

Cavendish Imaging Oxford

Quality Report

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Date of inspection visit: 21 September 2018, 4
October 2018

Date of publication: 21/12/2018

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

Good



Are services safe?

Good



Are services effective?

Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Cavendish Imaging Oxford is operated by Cavendish Imaging Limited. It provides a private scanning service for patients as part of planned dental work, often for dental implants. The service is on the ground floor and occupies a room within a building used by healthcare professionals. The service's single, combined imaging unit is in a small room in the core of the building, with an adjacent administration area. There is a shared reception area and waiting room, also on the ground floor. There are no overnight beds.

The service provides imaging services for adults, young people and children. It is open approximately four days a month.

We inspected this service using our comprehensive inspection methodology. We carried out the short-notice announced inspection (48 hours) on 21 September 2018. The unit was not operational on the day of our visit, and after our site inspection we gained consent from recent patients to telephone and ask them about their care.

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.

The main service provided was diagnostic imaging.

Services we rate

We rated it as good overall.

- The provider established safe systems for delivering imaging services at this unit. For example, it recruited registered radiographers to deliver the imaging services, and checked their competencies and skills regularly through a systematic appraisal and training programme. Data was stored and transferred securely, using protected, electronic platforms.
- A key aim for the service was to provide a caring, patient-focused service, and the provider sought feedback from patients to help identify improvements. Patients said they were treated with kindness and staff were professional and courteous.
- Staff were aware of policies and procedures for delivering safe care, including those relating to safeguarding adults and children.
- The imaging equipment was maintained and safety tested and the Local Rules defined safe operating procedures.
- There was appointed and accessible safety staff; the radiation protection supervisor, radiation protection advisor and the medical physics expert. The radiographer at the Oxford service was the provider's infection control lead, and was supported to develop this role. There was an audit programme that included image quality control assessments, health and safety and infection control audits.
- The provider's policies and procedures were aligned to the Ionising Radiation (Medical Exposure) Regulations, to promote safe practices.
- There was clear leadership of the service and staff felt supported and able to raise concerns. Issues were reviewed for learning and to improve practices, and staff had regular meetings. These were used for staff to discuss areas for improvement, celebrate successes and learn about any company changes.

Summary of findings

- The unit was located on the ground floor and accessible to people in wheelchairs and for those with a hearing impairment. Patients attended pre-booked appointments, and there was no waiting list.

However, we also found the following issues that the service provider should improve:

- The provider should ensure that patients have access to the complaints process.
- The provider should ensure patients receive information in advance about what to expect.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service

Diagnostic imaging

Rating

Good



Summary of each main service

We rated this service as good because it was safe, caring and responsive and well led. We do not rate effective in this type of service.

The service was operated by a radiographer from the provider's main site in London, approximately 4 days a month

Summary of findings

Contents

Summary of this inspection

	Page
Background to Cavendish Imaging Oxford	7
Our inspection team	7
How we carried out this inspection	7
The five questions we ask about services and what we found	9

Detailed findings from this inspection

Overview of ratings	13
Outstanding practice	27
Areas for improvement	27

Good



Cavendish Imaging Oxford

Services we looked at

Diagnostic imaging

Summary of this inspection

Background to Cavendish Imaging Oxford

Cavendish Imaging Oxford is operated by Cavendish Imaging Limited. The service is in Oxford and serves the surrounding communities within Oxfordshire. It also accepts patient referrals from outside this area.

The service is registered to provide the regulated activity diagnostic and screening and its registered manager has been in post since 2012.

The service specialised in providing cone beam computed tomography (CBCT) and offered panoramic (orthopantomogram, or OPG) dental X-rays of the lower face. It also offered cephalometric X-rays for side views of the face. Dental CBCT is a type of X-ray used to produce three dimensional images of teeth, soft tissues, nerve pathways and bone in a single scan. An orthopantomogram is an X-ray image of the whole mouth, including upper and lower jaw, produced when the X-ray machine moves around the head to provide an ear-to-ear image. A cephalogram is an X-ray of the skull and soft tissues, used to assess the relative position of teeth, jaws, skull and soft tissue.

Patients were referred by dentists, orthodontists and craniomaxillofacial surgeons. The service sent the resulting images to the referrers, however the provider could also offer a reporting service by a consultant radiologist, if this was required.

The service operated an appointment service, on average 4 days a month.

The Care Quality Commission (CQC) report from the last inspection, published in March 2013, showed Cavendish Imaging Oxford met the five standards inspected, taken from the essential standards as described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. The five standards selected for inspection were: respect and involve, care and welfare, safeguarding, safety and suitability of equipment and assessing and monitoring the quality of service provision.

For this inspection, we announced our site visit at short notice (48 hours) on 21 September 2018, in line with our methodology for a service of this size. The service asked recent patients if they would consent for us to phone them after the visit, to speak with them about their experience of care. We carried out these phone calls during week commencing 1 October 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in imaging. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the diagnostic room, administration area, reception area and shared waiting room. We spoke with the registered manager, compliance manager and the radiographer trained to work at this

unit. After the on-site inspection, we telephoned six patients who had received care at the service, and spoke with five. During our inspection, we reviewed five sets of patient records.

Activity (1 September 2017 to 31 August 2018)

Summary of this inspection

- The service provided imaging for private patients. A small percentage of these were children and young people.
- One radiographer was employed by the service at the time of the inspection.

Track record on safety

- zero Never Events
- clinical and non-clinical incidents were monitored at provider level, not by location
- zero serious injuries
- zero incidences of hospital acquired infections (eg Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA) or Clostridium difficile (c.diff))

- zero complaints

Services accredited by a national body:

- The service achieved ISO 27001 accreditation (an information security standard) in June 2016. The most recent annual inspection by the notified body was carried out in June 2018.

Most scans were reported on by the referring dentist. The rest were mostly outsourced to external, UK-based teleradiology services and a smaller number were reported on by a small pool of radiologists, who Cavendish Imaging Limited engaged under practicing privileges.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good



- Staff had completed their mandatory training, and there were systems for monitoring and reporting this. This included safeguarding for adults and children, basic life support, information management and infection control.
- There were policies and procedures to safeguard people from abuse, and staff were aware of these and what action to take.
- The unit was clean and the radiographer at the unit had been appointed the provider's infection control lead to review the infection control policies and procedures.
- There were procedures in place to maintain a safe environment for staff and patients. The imaging equipment was regularly serviced and maintained and there was appropriate signage and lighting to demonstrate a controlled area for radiation.
- The local rules were up to date and available on site, outlining the specific imaging procedures as well as the staff assessed as competent to use the equipment. There was an appointed radiation protection supervisor, a radiation protection advisor and a medical physics expert.
- There was a clear pathway for the radiographer to follow, to ensure they carried out safety checks. These were based on the Society and College of Radiographers' 'Paused & Checked' checklist, adapted for the imaging carried out at this location.
- The radiographer knew how to report incidents, using the provider's reporting system, and observations of concern shown in an image. There had been no incidents relating to significant unintended or accidental exposure to radiation. They were familiar with their duties in respect of the duty of candour.
- There was one radiographer trained to use diagnostic equipment at the Oxford site, which was sufficient for the running of this unit. The provider planned to train additional staff for contingency.
- There were safe systems for receiving and sharing referrals and images. The provider had set up a password protected electronic portal and also used a nationally recognised system, regularly used by NHS trusts.

However

- Some patients could not recall being asked to confirm their identity details.

Summary of this inspection

- Two of the five patients said they could not recall discussing the risks and benefits of the type of radiation imaging provided.

Are services effective?

Are services effective?

- The service's policies and procedures reflected the latest regulations for this specialist area; the Ionising Radiation (Medical Exposure) Regulations 2017.
- The service followed nationally agreed guidance and professional best practice when taking images. They audited their practices to check they maintained high-quality standards.
- The service took part in the provider's audit programme, to monitor the quality of outcomes for patients and standards against best practice.
- The provider offered training for dentists who made referrals to them, in line with government guidance and the European Congress of Dentomaxillofacial Radiology requirements.
- There was an effective audit programme to review the quality of practice. The outcomes of these audits were above the agreed minimum levels and actions for improvement were discussed at team meetings.
- Radiographers had access to training, appraisals and development and their competency was regularly assessed.
- There were systems for staff to work effectively with referrers. They aimed to support a seamless journey for patients through their treatment plan.
- Staff understood and respected patients' choice if they chose not to have their image taken.
- The service carried out scans on children and ensured they were happy to progress with the procedure before they started the scan.

Are services caring?

Good



- People told us they were treated with kindness, courtesy and professionalism. This helped them feel relaxed.
- They said the radiographer explained the procedure and what would happen, which they found reassuring.
- Staff said they allowed extra time for patients with specific additional needs, or anxieties about the procedure.

However

- Patients said they did not receive written information in advance about what to expect.

Summary of this inspection

Are services responsive?

Good



- The premises were accessible. The service enabled patients to receive specialist imaging at a location outside London. It was on the ground floor and could be accessed by people in a wheelchair. There was also a portable hearing loop system for people with hearing problems.
- The provider's website provided information for patients, including what to expect.
- Patients said they were seen promptly and it was easy to get an appointment. Some patients said they appreciated receiving a reminder before their appointment.
- The service had the flexibility to match capacity for appointments against the demand from referrers and patients.
- The provider had a complaints policy and procedure. There had been no formal complaints in the past year.

However

- There was no information about how to make a complaint on the website and we did not observe guidance on how to make a complaint on display when we visited.

Are services well-led?

Good



- There was clear leadership of the service and staff said the registered manager was approachable and supportive. As the radiation protection supervisor and a medical physicist with a doctorate in medical imaging, the registered manager brought skilled leadership to the service. They had appointed a compliance manager to provide additional operational support.
- The provider's annual plan for 2018 outlined the priorities for the year and the staff recognised the company's ethos, to provide a patient focused service.
- The statement of purpose included the aims of the company.
- Staff described the culture of the service as 'like a family', where staff were encouraged to support each other, and raise concerns and suggestions.
- There was a straightforward governance framework. The provider had set up regular weekly staff meetings and quarterly governance meetings to support effective communication and learning. It had introduced an on-line training package and promoted the use of their own style of incident reporting forms. Staff carried out audits of systems and outcomes, and shared results to improve the quality of service.

Summary of this inspection

- There was a risk assessment of the premises and a business continuity plan. There was also a radiation risk assessment for the Oxford location.
- There were secure systems for managing information. The provider had achieved and maintained accreditation with ISO27001 since 2016.
- The service issued emails to obtain feedback from patients and the provider aimed to improve the level of engagement.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are diagnostic imaging services safe?

Good 

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- There was one radiographer training to work at Cavendish Imaging Oxford, and they were up to date with mandatory and statutory training. This included safeguarding adults level 2, safeguarding children level 2, medical emergencies and basic life support, fire safety, infection control and Ionising Radiation (Medical Exposure) Regulations IR(ME)R. The provider had recently adopted an e-learning and development system, specifically designed for healthcare professionals, that included modules in, for example, fire safety, health and safety, information governance and equality and diversity. They continued to use their own training materials for paediatric resuscitation, as they had found this was not available within the on-line suite of training. Algorithms were available on the provider's intranet.
- The radiographer said they could access the on-line courses whilst at the Oxford location, or at the main location in London where they also worked.
- The compliance manager monitored and reported on completion of mandatory and statutory training. Staff knew what training they required.

Safeguarding

- **Staff understood how to protect patients from abuse.** Staff had training on how to recognise and report abuse they knew how to apply it.
- The safeguarding adults and safeguarding children policies were held electronically on the provider's intranet site and could be referenced from the Oxford unit. It included guidance on adult and children safeguarding, as well as topics such as child sexual exploitation, female genital mutilation, modern slavery and human trafficking.
- The radiographer employed at the service had completed training designed for healthcare professionals in recognising and reporting abuse; safeguarding adults level 2 and safeguarding children level 2. They could explain what actions they would take if they had any concerns relating to potential abuse. They had not had cause to raise concerns whilst employed at the service.
- The registered manager was trained to level 3 safeguarding children, to be able to contribute to assessing allegations of abuse.
- There was guidance on who to contact within local safeguarding teams on display within the unit, for easy reference.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Diagnostic imaging

- The unit appeared clean and there were processes in place to maintain a clean environment. There were clinical wipes available to clean the equipment between patients, disposable covers and hand gel.
- Patients said the environment was clean and they had observed the radiographer using the wipes and hand gel. They said the radiographer used personal protective equipment, such as gloves, and disposed of them appropriately.
- The radiographer at the unit had recently taken on the role of the provider's infection control lead. They planned to undertake specific training for them to develop this role.
- The last infection control audit was in March 2018 and showed staff complied with safe practices, for example in relation to cleaning the environment and cleaning between patients. The audit had not identified any areas for improvement.
- There was an infection control policy accessible to staff on the provider intranet. The lead for infection control had been tasked with reviewing and updating this to reflect local requirements based on a review of best practice.
- The radiographer explained they or the patient could stop the imaging equipment at any time, using an emergency button.
- The service held records for commissioning equipment and there was a programme for routine maintenance.
- New imaging equipment had been installed at the Cavendish Imaging Oxford location in February 2018. We saw it had passed its Critical Examination for radiation safety and commissioning assessment, under the Ionising Radiations Regulations 2017 (IRR 2017). The previous imaging equipment had been regularly serviced in accordance with IRR 2017, most recently in January 2018. The reports showed all the safety features and warning devices operated safely.
- At the time of our visit, the current imaging equipment was under repair by the suppliers, having lost communication with the computer. We saw the service reports and repair comments that showed the unit was recommissioned and safe for use.
- Staff said they checked the equipment before each session, which included checking for its calibration.
- The unit did not have protective lead aprons on site, and the radiographer confirmed that relatives or escorts could not remain in the imaging room whilst the scanning equipment was in use.
- To monitor staff exposure to radiation, the radiographer was provided with a radiation dosimeter, which was reviewed and monitored after a 13-week period. The service advised they could also provide pregnant radiographers with a personal real time dosimeter, which would monitor and alert the user to any unintended radiation exposure.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The room for the imaging unit was small, but there was adequate space for the single imaging unit, a patient and a staff member. The room had no external windows and there was a lead-lined sliding door which the radiographer closed and secured whilst the imaging unit was in operation. Staff could maintain visual contact with the patient through the lead-lined window, and if necessary staff and patients could communicate with each other whilst the door was secured.
- There was suitable signage showing the room was a controlled area for radiation. The controlled light sign, on the wall in the administration area, turned on automatically when the imaging unit was in operation, as a safety warning.

Assessing and responding to patient risk

- **Staff reviewed and updated risk assessments for each patient via the referral forms.**
- The unit received referrals from dentists for Cone Beam Computerised Tomography (CBCT), often for treatment involving dental implants. The Cavendish Imaging Ltd referral form included prompts to ensure the referrer had discussed pregnancy risks with the patient, and identified any special needs (such as support with language, mobility or cognition). The

Diagnostic imaging

referral form included details of the type of image required and the purpose of the scan. This was to ensure the type of scan was appropriate for the investigation or examination required.

- The referral form also required referrers to state the software options for the CBCT scans they required, as well as their preferred method for receiving the image. This was to facilitate communication and minimise the risk of having to repeat scans unnecessarily.
- The referral form also required referrers to state whether they required Cavendish Imaging Ltd (CIL) to carry out radiological reports. If this was the case, the referrer was required to include the patient's medical history, in line with IR(ME)R regulations. CIL offered a contracted-out consultant radiology service if this was required by the referrer.
- The radiographer at the Cavendish Imaging Oxford described the patient pathway as a 2-stage process, intended to reduce the risk of errors. They said they carried out a six-point check of patient identity, discussed and confirmed the area to be scanned, and obtained patients' verbal consent. They checked patients removed jewellery and verified pregnancy status as appropriate.
- When we spoke with patients, four of the five we spoke with could not recall being asked to give their full details for an identity check. The provider informed us it was their policy for all patients to have their identification checked prior to an image being taken. We were unable to observe any direct patient interaction and we therefore asked the patients we spoke with by phone about this aspect of their care. These interviews took place some time after their appointment and these details may have been forgotten.
- The radiographer said they set the equipment to carry out imaging in line with the referrers instructions, with the aim of minimising the need for unnecessary, additional scans that would increase the patient's exposure to radiation.
- The service had adopted the Society and College of Radiographers 'Paused & Checked' approach to carrying out diagnostic imaging, and adapted it for their specific purposes. The 'Have you "paused and checked"' checklist' prompts staff to check for five key elements of the imaging examination. These are the Patient, Anatomy, User, System & Settings, and the End of a procedure. Some aspects of this had been carried out prior to the patient arriving at the service. For example, the referring dentist assessed the suitability of CBCT imaging and including the details of images required on the referral form.
- Some of the patients we spoke with said they had not discussed the relative risks and benefits of procedures with either their dentist or with the radiographer. Others said the Cavendish Imaging Oxford radiographer had described the radiation levels in a way they could understand.
- If the radiographer observed areas of a scan that could indicate concerns, they contacted the referrer directly, to explain their findings. The radiographer outlined a case where they had done this, having identified possible sinus issues from an image. They explained what they had observed to the patient and advised them they would contact the referrer for a full assessment of the image.
- We saw the service had up to date local rules (May 2018) that described the safe operation of the specific item of equipment, who may operate the equipment and the name of the radiation protection supervisor. The service's registered manager was the radiation protection supervisor (RPS), and they had received their last update training in May 2018. Their role was to ensure the service's compliance with the Ionising Radiations Regulations 2017 (IRR2017) to support safe working practices. The radiographer employed at Cavendish Imaging Oxford said their RPS gave them the support and training they needed and attended the Oxford service regularly. The radiographer was also booked to attend training to become the RPS at the service.
- The service used an experienced and competent radiation protection advisor (RPA) to provide advice on compliance with the IRR2017. There was an appointed medical physics expert.
- The radiographer understood their responsibility to report any significant unintended or accidental exposure to ionising radiation. The RPS and

Diagnostic imaging

compliance manager knew that if an exposure level had been too high, they needed to report this to the Care Quality Commission. This type of event had not occurred at this location.

- If a patient became unwell whilst at the service protocol was to call emergency services. All staff were trained in basic life support. The provider's medical emergency policy and procedure (August 2018) outlines actions to take should a person become unconscious, or have a seizure.
- The basic life support training included cardio pulmonary resuscitation in cases of cardiac arrest adult, children and babies, fainting and collapse (recovery position) in adult children and babies, anaphylaxis, and choking in adults and children. The Oxford location had set up a memorandum of agreement with neighbouring providers of healthcare on the premises to assist with medical emergencies.
- The radiologist selected diagnostic reference levels for adults based on recommended settings, with levels for children based on their size.
- There was a dose checklist for children as well as adults showing they were monitoring the radiation dose for children and diagnostic reference levels.

Radiography staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- At the time of the inspection there was one radiographer trained for providing services at the Oxford location. This was sufficient since the unit opened on average four days a month. The provider intended to train further staff in the use of the equipment at Cavendish Imaging Oxford, to provide staffing contingency.
- The provider did not use agency staff. If the trained radiographer was not available, the service did not plan lists for that day. The service reported 12 procedures delayed in the 12 months to 1 September 2018 due to staff availability.
- The recruitment process for the radiographer included employment checks to ensure they were safe and

suitable to work for the organisation. For example, there was evidence on their recruitment file of identity checks, a Disclosure and Barring Service check, registration with the Health and Care Professional Council (HCPC), clinical references and professional indemnity. The radiographer had completed a structured induction programme, which included use of equipment and the office systems as well as the referral and reporting processes.

- There were always other staff within the building, not employed by the provider, when Cavendish Imaging Oxford was open, should the radiographer need to call for assistance. These included the receptionist and other healthcare professionals. This arrangement had been reviewed as part of the unit's risk assessment.
- The radiographer could access the RPA for advice, or the referring professional if they had queries relating to the image request.

Records

• Staff kept records of patients care.

- Referral information was received electronically or by post. Referrers entered their referral details onto the provider's portal and information was logged against patients' individual details. The radiographer sent the images back to the referred via the portal and/or by post and on CDs.
- Patient records were stored on an electronic record system. The records included details of patients and their referrers, their checked pregnancy status and an event log. The event log showed actions taken by the service such as at the booking, scan and image-upload. Care records were shared with the referrer.
- Access to the service's electronic systems was password protected for security.
- The radiographer delivered the image as soon as practical after completing the scan, and within 24 hours.

Medicines

- Staff did not store or administer medicines from this service.

Incidents

Diagnostic imaging

• The service managed patient safety incidents well.

- Staff were encouraged to report all incidents, concerns and complaints using the Good Observation and Learning Forms (GOLFs), introduced in May 2018. Staff submitted completed forms to the compliance manager for review, rating and, where appropriate, shared learning. The radiographer could describe the process but said as a relatively new employee, they had not had cause to submit a GOLF relating to a safety incident.
- The provider used information from the GOLFs to identify and address areas to improve patient outcomes. For example, the provider reviewed these forms and found an emerging trend that patients did not always receive their images as agreed. This issue was raised with radiographers at their meetings, to improve procedures.
- Incidents were not associated with specific locations, and the data on incidents we received for this inspection reflected incidents reported across the provider's five locations. The organisation took this approach as staff could potentially work across different sites and learning could be shared more effectively. However, this meant we could not review specific incidents relating to the Oxford location.
- The registered manager explained that when incidents occurred relating to radiographer procedures, they also provided individual support and tailored this support to the person's specific needs. They outlined an example of how they had implemented this approach following a trend of wrong side scanning by a staff member not at this service.
- Across the provider, there had been 22 incidents reported in June 2018 and 18 in May 2018. These incidents included, for example, delays in emailing information to patients and data protection incidents. The incidents were categorised for type, such as administrative procedures, radiographer procedures or website functionality, and then risk rated. We saw evidence from minutes of meetings that incidents and trends were discussed at the weekly meetings to promote improvement.

- An example of learning from incidents included the introduction of a daily email checklist, to reduce the risk of missed communications.
- There had been no incidents that required reporting to bodies such as the Ionising Radiation (Medical Exposure) Regulations (IR(ME)) or the information commissioner.
- Staff were familiar with the need to offer an apology where necessary, and with the principles of the duty of candour. The compliance manager reviewed GOLF reports and checked whether the duty of candour was applicable.

Are diagnostic imaging services effective?

Evidence-based care and treatment

- **The services provided care and treatment based on national guidance evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- The service based its policies and procedures on the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017), and had adopted aspects of the 'Paused & Checked' checklist to enhance consistency of safe practice. The local rules were up to date and reflected the equipment, staff and practices at this location.
- The provider's policies and procedures were subject to review by the radiation protection advisor and the medical physics expert, in line with IR(ME)R 2017 requirements.
- The service followed nationally agreed guidance on diagnostic reference levels, for adults and children, when taking 2D x-ray images. They applied recognised best practice standards for CBCT, as recommended by the radiation protection advisor and medical physics expert. They audited these levels to check they maintained high-quality standards.
- Staff had access to policies and guidelines via an online portal. There were processes for regularly reviewing and updating policies.

Diagnostic imaging

- The provider offered Core Training Programmes in cone beam computed tomography (CBCT) radiography for the dentists who referred or reported on CBCT scans. This was in line with government guidance and European Congress of Dentomaxillofacial Radiology requirements, and promoted safe practices in patient referrals.

Nutrition and hydration

- Patients could access water from the reception area. Patients told us they were aware of this.

Pain relief

- Staff did not provide pain relief to patients. There was information on the website assuring patients that they would not feel any pain as a result of the procedures.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the finding to improve them.** They compared results across their services.
- The service had implemented a programme of audits, that included audits relating to patient outcomes, such as radiation safety and imaging examinations. Audits were discussed at team meetings.
- The service carried out the child protocol audit in December 2017, to ensure radiographers were using the correct settings to minimise children's exposure to radiation. Results of the audit showed that out of 12 children audited, staff used the correct parameter of reduced dosage to minimise the children's exposure in 11. The one case where it was not used was documented in the notes. The audit concluded staff were aware of child protocols but highlighted areas of improving documentation.
- A wisdom teeth audit carried out in March 2018 showed staff were familiar with and applied the agreed examination protocols.
- The six-monthly radiation safety audit for January to June 2018, across all locations, showed 99% of 2-dimensional orthopantomogram and cephalometric scans were graded as 'quality control 1' (QC1), meaning no errors of exposure, positioning or processing, against a target of not less than 70%. Audit results showed reasons for any radiographs that were rated 'QC2' (acceptable, but some errors) or 'QC3' (where

the radiograph was diagnostically unusable), and these mostly related to positioning. For CBCT, 98% of scans were graded QC1, against a target of not less than 95%.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staffs work performance and provided support.
- The staff using the equipment was a trained radiographer, with a Health and Care Professional Council (HCPC) registration. They were booked to complete an update in IR(ME)R and IRR in November 2018. Staff understood their responsibility for continuous professional development and knew how to access courses.
- They had received training on the use of the scanning equipment and the Cavendish Imaging Limited office systems, as part of their induction programme, and the RPS had assessed their competency. Staff files included competency sign-off sheets.
- Staff had regular informal and formal meetings with the registered manager and Cavendish Imaging Limited had implemented a formal appraisal system. This was a two-way process with staff and their manager discussing aspects of performance, such as attendance and attitude as well as developmental objectives.
- Radiography staff completed the same basic training, so they could work at the provider's different locations. At the time of the inspection, only one radiographer had completed training on the equipment at the Oxford location, however the provider planned to train another radiographer to provide a backup staff member.

Multidisciplinary working

- **Staff worked together as a team to benefit patients.**
- Staff at the service aimed to work closely with the patients and referrers to support a seamless treatment pathway. If they identified concerns from scans they

Diagnostic imaging

escalated them to the referrer and had access to radiological support through their radiology protection supervisor and the radiology protection advisor.

- The provider offered different systems for sharing scan results with referrers, to promote better joined up working. For example, they checked what software options different providers used and what they required in terms of view. They shared images via their own website, a national electronic portal used by many trusts in the NHS, or by CD.

Seven-day services

- The service operated approximately once a week. The specific date was planned and communicated to staff and referrers about a month in advance.
- There was no requirement for the service to offer emergency scans or a walk-in option at this location.

Health promotion

- The service did not provide a role in health promotion.

Consent and Mental Capacity Act

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**
- Staff understood their responsibility to gain consent from patients before they took a scan. They recognised and respected a patient's choice if they chose not to have a scan when they arrived for their appointment. Staff stated their priority was to ensure a good patient experience and this was a key part of the Cavendish values.
- Staff informed us they explained imaging procedure to patients and obtained verbal consent before proceeding.
- The service was registered to treat children. In practice, they treated children and young people who, after discussion, could consent to having the scan taken without needing parental support within the treatment room.
- Staff were aware about their responsibility in relation to patients who lacked mental capacity. They said they would normally receive information in the referral

form about a patient's capacity, and they understood the Mental Capacity Act 2005. They had not had experience of supporting a patient assessed as lacking capacity to make decisions about the imaging procedure.

Are diagnostic imaging services caring?

Good 

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness
- People told us they were treated with kindness and courtesy. They commented that the radiographer and receptionist were professional, polite and had made them feel relaxed.
- Staff said they shared the service's philosophy of 'give the love', to consider the needs of patients as though they were a close relative, and to provide a caring experience.
- The radiographer said they allowed additional time for patients who had specific needs or anxiety about the procedure. They felt this was appreciated.

Emotional support

- **Staff provided emotional support to patients to minimise any distress.**
- When patients arrived for their scans, their treatment options had already been discussed with the referrer, who noted any specific issues relating to a patient's medical history or needs on the referral form. We were told that staff in the central administration role telephoned patients if the referral form indicated there might be a requirement for additional support for the procedure.
- Staff offered a personal approach to their care, and helped patients to relax if they were anxious.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care.**

Diagnostic imaging

- We spoke with patients by telephone, some days after their care, about their experiences at Cavendish Imaging Oxford. Patients said they felt involved in the process and staff were professional and explained the procedures and what they would experience.
- Three patients said the radiographer had described the radiation levels in a way they could understand, however some of the patients we spoke with said they had not discussed the relative risks and benefits of procedures with either their dentist or with the radiographer.
- Most patients understood the payment options and cost of their procedures. However, one of the five people we spoke with said they had not fully understood the costs before they attended.
- When we asked patients about their care, two patients said they could not recall any discussion relating to the risks or consequences of the procedure with their dental referrer or at the service with their radiographer. We did not observe direct care, and we spoke with patients some time after they had attended for their procedure. Patients said although they did not have any concerns about receiving a scan, they were not signposted to any information about the imaging process, such as leaflets, whilst at the service.
- The provider was proud of its customer service and we were told they offered patients a copy of their scans if they, or their referrer, requested one, at any time after they had taken the image.
- The equipment onsite enabled the service to offer special X-rays of the lower face, teeth and jaws, most often for orthodontic purposes.
- Having been greeted by the receptionist, patients had access to a waiting area shared with other health professionals occupying the premises. There was a water dispenser and disposable cups in reception.
- There were toilets, including a toilet for the less able, and handwashing facilities on the ground floor adjacent to the unit.
- The stairs to the staff room were in the administration area, however staff said this was rarely used during the time the unit was receiving patients. Patients said their appointments had not been interrupted by healthcare staff accessing the stairs.
- The provider's website provided useful information about the service and the referral process.

Meeting people's individual needs

- **The service took account of patients' individual needs** and put them at the heart of services.
- There was a hearing loop facility in the unit to support patients with hearing difficulties. The provider could provide large print literature on request.
- The imaging equipment was located on the ground floor, and the service advertised it could provide a ramp for the entrance steps if necessary for access. There was information about wheelchair access on the website, which stated wheelchairs could usually be positioned in front of the imaging equipment.
- The provider's website included a section on frequently asked questions, such as how long to expect to wait, what will happen during the scan and the typical radiation dose.
- Staff said they could provide translation services when required. They asked information about people's specific needs on the standard referral form, so that clinicians making the referral could outline any special requirements.
- The service offered patients, as well as their referrers, copies of any scans taken, so they had their own records for future reference.

Are diagnostic imaging services responsive?

Good 

Service delivery to meet the needs of local people

- **The provider planned and provided services at this location in a way that met the needs of local people.**
- The provider's main base was in London, and this service in Oxford extended choice for patients and referrers.

Diagnostic imaging

- Patients told us they had found parking nearby, or used public transport. Two patients said they would have appreciated more guidance on where to park.
- Patients said they knew what to expect from their appointment. However, they did not recall seeing information leaflets on display or being offered any information to read. When we visited, we observed the unit had leaflets available to help explain the risks and advantages of different types of diagnostic imaging to patients.

Access and flow

• **People could access the service when they needed it.**

- The service offered appointment-only scans, usually through referral from a dentist. It did not take NHS referrals. Staff at head office prepared the list of patient appointments in advance, following contact with referrers and patients as necessary, to arrange suitable appointment times.
- The referrals to Cavendish Imaging Oxford were received and managed by a central administration team based in London, who contacted individual patients or their dentists, to agree the time, date and location for appointments. They also liaised with the referrer for further information if necessary. Some patients said they had receive calls from Cavendish, but others relied on information from their dental referrer regarding the appointment details.
- All referrals and communications were directed through the provider's head office. This avoided the risk of unanswered calls and minimised the risk of missed appointments. Some patients told us they had received a reminder about their appointment which they appreciated.
- The service did not have a waiting list and could increase capacity to meet demand. The provider could offer patients alternative locations for their scans. For example, when we visited this service in Oxford, the equipment was not in use, and patients had been offered options to receive the diagnostic imaging from an alternative centre or on an alternative date.

- People told us they did not spend long waiting for their appointment, and the environment was comfortable and welcoming. They said the appointment system worked well.
- The service reported there had been 12 delayed procedures for non-clinical reasons in the 12 months to 1 September 2018. This had been due to staff availability. At the time of our inspection, there was a fault in the equipment at Cavendish Imaging Oxford and the service had cancelled procedures. The registered manager explained how they had managed the situation, offering options and apologies to both patients and referrers.
- The provider organised appointment availability to meet referral demand, by adding extra days as required. Referrers requested imaging to be scheduled in alignment with treatment plans.
- The radiographer at Oxford made the image available on the referrer portal on the day the image was taken.

Learning from complaints and concerns

• **The service investigated concerns and complaints and shared lessons learnt with all staff.**

- There had been no formal complaints in the 12 months to September 2018. It had received three compliments.
- The provider had a complaints policy (last reviewed August 2018) that included reference to being open and transparent with people when things went wrong, and complying with the Duty of Candour.
- Complaints were managed in line with the incident reporting policy, so that staff logged and notified the compliance manager any concerns raised by patients or their relatives/carers. Staff were required to read all policies and there was a system for monitoring this.
- The unit had a feedback box for patients for give their comments in the waiting room. We were told that after their appointments, the service also sent an automatic email to patents, asking for feedback. One patient told us they had tried to complete this, but could not upload their finished response.

Diagnostic imaging

- The complaints policy differentiated between formal and informal complaints, with defined timescales for the provider to acknowledge and respond to formal complaints.
- We did not observe any complaints leaflets on display when we visited, although the provider informed us information on how to make a complaint should be on display. The Cavendish Imaging complaints process was not available on their website.

Are diagnostic imaging services well-led?

Good 

Leadership

- **Managers had the right skills and abilities to run a service providing high-quality sustainable care.**
- The service's registered manager was also the managing director of the company and the registered manager of the provider's other four sites.
- The registered manager was the radiation protection supervisor (RPS) of the Oxford location, however the radiographer at Oxford was due to receive training to become the RPS in November 2018.
- Staff said the registered manager was approachable and supportive, and visited the location regularly, about once a month.
- The registered manager had been in place since the service was first registered in 2012 and was a medical physicist by training. She held a doctorate in medical imaging, maintained her registration as a clinical scientist and had a master of business administration qualification. She had a passion for providing a high standard of service for patients and encouraging high standards amongst the provider's staff team.
- The company had recently employed a compliance manager to support the registered manager with the governance and management of the services.
- The company's clinical director was a dental surgeon specialising in implant treatments for patients.

Vision and strategy

- **The provider had aims and plans for the service.**

- Cavendish Imaging Limited had developed an annual plan for 2018, which summarised priorities for the year. These included increasing patient feedback and quality assurance capacity, training staff in line with guidance from their radiation protection advisor and providing educational courses to dentists on referring and reporting on CBCT.
- Their statement of purpose stated that Cavendish Imaging Limited aimed to provide high quality specialist imaging services to all patients. Their key objective was to put state-of-the-art imaging equipment to the service of the patient and referrer and provide a smooth service for both the patient and the referrer. They aimed to use evidence-based guidelines, comply with radiation safety regulations and provide helpful, consistent and clear documentation.
- Staff recognised the key organisational value was to provide a patient focused service. They quoted their philosophy of 'give the love', to consider the individual needs of each of their patients.

Culture

- **Managers and staff promoted a positive culture, creating a sense of common purpose based on shared values.**
- The staff working at the Oxford location also worked at other centres. The culture of the organisation aimed to be one of a close-knit, professional team striving to develop staff and systems to deliver improved patient care.
- Staff said they enjoyed working in the organisation, and it felt like a supportive, cooperative 'family'. They said they could ask questions, raise concerns and were respected.
- Cavendish Imaging Limited operated a No Blame culture and had a whistleblowing policy.
- The radiographer at Cavendish Imaging Oxford said they knew how to report incidents, and would feel comfortable doing so, although they had not done so as they were relatively new. They recognised their responsibility in relation to the Duty of Candour.
- The radiographers had weekly meetings and this helped them understand the organisational priorities

Diagnostic imaging

and how to improve their service. The organisation had recently experienced a significant level of staff turnover and the focus was to improve communication through regular team meetings and briefings. These were used to promote an open and honest reporting culture.

- The provider had set up systems to support staff with training and development. The radiographer at the Oxford service had been appointed the infection control lead, and the provider was planning support to enable them to have protected time for this role.

Governance

- **The provider systematically improved service quality and safeguarded high standards of care.**
- The provider had recently appointed a compliance manager to implement a formal governance system. At the time of the inspection, they had focused on policy reviews, incident reporting and rolling out an audit programme for the year.
- The policies were available on line for staff to read and there was a system to monitor and highlight when staff had read the policies. The provider had introduced an on-line learning platform and monitored staff training.
- There was a programme of weekly staff meetings. These were documented and available on line for all staff to read and review. The meeting minutes showed staff discussed the Good Observation and Learning Forms (GOLFs) following local incidents, any learning points, and created action plans. For example, the service had adapted the Paused and Checked checklist and the reasons for this were discussed at the meetings to improve standards.
- The provider held and quarterly governance meetings. These followed a standard agenda and issues discussed included staffing, radiography practices, patients and organisational matters.
- In addition, the provider communicated changes in legislation, such as the IR(ME)R regulations and the General Data Protection Regulation (GDPR) with staff. Cavendish Imaging Limited required their radiology contractor to confirm compliance with the GDPR.

Managing risks, issues and performance

- **The provider had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- Cavendish Imaging Limited's risk management policy (August 2018) outlined the use of audit, incident reporting, risk registers, benchmarking and impact assessments as assurance of safety and quality service provision. The provider had employed a compliance manager in 2018 to have oversight of the risk register.
- The risk assessment for the Oxford location (no date) covered hazards and precautions in relation to a range of factors, including abuse, infection control, electrical safety, fire safety and substances hazardous to health. Where relevant, the service had received evidence of assurance from their landlord of, for example, regular fire inspection, insurance and water testing.
- The provider had carried out a radiation risk assessment specific for the Oxford location, which was within their radiation file. This covered the application of the Ionising Radiations Regulations 2017 to work with dental and medical X-ray equipment.
- The provider had systems to monitor performance, including incidents (through GOLF reports), patient feedback, audits and staff appraisals. These systems highlighted areas of good practice and opportunities for learning.
- Some areas for improvement had still to be implemented. As a result of a review of patient feedback, between January 2018 and June 2018, the provider planned to implement a systematic way of emailing patient information leaflets with all booking confirmations.
- The audit programme showed a breadth of audits planned for the service. This included an 'audit of audits', to review the plan, learning and opportunities from the audit process.
- The GOLF reports provided routes for identifying staff performance and patient experience, as well as incidents. The provider had identified a backlog in reviewing these reports and had implemented a plan to clear this by the end of 2018, and use the findings for a comprehensive performance review.

Diagnostic imaging

- There was a business continuity policy which highlighted key hazards and mitigations, contact details and relevant staff and an emergency response checklist. These risks were general risks, as opposed to ones specific to the Oxford location.

Managing information

- **The provider collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.**
- The service provided electronic access to diagnostic results, via the provider's password secured portal. This supported a safe, quick exchange of images and referral forms.
- Staff reported good access to this system from the Oxford location, as well as good access to online resources provided by Cavendish Imaging Limited, such as training packages and policies.
- The provider was signed up to a national electronic portal, used widely in the NHS, to support the safe and secure transfer of images without the need to create CDs. They could transfer images securely by other systems including via CDs sent by secure mail.
- The service had been accredited by ISO 27001, a specification for an information security management system (ISMS). This provided a framework for organisational policies and procedures including information risk management processes.
- The provider had addressed the needs of the General Data Protection Regulation (GDPR), implemented in 2018, and was GDPR compliant.

Engagement

- **The provider engaged with patients, staff and referrers to plan and manage appropriate services.**
- The provider said they had set up a system for emailing patients after their appointments to request their feedback on the quality of service. This was monitored and reported on. Results showed there had been about 30 responses. Not all the patients we spoke with had received these emails, however the

provider was aware that some patients did not provide email contact details. One patient said they could not submit their completed form, which they attributed to a system error.

- The radiologist commented that Cavendish Imaging Oxford had recently received a significant number of positive patient reviews and they were proud of this feedback.
- From the patient audit carried out between January 2018 and June 2018, the provider-wide patient satisfaction levels were high, with the highest scores received for staff. Lowest levels of satisfaction related to information, and this had been identified as an area for development in the 2018 action plan.
- Staff gave their own feedback informally, at meetings and through the appraisal process. The radiographer had requested improved IT equipment at the Oxford location, and was pleased that the provider had installed a new computer with a higher specification as a result.
- Feedback from referrers was captured in GOLF reports. For example, referrers highlighted any miscommunications or failings to upload images onto the portal.
- In addition, the provider employed a referrer liaison lead, to engage with referrers, address their issues and develop the service accordingly. Cavendish Imaging Limited also offered face to face training sessions with referrers to understand the type of support they wanted from the service.

Learning, continuous improvement and innovation

- **The provider was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- The provider offered training and technical support to referring dentists on the software to view the cone beam computed tomography (CBCT) images, referral criteria, regulations. This was to support improved understanding of CBCT, practices and communication, and to minimise radiation exposure to patients.
- The clinical director contributed to the national guidance for use of CBCT scanners in dentistry.

Diagnostic imaging

- The provider had invested in an online training portal for staff to access a range of courses included those required for mandatory training.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that patients have access to the complaints process.
- The provider should ensure patients receive information in advance about what to expect.