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.
- Radiologists used internal professional standards and advisory guidelines to report unexpected and significant findings through an exception management process called the 'significant finding notification process'. This was a structured system to ensure significant findings were acted on consistently.
- Each NHS trust, or 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 phone and provided a verbal report in addition to the written report. The operational coordinator maintained oversight of all significant findings communications, which ensured the service maintained a continual audit trail.
- The provider had developed a protocolling matrix for each referring NHS trust and the clinical director maintained oversight of this. The matrix detailed each trust's clinical indications for emergency imaging, which meant reporting radiologists accepted referrals based on each trust's referral protocols.
- A dedicated urgent findings team was available at all times. Radiologists had instant online messaging access to this team regardless of where they were working from. A coordinator in the urgent findings 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.
- Staff monitored the national patient safety alerts and were prepared to act on recalls or reviews.
- Radiologists triggered a red alert system to escalate urgent findings to the NHS referrer. This system was 24-hours, seven days a week and meant referring clinicians were alerted quickly in the event a radiologist found urgent action was needed to treat a patient.
- Accountable senior staff maintained oversight of reporting cases on hold to avoid delays in reporting.
- The reporting system tracked each referral individually to ensure a seamless transition between radiologists where more than one individual was involved in the

case. For example, if the protocolling radiologist and reporting radiologist were two different people, the system ensured both individuals had access to all of the information and could communicate with each other using an instant messaging service.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide diagnostic reporting services.

- Seventeen radiologists on the General Medical Council (GMC) specialist register and registered with the Royal College of Radiologists (RCR), or international equivalent, regularly worked from the London reporting centre. This team worked to zero-hour contracts and were in substantive posts in the NHS. An additional three radiologists were contracted to work specific hours for the service.
- As of December 2018, the service had 181 active reporting radiologists in the UK, which included recruitment of 62 radiologists between January 2018 and December 2018.
- The service recruited on a rolling basis and had no limits to the number of radiologists that could report for them.
- Radiologists were required to comply with UK regulations on revalidation regardless of their main location of work, in addition to local laws.
- Sickness in the service was very low, with 0% sickness amongst 13 of the 15 staff groups between October 2018 and January 2019.
- The scheduling team planned staffing levels in advance based on known trends and predicted changes in demand. The team provider 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 from home and from the provider's reporting rooms, including who was based in the UK and those offshore. 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.
- A protocolling radiologist was always on shift and triaged referrals from NHS trusts before the operations team assigned these to a radiologist.
- Key stakeholders from each department joined a daily briefing to discuss the day ahead, including staffing and anticipated challenges. The senior executive team supplemented this with a weekly capacity council meeting to review workflow tracking and radiologist availability.
- Radiologists were required to have gained qualifications and recent experience in the UK before providing services from abroad. In addition, each radiologist was required to maintain current GMC membership.
- Established processes ensured the service was not impacted by the non-availability of a radiologist if they were needed for a query following a report. For example, if a discrepancy was found and the original radiologist was unavailable for five days or more, the medical leadership council would review the case in their absence.
- The service acted on Healthcare Professional Alert Notices (HPANs) issued by NHS Resolution. HPANs are notices that alert providers that a healthcare professional may pose a risk of harm to patients, staff or the public. The service used this system to ensure radiologists were of good standing and meant the senior team had greater oversight of a large team of clinicians who worked to varying times and from varying locations.
- An operations team worked across the provider's UK network to coordinate services. 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 and an average throughput of 1400 studies for reporting per day. As of December 2018, a team of 12 administrators, including a team leader, worked within the operations team and were on-site from 9am to 8pm Monday to Friday and provided basic coverage during weekend daytimes. The overnight operations team worked across the provider's international network to ensure there were always enough coordinators and call handlers to meet urgent demand.
- As of December 2018, a team leader and four medical editors supported radiologists who required their reports to be edited before being released to the referring hospital. The team typically provided services between 7.30am and 11pm and matched availability to radiologist's working patterns.

Diagnostic imaging

- The provider had established a dedicated department, called RadCare, to manage capacity and demand through a responsive recruitment and scheduling system.
- A team of five schedulers worked seven days a week and coordinated radiologist cover across each subspecialty. This team planned for expected levels of demand and worked with operations and account management colleagues to respond to spikes in demand by utilising an international group of bank radiologists. A capacity council met weekly with stakeholders to forecast demands on the service and to plan staffing in advance. This system ensured the service could consistently match capacity and demand, including during known peak periods, such as bank holidays when NHS trusts typically sent significantly more requests.
- The service used a sustainable recruitment and resourcing model that ensured demand was met by using an international base of radiologists that were best-placed to provide services based on their local time of day. For example, radiologists in the southern hemisphere increased their level of cover during the summer months, when radiologists in the northern hemisphere typically took extended holidays. This system prioritised offshore radiologists based outside of the UK who were awake during the night due to time differences, which meant reporting radiologists were not fatigued. The provider also limited maximum shift times and mandated breaks as part of a policy to ensure radiologists did not work when excessively tired.
- The recruitment system was linked with the sales system, which meant the provider maintained continual oversight of staffing provision. For example, the sales team worked with NHS trusts new to the service to identify their planned demands and volume of work prior to the start of the contract.
- A dedicated recruitment manager maintained oversight of all recruitment. They worked with the clinical director to carry out a check of professional registration and restrictions on practice. The credentialing team ensured each individual had up to date Disclosure and Barring Service (DBS) clearance. New staff were required to provide evidence of continuing professional development and medical insurance. The credentialling team maintained a live, electronic system of all of this information, which enabled them to maintain continuous oversight of staff working for the service.
- Senior staff ensured non-clinical teams could always meet capacity and demand through a scheduling system that provided team leaders with protected non-operational time. This meant they could cover sickness or unexpected increases in demand at short notice without interrupting the service.
- Team leaders carried out a formal handover at each shift change. This included staff working remotely and offshore through an e-mail distribution list.

Records

Staff provided detailed records of patients' diagnostic assessments. Records were clear, up-to-date and easily available to all staff providing care.

- The provider 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. This also meant staff had assurance that all information relating to a patient was updated immediately on receipt of any follow-up from the trust.
- Although the provider was responsible only for diagnostic reporting, the operations team had access to each patient's clinical informationprovided with the referral through agreements with each NHS trust. This meant radiologists could access important information where they identified a need to review a patient's clinical history to be able to provide an accurate assessment.
- The provider requested prior imaging, prior reports and comments from the referring team for each referral. This ensured diagnostic reports considered previous radiology outcomes and was a standard requirement established with each referring NHS trust. For example, where trusts referred scans for renal function diagnostics, the provider required pathology results in advance to ensure the administration of contrast to the patient had been justified.
- Effective processes ensured accuracy when referring doctors sent scans for multiple patients. Radiologists used unique patient identifier numbers and a protocolling template to reduce the risk of cross-contamination of reviews where they received multiple referrals at the same time.

Diagnostic imaging

- The provider used a digital workflow system that could be fully integrated with the referring NHS trust's picture archive and communication system (PACS) if they had compatible software. This meant reporting radiologists could seamlessly integrate diagnostic reports into the patient's records. Where the referring trust did not have this system, the provider established manual procedures. The fully automated system had a manual back-up, which meant reporting radiologists could provide reports without delay in the event of an IT systems failure.
- Each radiologist had a personalised worklist that meant they could only access referrals assigned to them. All of 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 meant radiologists had straightforward access to the case at hand and reduced time spent searching for documents or other information.
- 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. This meant the trust's nominated recipients received immediate notification of attachments to reports.
- Operations coordinators created a list of referrals awaiting a report, ordered these based on the level of urgency and assigned them to appropriate radiologists. The team reviewed each referral for the correct number of images and clinical information prior to assigning them. This meant radiologists always had clear information on which to carry out a diagnostic review.
- The operations coordination team monitored turnaround times using a live digital dashboard, which included the report due time and a countdown timer for each referral.
- The medical leadership council reviewed the structure and accuracy of a radiologist's reporting style as part of the initial recruitment assessment process, which was demonstrative of the importance the service placed on this quality measure.

Medicines

- The service did not store medicines, nor was it responsible for administering contrast media for procedures.
- The provider had established protocolling guidelines that included contrast prescription guidance for when a referring trust did not have patient group directions (PGDs). PGDs are written instructions that enabled non-prescribing staff with training to administer specific medicines for named conditions within controlled rules. These guidelines ensured the provider accepted scan images only when they had assurance the referring trust had adhered to safe standards of practice.
- Protocoling radiologists recommended contrast protocols for emergency body scans. This meant the service's protocoling team provided expert advice to NHS clients to carry out scans that would result in high quality images for urgent reporting.

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.

- The information security officer was responsible for the implementation and fulfilment of the incident reporting policy. This was focused on data management and information security, which was in line with the nature of the organisation. The policy provided staff with a framework to report near misses, incidents and serious incidents through a management structure that promoted learning and a 'no-blame' culture.
- The provider did not provide direct care to patients and had no contact with patients. However, where NHS trusts reported a serious incident (SI) to with strategic executive information system (STEIS), the service worked with them during the investigation.
- Reporting radiologists provided feedback on SIs that included diagnostic reporting and the provide reviewed reports to identify opportunities for learning.
- The provider used an SI tracking system that chronological access to investigation documents, including coroner reports and police statements. The senior team also tracked incidents relating to information governance, health and safety and personal data.
- The senior team used bi-monthly educational webinars based on discrepancies and SI trends to provide feedback to radiologists and identify lessons learnt.

Diagnostic imaging

- Where a non-clinical operational issue contributed to an incident, such as a significant finding not communicated, the operations manager led the investigation to identify opportunities for learning.
- The provider offered to attend meetings with NHS trusts where a duty of candour (DoC) trigger had been reached due to an incident. In 2018, staff attended two DoC meetings with referring trusts.
- Where a patient subsequently died, and the coroner held an inquest, the service obtained the patient's clinical records from the trust to help them contribute to an investigation of care.
- Radiologists used an electronic checklist to ensure communication with referrers and stakeholders was consistent and timely where the trust had declared a clinical incident. This formed part of the formal response procedure, which ensured appropriate individuals involved in the incident maintained communication.

Safety Thermometer (or equivalent)

The service used safety monitoring results well. Staff collected safety information and managers used this to improve the service.

- The service did not provide direct care to patients and did not have direct communication with patients. However, the provider had established safety governance pathways that reflected their responsibilities within each patient's medical pathway. This included a clinical auditing process that involved systematic reviews and notifications from referring NHS trusts. This process meant the senior team had continual oversight of discrepancies, which the medical leadership council reviewed on a quarterly basis alongside each radiologist's performance.
- There was no national benchmark for acceptable levels of discrepancies within teleradiology services and no systematic system of peer review. To address this, the provider had established a system of internal peer review with senior clinical oversight. This included second review of up to 10% of all reports each month, which met the aspirational Royal College of Radiologists target.

Are diagnostic imaging services effective?

We do not currently rate effective for diagnostic imaging services**.**

Evidence-based care and treatment

The service provided diagnostic reporting services based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- The service sought out quality and safety accreditations to demonstrate consistent standards in line with national and international guidance. This included ISO27001 accreditation, which indicates standards of data and information security. The service had also achieved the Information Governance Statement of Compliance, which enabled them to use NHS systems.
- The service was working towards the Royal College of Radiologists (RCR) Quality Standard for Imaging (QSI). The QSI replaced the Imaging Services Accreditation Scheme (ISAS) and is awarded when a service can demonstrate consistently high standards of practice. In preparation for this, the service had implemented a traffic light system to monitor performance and had completed an annual policy review. Each department participated in this and the service planned to achieve accreditation by 2020.
- At the time of our inspection the team was working towards achieving ISO9001. ISO9001 is an international standard for quality management. The senior team had carried out a gap analysis as part of preparation and all staff had been interviewed regarding their role in quality management. Following our inspection, the provider achieved accreditation.
- All staff had digital access to procedure manuals, standard operating procedures and organisational policies remotely from wherever they were working. This ensured they adhered to consistent, standardised reporting processes. The provider maintained hard copies of guidelines, such as business continuity plan guidelines, in the event of a systems failure. The provider required all staff to read relevant policies annually and documented this.
- 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 RCR guidance for trauma patients who experienced a severe injury. The service encouraged radiologists to produce primary and secondary reports for polytrauma cases in line with national guidance and noted where certain NHS trusts mandated this.

- All staff, including reporting radiologists and operations coordinators, had remote access to the service's policies and protocols for urgent reporting situations. This included the significant finding notification process that guided reporting for urgent conditions. The system meant all staff had the same level of access regardless of where they were working from and meant staff working from home and locations outside of the UK could access local policies.
- Radiologists adhered to a guidance for scan protocol that included a summary of the recommended computed tomography (CT) scanning protocols within the principles of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) (2017). This meant protocoling radiologists had access to the most recent national guidance on CT scan safety and used this when communicating with referring clinicians to ensure they followed best practice.
- Radiologists had access to a protocoling matrix online whenever they were working. A radiology protocol refers to the process used to identify the most appropriate type of exam for the patient's presenting problem and reduces unnecessary testing and radiation exposure.
- Reporting radiologists audited up to 10% of all reports each month as part of an internal peer review system. This met the RCR's aspirational guidelines and meant the service achieved a rolling programme of peer review.
- The medical leadership council (MLC) reviewed and updated all clinical policies annually as part of a process of continuous improvement. This was also a requirement of the service's ISO27001 certification and meant the service responded quickly to changes in legislation or regulation.
- Heads of department held responsibility for implementing changes to processes and practice. They used weekly bulletin e-mails to update staff of such changes in addition to briefing them in team meetings and governance meetings.
- The service operated a clinical feedback loop audit process as part of a continuous cycle of audit. This included monthly and yearly volume reports for each radiologist.
- An MLC member reviewed each level 1 and level 2 discrepancy and sent these to the reporting radiologist for comment and personal reflection, which was in line with RCR guidance. The MLC communicated with the referring NHS trust and provided feedback as part of the audit process. The levels of discrepancy refer to the seriousness of the instance against RCR guidelines. The council selected case studies monthly to discuss in more depth with the radiology team to identify opportunities for evidence-based improvements.
- Where a discrepancy was found through a peer review, the second radiologist added an addendum and the MLC reviewed this with a radiologist specialist. In all cases, the senior team completed a clinical impact of error assessment.
- The service provided summary reports of internal peer reviews to NHS trusts on a monthly basis as a measure of the standard of service.

Patient outcomes

Managers monitored the effectiveness of reporting used the findings to improve the service. They compared local results with those of other services to learn from them.

- The service had a key performance indicator of a 60-minute turnaround for urgent out of hours report requests. Between December 2018 and January 2019, the service consistently achieved over 99% compliance.
- The service demonstrated a continuous, proactive approach to improving the standards of radiology reporting. For example, in September 2018 the team identified gaps in reporting of some computed tomography (CT) scans because radiologists were unfamiliar with the way in which the reporting NHS hospital sent contrast images. The provider worked with the NHS trust and radiologists to ensure all images were accessed for review.
- The provider had introduced new guidelines for radiologists when reviewing scans without a prior medical or clinical history. In such cases, radiologists were required to suspend their reporting and arrange for the administration team to obtain the patient's previous information from the client information system.

Diagnostic imaging

- Radiologists contacted the referring NHS trust within two hours where they found issues with the quality of images, referrals or reports.
- Each NHS trust established a maximum reporting discrepancy rate, which the service monitored and continually achieved.
- The service monitored discrepancies as part of a quality assurance (QA) review, which staff used to detect significant discrepancies. We reviewed the error and discrepancy rates for the 12 months leading to our inspection and found these to be consistently low. This reflected good practice and meant the service provided high levels of reporting accuracy. Staff used eight categories to trigger a QA review, the most common of which was a request by the referring clinician. This system effectively ensured discrepancies were identified and monitored to identify opportunities for learning.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

- All staff other than non-clinical staff employed on zero-hour contracts were required to undergo an annual appraisal. In January 2019, 95% of staff had completed an appraisal in the previous 12 months. This reflected 100% of all teams, except for the IT team (67%) and contracted radiologists (85%).
- Radiologists were not able to work unless they had completed an annual appraisal internally or provided evidence of an external appraisal. Each individual was required to submit evidence of indemnity cover.
- The provider reviewed each radiologist's license to practice annually. At the time of our inspection, the service demonstrated 100% compliance.
- Appraisals for clinical staff adhered to the General Medical Council's four domains of good medical practice. We reviewed one anonymised appraisal that had taken place within the previous 12 months and saw the process promoted peer review and self-reflection.
- Each team had regular meetings to review their training needs and discuss changes in practice.
- The training team provided bi-monthly educational webinars and mandated a 50% annual attendance rate for radiologists. The medical leadership council monitored attendance times electronically. This demonstrated the embedded culture of continual professional development facilitated by the provider. The service operated the webinars as learning forums and included updates on changing NHS policies. Webinars operated from the London office and an office in Australia and were broadcast across the provider's online platform.
- Topics for recent webinars included CT stroke and CT angiogram update, lessons from urology case studies, MRI prostate and bladder and non-accidental injury in children. The service mandated attendance in specific webinars for radiologists who worked out of hours on urgent cases. This meant the team responsible for emergency and urgent reporting was well-equipped to provide reports for polytrauma cases.
- Staff had access to online learning, which the provider continually reviewed and updated to reflect national standards and leading-edge research and understanding. For example, radiologists reporting on urgent and emergency cases were required to have completed online learning in intracranial CT angiography interpretation in imaging for thrombolysis.
- On joining the service, each radiologist was assigned a nominated trainer to provide support and supervision. Non-clinical staff had a 60-day induction period followed by a one-to-one review with the registered manager.
- The medical leadership council (MLC) used test cases for prospective new radiologists as part of a structured induction process. Test cases covered each modality the radiologist would be reporting in. All members of the MLC were required to approve of the radiologist's performance before they could successfully complete the induction process. Following completion of test cases, existing radiologists carried out a review of the first 50 reports completed by the new radiologist as part of an initial quality assurance process. The MLC reviewed the results and completed a full portfolio review of outcomes and performance after the first three months. New radiologists were required to successfully complete all stages of the induction process before they could report on urgent out of hours cases.

- The induction process also included a requirement that new staff study the employee handbook and document completion of this. Non-clinical staff were required to review the handbook annually.
- The service issued continuing professional development credits when radiologists attended training webinars and clinical governance meetings.
- New non-clinical staff completed a probationary period before they were able to take up a permanent post. This ensured new staff were competent in their role, which provided assurance of patient safety through good performance.
- The service promoted the use of self-reflection as a tool to improve individual practice and performance. This encouraged staff to learn from discrepancies and errors and enabled the senior team to identify recurring learning points and opportunities for process changes. The MLC reviewed all personal reflection forms and recommened that radiologists used these for appraisal and revalidation purposes.
- The provider used a personal reflection on discrepancies and adverse events tool to help clinicians improve their professional practice. The tool was based on RCR standards and helped radiologists collect information for revalidation. The tool enabled radiologists to reflect on specific cases and to include information such as whether they had presented the case at a discrepancy or morbidity and mortality meeting.
- All radiologists had recent experience of working in the NHS, which meant they were familiar with standard pathways and practices. The MLC assessed this during annual appraisals.
- The provider had developed a bespoke, specialised peer review system that enabled the senior team to combine the results of internal peer reviews with external peer reviews and assess performance alongside audit scores and addenda. This formed part of an overarching framework for competency assessment and review.
- The MLC adhered to the RCR principles of learning and system improvement when reviewing discrepancies. For example, the senior team valued debate and discussion when discrepancies were challenging or contentious but did not enter into prolonged debates that would detract from key outcomes.
- The MLC monitored RCR guidelines in relation to peer review best practice and updated these accordingly. For example, the service implemented behavioural standards for radiologists when peer reviews were used to improve discrepancies. The service also implemented RCR guidelines when peer reviews involved cases in hindsight.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Clinicians and non-clinical professionals supported each other to provide good standards of reporting.

- The service provided reporting to NHS trusts across the UK and a dedicated account manager was the point of contact for each. A project manager supported NHS trusts when establishing a new relationship to ensure the implementation process was effective.
- Radiologists worked within agreed protocols in their sub-specialty and discussed referrals with the patient's clinician directly when needed. Where they declined cases because they did not meet the referral criteria or scope of the service, the senior team provided feedback to the trust.
- Established processes ensured radiologists could contact referring doctors where they needed more information about the images sent to them. The operations team maintained a live, 24-hour messaging system so that radiologists could make instant contact with the team to liaise with hospitals.
- Clinical directors were always available for a multidisciplinary review on request from radiologists. Similarly, radiologists contacted others on shift to ask for a second opinion or to discuss complex cases.
- A team of medical editors supported radiologists in preparing reports when needed. This team added an additional note to the reports for significant findings.
- Each NHS trust provided the service their individual protocolling requirements, which the clinical director documented using a matrix. The matrix ensured radiologists had access to each referring organisation's clinical indications for emergency imaging.
- Referring radiographers and clinicians could contact reporting radiologists for advice prior to sending scans as part of agreements with each NHS trust. The operations team facilitated this process to ensure the most appropriate radiologist spoke with the referrer.

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- Systems ensured referring clinicians could always speak with the reporting radiologist, or a member of the medical leadership team if they were unavailable. This meant referrers always had a clinical point of contact to discuss results.

Seven-day services

- 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, which reduced the risk of service interruption. All modes of the service were available at all times, with no reduction in service overnight or during other periods usually classed as out of hours.
- Radiologists were based globally and provided continuous responsive protocoling and reporting services. Non-clinical services, such as scheduling and operations, provided advanced coordination and planning services that ensured unexpected increased demands or shortfalls in planned staffing did not affect service standards.

Are diagnostic imaging services responsive?

Outstanding ☆

We rated responsive as outstanding**.**

Service delivery to meet the needs of local people

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

- The service did not provide direct care to patients and based the availability of diagnostic reporting on the needs of referring NHS trusts.
- The service operated an urgent report pathway, which included the facility for the referring clinician to speak with the reporting radiologist directly.
- Reporting radiologists were available to speak with referring clinicians on request to discuss reporting requirements or complex needs.
- 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 senior team met with NHS trust counterparts formally every quarter to discuss service planning and any changes in their partnership that required attention.
- The service provided NHS trusts with access to specialist reporting services to fill gaps in local provision. This meant regional trusts had additional capacity during a period of persistent, substantial increases in demand, through services provided by radiologists who had left the UK or moved out of area.

Access and flow

Clinical referrers could access the service when they needed it. Waiting times from the submission of a scan to the production of a report were in line with good practice.

- The operations team was arranged into a daytime service and an overnight service. The daytime service operated from 7am to 8pm and coordinated the routine studies sent for processing. These were non-urgent studies with a pre-determined turnaround time arranged between the referring NHS trust and this provider. The overnight service team were available from 5pm to 7am and processed urgent studies that needed to be reported and delivered within one hour. The overnight team was co-located across the provider's international offices and processed an average of 600 studies per night.
- The service used a digital business intelligence system to forecast the requirements of new NHS clients, including the predicted volume of scan requests. This formed part of the sales and planning system that enabled account managers to request radiologist hours in advance to ensure referring hospitals were assured of adequate levels of cover.
- The provider used a customised order management system to plan additional capacity for increased demand from referring NHS services. The operations and resourcing teams used a live management dashboard as part of this process, which allowed them to respond quickly to changes in demand and to continually map capacity to demand.

- A pool of overflow agents managed a call handling system that tried to ensure no referrer ever waited longer than three minutes to speak with the service. Staff used this system to flexibly manage changes in demand.
- Radiologists were based in all major time zones, using the provider's 'follow the sun' model. This meant planning teams utilised time zones to the advantage of referring organisations and radiologists.
- A dedicated liaison team coordinated trends and demands on the service with the availability of radiologists. This team used weekly bulletins to ensure radiologists only signed up for shifts they intended to complete and were accurate and realistic when submitting their availability. The team recognised the nature of the business structure as presenting a challenge when radiologists had signed up for shifts but did not complete them or cancelled them at short notice.
- At any given time at least one of the provider's global offices was fully operational, which supported the 24-hour service.
- Radiologists worked to report turnaround times (TATs) established with each NHS trust prior to the start of the contract. This information was readily available to radiologists and operations staff to ensure they worked within the contractual requirements. Standard TATs were one hour for out of hour routine reporting and 15 minutes for polytrauma cases and 24 to 72 hours for daytime routine reporting. In stroke cases being assessed for thrombolysis, radiologists reported within 30 minutes.
- Between January 2018 to December 2018, TAT compliance for routine referrals was 96%, with an average reporting time of 27 hours. This reflected a wide range of performance, from 16 hours to 39 hours. In the same period, urgent TAT compliance was over 99% with an average time of 28 minutes.

Learning from complaints and concerns

- The quality and governance manager were responsible for the complaints policy, which had been reviewed and updated regularly. The policy clearly differentiated between complaints, minor concerns and requests for a quality review of a clinical report and provided well-defined guidance for staff to follow in each scenario.
- The medical director maintained oversight of clinical complaints and worked with the quality and governance manager to ensure follow-up actions were identified and completed. The scope of the policy meant senior staff always reviewed the outcomes of complaints to identify training and development opportunities for staff.
- The provider based the complaints policy on the NHS Constitution, which meant it was closely aligned with the complaints procedures of the hospitals it provided services to.
- The complaints policy included a timeline and investigation framework under which a senior manager would acknowledge the complaint within two working days and initiate an investigation the same day or next working day. Further benchmarks for investigation completion were set at 10 days and 20 days, with communication made with the complainant at key points. An internal appeals process provided complainants with the opportunity to have outcomes reviewed and the policy ensured staff would signpost to the Parliamentary and Health Service Ombudsman in the event an internal appeal failed or was rejected by the complainant.
- Account managers provided a dedicated point of contact service to NHS trusts and were the first port of call in the event the trust wanted to raise a concern or complaint. The medical leadership council also proactively engaged with trusts and referring clinicians in the event they wanted to discuss the service or an individual case.
- The service was demonstrably focused on using complaints and feedback to drive improvements. For example, the investigating member of staff included the lessons learnt and changes implemented in each formal complaint response and offered to discuss these personally with the complainant. Where this had involved rejected referrals or delays to reports, the investigator involved each member of staff who had been involved in the process.
- The senior team discussed complaints and outcomes in a variety of settings, including governance meetings, weekly communications and bi-monthly education talks. These discussions were embedded into the ethos of the service and contributed to transparent communication with referring clinicians and trusts.

Outstanding ☆

Diagnostic imaging

Are diagnostic imaging services well-led?

Outstanding ☆

We rated well-led as **outstanding.**

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable services.

- A team of five directors were responsible for the provider's functions, with oversight from the chief executive officer (CEO). The medical director was responsible for clinical service delivery and was supported by two clinical directors. The quality and governance manager was the registered manager and represented the service on the medical leadership council (MLC) along with the senior clinical team and two senior radiologists. A team of directors led specific functions, such as IT and sales and marketing, supported by specialist managers, executive officers and operations staff.
- The senior leadership team was organised at provider level and staff moved between office locations to provide the service. The structure was appropriate based on the demands on the business and staff we spoke with were positive about leadership access and support.
- The organisation provided leaders with ongoing development opportunities and promoted a 'pause, reflect, clarify' model that helped them to be effective.
- Team leaders were based in the office during prescribed hours and staff working out of hours or remotely always had a named point of contact for support and escalation.
- Managers and their teams met regularly to maintain good working relationships and effective lines of communication.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and stakeholders.

- The provider had an overarching people and culture strategy that focused on organisational development and the implementation of multiple targets and initiatives. As part of the vision, a design team represented the multidisciplinary nature of the provider and scoped and developed opportunities for improvement and growth.
- At the time of our inspection, the provider had seven distinct initiatives as part of the vision, each of which had well-defined objectives and involved key members of the team.
- The provider placed staff and the service provided for NHS clients at the heart of its future vision, strategy and plans. This was reflected in our discussions with staff, all of whom were demonstrably invested in service improvement and development.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- All of the staff we spoke with were positive about working for the organisation. They described good relationships with the senior teams and a working culture that valued the input of each individual. One member of the team said, "I really enjoy working here, it's a very positive working environment."
- The provider had a people and culture strategy and a 'connect' programme that fostered good working relationships and opportunities for shared experiences.
- The provider had introduced connect interviews for existing staff, which provided them with a structured forum in which to talk, connect and share their experiences. The service planned to extend this to radiologists following its success with operations staff. The provider had secured training from a neuroscience specialist to help staff build strong working relationships by recognising how they perceived each person's style of communication. Staff spoke highly of this process and said it had led to greater respect in the workplace.
- Radiologists described a supportive culture in which mistakes or discrepancies were used as opportunities for learning.
- Staff worked within the remit of an employee handbook that guided them in the principles of the organisation, such as a willingness to continuously develop their knowledge and to support ethical business practice.

- The provider had various policies for staff to obtain advice or assistance, including for bullying and harassment and for reporting grievances. An equality and diversity policy ensured staff understood the provider's expectations of behaviour, respect and conduct. Such policies promoted a culture of mutual respect amongst all colleagues although with an expectation that staff would work with courtesy and honesty. Radiologists were required to avoid making detrimental remarks about the quality of scans to referring clinicians as part of professional conduct.
- The provider facilitated a culture of continual reflection and review as a strategy to sustain high standards of practice. Radiologists requested internal quality assurance reviews of their reporting when subsequent imaging or new learning indicated opportunities for improvement in previous work. For example, in December 2018, five radiologists implemented quality assurance reviews in this manner.
- The provider used a performance management and development system, called 'Connect', to drive the strategy of facilitating a culture in which each member of staff could thrive. As part of this, the senior team worked with staff to identify their own goals and their preferred type of work, which senior staff would then help to implement. Supervision meetings meant staff had the opportunity to continually reflect on their needs, feelings and development. The Connect programme had a team-base element that enabled teams to establish joint objectives that led to improvements and innovation.
- Senior staff used the outcomes of team activities to identify challenges to quality and sustainability and used these improve support for staff.
- The provider used a range of strategies to drive a positive culture in which senior staff wanted their teams to feel proud to work for the organisation. This included monthly briefings from the chief executive and an environment in which staff were encouraged to openly suggest improved or new ways of working.
- Staff did not have direct contact with patients, which meant they were not involved in organising duty of candour (DoC) discussions as a result of serious discrepancies or incidents. However, the senior clinical team offered to join DoC meetings with NHS trusts where they identified serious incidents and planned to meet patients and relatives affected. This formed part of the service's overall approach to transparency, in which staff were empowered to identify mistakes and use them as learning opportunities.
- Following a merger in 2017, the organisation had commissioned an external review of the working culture. This included an evaluation of how staff felt about working there and measured these against evidence-based workplace culture knowledge and research of best practice. Results showed staff were likely to recommend the organisation's services and felt the senior team could demonstrate leadership more aligned with the organisation's values.

Governance

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish

- The registered manager was the designated quality and governance manager and the medical director was the Caldicott guardian. Their roles and responsibilities were clearly defined and contributed to consistent practice.
- The service used a series of third party suppliers to maintain IT systems and an established overarching governance system to ensure consistent quality and security standards.
- The provider used a reporting standards policy, a clinical governance policy and clinical governance webinars to ensure radiologists and non-clinical staff maintained up to date understanding of organisational standards. Radiologists were required to achieve a minimum of 50% attendance at webinars per year.
- Governance processes adhered to an established structure led by four key members of staff; including senior staff from the radiologist support team, Radcare, and quality and governance managers from the UK and the Australian operations.
- 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.

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- A dedicated information governance forum monitored policies and carried out a full review annually. Forum members considered lessons learnt from incidents and feedback from staff and NHS referring clinicians to update policies.
- The digital reporting system enabled referring clinicians to add addenda to reporting radiologist's reports. The provider's notification system tracked these notes and ensured the reporting radiologist received and reviewed them as part of the clinical governance process.
- Governance processes provided clinical oversight for staff who worked remotely. For example, the MLC reviewed the quality assurance data and discrepancies review for each radiologist as part of a dashboard approach that enabled the senior team to review the quality of reporting consistently. The MLC reviewed dashboard data in detail and compared factors such as productivity and volume for each reporting radiologist and compared this with their professional track record and experience.
- The provider placed value on standards of practice governed by national and international professional organisations and was actively working towards accreditation from a number of bodies. The senior team had a clear vision for how such accreditation would benchmark and improve governance standards.
- The MLC and liaison and marketing team promoted attendance at clinical governance meetings and webinars, which staff could join remotely by phone or using audio-visual software the provider facilitated.
- The business continuity plan was comprehensive and contained call-out plans and decision-making frameworks for staff on duty to follow. The plan meant critical services could be seamlessly transferred to radiologists working remotely and operations staff in other offices, including those outside of the UK. Staff had access to an emergency grab pack that provided immediate support in emergency situations, such as an office evacuation or an IT failure. This meant delays in reporting to NHS hospitals and their patients would be minimised. A designated emergency response team leader would assume command in such an event and would coordinate the operations team. This individual would liaise with NHS trusts and carry out a debrief and reflective learning exercise after such an event. The service carried out regular testing of business continuity and emergency response processes.

Managing risks, issues and performance

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

- Clinical governance systems were focused on identifying and managing risk and performance. The service had a comprehensive peer review programme as part of this structure, which involved internal quality checks on up to 10% of radiology reports each month.
- Each radiologist was required to double read a number of reports as part of their planned workload and within the provider's discrepancy methodology. The MLC maintained oversight of discrepancies and reviewed all level one and level two instances as part of the risk management system.
- The MLC based the risk management and discrepancy review system on Royal College of Radiologists (RCR) guidance. For example, the MLC engaged with clients and radiologists where discrepancies arose to foster a culture of continuous learning and improvement.
- The workflow manager supported a weekly capacity council meeting to review capacity and demand as part of an overall performance management structure. The account management team were a key part of this process and planned the service to ensure capacity outweighed demand. They worked with NHS client trusts to understand their changing requirements and to plan ahead for seasonal changes, such as during the winter pressures period. A designated group of radiologists were committed to working variable hours during seasonal changes known to impact health risks, such as extreme heat or winter storms.
- The senior team used monthly MLC meetings to review various aspects of the service. For example, one MLC took place to review the performance of each radiologist and to act in situations where they had concerns about their practice or performance. We reviewed the minutes of eight MLC meetings that had taken place in the previous 12 months and found the provider acted quickly to review issues or restrict practice, such as when the radiologist had a high error rate or when the provider was notified by an NHS trust of concerns. The provider implemented quality assurance requirements of specific types of scan reporting for individual radiologists when they noticed changes in the quality of their work.

- We reviewed a sample of eight MLC meeting minutes that were dated between January 2018 and December 2018. In each meeting appropriate staff discussed areas such as quality goals, policy updates, a review of new services and a review of the clinical risk register. Meetings were well structured and demonstrably tied to clinical outcomes.
- The service provided monthly anonymised discrepancy rates to each NHS trust, by modality, and worked with the trust to investigate trends in performance.
- Performance was a standard element of appraisals for all staff, regardless of role or level of seniority. This helped to ensure each individual understood the standard of their current work and identify future or ongoing objectives.
- Staff used an instant messaging system to continually update each other with real-time performance and issues in operations.
- The service had acted on feedback from NHS clients in relation to risk and performance management and had increased the involvement of reporting radiologists in discrepancy reviews and quality reports. This improved on the previous system whereby only the MLC was involved in reviews and reflected a significant improvement in clinical governance. The improved system meant each radiologist received specific feedback and each NHS client trust received more detailed, consistent assurance of quality. This included clinical impact and reflection from the reporting radiologist.
- The service had appropriate safeguards in the event a reporting radiologist was unavailable for more than five days after a discrepancy needed discussion or review. In such instances a member of the MLC reviewed the case.
- The radiologist induction process was integrated with risk and performance management systems. For example, the MLC led a probationary period for each radiologist that led to peer review capability. The induction process could not be completed without the radiologist demonstrating competency in the peer review process. This ensured all reporting radiologists provided reporting services that met the requirements of the provider's clients.
- Each department was required to maintain a privacy impact assessment, which also formed part of the process for assessing the feasibility of new clients. The process meant the service would only provide reporting functions to NHS trusts once they had established assurance this could be done safely and appropriately.
- The provider used a risk treatment plan to identify, track and address risks as a live, ongoing process. The MLC managed a clinical risk register. The CEO maintained the corporate risk register and maintained oversight of the clinical risk register. At the time of our inspection there were seven active risks that applied to this location. Each item had an accountable senior person who had reviewed the risk at appropriate intervals and implemented mitigating actions.

Managing information

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

- The registered manager was the designated information security manager and data protection officer. Roles were clearly defined and meant staff across the location and wider organisation had a designated point of contact and escalation. This structure ensured standards were effective and consistent.
- The service was fully compliant with the General Data Protection Regulations (GDPR) 2016/679 and had completed a gap analysis to identify areas for improvement. The service completed an annual information governance statement of compliance (IGSOC). IGSOC is a standard that enables non-NHS organisations to comply with NHS provider practices in relation to data security and information governance.
- The nature of the service meant most key risks related to information security and data protection. Risk management systems were demonstrably focused on this area and staff used a risk treatment plan to address existing and emerging risks.
- The information governance forum (IGF) maintained oversight of new NHS clients to ensure the various systems used by both organisations worked together to ensure information governance standards were maintained.
- The information governance team reviewed the needs of new NHS trusts before referrals could be accepted. This ensured patient data privacy could be maintained and established risk assessments specific to the new relationship.

Diagnostic imaging

- A communications room with restricted, PIN-controlled access was available on site. Staff used this to discuss patient scan outcomes in a controlled, secure environment.
- The service had developed manual reporting systems where NHS trusts did not have digital automation in place. This included administrative tasks such as pasting reports and reconciliation. The dedicated operations team coordination and administered all elements of these processes.
- Radiologists were required to read the provider's clinical governance policies, including information governance practices, before they were able to carry out reporting duties. The provider maintained an up to date record of this and restricted the work of any radiologist who had not provided evidence of their understanding. Non-clinical staff completed information governance training within 60 days of taking up their post, which included face-to-face training, an exam and structured time to study policies. This reflected the lead role non-clinical teams played in information governance and data management.
- The service had subscribed to nhs.net e-mail addresses. This was an industry-standard, secure communication system that meant staff could communicate with NHS teams and share information in line with GDPR requirements. All staff signed and adhered to an acceptable use policy that adhered to NHS Digital guidance.
- Seven key senior members of staff formed an information governance forum (IGF). The IGF maintained oversight of the confidentiality of the service and acted as a strategic lead for provider-level security. The forum had a broad, well-defined scope, which included a review of the systems of all new NHS clients to ensure they could adapt the service to meet the challenges provided by the varying levels of information security found between different trusts.
- The IGF carried out privacy impact assessments whenever a business process changed, which ensured the confidentiality of data was maintained.
- We reviewed the minutes of six IGF meetings that took place between January 2018 and December 2018. Each meeting was well structured with clear objectives and a risk and quality review function.
- The clinical director was the responsible officer for security information and the Caldicott guardian. The IGF provided assurance of the integrity and work of the responsible officer, which reflected international best practice guidelines.
- The IGF, with the support of the information security manager, was responsible for the implementation and upkeep of the information security management system, which was a policy that incorporated the requirements and standards of IS027001. The policy included clear role designations for data controllers, the information security manager, data processers and data protection officers and was a key element of the organisation's demonstrable focus on data and information security.
- The information security manager led implementation and training on use of patient NHS numbers protocol. The protocol was part of the provider's overall information governance toolkit and established minimum standards of information required when NHS trusts sent patient information. The provider supplemented the NHS number with an internal unique identifier to provide additional confidence in data security and traceability.
- The service used model clauses for data protection when radiologists reported from outside of the European Union. Model clauses, or data transfer agreements, are structures that enable information and data sharing outside of the UK and EU whilst adhering to GDPR requirements.
- The provider had established protocols for dealing with missing information in scan referrals. A designated member of staff contacted the referring trust daily until the information was provided. If this was not provided within ten days, the scan data was returned to the trust and the study cancelled on the provider's system. This ensured radiologists completed reports only when they had enough information to do so accurately and safely.
- Staff adhered to an identity verification process when accepting, reviewing and processing scans. This meant 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.

- Staff worked within an organisational culture in which confidentiality, information sharing, and patient identifiable data were key priorities. Induction, training and operational policies all reflected this.
- All staff were required to sign off that they had read 31 policies and additional human resources paperwork including confidentiality agreements that reflected all aspects of the service and types of data and information they would be working with. This reflected an effective, evidence-based policy framework that reflected the service's accreditations and operating principles.
- Appropriate access and security safeguards protected the provider's radiology information system and picture archiving and communication system.

Engagement

The provider engaged well with staff and client organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

- The provider used a wide range of methods to ensure all staff remained up to date with the organisation. This meant staff who worked remotely and between different sites had consistent information. This included weekly electronic communications and daily updates, which appeared on each individual's computer screen when they logged in.
- The provider engaged with referring organisations, through to stakeholder interviews, to obtain feedback on the service and identify opportunities for improvements. For example, the service provided direct contact details for radiographers after one referring organisation identified delays in communication when using the central switchboard. One referring organisation identified a need for improved quality in reports through proof-reading after finding an increase in typographical errors. Other feedback indicated referrers were less confident in the accuracy or viability of reports when they were too brief.
- The responsible officer was responsible for the responding to concerns policy, which adhered to the General Medical Council ethical guidelines for the conduct of doctors. This meant staff and stakeholders had a framework for escalating concerns about a clinician, anonymously if needed, and the provider would investigate these accordingly. Appraisals for non-clinical staff followed a similar structured format and focused on the individual's reflection on their work and how their manager viewed their progress.
- The provider also visited referring organisations to discuss their services with staff and identify areas they were pleased with and opportunities for improvement. Recent feedback included that referrers were happy with the level of detail in reports and they found radiologists easy to contact when they had queries or needed a follow-up discussion. One provider said they would like to be given advance notice of periods the service would be busy, so they could arrange a contingency plan in the event they developed a backlog of reports.
- In November 2018 the service had facilitated a leadership programme for emerging and future leaders in all departments. This provided staff with the opportunity to identify the skills and development support they would need to progress as leaders. This was a two-day event that reflected the organisation's approach to develop staff in-house to ensure future sustainability.
- Prior to the programme, directors had carried out Mayer-Salovey-Caruso Emotional Intelligence Test assessments and strength profiles. The team planned the programme to include 21 distinct topics that focused on personal and professional development and models of leadership. This reflected the ethos of the organisation in using evidence and research-based strategies to support staff development and to establish advanced team-working cultures.
- The senior team facilitated a culture that valued each individual's input and contribution and provided support during challenging periods. Staff had 24-hour access to an independent, external professional support organisation in the event their line manager could not help to resolve a problem. The senior team had chosen the provider of this service because of their approach of empowerment to individuals in need, which reflected the values of the organisation.
- The provider had a series of structured, ongoing opportunities for staff to engage with them and with the wider organisation. These included people and culture initiatives, connect meetings, an international exchange programme and design team opportunities.
- It was common practice for home worker radiologists to be substantively employed by an NHS organisation and

complete work at various times for this provider. The MLC monitored these relationships within a code of conduct that aimed to ensure internal professional standards and those of the NHS were adhered to. For example, the MLC responded to concerns raised when a radiologist was off work sick from their NHS post but attempted to complete work for this organisation.

- Dedicated account managers led quarterly review meetings with NHS trusts and liaised with clinical directors and clinical leads to resolve issues. This process included a focus on IT issues that occurred as a result of integration with multiple different systems and the provider's IT team worked with their NHS counterparts to streamline processes.
- The provider had developed a client feedback process that enabled each NHS trust to feedback on discrepancies and to provide more general feedback. This had led to improved processes for out of hours trauma cases and the introduction of several new report templates, such as for polytrauma and prostate MRI. It had also led to improved radiologist education and improved compliance with National Institute of Health and Care Excellence (NICE) guidance for CT head scans.

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, research and innovation.

- Staff used a change management process to scope, plan and implement service improvements. The process enabled staff to ensure plans were compliant with various other standards, including information governance and privacy impact assessments. This formed part of a demonstrable, continuous drive for improvement. Exercises such as departmental data mapping, capacity and demand monitoring and client engagement were designed to identify opportunities for improvement as part of a tested change management strategy.
- The service had demonstrated a rapid response to a major mass-casualty incident by anticipating the need for a substantial increase in radiologists able to provide urgent reports for emergency care.
- The provider had established an electronic training, education and communication system that enabled them to make new training and development packages available to all staff, regardless of location or hours of work. For example, the provider used the system to make available new clinical stroke imaging training for reporting radiologists.
- The provider had an overarching plan for improvement and innovation, which included 11 distinct projects. Each project had clear objectives and evaluation processes and were project managed to ensure staff had appropriate access wherever they were usually based.
- A service improvement plan for 2018 included 55 individual points, each of which had an accountable individual and an associated action plan. The improvement points reflected the growing needs of the provider and the increased demands on its services. Improvements were also based on learning from challenges and feedback.

Outstanding practice and areas for improvement

Outstanding practice

- All staff had a demonstrable, highly driven approach to improving standards for patients and clients. This included multiple, responsive processes that senior staff continuing sought to develop.
- The service was highly responsive to client and patient needs and had implemented tested, evidence-based solutions to service issues in a timely manner.
- There was a continual, well-defined focus on improvement and innovation. Staff continually reviewed work processes and systems to identify opportunities for improvement.
- The provider had developed innovative solutions to challenges relating to 24-hour working. This included scheduling work hours based on the report writer's location to avoid the fatigue associated with night shift.
- The senior team placed value on good communication and good working cultures between staff and provided opportunities for advanced development. For example, the provider had secured training from a neuroscience specialist to help staff build strong working relationships by recognising how they perceived each person's style of communication.