Fusion Radiology

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	Inadequate
Are services safe?	Inadequate
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Fusion Radiology Limited is a UK based teleradiology service. Teleradiology is the transmission of patients' radiological images between different locations to produce an imaging report, expert second opinion or clinical review.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 02 April 2019.

Fusion Radiology initially began by providing a reporting service for general MRI scans. The service since inception has developed its capacity and created a consultant radiologists' panel to provide dental cone beam computed tomography (CBCT) and magnetic resonance imaging (MRI) neurology reporting. CBCT is a special type of x-ray equipment used when regular dental or facial x-rays are not sufficient.

The registered manager informed us that they are currently not reporting any activity for general MRI and have focused on neurology (brain injury) and dental images. The service continues to maintain the general MRI reporting service activity should they wish to continue in the future.

The registered location is in Luton, Bedfordshire and provides general and subspecialty reporting services to support existing radiology departments within NHS, private healthcare and dental organisations.

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.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

This service has not been previously rated. We rated it as **Inadequate** overall.

We found the following issues that the service provider needs to improve:

- While the service had systems for identifying risks, they did not have effective processes to manage them.
- While the service had processes to respond to diagnostic reports received, there were not effective processes to manage the quality of the reports.
- The service did not have processes to manage discrepancies which included disseminating information to all staff. This was not in line with the Royal College of Radiologists (RCR) guidance.
- The service did not have processes to ensure they complied with the European Union Health and Safety legislation regarding the working time directive.
- While the service recorded safety incidents, but lessons were not always shared or disseminated with the whole team. There had been nine reported incidents from January to March 2019 which related to administration errors which included wrong patient data being paired up with wrong images when downloaded from the client imaging portal directly. The service did not have effective processes in place for learning from clinical incidents
- Staff did not always work together and support each other as a team. There was no regular contact with contracted staff to ensure they provided high-quality sustainable care.

We found good practice within the service:

- Staff understood and knew how to identify, protect and report patients from abuse.
- The environment was suitable for the management of imaging services and there were processes in place to maintain the equipment.
- The service had enough staff with the right skills and experience to keep manage patients' imaging reporting needs

Summary of findings

- Records were kept in locked in a cupboard and were only accessible to authorised staff, to maintain confidentiality.

Following this inspection, we told the provider that it must take some action to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice. Details are at the end of the report.

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Nigel Acheson

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Inadequate 	We rated this service as inadequate overall, as we found it inadequate in safe and well led. The effective and responsive key questions were not rated within this core service. Caring was not inspected during this inspection as the tele-radiology services did not see patients and they did not visit the premise due to the nature of the service provided.

Summary of findings

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Summary of this inspection

Background to Fusion Radiology

Fusion Radiology Limited is a teleradiology service working in the UK and owned by one individual who is the nominated registered manager. Teleradiology is the transmission of patients' radiological images between different locations to produce a primary report, expert second opinion or clinical review.

The location has not previously been inspected and we visited the service for a short notice announced inspection on 02 April 2019.

The service was incorporated in October 2015 and registered with the Care Quality Commission in May 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in diagnostic imaging. The inspection team was overseen by Phil Terry, Inspection manager, and Bernadette Hanney, Head of Hospital Inspection.

Information about Fusion Radiology

The service provided by the service was teleradiology. Teleradiologists reported on both children and adult images.

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

- Diagnostic and screening procedures.

During the inspection, we visited the location. The service did not work directly with patients as it was a remote provider of reporting services. We spoke with three staff which included the director of the service. During our inspection, we reviewed records appropriate to a teleradiology service which included policies and audits.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has not been inspected previously and this was the services first inspection since registration with CQC, which found that the service was not meeting all standards of quality and safety it was inspected against.

Activity (April 2018 to March 2019):

- In the reporting period April 2018 to March 2019, the service reported on 720 images, of which 90 related to orthopantomogram (OPG). OPG is a scan that gives a panoramic view of your jaw and mouth.

Five tele-radiologists and a part-time administrator were contracted to work for the service. The service director was also the registered manager.

Track record on safety:

- Zero Never events.
- Zero serious injuries.
- Zero complaints.

Services accredited by a national body:

- There were no services accredited to the service by a national body.

Services provided to the service under service level agreement:

- The service was supported by a dedicated picture archiving and communication system (PACS) service who supported their hardware and software infrastructure. PACS is a system for securely storing and digitally transmitting of electronic images together with clinically relevant reports.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate
Overall	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate

Notes

We inspected effective and responsive but have not rated them. We did not inspect caring.

Inadequate

Diagnostic imaging

Safe	Inadequate
Effective	
Caring	
Responsive	
Well-led	Inadequate

Are diagnostic imaging services safe?

Inadequate

The location has not previously been inspected. We rated it as **inadequate**.

Mandatory training

- **The service did not have effective processes in place to ensure all contracted staff completed and provided them with their training details.**
- The registered manager said they recognised the importance of having staff who were fully trained and up-to-date in underpinning the delivery of high-quality services.
- There was a training programme in place which included training in the following areas for administration staff; confidentiality in the workplace and the essentials of general data protection regulation (GDPR), information sharing and safe record keeping. GDPR came into force in May 2018 and is designed to protect the personal information of individuals while giving them more control over their information. We saw a training record which showed compliance with all identified training.
- The registered manager informed us they had five contracted tele-radiologists to whom they provided picture archiving and communication system (PACS) training via an external service. PACS is a medical imaging technology which allows organisation to securely store and digitally transmit electronic images and clinical-relevant reports. This was confirmed in correspondence provided to us by the service.
- The registered manager informed us they requested the tele-radiologists to provide them with evidence of their training compliance at commencement of their employment with Fusion Radiology. For example; the registered manager could not provide us with evidence that the dental tele-radiologists had completed a course in CBCT which should include; three-hour theory, two-hour radiation interpretation and a six-hour practical course. After the inspection, the service provided us with feedback from two of the dental tele-radiologists stating that they had undergone dental and maxillofacial radiology training by the Royal College of Radiologists which incorporated a four-year programme enabling them to be registered with the GDC. However, we did not see evidence of training compliance for the other three tele-radiologists contracted. This meant that we could not be assured that the manager had oversight of all contracted staff's training to manage patient safety.

Safeguarding

- **Staff understood how to protect patients and knew how to recognise and report abuse.**
- The service did not work directly with patients as they were a remote provider of reporting services.
- We saw the service had an up to date safeguarding policy. The registered manager was the safeguarding lead for Fusion Radiology Limited. Administration staff had received level one adult and children safeguarding training.
- The registered manager during the inspection was not aware of the levels of adult and children safeguarding training undertaken by the tele-radiologists contracted. However, after the inspection the provided us with confirmation that tele-radiologists had attended level two adult and children safeguarding training.
- Tele-radiologists spoken with confirmed they followed adult safeguarding and protection of young children guidance together with the Royal College of Radiology (RCR) 'Radiological investigation of suspected physical

abuse in children' guidelines (November 2018). They confirmed they had undertaken level two adult and children safeguarding training with their primary employer.

- Tele-radiologists told us that should they suspect abuse when reporting images, they would escalate their concerns to the administration team. Tele-radiologists outlined details they had recently taken regarding suspected abuse which included ensuring that the report was returned to the referrer as urgent. The registered manager said they had processes in place whereby they would telephone or e-mail the referrer. However, this was not logged and there was not an effective system to ensure the referrer acknowledged receipt.

Cleanliness, infection control and hygiene

- **The service kept equipment and the premises clean.**
- The service did not provide any onsite reporting services and did not work directly with patients. All reporting was done within the tele-radiologist's home location.
- This meant that a healthcare associated infection was highly unlikely and the service did not have any reported incidence of a healthcare acquired infection.

Environment and equipment

- **The environment was suitable for the management of imaging services and there were processes in place to maintain its equipment.**
- The service was committed to providing a safe and appropriate environment to the staff employed.
- The service had invested in systems and technologies to ensure accurate reporting. These included high specified monitors and voice recognition systems for the radiologist whom the service loaned equipment for reporting purposes.
- The service did not have records to verify electrical equipment within the office had been portable electrical appliance tested. We observed the fire extinguisher did not have the date recorded and the pressure seen was at 50**%.** This was brought to the attention of the registered manager during the inspection who immediately actioned our concern. Test certificates provided showed that this had been completed on 4 April 2019. This identified that all equipment had passed the electrical appliance test. The registered manager informed us that they had purchased two new extinguishers to replace the existing one.
- Equipment was maintained annually by an external service. This was based on a rolling 30-day contract from November 2017. We saw a copy of the letter which confirmed technical support Monday to Friday 9am to 6pm.
- The registered manager confirmed that the radiologists notified them verbally of any faults with the equipment and repairs were carried out by the external service. The manager did not have available a record of identified faults during the inspection. However, after the inspection, the manager provided us with a report from the external company which outlined the fault, the number of days to resolve and the resolution. We saw there had been 34 faults registered from June 2108 to March 2019. The report identified that 18 of the faults were repaired the same day, six within one day, eight within two days while the remaining two faults took five and 12 days respectively. We saw the resolution was to provide training and the creation of a second virtual machine to resolve the problem.

Assessing and responding to patient risk

- **The service had processes in place to respond to diagnostic reports received. However, there was no processes to manage the quality of the reports in line with the Royal College of Radiologists' (RCR) guidance.**
- The service only provided the diagnostic report of patients and therefore only completed part of the medical pathway for the patient. The service was not advised of the final outcomes.
- The service did not deal directly with patients regarding abnormalities or risk factors that may require additional support or intervention or changes to patient's care or treatment. Fusion Radiology Limited did have a significant findings pathway to alert the clients of expected or significant discoveries from diagnostic reports.
- The service had a contract with an NHS hospital, private healthcare organisations and dental surgeries. This meant that the service could ensure that reporting referrals were made by registered healthcare professionals in accordance with the Ionising Radiation

(Medical Exposure) Regulations 2017 (IRMER 17). The IRMER 2017 is a legislative framework intended to protect patients from the harm associated with ionising radiation.

- Teleradiology referrals were organised by the administration team. The service ensured they had tele-radiologists who were proficient in the required subspecialty so that difficult cases received the appropriate interpretation. Where appropriate, the imaging report incorporated advice to the referring clinician on further investigation or referral to another specialist team.
- The setting of standards regarding the sharing of patients' imaging data and reports via teleradiology was recognised by the Royal College of Radiologists (RCR) as being essential to maintain high-quality diagnostic imaging reporting within the United Kingdom. The service had processes in place in line with the RCR standards for the provision of teleradiology. These were:
  - Data transfer: A clear and transparent system for the rapid, secure transfer and review of images and where necessary, storage of patient data while ensuring patient confidentiality.
  - Reporting: Ensuring that the reporting was of the same standard as they would have in the base hospital. This included patient details, current and previous clinical information, previous examinations and laboratory data.
  - Communication of the result: the service ensured that the same person interpreted the examination and issued the report to the referring clinician and were clearly identified.
  - Quality assurance: the service ensured that tele-radiologists were registered on the general medical council or general dental council register and indemnified to the same standards as those of their base location. Senior staff confirmed they had a contractual agreement between themselves and their clients.
- The service used an external service to download radiographic images from various modalities to sustain diagnostic information and images. This ensured that data transfer was secure while maintaining patient confidentiality. There was a clear and transparent system in place for the rapid, secure transfer and review of images and where necessary, storage of patient data.
- The registered manager informed us there was effective communication with administration staff to ensure a smooth and safe workflow. This was not observed during the inspection as the administration staff were not contracted to work on the day of the inspection.
- Tele-radiologists had access to the same patient information as they would in the base hospital. This included patient details, current and previous clinical information, previous examinations (reports and images) and laboratory data. This data was viewed using equipment (hardware and software) of the same standard as would be expected in the base hospital. This meant that patients could be confident that even though their examination was not being reported within the base hospital, it was being done to the same standard with equivalent security.
- The registered manger informed us that there were no handovers between tele-radiologists. All outstanding works were identified the next working day when the administration staff reviewed the allocated distribution list. Tele-radiologists confirmed they did not participate in any handover which they felt would be beneficial as they were unaware of other colleagues' outstanding reporting lists until contact was made by the administrator who reallocated the work. They said they often informed the administrator they were unable to accept all the outstanding work due to time constraints which impacted on their key performance indicator of a 48-hour turnaround time.
- The service had a reporting query log. This was an internal document which enabled the service to monitor and follow up the administrative error of their clients and the reporting error of the tele-radiolgosits. From November 2018 to February 2019, there had been eight queries. Examples included asking the tele-radiologist to report in more details and another where they had not differentiated the wording for different teeth on a report. We saw the report did not have any identified actions or outcomes. This was brought to the attention of the registered manager who immediately addressed our concerns. They provided us with an updated report query log with outcomes clearly highlighted. For example, we saw addendum reports had been provided for queries raised by the client. The registered manager confirmed that they did not log/

record their conversations with the tele-radiologists. However, we saw that addendum reports had been submitted based on the query which indicated that tele-radiologists had responded accordingly.

- The tele-radiologist who interpreted the examination and issued the report to the referring clinician was clearly identified. Unexpected, significant or urgent findings identified by the tele-radiologist were notified to the administrator who confirmed they forwarded the information to the appropriate client by either an e-mail or facsimile (a telephonic transmission of scanned printed material to a telephone number connected to a printer or other output device). The registered manager said this was followed by a phone call to the relevant referrer. However, there was no flagging system in place to highlight the urgency of the report and no evidence the receiving client was made aware of this. The service said they did not send the report with a "read receipt" to verify timely access by the receiving client. This meant there could be a delay in treatment for the patient which could impact on patient safety.
- Tele-radiologists confirmed they could contact the referring clinicians directly to discuss any report findings query when required, but most of the contact was managed by the administration team. They said this was beneficial as it protected their work time.
- Staff were trained to ensure patient information was protected. Reports written by tele-radiologists followed best practice and guidance from the medical council.
- Fusion radiology administration staff provided the patient's historic report and clinical information prior to assigning scans to tele-radiologist for reporting. This meant that information was available to tele-radiologists at the time to ensure reporting turnarounds were met.
- The service assessed and responded to patient risk by ensuring that it was committed to protecting the service users' data which showed that they valued their customers and respected their right to privacy.

Teleradiology staffing

- **The service had enough staff with the right skills and experience to meet the imaging reporting needs of patients.**
- The registered manager informed us that they completed most of the administrative work as it was manageable which resulted in very limited staff.
- The service did not use agency staff but had recruited one staff on a zero-hour contract to support their administration work. They were employed on an "ad hoc" basis of 12 to 15 hours a week. Their role was to support the registered manager in the allocation of scans to the reporting tele-radiologists.
- There were no tele-radiologists employed directly by the service. All tele-radiologists worked under a mutually agreed contract. All tele-radiologists carried out procedures that they would normally carry out within their substantive post.
- The service manager informed us they ensured that the tele-radiologists contracted had acquired their professional registration and indemnity insurance revalidation. Copies of these were provided after the inspection.
- The service did not use reporting radiographers.
- The number of tele-radiologists the service had on their reporting panel was based on estimated volume of scans expected against each modality. The service currently had a panel of five tele-radiologists which included for example; three dentists of which had a speciality in radiology and a neurologist. All tele-radiologists had individual speciality expertise and requirements as identified by the service's clients.
- The service had a rostering management system that managed the tele-radiologist's availability. This enabled them to allocate the tele-radiologists' work list. When advised of additional volumes the service reviewed the roster to look at the availability of the tele-radiologists to ensure they could cover the reporting demand.
- The service did not have processes in place to ensure that contracted staff complied with the European Union Health and Safety legislation regarding the working time directive. The service did not have processes in place to ensure that contracted staff worked the limited 48 hours of work each week. The service had not reviewed and checked that the "opt-out" procedure had been completed by the tele-radiologists so they could identify staff carrying out high volume reports. This meant there could be a risk of radiological accuracy and patient safety if viewing time of images decreased and errors increased with excessive workload.

Records

- **Records were kept in locked cupboards and were only accessible to authorised staff, to maintain confidentiality.**

Diagnostic imaging

- The service had access to the same patient information as the base hospital/clinic. There was a clear system in place for rapid, secure transfer and review of images, and where necessary storage of patient data.
- The service used an integrated system to attach clinical records. The reporting images used multiple parameters such as; unique identifier number, patient name, date of birth and examination date.
- Tele-radiologists worked off a personalised worklist which only showed them the reports allocated to them. When a tele-radiologist selected a case for reporting they would be provided with the same patient information as the base hospital/clinic. There was a clear system in place for rapid, secure transfer and review of images, and where necessary storage of patient data.
- The service's clients sent the following information to ensure the tele-radiologists could report effectively. All reporting requests included the patient's history, previous imaging, current symptoms and signs and the results of other diagnostic tests.
- There were processes in place to manage client privacy and confidentiality by ensuring they kept their records safe and inaccessible to others except for staff who may require access.
- We saw a data protection policy which assured confidentiality from initial enquiry to final review.
- The service did not amend or alter the patient's clinical history. Images were sent for reporting and returned electronically matching the client and patient's identification.
- Tele-radiologist used a two-tier remote login system to access patient information and images to read and report scans. Reports were stored in the picture archiving and communication system (PACS) system. PACS is a medical imaging technology system to securely store and digitally transmit electronic images and clinically-relevant reports.
- The service's administration team manually sent reports to GPs and clinics by secure NHS systems or remotely accessed the client's system to upload reports.
- Office computers were locked when not in use. This prevented unauthorised access and protected patients' confidential information.

Medicines

- **The service did not see patients or manage their care. Contrast administration to patients were administered by the service's clients.**
- The service did not store or administer any medicines or controlled drugs.

Incidents

- **The service managed and recorded safety incidents. The registered manager investigated incidents, but lessons learnt had not been shared with the whole team.**
- The service did not deal directly with the patient. In the event of a patient death they could be notified of a discrepancy or be an interested party in an inquest or serious incident and would provide support or information if required. The registered manager confirmed they had not been involved in any investigation since the inception of the service.
- There had been nine reported incidents from January to March 2019 which related to administration errors arising from the services' clients which included wrong patient data being paired up with wrong images when uploading an image or transferring images to the service for reporting.
- The service did not have effective processes in place for learning from clinical incidents. These were not always discussed with staff and there was no evidence of what actions had been taken to review the workflow to prevent any future reporting errors.
- The service did not determine whether a trigger for duty of candour had been reached. Their clients would advise the service accordingly. The registered manager confirmed they had not been asked to attend any duty of candour meetings.

Safety Alerts

- **The service planned for emergencies if one should happen.**
- The service did not see patients and they did not visit the premise due to the nature of the service provided.
- The location of the office was designed to adhere to safety legislation. Fire exists were unblocked and facilitated unhindered evacuation in an emergency. Entry to the office was not restricted but they had an up to date risk assessment to cover eventualities such as theft and access by unauthorised personnel.

- The service had a business continuity plan to ensure there were processes in place to ensure it could operate its service with minimum disruption.
- In the event of a failure, the service desk team of the external service would provide hardware infrastructure and software support. This was provided Monday to Friday 9am to 6pm. The external service also provided a dedicated information technology service desk which was manned by qualified technical support. In the event of a failure the service desk would be notified whose primary focus was to resume the service in a timely manner.

Are diagnostic imaging services effective?

This is the first inspection for Fusion Radiology Limited. We currently do not rate effective for teleradiology services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance.**
- Policies, procedures and protocols seen to manage patient's safety were up to date except for the confidential personal information and determining the legal basis policy which was due for review in December 2017. This was brought to the attention of the registered manager who confirmed they would review and update the policy. Policies were referenced against national guidance to ensure they worked in line with legislation, standards and evidence-based guidance.

Nutrition and hydration

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

Pain relief

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

Patient outcomes

- **The service did not monitor the effectiveness of care and treatment which meant there were no processes to improve the service.**
- The service did not participate in the Imaging Services Accreditation Scheme (ISAS). The Royal College of Radiologists (RCR) and the College of Radiographers have developed the ISAS to support diagnostic imaging services to manage the quality of their services and make continuous improvements; ensuring that their patients consistently receive high-quality services delivered by competent staff working in safe environments.
- The registered manager confirmed that all radiology reports answered clinical questions asked and the report considered the patient's prior investigations from the same and/or different imaging modalities. This considered all relevant clinical information, laboratory results and histopathology reports.
- There was not a defined audit schedule which the service completed and audited regularly.
  Tele-radiologists spoken with were not aware of any completed audits or their results. The majority of scans reported related to dental implants and cosmetic maxillofacial images which were regulated by the GDC and not the RCR. However, the service followed the RCR guidelines as best practice.
- The RCR standards for the provision of teleradiology within the United Kingdom states that "an audit of teleradiology service provides imaging reports to monitor the report structure, content, accuracy and quality of any advice given in the report, for instance, regarding further imaging requirements is essential."
  The registered manager confirmed that they had an internal peer review processes in place for 10% of all cross section individual tele-radiologist reports (MRI and CT) to be audited. The manager informed us that reports were audited at the end of each month by an independent auditor who was a GDC registered dentist. They stated that the audit looked at the report structure wording and accuracy and, where required, corrections were followed up with an addendum report. However, we did not see any actions or outcomes relating to the results. The manager did not provide evidence of who oversaw the reports of non GDC tele-radiologists contracted which meant that we could not be assured there were effective processes in place in accordance with guidelines.
- The service had processes in place to record identified discrepancies from their clients which was in line with RCR guidelines. A reporting discrepancy occurs when a retrospective review, or subsequent information about a patient outcome, leads to an opinion different from that expressed in the original report. We saw the discrepancy

report from September to December 2018 and January and February 2019 which totalled 51 discrepancies. Areas identified included typographical errors, left and right sides used incorrectly in the report and a request for the radiologist to review the radiograph.

- The company provided us with their discrepancy investigation process which said that all identified discrepancies would be forwarded to the quality team and logged in the client issues register. The identified concern would be overseen by the company's auditor for review and categorisation of error. This would be dealt with by the medical advisor in the absence of any auditor. However, we did not see any audited reports regarding discrepancies together with any actions or outcomes.
- The investigation procedure also identified that discrepancy details would be entered into the company's quality assurance process which monitored each tele-radiologist's reporting output against set criteria. Tele-radiologists spoken with were unaware that their work was being audited and confirmed they had not received any feedback regarding the quality of their work. We saw the service did not ask the tele-radiologists to complete the "personal reflection on discrepancies and adverse events" form used by the RCR following discrepancies arising from an internal peer review. We did not see quality assurance processes confirming that these audits were reported back to the referring client as it may affect the onward patient management.
- In line with the RCR guidance, teleradiology companies should have structured discrepancy meetings, where discrepancies could be discussed in an open learning, no blame forum. These meetings should occur a minimum frequency of every two months and include; how often the meetings occur, who attends and how learning points are disseminated to staff. The service had not held any discrepancy meetings and there was no evidence of shared learning or any action points where appropriate. Tele-radiologists spoken with confirmed they had not received any feedback on discrepancies identified which meant we could not be assured there were processes in place to ensure tele-radiologists attended and received outcomes to support shared learning.

Competent staff

- **The service did not always have processes in place to ensure staff were competent for their roles.**
- All tele-radiologists reporting on patient images in the United Kingdom are required to be registered with a UK healthcare regulator and comply with their requirements for example, revalidation.
- All tele-radiologists contracted by Fusion Radiology Limited were registered with either the general medical council (GMC) or the general dental council (GDC). We saw that of the three tele-radiologists registered with the GDC two had a speciality in radiology. The service provided us with evidence which showed that tele-radiologists had completed their continued professional development (CPD) in line with the royal college of radiologists (RCR). The two records seen were dated from January 2013 to December 2017 and January 2012 to December 2016 respectively. The RCR CPD scheme maintains the principle that "doctors should have as a minimum, achieve at least 250 credits over five years to remain up to date in their specialities. Ideally this should be evenly spread, with approximately 50 CPD credits achieved per year." The registered manager stated they requested tele-radiologist to provide evidence of their CPD credits annually in line with RCR guidance.
- The registered manager informed us they relied on the tele-radiologists' General Medical Council and General Dental Council's registration as confirmation of their appraisals and revalidation.
- The service had an induction handbook which outlined its procedures. Staff were expected to read and sign to say they had understood the content. Tele-radiologist spoken with said they were unaware of the availability of an induction booklet and had not received an induction with the service.
- The registered manager mentored administrative staff to ensure they were competent and had appropriate and relevant skills which included good communication and knowledge of information technology skills and systems. To ensure efficiency the service provided on the job training in data control and GDPR.

Appraisals:

- Zero hour contracted staff did not have to receive an appraisal.
- Tele-radiologists registered with the GMC received annual appraisals by their parent service and their re-validation was due every five years. Revalidation was

not required for GDC registered radiologists as the GDC oversaw and ensured their dentists were registered and fit to practice. The registered manager confirmed they requested copies of registration of the contracted tele-radiologists on commencement of their employment. The registered manager informed us they held appraisal records for only some of their tele-radiologist who considered the appraisal held by their employer as a confidential document between their main employer and themselves and had refused to provide copies for their records.

- The registered manager as the responsible officer for the service confirmed they did not have meetings with the contracted tele-radiologist's corresponding responsible officer to discuss competencies, mandatory training, appraisals and revalidation where appropriate. The tele-radiologists spoken with said they had not been requested to provide any documentation and we saw no evidence of this during the inspection. This meant that we could not be assured of the service's oversight of contracted staffs' competencies.
- Tele-radiologists spoken with confirmed they had not been requested to provide further evidence of their appraisals. This meant that we could not assured that the provider had up to date information to ensure the teleradiology staff contracted were competent to carry out their role.

Multidisciplinary working

- **Staff did not always work together and support each other as a team to provide good care.**
- Tele-radiologists spoken with confirmed they had very limited contact with the leadership of the service and often felt that they worked in silo. This meant that tele-radiologists worked as individuals and did not work and support each other to share information or knowledge.
- Tele-radiologists could support their written report with verbal communication when required. The service had processes in place whereby the referring doctors could discuss the imaging findings in complex cases with the tele-radiologist to understand the implications and reliability of the findings, or to provide further clinical information which may alter the interpretation. Tele-radiologists spoken with confirmed they liked the process of all communication going via the administration team as it protected them from continuous requests from referrers.
- Tele-radiologists spoken with said that they had a good working relationship with clients. They communicated well and worked effectively with clients' team to ensure the smooth workflow for reporting.

Seven-day services

- **The service did not provide a seven-day teleradiology service.**
- The service worked Monday to Friday 9am to 5pm. Tele-radiologists spoken with confirmed they often worked weekends which fitted in with their work life balance. We enquired with the registered manger what support was available should a concern be raised at the weekend due to the service's working hours. The manager said that the tele-radiologists had access to his mobile phone should they require any additional support at weekends. This was confirmed with tele-radiologists spoken with.

Health promotion

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service did not see patients and they did not visit the premises due to the nature of the service provided.
- The registered manager informed us that consent was initiated at the referring hospital.
- Tele-radiologists confirmed that most consent was identified on the referring paperwork, but this was not consistent from all clients using Fusion Radiology Limited.

Are diagnostic imaging services caring?

We did not inspect this key question given it was a teleradiology service.

Are diagnostic imaging services responsive?

We inspected this key question but not have rated it.

Service delivery to meet the needs of local people

- **The service did not see patients and they did not visit the premises due to the nature of the service provided. However, they ensured that the service delivered met the needs of clients using the service.**
- The service's operating times were Monday to Friday 9am to 5pm. Tele-radiologists spoken with confirmed they often worked weekends which fitted in with their work life balance.

Meeting people's individual needs

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

Access and flow

- **Clients could access the service when they needed as outlined in their individual contracts. However, tele-radiologists did not always meet their key performance indicator of turning around reports within 48 hours.**
- Fusion Radiology Limited did not deal directly with patients and was not involved in making care and treatment decisions to enhance the delivery of effective care to support people's independence. However, with the availability of technology and equipment they could provide the tele-radiologists with a single interface so that they were able to focus on providing a report to support the diagnosis and ultimately treatment and care of the patient in a timely manner.
- The registered manager said the service was committed to providing reports within expected turnaround times and meeting urgent follow up reports as soon as possible. The registered manager said that they had an agreement with their clients to provide turnaround within 72 to 96 hours. Tele-radiologists spoken with said they had a 48-hour turnaround/benchmark time which was confirmed by the manager during the inspection.
- We saw the turnaround report from January to March 2019 which totalled 176 reports. The report identified that tele-radiologists did not always meet their key performance indicator of turning around reports within 48 hours. The report identified that 81 reports (46%) did not meet the 48-hour turnaround time. The report showed the following; one over eight days, four over six days, 12 over five days, 41 over four days and 23 over three days. The manager informed us, after the inspection, that the service worked to five working days whereas the external company worked on a seven-day interval which was why the turnaround report provided reflected a high number of reports breaching 48 hours. The service's administration team monitored and compared the reporting activity list. They informed us they compared the received patient list with the reported examination list daily and took action on unreported examinations to avoid turnaround time breaches. There were no procedures or processes in place to manage the efficiency or variance of turnaround time breaches, so they could be investigated for the reasons why and followed up. There was also no evidence of the interaction between the service and its clients regarding delays in reporting and meeting the deadlines. This meant that there could be a risk to patients not receiving timely treatment.
- The registered manager informed us they had a rostering management system which co-ordinated the tele-radiologist's availability. When the tele-radiologists were on annual leave, the service would suspend their speciality work pending their return. This enabled them to allocate the tele-radiologists' work list accordingly.
- The registered manager said they would request tele-radiologist to provide extra session to meet increased reporting demand. Tele-radiologists spoken with confirmed that they were often asked to undertake extra sessions to meet both demand and outstanding work lists from their colleagues but said they did not always have the capability to meet this. They said they often felt pressurised to meet the additional requests which impacted on their ability to report within 48 hours.
- Fusion radiology used the picture archiving and communication system (PACS) that supported tele-radiologists to deliver reporting on time.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- The service had procedures in place regarding complaints, comments and suggestions.
- The registered manager informed us that should they receive any complaints they would aim to resolve them in a short time scale in accordance with their complaints policy. There had been no complaints recorded by the service.

Inadequate

Diagnostic imaging

Are diagnostic imaging services well-led?

Inadequate

We rated it as **inadequate.** We found that:

Leadership

- **The service had an administration manager who did not have regular contact with tele-radiologists to ensure they provided high-quality sustainable care.**
- The management team consisted of the service director who ran the day to day business and most administrative duties for the service. He was also the registered manager for the service.
- The service did not have systems in place to ensure staff working remotely interacted with each other. For example, tele-radiologists confirmed they felt they worked as individuals and were not a team. However, tele-radiologists spoken with said that the registered manager could be approached when required.
- The registered manager said they provided personal contact to the tele-radiologists and was available both by telephone and e-mail at all hours on a day to day basis.

Vision and strategy

- **The service did not have a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed.**
- Fusion Radiology Limited's overall objective was to deliver the highest quality of service to people who use services. The registered manager informed us they would continue to develop the service in line with regulatory changes.
- The registered manager confirmed they did not have a strategy for the service but had a vision of what they would like to achieve. However, this was a work in progress with no identified timeframe for completion.

Culture

- **The service director did not have effective processes in place to prompt a positive culture that valued staff.**
- The registered managed confirmed that contracted staff acted within the requirements of the service's policies and respected the diversity, values and human rights of people using the service.
- The service met the requirements of the Equality Act 2010 and the Human Rights Acts.
- The registered manager did not have a system in place to manage staff working remotely. They did not hold team meetings or review the care and welfare of contracted staff.
- The registered manager relied on the tele-radiologist's General Medical Council or Dental Medical Council's qualification as confirmation that staff had received their annual appraisal and revalidation. This meant that we could not be assured that senior management had up to date information regarding the competencies of tele-radiologists contracted.

Governance

- **The service did not have a systematic approach to 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 informed us they were looking at adopting and developing a corporate governance framework that would allow them to implement a culture of transparency and fairness. However, there was no process in place to develop this framework or timeframe when this would be implemented.
- The registered manager confirmed they had a clinical advisor who provided oversight of the service. There was no evidence to confirm the processes in place for example; input from the clinical advisor or documented meetings. This meant that we could not be assured that leaders always understood the challenges to quality and sustainability or identify the actions needed to address them.
- Contracted staff spoken with confirmed they were clear about their role and understood who they were accountable for and to whom.
- The service had a service level agreement with an external service to supply their picture archiving and communication system (PACS) images which included direct uploads from folders, compact discs and universal serial bus (USB). USB is an interface system which enables communication between devices such as a personal computer.

Diagnostic imaging

Managing risks, issues and performance

- **While the service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected, they did not have processes to manage the risks.**
- The registered manager said they aimed to improve the service by learning from any adverse events, incidents, discrepancies or errors that might occur. However, the service did not have processes in place to manage this such as meetings to share learning which meant we could not be assured there were procedures to manage risk and improve performance.
- We saw that tele-radiologists worked to the same standards as their base hospital as well as that required by the service. This meant that patients could be confident that even though their examinations were not being reported within the base hospital, it was being completed to the' same standard and with comparable security. This was in line with the RCR guidance: Standards for the provision of teleradiology within the United Kingdom' (December 2016).
- We saw there were reports available to manage the risks within the service. For example, turnaround rates and query and discrepancy reports. However, there were no processes in place to assess the data with no actions or outcomes identified to manage the information. There was no sharing of information with contracted staff to ensure shared learning.
- The service had a business continuity plan which looked at the effects of disruption on services, systems and business processes caused by service interruptions and failures. The plan detailed the arrangements which covered three main business areas which included; service continuity, information management and technology and major incidents. The plan ensured the service could continue to operate its core service at a minimum pre-determined level. We saw this was up to date with a review date of June 2019.
- The service's hardware and software infrastructure was supported by a dedicated PACS provider. They were available Monday to Friday 9am to 6pm.
- The information technology service desk was manned by qualified technical resources which included both mobile and landline telephone systems. In the event of a failure the service desk team would be notified who would be responsible to resolve the incident. Primary focus was on resuming services and keeping downtime to a minimum.
- The service had processes in place to ensure it was protected from financial claims by having the appropriate insurance to cover all relevant insurable risks. Areas covered included: public liability and equipment failure or malfunction.

Managing information

- **While the service used information well to support its activities using secure electronic systems they did not have processes in place to manage this.**
- The information management and security policy underpinned the confidentiality of information once reports were completed. Information governance (IG) is the way organisations 'process' or handle information. It covers personal information relating to patients/service users, employees and corporate information.
- The manager informed us they had a contractual agreement with its clients to provide turnaround within 72 to 96 hours. During the inspection the manager informed us that tele-radiologists had a 48-hour turnaround time which was confirmed by contracted staff spoken with. The service had access to report turnaround times to ensure reports were available in a timely manner. Records seen showed that from January to March 2019 54 reports (43%) did not meet the 48-hour turnaround time as allocated to the teleradiologists contracted. There were no procedures or processes in place to manage the efficiency of turnaround time breaches, so they could be investigated for the reasons why and followed up.
- Reports received by the referrer was by a secure system provided by an external service who ensured that all data was encrypted. The external service could provide monthly and quarterly statements of service use. The registered manager confirmed they used this information to manage the day to day running of the business.
- The tele-radiologists completing the examination and issuing the report to the referring clinician was clearly identified. Unexpected, significant or urgent findings identified were forwarded the information to the appropriate client by either an e-mail or facsimile. The registered manager informed us they followed this up this up with a phone call to the relevant referrer.

However, there was no flagging system in place to highlight the urgency of the report and no evidence the receiving client was made aware of this. The service said they did not send the report with a "read receipt" to verify timely access by the receiving client. This meant there could be a delay in treatment for the patient which could impact on patient safety.

Engagement

- **While the service engaged well with external organisations they did not have process in place to action the feedback received.**
- The service had processes in place to receive feedback from its clients. We saw feedback forms from three clients. All feedback forms said they were satisfied with the administration team and confirmed that report writing was "on time." Recommendations seen included:
  - Reports could follow a structured format and the key images could be clearer / brighter.
  - The online image transfer portal could be streamlined to make it easier and faster to use.
  - To ensure any queries are followed up to conclusion.
- Senior staff told us they communicated regularly with their clients to discuss concerns. However, there were no processes in place to action the feedback recommendations.

Learning, continuous improvement and innovation

- **While the service was committed to improving services through continuous improvement by learning from when things go well and when they go wrong, promoting training and innovation they did not have processes in place to manage this.**
- The service had been awarded grant funding as part of an Innovation Bridge research collaboration project with the local university. The funding enabled the service to adapt to the GDPR changes and allowed them to purchase additional high specific diagnostic monitors which would support more accurate dental reporting.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are effective processes in place for the provision of discrepancy meetings in line with the recommendations of the Royal College of Radiologists guidance.
- The provider must ensure they have a flagging system in place to highlight the urgency of unexpected and urgent reports for acknowledging by the referrer.
- The provider must ensure that lessons learnt from incidents are disseminated to staff.
- The provider must ensure that they have a defined audit schedule which is regularly audited.
- The provider must ensure they have systems to monitor contracted staff's training, appraisals and revalidation.
- The provider must ensure they have systems in place to manage the efficiency of turnaround time breaches.
- The provider must ensure there is an effective governance framework to manage the risk, issues and performance of the service.

Action the provider SHOULD take to improve

- The provider should ensure they have handover processes in place to review outstanding reporting lists and the reallocation of work.
- The provider should ensure they have systems to monitor the European Union Health and Safety legislation regarding the working time directive.
- The provider should ensure they have a vision and strategy for the service.
- The provider should ensure they have systems in place to action the feedback recommendations received from their clients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not have effective systems in place for unexpected and urgent reports to be timely acknowledged by the referrer. • The provider did not have effective systems in place so that lessons learnt from incidents are disseminated to staff. • The provider did not have effective systems in place so that it had a defined audit schedule which is regularly audited. • The provider did not have effective systems in place to monitor contracted staff's training, appraisals and revalidation. • The provider did not have effective systems in place to manage the efficiency of turnaround time breaches. • The provider did not carry out any discrepancy meetings in line with the Royal College of Radiologists guidelines to ensure shared learning was disseminated to staff. • The provider should ensure there is an effective governance framework to manage the risk, issues and performance of the service. Regulation 17 (1)(2)(a)(e)(f)(3)(a)(b)