

Image Diagnostic Technology Limited

# Image Diagnostic Technology Ltd

## Inspection report

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Date of inspection visit: 10 May 2023, 13 May 2023  
Date of publication: 20/06/2023

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

## Ratings

### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Inspected but not rated 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

## Overall summary

Our rating of this location improved. We rated it as good because:

- Staff employed at the service received and completed a list of mandatory training that was applicable for their job role.
- Clear patient records were kept in line with General Data Protection Regulation (GDPR).
- Incidents were clearly reported in a suitable format to enable learning or improvement.
- The service had access to another tele-radiology provider to assist with a backlog of reports.
- The manager had effective audits in place to measure the effectiveness of the service that they provided.
- Staff we spoke with spoke highly of the manager.

However:

- Although the service had implemented policies the manager had not assured that staff had read them all. However, since the inspection we have been assured that all provider policies have been read by the appropriate staff members.

# Summary of findings

## Our judgements about each of the main services

### Service

#### Diagnostic and screening services

### Rating

Good



### Summary of each main service

Our rating of this service improved. We rated it as good because:

- All staff had up to date training in key skills. There was clear safeguarding oversight. The provider had data security assurances to protect personal patient data. The service had access to enough radiologists to review images for clients. The provider kept detailed patient records. The service managed safety incidents well and they learnt lessons from them.
- Managers monitored the effectiveness of the service through thorough auditing processes to ensure assurance of staff competencies.
- The service took account of client's individual needs and there were formal processes in place to provide feedback.
- Leaders ran the services well, there was reliable information systems that assured the manager that they had staff with the appropriate skill sets. The manager was clear of the services vision and business model and there was an appropriate business contingency plan in place.

However:

- Although the service had implemented policies the manager had not assured that staff had read them all. However, since the inspection we have been assured that all provider policies have been read by the appropriate staff members.

# Summary of findings

## Contents

### Summary of this inspection

Background to Image Diagnostic Technology Ltd

Page

5

Information about Image Diagnostic Technology Ltd

5

---

### Our findings from this inspection

Overview of ratings

6

Our findings by main service

7

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# Summary of this inspection

## Background to Image Diagnostic Technology Ltd

Image Diagnostic Technology also known as IDT Scans Ltd is a limited company founded in 1991. The provider's main work is to provide diagnostic dental reports for dental imaging centres, for patients requiring dental treatment or diagnosis using teleradiology. Teleradiology is the transmission of patients' radiological images between different locations to produce an imaging report, expert second opinion or clinical review. The provider works with a network of dental imaging centres providing a service for the whole of the UK and Ireland.

The service is registered to provide the following regulated activities:

Diagnostic and screening procedures.

The provider has a manager registered with CQC. The provider employs two staff members, the registered manager and the company's secretary. IDT Scans Ltd subcontracts three Radiologists to review and provide the dental imaging reports.

The provider was previously inspected in June 2022 and was rated as inadequate overall. A requirement notice was put in against the provider on the back of the inspection and the CQC received an action plan to address actions in the requirement notice. During the inspection on 10 May 2023, we found that all actions were met from the requirement notice and were well embedded within the service.

## How we carried out this inspection

We carried out a short notice inspection on the teleradiology service on 10 May 2023. As a direct result of the inadequate ratings found in June 2022 and the action plan received in September 2022. We inspected this service using our comprehensive methodology. The inspection was carried out by two CQC acute hospital inspectors.

During the inspection visit, the inspection team:

- Visited the main office of IDT scans Ltd.
- Spoke with the registered manager, the company secretary and carried out a telephone interview with a radiologist.
- Looked at documents relating to the running of the service.

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

## Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

### Action the service SHOULD take to improve:

The service should ensure that all policies are read and understood by staff where it is applicable to their role.





# Our findings

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic and screening services	Good	Inspected but not rated	Not inspected	Good	Good	Good
Overall	Good	Inspected but not rated	Not inspected	Good	Good	Good

# Diagnostic and screening services

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

## Is the service safe?

Good 

### Mandatory training

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

During the last inspection in June 2022, not all staff employed by the service had completed the appropriate mandatory training. During the inspection on 10 May 2023, we found that staff had received and kept up to date with their mandatory training.

The mandatory training was comprehensive and met the needs of the service. Training modules included data security, fire training, equality diversity and human rights. We observed certificates and records of completed training for the registered manager and the company secretary.

The registered manager monitored mandatory training and alerted staff when they needed to update their training. We reviewed the training log that was kept for the registered manager and the company secretary, which included expiry dates of the training.

We reviewed the mandatory training log for the subcontracted radiologists which showed dates of completion and expiry dates. Training included data security, fire safety and health and safety. We saw all radiologists were up to date with their mandatory training. The registered manager had automatic reminders to request refresher training evidence for each radiologist when it was due.

### Safeguarding

#### Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received safeguarding training specific for their role on how to recognise and report abuse and were up to date with it. Both employees of Image Diagnostic Technology Ltd (IDT Scans Ltd) had completed safeguarding training level one. The three subcontracted radiologists had completed training level two or three for safeguarding in adults and level one for children.

# Diagnostic and screening services

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to describe how they would make a safeguarding referral if they had concerns. The service had an up-to-date safeguarding policy to which they could refer to. The service had access to an NHS app which told them which local authority to send safeguarding referrals to if the patient in question was not local to Ealing.

The company secretary was the safeguarding lead and had suitable safeguarding training up to level one. The provider had never had a safeguarding concern but could give examples of the type of concerns that could be seen from a dental image.

The level of safeguarding training was appropriate for this provider as there was no physical contact with patients and the CQC was provided with clear assurances that IDT Scans Ltd were aware of the process to raise a safeguarding concern.

During the last CQC inspection in June 2022 there was a lack of policies including a safeguarding policy. During the inspection on 10 May 2023, we found a newly implemented safeguarding policy up for review in September 2023. We found that despite knowing how to handle a safeguarding concern, not all staff had read the safeguarding policy at the time of the inspection. This was raised with the registered manager and following the inspection we were told staff at the service and the radiologists have read the policy.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed non-clinical waste well.**

The service carried out routine safety checks of specialist equipment. We saw evidence that equipment used at the location in Ealing had recently been electrical tested in April 2023. This included a computer, a laptop, a shredder, and an external hard drive.

Staff disposed of non-clinical waste safely. Most work conducted at the service was produced electronically however, the service had access to a shredder should paper notes hold sensitive patient information.

The service had enough suitable equipment for radiology purposes. Radiologists used their own equipment and were responsible to ensure that equipment was suitable for reporting. The service also sent each radiologist a tool to measure the accuracy and quality of their monitors from the American Association of Physicists in Medicine (AAPM). This tool measured resolution, quality and luminance, by looking at contrast and greyscale gradients.

Radiologists we spoke to said that they referred to the Royal College of Radiology (RCR) guidelines "Homeworking for Radiologists for the Technical Requirements of a Home Work Station for Reporting on Different Modalities". Radiologists were responsible to set up their own work stations at home and adhered to suitable lighting recommendation to provide darkness and reduce reflection and glare.

## Assessing and responding to patient risk

**The service had processes in place to respond to diagnostic reports received.**

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.



# Diagnostic and screening services

The service had a significant findings process whereby all patient information was passed directly back to the client. Radiologists that identified abnormal or unexpected findings in an image would notify the manager, usually via email. The manager would then forward the findings on to the client. We reviewed a significant findings logs which showed 19 significant findings were found and reported back to the client since 2019. There were three logs entries for 2023. All logs had a response from the client recorded which was shared with the reporting radiologists.

The manager checked that all requests for medical exposures were justified by an Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) practitioner. The manager routinely checked that requests for medical exposures were justified by an appropriate practitioner who was registered with the General Dental Council (GDC) to ensure patients were not being exposed to excessive radiation. The manager showed us examples of concerns that were raised to the clients. For example, one referral form was signed by the practice manager who was not registered with the GDC, and therefore was not able to justify a radiation medical exposure. This was escalated and returned back to the provider to ensure a registered practitioner had justified the exposure and had signed the form.

## Staffing

**The service had enough staff to review and report dental images with the right qualifications, skills, training, and experience.**

The service kept up to date personnel files on the employees of the service. We saw Disclosure and Barring Service (DBS) certificates, appraisals and in date training records.

The service subcontracted enough radiology staff to support the needs of the service. The service had three subcontracted radiologists to review and report on dental images. The registered manager kept up to date files on the three subcontracted staff. This included the indemnity insurance, DBS checks, continual professional development, mandatory training, and an up-to-date current Curriculum Vitae (CV). We also saw their appraisals, GDC registration, and original qualifications.

Radiologists were self-employed and were able to refuse or turn down work if they felt over worked. The manager had access to another teleradiologist provider for support when workloads increased due to annual leave or sick leave.

## Records

**Staff kept detailed records of patient information. Records were clear, up to date, stored securely and easily available to all staff requiring access.**

Patient notes were comprehensive, and all staff could access them easily. Patient records were electronic and were complete. Patient identifiable information was input onto an electronic template report and sent to the radiologists to complete. The manager highlighted that this process caught mistakes made on patient identifiable information made from the client. Radiologists we spoke with were happy with the amount of information that was sent to them in order to complete their report. Radiologists were able to access previous images and reports of patients if they were repeat patients or could request additional data or images from the client if the patients were new to IDT Scans Ltd. Images were kept on a hard drive in a secured commercial locked storage. This allowed for old images to be recovered if needed. The hard drive was password protected.

# Diagnostic and screening services

Records were stored securely. Electronic records were secure and were password protected. The provider encouraged clients to use Secure File Transfer Protocol (SFTP) to transfer patient data to the provider. SFTP had been set up with limited user IDs with secure passwords. Radiologists were able to access the SFTP from any computer securely. The providers website detailed the benefits of using SFTP to their clients and patients.

The service used the Picture Archiving and Communication System which was secure, and password protected.

The provider also rented space on a server in Cork, in Ireland; for 12 months' worth of patient data and images. The manager was aware that GDPR in the EU (Ireland) matched the GDPR legislation in England. Images being sent outside the United Kingdom to Ireland for storage were in compliance with the GDPR.

Additional images were stored on a hard drive at the providers address. This hard drive had two security firewalls and it was password protected. The provider operated from a private network and used cables to access the internet instead of using Wireless Fidelity (Wi-Fi) and had two firewalls to boost security. The property was alarmed. Security measures in place were proportionate to the patient data held. The only identifiable patient information on the images was the patients name and sometimes their date of birth.

Radiologists were responsible for their own data security within their working environments as stipulated in their agreement with IDT Scans Ltd. Radiologists confirmed that they had appropriate security in their working environment.

## Medicines

We did not inspect this element using our key lines of enquires as it was not applicable to this service. The provider did not dispense or administer any medicines as part of this service.

## Incidents

**The service managed patient safety incidents well. The manager investigated incidents and shared lessons learned. When things went wrong, the manager apologised and gave clients honest information and suitable support.**

The registered manager knew what incidents to report. Staff raised concerns and reported incidents and near misses in line with the service's policy. We reviewed the incident policy which was in date and had been read by the radiologists. The policy provided a clear description of what constituted as an incident, serious incident and a never event. The policy also detailed who was responsible and who investigated all incidents at IDT Scans Ltd.

There were 29 documented incidents in the last 12 months. The manager was able to give examples of incidents that had occurred in the past and the actions and learning taken as a result of these incidents. In one particular case an image was rotated before being sent to IDT scans Ltd. The registered manager had since advised all clients to reset the image rotation before exporting the images to IDT Scans Ltd. Radiologists we spoke with described incidents as rare but, were able to give us other examples of what constituted as an incident.

We were able to review the incident log which captured detailed information about the incidents. All incidents had a category, actions taken, resolution and lessons learnt recorded in the log.

# Diagnostic and screening services

Staff understood the duty of candour. They were open and transparent and gave clients and radiologists a full explanation if and when things went wrong. Patient contact was rare at this provider, but the provider was able to describe how they would extend the duty of candour to a patient if things went wrong.

## Is the service effective?

Inspected but not rated 

**We currently do not rate effective for teleradiology services.**

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

The manager had developed new policies for IDT Scans Ltd since the previous inspection and all policies checked were in date. Staff were aware of the policies and followed policies set out by the provider. Radiologists we spoke to after the inspection confirmed that they had read and followed all the policies at IDT Scans Ltd.

The provider was not aware of any national guidance specifically for dental reporting. The manager ensured that Radiologists followed Royal College of Radiology (RCR) guidelines where applicable, for example all reports should be timely. The manager was open to following guidelines and recommendations if they were applicable to dental reporting. Radiologists we spoke with confirmed that there were no specific guidelines for dental reporting, but they adhered to parts of the RCR guidelines and parts of the Safety and Efficacy of a New and Emerging Dental X-ray Modality (SEDENTEXCT) guidance that were applicable to their work.

The service reviewed six reports every two months at the Radiology Events And Learning Meetings (REALM), in line with the RCR guidance Standards for Radiology. The REALM meeting was an opportunity for the radiologists to present interesting cases for leaning purposes and for the registered manager to discuss any other business. We reviewed meeting minutes and saw learning outcomes clearly documented. This learning process had been embedded since the last inspection.

The service audited their work through an external company and had sent out nine reports for audit since November 2022. The results of these audits were shared with the Radiologists who completed the report. Audit results showed very few discrepancies, and similar findings to the original report produced. This was an improvement since the last CQC inspection.

### Nutrition and hydration

We did not inspect this element using our key lines of enquires as it was not applicable to this service.

### Pain relief

We did not inspect this element using our key lines of enquires as it was not applicable to this service.

# Diagnostic and screening services

## Patient outcomes

### **The registered manager monitored the effectiveness of the provider.**

The service had a Key Performance Indicator (KPI) of three to five days for routine report turnaround times. At the time of the inspection the service was able to meet their KPI and exceeded for turnaround times. The service had a 95% target for the KPI. The service achieved 97% in their KPI in the first quarter of 2022 and 98.4% between July and December 2022.

Radiologists notified the registered manager of significant or unexpected findings. This was then escalated by IDT Scans Ltd to the referrer by phone call or by email.

We saw evidence that unexpected, significant, or urgent findings identified by the radiologist were notified to the registered manager, who confirmed they shared this information to the appropriate client. This was then followed up with a phone call to the client to document what was done about the findings. For example, some patients have been referred on to Ear, Nose and Throat (ENT) specialists. Clients normally took two to three days to respond to the significant findings, the registered manager chased clients after five days if there was limited communication regarding an update.

## 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 development.**

We were assured that staff were experienced, qualified, and had the right skills and knowledge to meet the needs of their clients. During the last inspection in June 2022, we found incomplete staff personal files and a lack of evidence to support the competencies of the radiologists. During our inspection on 10 May 2023, we reviewed staff records and found that these were updated. We saw indemnity insurance, continual professional development, mandatory training, and a current curriculum vitae (CV) for the three subcontracted Radiologists. We also saw appraisals, and original qualifications. All 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. The manager was able to provide evidence that the three radiologists that reported for the service were registered with the GDC. The manager informed us that their GDC pin numbers were on all the reports submitted to the manager.

The radiologists belonged to the GDC specialists list of Dental and Maxillofacial Radiology. They were also a member of the British Society of Dental and Maxillofacial Radiology (BSDMFR) and had completed peer reviews with certifications through this society. The registered manager kept a copy of these certificates in staff files. The Radiologists had Fellowships of the Higher Education Academy (FHEA) or a Doctor of Philosophy (PHD).

During the last inspection in June 2022, we found a lack of Disclosure and Barring Service (DBS) checks. During our inspection on 10 May 2023, we found that the manager had checked that the three radiologists had DBS checks.

The company secretary also had a DBS check, had attended mandatory training, and had access to additional learning and training when required to support them in their role.

# Diagnostic and screening services

Staff employed at IDT Scans Ltd supported one another to develop through yearly, constructive appraisals of their work. We saw evidence that the manager and company secretary had completed appraisals for each other and made clear and honest remarks on their working performance.

The companies handbook was under review but had been used to induct staff when commencing work at IDT Scans Ltd. The handbook included information on salaries, annual leave, sickness/injury, safeguards and so on. There was also an induction check list which the registered manager could use to ensure new staff were appropriately inducted to the service.

The service only used the highly experienced radiologists to report on images. The manager told us that staff that had underperformed in the past was not used or contacted to provide any more work for IDT Scans Ltd. The radiologists used were experienced and they provided training to other radiologists and had completed extensive training themselves.

## Multidisciplinary working

### Staff worked in silos completing individual tasks and managing their workload.

Due to the nature of the service, and radiologists working remotely, there was very limited physical contact with each other. However, we saw regular email communications between the radiologists and the registered manager, and they frequently met up to discuss cases virtually through the REALM meetings.

The manager had developed good rapport with practice managers and administrative staff for their clients. This heightened working relations, and resulted in effective relationships and queries could be resolved promptly. Requests for reports from clients required patient demographics and clinical details of patients; where clinical details had been insufficient the manager was easily able to request additional information.

Clients had the option to speak directly to the radiologist for advice over phone or via email.

## Health promotion

We did not inspect this element using our key lines of enquires as it was not applicable to this service.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We did not inspect this element using our key lines of enquires as it was not applicable to this service.

## Is the service responsive?

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

## Service delivery to meet the needs of local people.

# Diagnostic and screening services

## **The service planned and provided care in a way that met the needs of local people and the communities served.**

The manager planned and organised the service so that it could meet the needs of their clients. The manager monitored and took action to minimise delays in turnaround times for reporting. We saw evidence that radiologists were contacted to ensure that reports were delivered within the three-to-five-day reporting turnaround time. Clients were easily able to contact the provider for reports.

The manager told us that there was a 95% target for meeting all report targets, which was met and exceeded.

The manager was able to match the clients expectations with individual radiologists and their style of reporting. This was particularly helpful as different clients expected different levels of details and reports could be personalised to the needs of the client.

The service operated from Monday to Friday 9am to 5pm. Radiologists were free to work on days and times that suited them.

## **Meeting peoples individual needs**

### **The service did not see patients and patients did no visit the premises due to the nature of the service provided.**

#### **Access and flow**

#### **Clients could access the service when they needed it.**

The service used Picture Archiving and Communication System (PACS) which supported radiologists to upload and submit their reports safely and securely. Radiologists received a notification when they had pending images waiting for review via email.

Radiologists received a prepopulated template report with the patients name and date of birth and the urgency of which the report was required along with the patients images, via SFTP.

The clients were able to state how quickly they required a report and were given a choice between three to five working days. There were options for a tighter turnaround time at an additional cost.

Clients were only contacted about delays in reports when reports were stated as urgent.

Radiologists were open and honest about timelines and workloads and were able to turn down work due to capacity. When this occurred, the manager was able to utilise another teleradiology service to ensure that timelines were met. The manager had a formal service level agreement in place with this provider and had assurances of the work produced by this provider. Work would also be transferred to this provider to cover sick leave and annual leave.

The service had a business contingency plan should there be a disruption in the service. The provider had four major clients and had the contact details of these providers in the plan. The service would use automated email replies to inform other providers of a break in service.

# Diagnostic and screening services

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. However, the service did not share learning from complaints with radiology staff.**

The service clearly displayed information about how to contact them to raise a concern on their website, which was the main method of relaying information to clients.

There was an up-to-date policy on complaints, and staff knew how to handle them and resolve any arising issues.

The service had received two complaints in the last 12 months. One complaint was a missing report that was held up in the postal strikes and the other regarded a lack of detail on bone measurements. Complaints reported to IDT Scans Ltd were very rare, there was a total of six complaints since 2017. Complaints received were kept in a detailed complaints log, and actions for complaints were documented. All complaints were resolved in a timely manner. However, the manager did not share feedback from complaints with radiology staff to improve the service. This was raised at the time of the inspection and the registered manager intended to do this moving forward.

## Is the service well-led?

Our rating of well-led improved. We rated it as good.

## Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.**

The registered manager was also the managing director. The manager had sufficient skills, knowledge, and experience to run the service. The registered manager had a Bachelor of Art degree in Physics and was a Doctor of Philosophy in Computer Science. They had worked with medical images since 1970, worked in nuclear medicines and radiotherapy for five years and had worked in radiology. The company had at one-point distributed scanning systems to providers and knew the workings of the scanner. The registered manager was involved in setting up the first ever PACS system in a London hospital. The registered manager attended international conferences and workshops relevant to their role, read journals and produced reflection statements for their continual professional development. This was well documented and sent to the Irish College of Physicists in Medicine on an annual basis. The registered manager kept up with their clinical professional development, lectured at universities in England and in Ireland and held webinars.

The company secretary was the safeguarding lead, first aider and the health and safety lead. They had completed the relevant training and were well suited for this role.

The manager understood the needs of the business and put their clients and radiologists first.

The manager was not physically visible to their clients and the radiologists but was always contactable by phone and email.

# Diagnostic and screening services

The registered manager attended webinars and conferences up to twice a month discussing topics such as safety culture and clinical safety.

## Vision and Strategy

### **The service had a vision for what it wanted to achieve.**

The vision was to stay small and provide a high-quality service.

## Culture

### **Staff felt respected, supported, and valued.**

Staff we spoke with felt respected and valued and spoke highly of their manager. There was a strong emphasis on the safety and wellbeing of staff. The culture encouraged openness and honesty at all levels within the organisation.

During the REALM meetings there was a culture of respectful sharing of knowledge with no blame or shame. Radiologists described a supportive culture in which mistakes or discrepancies were used as opportunities for learning. Staff we spoke with felt positive and proud to work for the service.

Whistleblowing procedures could be located in the grievance policy and staff were aware of this.

## Governance

### **The manager operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities.**

The service audited all discrepancies, turnaround times, incidents, and complaints as part of the governance process. There was currently no audit schedule in place for external audits, as the registered manager was having difficulties finding external radiologists to audit the reports due to national pressures in the industry. However, the registered manager described other ways they were trying to audit their reports, including having less experienced health care professionals to review the reports.

The business continuity plans detailed recovery controls to maintain service levels with minimum down time in the event of a system failure.

The radiologists we spoke with were clear about their roles and understood who they were accountable for and to whom.

The registered manager had systems in place to monitor radiologists training, appraisals, indemnity insurance and revalidation. The radiologists we spoke with confirmed that this information was shared with the registered manager upon request and we saw evidence of when this was last collated. Staff records reviewed were complete and there was evidence of Disclosure and Barring Service (DBS) checks and safeguarding training completion for staff employed by the service.



# Diagnostic and screening services

The REALM meeting provided the opportunity for radiologists to remotely meet, discuss interesting cases, learn from incidents and discrepancies, and receive service updates if any. The registered manager kept a log to document which reports had been looked at, and included information such as the clients information, discrepancies documented and impact of discrepancies.

Policies and procedures were newly implemented and had review dates in line with relevant national guidance.

The incident log was detailed and was set up as a result from the last inspection.

## Management of risk, issues, and performance

**The manager identified relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

The service had processes to manage and share learning from incidents, discrepancies or errors that might occur. The radiology events and learning meetings were held regularly and were scheduled around the availability of all the radiologists who actively attended and participated in the meetings. The registered manager provided minutes for each meeting and captured the responses, suggestions and learning from each meeting. This was shared with all of the radiologists. This was newly implemented after the last inspection.

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

The manager identified potential risks and provided a mitigating action to all risks through a risk assessment. We looked at the risk assessment, which was last revised in May 2023 and saw potential risks documented with control measures in place. Risks included localised and generalised risks to the provider, such as image misinterpretation of data and loss of electricity respectively.

The service had arrangements for identifying, recording, and managing risks. The registered manager maintained a risk register. All risks on the risk register had a risk score, mitigating actions and contingency actions. There were 13 risks recorded on the risk register.

The service had a business contingency plan in place for IT failures. For example, if there was a computer break down, there were two identical workstations which could be substituted in under an hour. There was also a spare monitor. Also, if the telephone line was disconnected calls would be automatically diverted to a mobile phone.

## Information Management

**The service collected reliable data. The information system was integrated and secure.**

The service provided electronic access to diagnostic images for reporting radiologists.

The manager would send a text reminder to radiologists the day before the report was due.

All communications with the client were done by email or phone call. Communications were quick and effective.

# Diagnostic and screening services

The information sent between the client and the service was GDPR compliant. Data was sent securely with end-to-end encryption between the client to service and between the service to the radiologists. There was no patient identifiable information in emails and all data was password protected.

## Engagement

### **The managers actively and openly engaged with organisations to plan and manage services.**

The manager told us that there were regular communications with their clients to help manage and meet expectations.

We saw that clients were able to contact the provider directly to express or share any concerns and feedback with the manager. The manager stated that they were open to feedback from both clients and radiologists.

The service had very limited contact with patients, despite this the service had a support page dedicated for patients on their website. The page was detailed, and the information provided was easy to read and follow.

The registered manager was open to input from the radiologists to better the service and was able to give examples of when this had been done.

## Learning, continuous improvement and innovation

### **The service was committed to continually learning and improving the service.**

The radiology events and learning meeting had a structured agenda which allowed the whole team to share learning from cases, present interesting cases and develop new skills.

The manager encouraged improvements from clients to include patients date of birth on all images as standard practice before sending the images to IDT Scans Ltd.

The manager strived for continuous learning and improvement and attended events and meetings through the RCR network, where opportunities arose to meet and network with similar providers and radiologists.

The manager openly expressed their desire to not expand the service further and was happy with providing a high-quality service on a small scale