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

Fusion Radiology initially began by providing a reporting service for general magnetic resonance imaging (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 MRI neurology reporting. CBCT is a special type of x-ray equipment used when regular dental or facial x-rays are not sufficient.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 3 March 2020.

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

Our rating of this service stayed the same. We rated it as **Inadequate** overall.

The service was previously placed into special measures following the last inspection in April 2019. Due to the significant concerns found at this inspection we issued a warning notice under Section 29 of the Health and Social Care Act 2008 on the 13 March 2020 and told the service it must improve by 30 April 2020. On the basis of this inspection the service will remain in special measures. We will continue to monitor the service closely and may take further action, in line with our enforcement procedures if compliance is not achieved.

We rated the service as inadequate because:

- The service did not have effective processes to ensure all contracted staff completed and provided them with their training competencies.
- The service did not have an appropriate safeguarding policy to safeguard vulnerable service users.
- Staff did not have safeguarding training and did not understand how to protect service users from abuse.
- Processes were not in place to ensure that the equipment used by the service was safe for use.
- There were no effective processes to disseminate lessons learnt.
- Policies and procedures were not reviewed and updated, in line with national guidance, or in a timely manner.
- The service did not have effective systems to ensure all staff were competent for their roles.
- The service did not have a written vision and strategy for what it wanted to achieve and workable plans to turn it into action developed.
- The systems and processes did not effectively maintain the overall governance of the service.
- 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.

Summary of findings

- The service did not have effective processes to manage and widely share learning from adverse events, incidents, discrepancies or errors that might occur.
- 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.

However:

- The service had enough teleradiology staff with the right skills and experience to meet the imaging reporting needs of patients.
- The service had processes to respond to unexpected and urgent report outcomes.
- Records were kept secure and were only accessible to authorised staff, to maintain confidentiality.
- The service monitored the effectiveness of care and treatment.
- Staff worked together and supported each other as a team to provide good care.
- Clients could access the service when they needed it as outlined in their individual contract.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The service manager had some skills and abilities to run the service, to ensure they provided quality sustainable care.
- The teleradiologist we spoke with praised the registered manager and felt supported to raise concerns.

In addition to the warning notice, we told the provider that it must take some actions 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. Details are at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals

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. Currently we do not rate effective for this core service. Responsive was not rated due to the limited information available. Caring was not inspected during this inspection as the teleradiology services did not see patients and they did not visit the premise due to the nature of the service provided.

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Background to Fusion Radiology

Fusion Radiology is operated by Fusion Radiology Limited, providing a teleradiology service. Teleradiology is the transmission of patients' radiological images between different locations to produce a primary report, expert second opinion or clinical review.

The service has had a registered manager in post since May 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in radiology. The inspection team was overseen by Mark Heath, Head of Hospital Inspection (Interim).

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 four staff which included the director of the service, who was also the registered manager. 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 been inspected once before, and the most recent inspection took place in April 2019 which found that the service was not meeting all standards of quality and safety it was inspected against.

Activity (February 2019 to January 2020)

- In the reporting period February 2019 to January 2020, the service reported on 1318 images, of which 219 related to their contract with an NHS trust and 1099 related to their independent dentist and clients.

Six teleradiologists and a part-time marketing executive were contracted to work for the service.

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 at the hospital under service level agreement:

- The service had a contract with a dedicated picture archiving and communication system (PACS) service who supported their hardware and software infrastructure.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

Our rating of safe stayed the same. We rated it as **Inadequate** because:

- The service did not have effective processes to ensure all contracted staff had completed training or to monitor compliance.
- The service did not have an appropriate safeguarding policy to safeguard vulnerable service users.
- Staff did not have safeguarding training and did not understand how to protect service users from abuse.
- Processes were not in place to ensure that the equipment used by the service was safe for use.
- There were no effective processes to disseminate lessons learnt.

However:

- The service had enough teleradiology staff with the right skills and experience to meet the imaging reporting needs of patients.
- The service had processes to respond to unexpected and urgent report outcomes.
- Records were kept secure and were only accessible to authorised staff, to maintain confidentiality.

Are services effective?

We currently do not rate effective for teleradiology services, however, we found:

- Policies and procedures were not reviewed and updated, in line with national guidance, in a timely manner.
- The service did not have effective systems to ensure all staff were competent for their roles.

However:

- The service monitored the effectiveness of care and treatment.
- Staff worked together and supported each other as a team to provide good care.

Are services caring?

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

Summary of this inspection

Are services responsive?

We inspected this key question but have not rated it. However, we found:

- Clients could access the service when they needed it as outlined in their individual contract.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Are services well-led?

Inadequate 

Our rating of well-led stayed the same.We rated it as **Inadequate** because:

- The service did not have a written vision and strategy for what it wanted to achieve and workable plans to turn it into action.
- The systems and processes did not effectively maintain the overall governance of the service.
- 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 service did not have effective processes to manage and widely share learning from adverse events, incidents, discrepancies or errors that might occur.

However:

- The service manager had some skills and abilities to run the service, to ensure they provided quality sustainable care.
- The teleradiologist we spoke with praised the registered manager and felt supported to raise concerns.

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

Our rating of safe stayed the same. We rated it as **inadequate**.

Mandatory training

The service did not have effective processes in place to ensure all contracted staff had completed training or to monitor compliance.

The registered manager told us that there were six radiologists and dentists, of which five were reporting and one was an auditor. The service also employed a part time marketing executive.

At the time of the inspection we asked to see evidence of mandatory training for staff employed by the service and also those contracted to report remotely.

There was a training programme for the part time marketing executive which included training in the following areas; 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 that the five contracted teleradiologists and dentists were provided with picture archiving and communication system (PACS) training. PACS is a medical imaging technology system which allows organisation to securely store and digitally transmit electronic images and clinical-relevant reports. However, there was no evidence provided to confirm that this training had been completed.

The registered manager did not always monitor mandatory training and alert staff when they needed to update their training. The registered manager informed us that they requested the teleradiologists and dentists to provide them with evidence of training compliance from their substantive roles in the NHS. During the inspection we saw a training spreadsheet that indicated if the radiologists and dentist were compliant with their mandatory training. However, there was no indication on the document when the training was completed and when it would be due for renewal. This meant that we could not be assured that the manager had oversight of all contracted staff's training to manage patient safety. This was highlighted in the April 2019 inspection as an area for improvement.

Following the inspection, we were provided with evidence of mandatory training compliance for four out of the five reporting radiologists and dentists.

Safeguarding

Not all 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.

Not all staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The registered manager was the safeguarding lead for Fusion Radiology Limited.

At the time of inspection, the registered manager had not been trained in safeguarding and lacked the appropriate

knowledge for identifying, reporting and investigating alleged abuse. They failed to display an understanding of the arrangements required to safeguard vulnerable service users. The part time marketing executive also did not have an up to date safeguarding training.

Following the inspection both the registered manager and the marketing executivem completed an online safeguarding awareness training and we were provided with the evidence of completion.

There were no clear safeguarding processes and procedures for safeguarding vulnerable adults and children. The service did not have an appropriate safeguarding policy. The document provided did not set out what safeguarding arrangements were in place if there was evidence of abuse or harm. There were no details of escalation or reporting procedures. The document did not include reference to relevant legislation and local requirements.

Following the inspection, we conducted telephone interviews with three of the reporting radiologists and dentists. All three 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. Following the inspection, we were provided with evidence of safeguarding training completion for five out of the six teleradiologists.

Cleanliness, infection control and hygiene

Not applicable in these services

The service did not provide any onsite reporting services and did not work directly with patients. All reporting was done within the teleradiologist'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 however there were no processes in place to maintain its equipment.

Processes were not in place to ensure that the equipment used by the service was safe for use. There was no evidence that all equipment was suitable for its purpose and properly maintained. The service did not have records to verify electrical equipment had been routinely checked for safety. This related to both office and on loan equipment to the remote teleradiologists.

On the day of the inspection we asked if any of the electrical equipment in the Fusion Radiology office and those used by the reporting radiologists and dentist had been serviced and tested in the last 12 months. We were not shown any evidence to assure us that appropriate testing had been completed on the electrical equipment.

Following the inspection, we were provided with a certificate of portable appliance testing for 12 appliances, dated 4 April 2019. However, the certificate did not indicate which equipment type was tested nor any serial number was used to specifically identify which equipment were tested. Therefore, we were not assured that all equipment was suitable for its purpose, properly maintained and used correctly and safely.

On the day of inspection there was no evidence to show that the reporting radiologists and dentists using the equipment had the training, competency and skills needed to correctly and safely use the equipment. There was no evidence of an induction process to familiarise staff with the Fusion Radiology software.

During the inspection we asked to see evidence that the reporting radiologists and dentists had undergone an induction process to familiarise them with the Fusion Radiology software including access to Picture Archive Communication System (PACS) and Dragon (voice recognition application). At the time of the inspection this was not provided.

Following the inspection, we were provided with a document named "mandatory training – Fusion checklist". This document was a check list with the name of reporting radiologists and dentist and the mandatory training that they had completed. 'Infinite – Picture Archive Communication System (PACS)' and 'Dragon (voice recognition application)' were two items listed and showed that the reporting radiologists and dentists had completed these two training items. However, this document did not include what was covered in the training and date of completion.

Diagnostic imaging

Risk assessments were not in place to ensure staff safety when using equipment. There was no evidence that the reporting radiologists and dentists using the equipment had the training, competency and skills needed to do so. Visual Display Unit (VDU) risk assessments were not completed for reporting radiologists and dentists. Action was only initiated for some clinicians after we raised concerns during the inspection. Following the inspection, we received display screen equipment (DSE) assessment for four out of six radiologists and dentists.

Therefore, we were not assured that the provider had systems and processes to evidence that the reporting radiologists and dentists using the equipment and systems had the training, competency and skills needed.

The registered manager confirmed that the radiologists notified them via email or phone call of any faults with the equipment and repairs were carried out. The manager had a log of identified faults and actions taken.

Assessing and responding to patient risk

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

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 unexpected 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 (IR(ME)R 17). The IRMER 2017 is a legislative framework intended to protect patients from the harm associated with ionising radiation.

Referrals were organised by the administration team. The service ensured they had teleradiologists who were proficient in the required sub-specialty so that difficult cases received the appropriate interpretation.

The service had a clear and transparent system for the rapid, secure transfer and review of images and where necessary, storage of patient data. 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.

The registered manger informed us that there were no handovers between teleradiologists. The administration staff would identify all outstanding work the next working day by reviewing the allocated distribution list. Teleradiologists confirmed they did not participate in any handover; however, the registered manager or part time marketing executive would reallocate any work that was outstanding. They said they often informed the registered manager 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 teleradiologists.

From January 2019 to September 2019, there had been 17 queries. Examples included missing booking form, missing scan file and wrong side scan uploaded to what was indicated in the clinical details. We saw the log had identified actions and/or outcomes. This was an improvement from the last inspection.

We reviewed four imaging reporting records. Where appropriate, the imaging reports incorporated advice to the referring clinician on further investigation or referral to another specialist team.

The teleradiologist who interpreted the examination and issued the report to the referring clinician was clearly identified. Unexpected, significant or urgent findings identified by the teleradiologist were notified to the registered manager who confirmed they forwarded the information to the appropriate client by an e-mail and followed up with a telephone call with the referring clinician.

Diagnostic imaging

Since the last inspection the service had implemented a flagging system to highlight the urgency of the report. The registered manager would email the referring clinician and follow up by phone. We saw that a "read receipt" was requested with all emails sent to the referring clinician to verify timely access by the receiving client.

Teleradiologists and dentists 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.

Reports written by teleradiologists followed best practice and guidance from the medical council. Staff were trained to ensure patient information was protected.

Teleradiology staffing

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

There were no teleradiologists or dentists employed directly by the service. All teleradiologists and dentists worked under a mutually agreed contract. They all carried out procedures that they would normally carry out within their substantive role.

The number of teleradiologists 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 teleradiologists which included; three dentists of which had a speciality in radiology, a neurologist and a musculoskeletal radiologist. A sixth radiologist acted as an independent auditor and did not report for the service.

The service had a rostering management system that ensured the teleradiologist's availability in advance. Work was allocated to the teleradiologists via a work list. If there was additional work than planned for, the registered manager reviewed the roster to look at the availability of the teleradiologists to ensure they could cover the reporting demand.

Following the last inspection, the service had put processes to ensure that contracted staff complied with the European Union Health and Safety legislation regarding the working time directive. The processes ensured staff worked the limited 48 hours of work each week. The service reviewed and checked that the "opt-out" procedure had been completed by all the teleradiologists so they could identify staff carrying out high volume reports. This meant the risk of radiological accuracy and patient safety was reduced if errors increased with excessive workload. This was an improvement from the last inspection.

The service did not use agency staff but had recruited one member of staff on a part time contract to support their marketing and administration work. They were employed to work three days a week. Their role was to establish and work on a business marketing plan for the service. In addition they also supported the registered manager in the allocation of scans to the reporting teleradiologists.

Records

Records were kept secure and were only accessible to authorised staff, to maintain confidentiality. Records were clear, up-to-date and easily available to all staff providing the report.

Reporting teleradiologists had access to the same breadth of patient information as they would in the base hospital and maintained the same standard regardless of whether an image was reported in an NHS trust or through an independent service provider.

The service did not amend or alter the patient's clinical history. Images were sent for reporting and returned electronically by matching the client and patient's identification.

The service had clear and transparent systems for rapid, secure transfer and review of images and where necessary storage of patient data.

The service had the same standard of reporting whether it was an NHS trust or an independent dentist. In addition, the service made sure the same person should interpret the examination and issue the report to the referring clinician.

The service had a data protection policy which assured confidentiality from initial enquiry to final review. All teleradiologists 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.

Inadequate

Diagnostic imaging

We reviewed four reports. All four reports clearly identified the reporting radiologist or dentist, with the results communicated and integrated into the base hospital's radiology information system (RIS), picture archiving and communications system (PACS) and electronic patient record (EPR) in a timely manner.

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

Medicines

The service did not 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.

Systems and processes to report and learn from incidents to mitigate risks for service users were not fully embedded. There was no evidence of shared learning between reporting radiologists and dentists. This was highlighted in the April 2019 inspection as an area for improvement.

The service did not deal directly with the patient. In the event of a discrepancy with a report they could be notified of a discrepancy or by 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 17 reported incidents from January to September 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 had a business continuity plan to ensure there were processes to ensure it could operate its service with minimum disruption.

Are diagnostic imaging services effective?

We currently do not rate effective for teleradiology services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance. However, policies and procedures were not reviewed and updated, in line with national guidance, in a timely manner.

Policies were referenced against national guidance to ensure they worked in line with legislation, standards and evidence-based guidance. During our inspection we reviewed 16 policies and procedures. However, 10 of these had exceeded their review date. Therefore, we were not assured that policies and procedures were being reviewed and updated, in line with national guidance, in a timely manner.

A number of the policies/procedures were not specific to the service. For example, the 'clinical audit policy' referred to an appendix 5, however this was not included in the body of the document. Another example was the 'teleworker policy and guidelines' where it stated that any issues would be escalated to the IT manager, however the service did not have an IT manager. Therefore, we were not assured that the policies and procedure were specific to the service provided.

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 monitored the effectiveness of care and treatment, however there were no processes in place to share the results widely to improve the service.

Diagnostic imaging

The service had an audit schedule in place. This was an improvement from the last inspection. The service carried out a monthly audit whereby 10% of the reported scans were audited by an independent specialist radiologist. The audit monitored the report structure, content, accuracy and quality of any advice given in the report, for instance, if further imaging requirements were essential. As a part of the audit process, the reporting radiologist issued an addendum when any discrepancy was highlighted by the auditor.

We reviewed the audit results from March 2019 to January 2020. Actions and outcomes relating to the audit results were recorded. We saw that each discrepancy identified had no impact or no significant impact on patient care. We also saw evidence that the referring clinicians were contacted, and an addendum issued in timely manner.

In line with the Royal College of Radiologists (RCR) guidelines, the service had processes to record identified discrepancies from their clients. 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. Areas identified included typographical errors, left and right sides used incorrectly

The service had a policy and process to investigate any discrepancy identified. The policy stated that the identified concern would be overseen by the independent auditor for review and categorisation of error. This would be dealt with by the medical advisor in the absence of any auditor. We saw audited reports regarding discrepancies together with any actions and outcomes. This was an improvement from the last inspection.

As part of the discrepancy investigation process, teleradiologists and dentists are asked to complete personal reflection on discrepancies and adverse events. We saw examples of personal reflection completed by teleradiologists, which was in line with the RCR's "personal reflection on discrepancies and adverse events" form. This was an improvement since the last inspection.

The teleradiologist we spoken with told us that that their work was being audited and confirmed they had received feedback regarding the quality of their work.

We saw that the service had quality assurance processes confirming that these audits were reported back to the referring client as it may affect the onward patient management. This was an improvement from the previous inspection.

In line with the RCR guidance, teleradiology companies should have structured local 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. In the last 12 months the service had held one local discrepancy meeting. The discrepancy meeting was not structured and did not following Royal College of Radiology (RCR) guidelines. There was no evidence of any actions or outcomes to the identified concerns.

Between June and August 2019, eight discrepancies where identified through the monthly audit. At the discrepancy meeting held in September 2019, only one of these discrepancies was discussed. When we spoke to registered manager, reporting radiologists and dentist, we were told that most of these discrepancies were typographical and not clinical and hence were not discussed at the discrepancy meeting. This meant we were not assured that lessons learnt, or any action points were being shared effectively.

At the discrepancy meeting held in September 2019, we were told interesting cases were discussed and shared with those who attended the meeting. However, there was no evidence of the meeting minutes being shared with those who were unable to attend the meeting. Therefore, we were not assured that information from the discrepancy meeting was being shared. This was highlighted in the April 2019 inspection as an area for improvement.

Competent staff

The service did not have effective systems to ensure staff were competent for their roles.

All teleradiologists 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.

Diagnostic imaging

All the teleradiologists that reported for the service were registered with either the general medical council (GMC) or the general dental council (GDC).

We saw that three teleradiologists registered with the GDC had a speciality in radiology. The service provided us with evidence which showed that teleradiologists had completed their continued professional development (CPD) in line with the royal college of radiologists (RCR). We reviewed three records which were dated from January 2014 to December 2018, January 2012 to December 2016 and January 2014 to December 2018 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 teleradiologist to provide evidence of their CPD credits annually in line with RCR guidance.

The systems to monitor contracted staff's training, appraisals, indemnity insurance and revalidation were not effective. Records were not fully complete and there was no evidence of Disclosure and Barring Service (DBS) checks for staff employed by the service. This was highlighted in the April 2019 inspection as an area for improvement.

On the day of inspection, we saw evidence of appraisal and indemnity insurance for one of the reporting radiologists. However, the registered manager had to go through a number of emails to find these documents. Therefore, we were not assured that systems and processes were in place for the registered manager to effectively monitor reporting radiologists and dentists had the correct and up to date paper work in place. This was highlighted in the April 2019 inspection as an area for improvement.

Following the inspection, we were provided with evidence of:

- appraisals in the last 12 months for three out of the six radiologists and dentists that report or audit for Fusion Radiology.
- revalidation for two out of the three reporting radiologists. (Revalidation was not required for GDC registered radiologists as the GDC oversaw and ensured their dentists were registered and fit to practice).
- indemnity insurance for all reporting dentists and radiologists.

The registered manager as the responsible officer for the service confirmed they did not have meetings with the contracted teleradiologist's corresponding responsible officer to discuss competencies, mandatory training, appraisals and revalidation where appropriate. This meant that we could not be assured of the service's oversight of contracted staffs' competencies. However, teleradiologists we spoke with confirmed that they had been requested to provide evidence of their annual appraisal.

The service employed a part time marketing executive. The service did not have a structured induction process. The registered manager told us that they trained the administrative staff on the job to ensure they were competent and had the appropriate and relevant skills including good communication and knowledge of information technology and systems. The administrative staff was also provided with training in general data protection regulation (GDPR).

Multidisciplinary working

Staff worked together and supported each other as a team to provide good care.

Due to the nature of the service, and teleradiologists working remotely, there was very limited contact with each other. However, the teleradiologist we spoke with said that they were able to contact the registered manager and raise any issues or concerns with them.

Reporting radiologist and dentist would follow up their written report with a phone call or email to the registered manager if any concerns or issues identified. The teleradiologists we spoke with told us that all communication to the referring clinicians went through the administration team.

Diagnostic imaging

The teleradiologist also reported that they have developed good relationship with the referring clinicians by making themselves available for discussions if there were any concerns with the written report and ensuring a better outcome for patients.

Seven-day services

The service did not provide a seven-day teleradiology service.

The service worked Monday to Friday 9am to 5pm. However, the teleradiologists we spoke with confirmed they often worked weekends which fitted in with their substantive roles.

The registered manger told us that the teleradiologists had access to their mobile phone should they require support, or any concerns were to be raised at the weekends. This was confirmed by the teleradiologists we spoke 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 and Mental Capacity Act

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. Teleradiologists confirmed that consent was identified on the referring paperwork.

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 have not rated it.

Service delivery to meet the needs of local people

The service did not see patients and patients did not visit the premises due to the nature of the service provided. However, they ensured that the service delivered met the needs of clients using the service.

The service worked Monday to Friday 9am to 5pm. However, the teleradiologists we spoke with confirmed they often worked weekends which fitted in with their substantive roles.

Meeting people's individual needs

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

Access and flow

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

Although the service did not deal directly with patients and was not involved in making care and treatment decisions, the service provided a panel of teleradiologists that provided a report to support the diagnosis and ultimately treatment and care of the patient in a timely manner.

The registered manager told us, and we saw from the contracts with the NHS trust that the expected turnaround times for reports was seven days from the day images were uploaded on to the image exchange portal (IEP) to the receipt of the report. The service had also had an agreement with private dentists and clients to provide a turnaround of reports within 72 to 96 hours.

We reviewed the turnaround report for the NHS trust from December 2019 to February 2020. In December 2019 there were 50 reports and the average turnaround time was 2.4 days. In January 2020 there were 38 reports and had an average turnaround time of 1.3 days. In February 2020 there were 43 reports and had an average turnaround time of 1.5 days.

We also reviewed the turnaround report from December 2019 to February 2020 for independent dentists and clients. In December 2019 there were 31 reports and the average turnaround time was 2.2 days. In January 2020 there were 55 reports and had an average turnaround time of 2.6 days. In February 2020 there were 54 reports and had an average turnaround time of 2.6 days.

Therefore, we were assured that all reports were being reported and uploaded within the agreed turnaround period for each client group. This was an improvement from the last inspection.

The registered manager monitored and compared the reporting activity list. They reviewed the patient image list with the reported examination list daily and took action on unreported examinations to avoid breaches in turnaround time.

The service used picture archiving and communication system (PACS) which supported teleradiologists to upload and submit their reports safely, securely and on time.

Learning from complaints and concerns

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

The service had procedures in place regarding complaints, comments and suggestions.

There had been no complaints recorded by the service during the 12 months prior to the inspection.

The registered manager told us that if complaints or concerns were raised the issue would be discussed with the party concerned, identify the issue and resolve it.

Are diagnostic imaging services well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as **inadequate.**

Leadership

The service manager had some skills and abilities to run the service, to ensure they provided quality sustainable care.

The service director, who was also the registered manager, ran the day to day business and most administrative duties for the service.

The registered manager said they contacted the teleradiologists and made themselves available to be contacted by telephone and e-mail at all hours on a day to day basis.

The teleradiologists we spoke with said that the registered manager communicated with them through email and was always approachable, efficient and provided support when needed.

We did not see evidence that the registered manager understood the challenges to quality and sustainability, and therefore they did not identify the actions needed to address them.

Vision and strategy

The service did not have a written 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 told us they had not been able to develop the business due to their previous inadequate CQC rating, as it deterred potential clients.

The registered manager also said that the vision was for the service to increase the volume of dental radiology reporting and maintain other reporting areas through new client contracts. This was a work in progress with no identified timeframe for completion. This was highlighted in the April 2019 inspection as an area for improvement.

Culture

The registered manager of the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values

The teleradiologist we spoke with praised the registered manager and felt supported to raise concerns. They told us that the registered manager was open and approachable.

The registered manager told us that they contacted staff working remotely as and when needed. They did not hold team meetings or review the care and welfare of contracted staff.

The service had recently introduced an online forum where teleradiologists can post interesting cases or

discussion topics to ensure staff working remotely interacted with each other. We saw some examples where articles from a peer reviewed journal were submitted for discussion and as a form of information sharing.

The service lacked systems and processes to confirm and review the teleradiologist's annual appraisal. Following the inspection, we were provided with evidence of appraisals in the last 12 months for three out of the six radiologists and dentists. This meant the management might not always have up to date information regarding the competencies of the reporting teleradiologists.

Governance

The systems and processes in place did not effectively maintain the overall governance of the service.

The service had a clinical advisor who provided oversight of the service. We spoke with the clinical advisor who told us that the registered manager would always be in contact if there were any clinical issues or concern. However, there was no specific examples or evidence to confirm the processes in place for any 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. This was highlighted in the April 2019 inspection as an area for improvement.

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

The systems in place to monitor contracted staff's training, appraisals, indemnity insurance and revalidation were not effective. This was highlighted in the April 2019 inspection as an area for improvement.

Records were not fully complete and there was no evidence of Disclosure and Barring Service (DBS) checks for staff employed by the service.

On the day of inspection, we saw evidence of qualification and passport details as part of the recruitment process for the part time marketing executive. However, when we asked to see evidence of DBS check we were only provided with the online update subscription service and not the actual DBS check certificate. Therefore, we were not assured if safer recruitment processes were being followed.

We also found gaps in the oversight for recording mandatory training including safeguarding training completion assurance where staff completed training within their substantive role. This was highlighted in the April 2019 inspection as an area for improvement.

On the day of inspection, we saw evidence of appraisal and indemnity insurance for one of the reporting radiologists. However, the registered manager had to go through a number of emails to find these documents. Therefore, we were not assured that there were effective systems and processes in place to monitor reporting radiologists and dentists had the correct and up to date paper work in place.

The service lacked systems and processes to confirm and review the teleradiologist's General Medical Council (GMC) or General Dental Council (GDC) qualification and revalidation. Following the inspection, we were provided with evidence of revalidation for two out of the three reporting radiologists, indemnity insurance for all reporting dentists and radiologists and evidence of safeguarding training for five out six radiologists and dentists.

Processes to assess, monitor and improve the quality and safety of the service were not embedded. Policies and procedures were not reviewed and updated, in line with national guidance, in a timely manner. At the time of our inspection, there was no evidence of a robust review process of policies and procedures in use. We reviewed 16 policies and procedures, 10 of which had exceeded their review date. For example, the policy for clinical audit was last reviewed in October 2017 with a review date indicated as June 2019. Another one was the teleworker policy and guidelines which was reviewed in February 2018 and didn't have a review by date. However, within the policy it stated that the document should be reviewed annually.

A number of the policies and procedures were not specific to the service. For example, the clinical audit policy referred to an appendix 5, however this was not included in the body of the document. Another example was the teleworker policy and guidelines where it stated that any issues would be escalated to the IT manager, however the service did not have an IT manager. Therefore, we were not assured that the policies and procedure were specific to the service provided.

Inadequate

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 effective processes to manage the risks.

The service did not have effective processes to manage and widely share learning from adverse events, incidents, discrepancies or errors that might occur. In the last 12 months prior to the inspection the service only had one discrepancy meeting to share learning. Therefore, we were not assured that there were procedures to manage risk and improve the performance of the service. This was highlighted in the April 2019 inspection as an area for improvement.

Prior to the inspection the service had submitted a risk register matrix with two items logged. The two risks logged were described as 'wrong body part reported' and 'corrections on request cards not picked up'. We asked the registered manager how risks were put on the register. We were told that the two risks on the matrix were potential risks to the service. At the time of our inspection both risks were closed and, on the matrix, a 'counter action' was logged as 'raised awareness of potential human errors' and 'discussed with clients not to overwrite request cards'. However, we couldn't see how this information was shared and corrective actions implemented to close the risk. Therefore, we were not assured that the service was able to recognise, rate and monitor risk. This meant the service might not identify issues that could cause harm to patients or staff and threaten the achievement of their service.

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

The service reported on turnaround rates and query and discrepancy reports. The service had put processes to assess the data and include any actions and outcomes. This was an improvement from the last inspection.

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.

There was a service level agreement with a third-party company to provide hardware and software infrastructure support, which were available Monday to Friday 9am to 6pm. Teleradiologists told us that they would contact the dedicated service desk telephone number with any systems failure.

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

Managing information

While the service used information well to support its activities using secure electronic systems, the processes to manage this was not fully in place.

The service had an information governance policy in place, which underpinned the confidentiality of information being reported. However, this policy was due to be reviewed in December 2017.

We also reviewed another two policies 'personal and sensitive information handling policy' and 'secure transfer and receipt of personal and sensitive information procedures'. Both these policies were due for a review in December 2019.

Information governance (IG) is the way organisations 'process' or handle information. It covers personal information relating to patients/service users, employees and corporate information. All transfer of data was encrypted or on a secure network between the referrer and service.

The service had made arrangements in place since the last inspection to report and monitor report turnarounds. The service had contractual agreements for the report turnarounds, which was seven days for the NHS trust and between 72 to 96 hours for private dentists and clients. The service had access to report turnaround times to ensure reports were available in a timely manner. We reviewed turnaround reports from December 2019 to

Diagnostic imaging

February 2020, where 100% of reports were with the contracted turnaround time. For this period the service reported on a total of 131 reports for the NHS trust and 140 reports for independent dentist and clients.

The service had put procedures and processes to manage the efficiency of turnaround time breaches, so they could be investigated for the reasons why and followed up. This was an improvement from the last inspection.

Referring clinicians received reports by a secure system provided by an external service who ensured that all data was encrypted. The external service provided monthly and quarterly statements of service use. This information was used by the registered manager to manage the day to day running of the business.

The reports that are sent to the referring clinician clearly identified the teleradiologists completing the examination and issuing the report. Unexpected, significant or urgent findings identified by the teleradiologist were notified to the registered manager who confirmed they forwarded the information to the appropriate client by an e-mail and followed up with a telephone call with the referring clinician.

The service had implemented a flagging system to highlight the urgency of the report. The registered manager would email the referring clinician and follow up with a phone call. We saw that a “read receipt” was requested with all email sent to the referring clinician to verify timely access of the reports with unexpected, significant or urgent findings to. This would eliminate delays in treatment for the patient which could impact on patient safety. This was an improvement since the last inspection in April 2019.

Engagement

The service engaged well with external organisations and had a process in place to receive feedback.

The service had processes to receive feedback from its clients on the quality of reporting. The registered manager told us that they received mostly positive feedback from their clients. Some of the recent feedback received include making amendments to reporting style or format to ensure the referring clinician can easily read and communicate the report.

The registered manager told us that they communicated regularly with their clients to discuss any concerns.

The service had recently developed and implemented an online forum as a platform for reporting teleradiologist to share ideas, concerns or learning.

Learning, continuous improvement and innovation

The service had taken some steps to improve the service however they did not have effective processes in place to manage continuous improvement with in the service.

The service attends events and meetings where they can meet and network with dental practitioners in order to expand the service.

The online forum has given the teleradiologists the opportunity to share interesting cases and learn from them.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that the equipment used by the service are safe for use (Regulation 12 (1)(2)(a)(b)(e))

The provider must ensure appropriate safeguarding policy to safeguard vulnerable service users (Regulation 13 (2)(3)).

The provider must ensure that lessons learnt from incidents are disseminated to staff (Regulation 12, (1)(2)(a)(b)(e)).

The provider must ensure they have effective systems and processes to monitor contracted staff's training, appraisals and revalidation (Regulation 17, (1)(2)(a)(d)(f)).

The provider must ensure effective systems and processes to review and update policies and procedure, in line with national guidance, in a timely manner (Regulation 17, (1)(2)(a)(d)(f)).

The provider must ensure there is an effective governance framework to manage the risk, issues and performance of the service (Regulation 17, (1)(2)(a)(d)(f)).

The provider must ensure Disclosure and Barring Service (DBS) checks are completed for all staff employed by the service (Regulation 17, (1)(2)(a)(d)).

Action the provider SHOULD take to improve

The provider should ensure the provision of discrepancy meetings are fully in line with the recommendations of the Royal College of Radiologists guidance (Regulation 12 (1)(2)).

The provider should ensure that all staff employed by the service has completed safeguarding training (Regulation 13 (2)(3)).

The provider should ensure they have a vision and strategy for the service (Regulation 17, (1)(2)).

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that the equipment used by the service are safe for use. The provider must ensure that lessons learnt from incidents are disseminated to staff. The provider should ensure the provision of discrepancy meetings are fully in line with the recommendations of the Royal College of Radiologists guidance.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider must ensure appropriate safeguarding policy to safeguard vulnerable service users. The provider should ensure that all staff employed by the service has completed safeguarding training.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure they have effective systems and processes to monitor contracted staff's training, appraisals and revalidation. The provider must ensure effective systems and processes to review and update policies and procedure, in line with national guidance, in a timely manner.

This section is primarily information for the provider

Requirement notices

The provider must ensure there is an effective governance framework to manage the risk, issues and performance of the service.

The provider must ensure Disclosure and Barring Service (DBS) checks are completed for all staff employed by the service.

This section is primarily information for the provider

Enforcement actions

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1)(2)(a)(b)(e)**

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (2)(3)**

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17, (1)(2)(a)(d)(f)**