Ct Dent Ltd (London)

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?	**Not sufficient evidence to rate**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

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

CT Dent (London) is operated by CT Dent Ltd. It provides a private scanning service for patients as part of planned dental work, often for dental implants. The service operates a flexible online appointment system and walk-in service seeing both children and adults.

It is an independent dental imaging service which provides dental cone beam computed tomography (CBCT) scans (Cone beam computed tomography is a medical imaging technique consisting of x-ray computed tomography where the x-rays are divergent, forming a cone. CBCT are used in treatment planning and diagnosis in implant dentistry).

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 23 October 2018.

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 by this unit was diagnostic imaging.

Services we rate

Overall the service is rated as Inadequate.

Our key findings across all the areas we inspected were as follows:

- There was no programme of mandatory training in key safety areas. which all staff completed, and systems for checking staff competencies.
- Not all staff were trained and understood what to do if a safeguarding issue was identified.
- There was no structured incident reporting system in place.
- The service did not operate safe recruitment processes
- The governance arrangements and their purpose were not applied consistently. The information that was used to monitor performance, make quality improvements or to make decisions was limited.

However, we found good practice in relation to:

- Equipment was maintained and serviced appropriately and the environment was visibly clean.
- The service used evidence based processes and best practice, this followed recognised protocols. Scans were timely, effective and reported on in good time.

  Staff demonstrated a kind and caring approach to their patients, supported their emotional needs and provided reassurance.

We found six breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to need for consent (Regulation 11), safeguarding service users from improper treatment (Regulation 13), premises and equipment (Regulation 15), receiving and acting on complaints (Regulation 16), good governance (Regulation 17). We issued a Warning Notice requiring the provider to comply with the breaches in regulation. These can be found at the end of the report.

Summary of findings

Dr Nigel Acheson

Deputy Chief inspector of Hospitals (London and the South East)

Overall summary

The service was located at Conan Doyle House, 2 Devonshire Place, London. The service undertakes dental imaging services which provide dental cone beam computed tomography (CBCT) scans.

The service had one standalone CBCT scanner and two hybrid scanners which were capable of taking both 2D and 3D images. The service also had an intra oral scanner which enabled the service to produce digital dental impressions.

All staff employed at the unit are employed by CT Dent. The service is open Monday to Friday, 9am to 5pm. The service is not open at weekends. The service operates a flexible online appointment system, dental referrals and walk-in service as well.

During the inspection, we visited the three dental scanning rooms and reception area.

We spoke with four staff including three radiographers and a clerical assistant. We spoke with two patients and reviewed online feedback. During our inspection, we reviewed five electronic records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

The service employed three radiographers, one radiography manager who was the registered manager, and two clerical assistants. The service also operated satellite services at Colchester, Altrincham and Nottingham. These services were managed through the London service.

Track record on safety;

- Zero Never events
- Zero clinical incidents
- No serious injuries
- No incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- No incidences of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of healthcare acquired Clostridium difficile (c.diff)
- No incidences of healthcare acquired E-Coli

Services accredited by a national body:

None

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Diagnostic imaging	Inadequate		Diagnostics was the only activity the service provided.

Summary of findings

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Inadequate

CT Dent Ltd (London)

Services we looked at
Diagnostic Imaging

Summary of this inspection

Background to Ct Dent Ltd (London)

CT Dent began operating on 12th March 2007. The company was created to provide healthcare professionals with quality dental x-ray imaging using the latest technology. The company began with one cone beam CT scanner in 2011 scans (Cone beam computed tomography is a medical imaging technique consisting of x-ray computed tomography where the x-rays are divergent, forming a cone. CBCT are used in treatment planning and diagnosis in implant dentistry). CT Dent has six satellite sites in the UK. These are in Manchester , Birmingham, Nottingham, Bristol, Leeds and Colchester. All these satellite units are managed from London. The London centre is the centralised location of the service with all communication coming through this location, including storage of company documents and the location of the senior management team.

CT Dent is a referral centre and accepts referrals from outside healthcare professionals for dental diagnostic imaging, taking the imaging and returns the results to the referrer. It also supplies radiology reports and more specialist scans.

The Care Quality Commission (CQC) report from the last inspection, published in January 2014 showed CT Dent met the five standards inspection, 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.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in radiological services.

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

We rated safe as 'Inadequate' because:

- The service did not have a process in place to deliver annual mandatory training courses. Staff we spoke with confirmed that they had not received annual mandatory training.
- The service was not meeting intercollegiate guidance: Safeguarding Children and Young People.
- A sink was not infection control compliant and did not have a hand washing guide located above it as a reminder to staff.
- On speaking with the manager of the service it was confirmed that there was no structured incident reporting system in place.
- The service did not operate safe recruitment processes

However we found,

- Equipment was serviced and visibly clean and processes were in place to ensure all items were well maintained.
- Staff reviewed and updated risk assessments for each patient via the referral forms.
- The service had enough staff with the correct, skills, qualifications, training and relevant experience to keep people safe from avoidable harm and to provide the right care and treatment.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs.

Are services effective?

Not sufficient evidence to rate

We do not rate this domain.

- The service based its policies and procedures on the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017). The local rules were up to date and reflected the equipment within the service, staff and local practices within the service.
- We were told and the staff confirmed that they had received training on the use of the scanning equipment and all were Health and Care Professions Council (HCPC) registered and met standards to ensure delivery of safe and effective services to patients.
- Staff demonstrated to us an understanding of their responsibility to obtain consent from patients prior to a scan.

However we found,

- Staff had not received training in the Mental Capacity Act 2005.

- Staff did not receive an appraisal or personal development plan.

The service did not conduct quality audits for images reported on by the dental radiologists in the UK or United States.

Are services caring?

Good

We rated caring as 'Good' because:

- Patients commented that staff treated them well and with kindness. We observed staff treating patients with dignity, courtesy and respect.
- Patients received information in a way which they understood and felt involved in their care. Patients were always given the opportunity to ask staff questions, and patients felt comfortable doing so.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this.

Are services responsive?

Requires improvement

We rated responsive as 'Requires Improvement' because:

- The service did not hold quality documents for these radiologists; such documents would include practising privileges agreement, service level agreements, evidence of indemnity insurance, evidence of appraisal to include scope of practice and maintenance of competency.
- The service did conduct quality audits for images reported on by the dental radiologists in the UK or United States.
- The service did not have a system of recording complaints in place so opportunities for shared learning or for service improvement were lost.

However we found,

- The service was planned and designed to meet the needs of the patients. The equipment onsite enabled the service to offer special x-rays of the lower face, teeth and jaws mostly for orthodontic purposes.
- Patients were seen quickly on the same day or soon after. They were offered a choice of time slot and many were seen via a walk-in service. Reports and images were returned to referring dentists within two days.

Are services well-led?

Inadequate

We rated well-led as 'Inadequate' because:

- The delivery of high-quality care was not always assured by the leadership and governance.

Summary of this inspection

- The service did not have a mission statement which could be displayed within the service or on its website; subsequently staff did not understand the services values.
- The governance arrangements and their purpose were not applied consistently. The information that was used to monitor performance, make quality improvements or to make decisions was limited.

However we found,

- Staff said the registered manager was supportive and was readily available. They all spoke positively about the management of the service.
- Patient satisfaction information was sought from patients via email. This feedback was mostly positive.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Inadequate	Not rated	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Not rated	Good	Requires improvement	Inadequate	Inadequate

Inadequate

Diagnostic imaging

Safe	Inadequate
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

Are diagnostic imaging services safe?

Inadequate

We rated safe as **inadequate.**

Mandatory training

- The provider did not deliver mandatory training in key skills to all staff and made sure everyone completed it.
- The service did not have a process in place to deliver annual mandatory training courses for such things as: fire safety and evacuation, health and safety for healthcare, equality and diversity, infection prevention and control, moving and handling objects and people/ patients, safeguarding adults, safeguarding children level 2, customer care and complaints, basic life support (BLS). Staff we spoke with confirmed that they had not received annual mandatory training. This meant the service could not assure itself that staff were providing safe care to patients.
- We did however see that the service obtained confirmation of professional qualifications for the radiographers it employed.

Safeguarding

- The provider did not have process in place to protect patients from avoidable harm and staff had not ben trained to recognise adults and young people at risk.
- The lead for safeguarding adults and children was the registered manager who was trained to level three and had received this training three years earlier.
- The service had a safeguarding policy in place of which staff could access via its shared internal computer system; however this policy was not in line with current guidance on the definitions of abuse. We were told that only two members of staff were trained to recognise adults and children at risk, the service was unable to provide evidence of this on the day. Staff we spoke with demonstrated an understanding of their responsibilities and suggested that they would report any incidents to the manager. We noted the service did not have a training plan in place this meant that we could not be assured that the service had identified a training need in relation to safeguarding.
- We found that 20% of the people seen at the service were children or it was possible children would be present with parents and relatives when they attended for an image.
- The service was not meeting intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.
- Patient records we reviewed did not contain any markings to inform staff that a person who attended the service may be subject to a safeguarding.
- The manager informed us that any safeguarding incidents reported would be reported back to the referring dentist.
- There were no systems or processes in place in which the service could learn from safeguarding incidents.

- We did not see contact numbers or information available for all local adult and child safeguarding referrals. Staff told us that any incidents would be referred to the manager of the service but were not aware of reporting incidents directly to the local adult and child safeguarding teams.
- Following the inspection the provider informed us of changes it made regarding safeguarding people who use the service.

Cleanliness, infection control and hygiene

- The service had infection prevention and control (IPC) policies and procedures which provided staff with guidance on appropriate IPC practice in for example, communicable diseases and isolation.
- The service was cleaned three times during the week by contract cleaners. Floor space was limited by the storage of boxes and the cone beam quality assurance equipment on the floor in the cone beam CT scan room. When the boxes were moved, there was evidence of dust and dirt behind them. The premises were otherwise visibly clean. Staff told us that deep cleans were carried out monthly although there was no record to evidence this.
- Radiographers told us the radiographic equipment was cleaned daily by the radiographers although this was not routinely recorded or evidenced by a cleaning checklist. Bite sticks were covered by single use bags to prevent cross infection between patients. Chin rests and head grips were wiped with suitable wipes between patients. The staff used hand gel between patients although this was not observed and the staff told us they did not undertake hand hygiene audits to measure compliance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene.' These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients.
- Staff had access to a sink for hand washing in the staff area and in the toilet. We found one sink with paper notes that had been placed behind the pipes running to the sink in the staff area and did not have hand washing guides located above it as a reminder to staff. The taps and sink had visible scale. We found this not to be infection control compliant and was contrary to compliance criterion two, HSCA Act 2008 (Code of Practice on the prevention and control of infections) in that providers need to demonstrate a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. The provider later told us later staff did not routinely use this sink.
- Patients we spoke with were positive about the cleanliness of the unit and the actions of the staff with regards to infection prevention and control.
- Between July 2017 and June 2018 there were no incidences of health care acquired infection in the service.
- The provider's arrangements for managing waste kept people safe. Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.
- The provider has informed us of changes they have made following the inspection regarding its approach to IPC.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The service had three pieces of ionising radiation equipment designed to produce images of the mouth and jaw for dentists and orthodontists. One piece of equipment had quality assurance (QA) undertaken each month and the other two pieces of equipment had QA undertaken three monthly. This was in line with manufacturers recommendations. Equipment was subject to planned preventive maintenance biannually.
- The service held records for commissioning equipment and there was a programme for routine maintenance. Imaging equipment had been regularly serviced in accordance with IRR 2017 with reports showing the safety and warning devices operated safely.
- The service had three rooms available for imaging; each room had sufficient space for a patient and staff member. Rooms did not have external windows and

there was a lead-lined door which was closed and secured when the imaging unit was operational. Staff, if necessary, could maintain visual contact with patients through the window.

- We found that there was suitable signage which informed people that the room was a controlled area for radiation. Each room had a controlled light sign on the wall adjacent to the door. This illuminated when the imaging unit was operational as a safety warning.
- Staff told us that they checked the equipment prior to each session, which included checking for its calibration.
- We saw that there was an emergency button which the patient could use at any time to stop the imaging equipment.

Assessing and responding to patient risk

- Staff reviewed and updated risk assessments for each patient via the referral forms.
- The service received referrals from dentists or people self-referred for Cone Beam Computerised Tomography (CBCT); often this was associated with treatment involving dental implants. The referral form used by the service included prompts for such things as pregnancy and referrers could highlight those people who may have special requirements. Staff told us that they would discuss with the referrer the specific needs (such as support with language or mobility) of those with special requirements.

The system used for patient records was a bespoke system for referral, billing and patient notes. It had in-built checks to remind the radiographer to check patient identification and correct scan prior to progressing to the test. Radiographers described checking identification via: Name, date of birth, referring dentist and scan area.

- The referral form used by the service included details for the type of image required and the scans purpose. This ensured the scan was appropriate for investigation or examination.
- The radiologist selected the relevant diagnostic levels for adults and children based upon recommended settings; there was a dose checklist in place and in use for patients showing monitoring of radiation doses.
- Staff told us that if the radiographers saw some pathology which may they considered to be serious this would be escalated to the manager. If the manager agreed, they would inform the referring dentist or if the scan was due to be reported then the manager would escalate as urgent to the reporting radiologist.
- The manager was aware of the changes to IRMER and IRR in Jan 2018.The medical physics expert team from an acute hospital trust's; 'Radiological Protection Centre', provided radiation protection advice and a nominated radiation protection advisor on compliance with IRR2017.
- The radiation protection advice team had updated the Local Rules for the scanning equipment at the site in 2018.Radiographers told us they had read the Local Rules although this was not documented. The Local Rules were on display in each scan room with a table on the wall indicating estimated dose levels for each procedure.
- Radiographers understood their responsibility to report any significant unintended accidental exposure to ionising radiation. The manager knew that if exposure levels were too high, there was a requirement to report this to the CQC. They confirmed that this type of event had not occurred at the service.
- If a patient became unwell whilst at the service staff confirmed that the protocol in place was to call the emergency services.
- The building had a defibrillator, this was not managed by the service and staff had not been trained in its use. This meant that in emergencies staff would be unable to provide life saving assistance and would be reliant on others in the building.
- We were unable to confirm that staff had received recent basic life support (BSL) training.

Radiography staffing

- The service had enough staff with the correct, skills, qualifications, training and relevant experience to keep people safe from avoidable harm and to provide the right care and treatment.
- On the day of the inspection there was three radiographers and a manager who were all training for

providing services. This enabled staff to see people promptly. The service did not use agency staff and confirmed that no procedures were delayed due to staff shortages in the 12 months prior to the date of the inspection.

- We saw that other staff were available within the service to be able to provide assistance should it be required. We were told, and observed an instance, that radiographers could also access the RPA for advice or the referring dentist if they had queries relating to the image request.
- The recruitment process for radiographers included employment checks to provide assurances that they were safe and suitable to work for the service. These checks included, proof of identity including a recent photograph, a Disclosure and Barring Service (DBS) check, registration with the Health and Social Care Professional Council (HCPC). However, we found that the service had not recorded in radiographers personnel files, such things as employment history, references or evidence of induction.

Medical staffing

- The service did not employ any medical staff.

Records

- Staff kept records of patients care.
- Referral information was received via the services electronic system. Referral details were entered onto the provider's system and relevant information was noted against a patients individual details. Images were returned using this same electronic system.
- Records themselves were stored on the electronic record system and included patient details, referrers, pregnancy status and comments box for radiographers to include any relevant information. The system allowed the storage of scan and image-upload.
- Access to the service's electronic system was password controlled for security. During the inspection we noted however that display screens in individual scanning rooms were not always routinely locked, this meant that we could see from the patient waiting area patient's confidential information, compromising patient's personal information.

Medicines

- Medicines were not stored or administered from the service.

Incidents

- The provider did not manage patient safety incidents well.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses to the manager of the service. Staff told us that there had been up to six incidents during the year, when asked how these were reported they informed us that this would be done either by means of an email to the manager or a handwritten statement.
- The radiographers did not use a defined incident reporting system to record and monitor these incidents. This meant they missed the opportunity to look for themes and trends and work with referrers to drive improvement and keep patients safe from the risk of unnecessary ionising radiation exposure.
- Staff were unaware of the new legislation related to the recording of dose for 'carers and comforters'. The manager told us the dose would be recorded in the patient record but no patient record could be found that had this recorded by the radiographers. There was no audit of this data. The Ionising Radiation (Medical Exposure) Regulations 2017 state that the service should have in place means to record individuals who have knowingly and willingly incurring an exposure to ionising radiation by helping, other than as part of their occupation, in the support and comfort of individuals undergoing or having undergone an exposure.
- On speaking with the manager of the service it was confirmed that there was no structured incident reporting system in place. The manager confirmed that errors occurred but the manager did not equate these with the term 'incidents'. Examples of errors were:
  - Patient attended the service with symptoms of a stroke and required emergency transfer to hospital via ambulance
  - Patient had the wrong scan e.g. upper jaw scanned when the lower jaw was required or vice versa

- Patient image CD sent to referrer with correct PID label but incorrect images and vice versa
- Equipment breakdown leading to patient cancellation (5 times in 12 months)
- Wrong side referral
- Incorrect name in computer system
- Wrong test e.g. orthopantomogram (OPG) instead of cone beam CT (CBCT)

- The manager told us that these errors would be recorded in the service user's clinical record. However, the system in use by the service was unable to produce a report or a list of people who had experienced an incident were comments had been added to their clinical record.
- The manager equated 'incidents' with 'accidents' and showed us paper accident book with one entry from 2013 and three documents from 2013, one 'date unknown' and 2016 describing incidents/complaints that had occurred.
- The manager was unable to describe any process for sharing learning from incidents. Staff told us that there were no formal staff meetings were incidents and subsequent learning were discussed. This meant that if things went wrong reviews and investigations may not thorough enough or recorded appropriately and lessons learned may not be communicated increasing a risk of repeating errors.
- The manager told us he was the lead for 'serious incidents' and in his absence, the operations director who is a dental nurse, provided cover.

Duty of Candour

The provider encouraged staff to apologise when things went wrong and to give patients honest information and suitable support. The provider had a duty of candour policy, which identified when duty of candour should be applied, and the ten principles of duty of candour:

1. Truthfulness, timeliness, clarity of communication
2. Recognising patient and care expectations
3. Professional support
4. Risk management and systems improvement
5. Multidisciplinary responsibility
6. Clinical governance
7. Continuity of care.

Staff were familiar with this policy and had access to it on the intranet. Staff confidently described the principle and application of duty of candour (DoC) in line with Regulation 20 of the Health and Social Care Act 2008. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide them with reasonable support.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

Not sufficient evidence to rate:

Evidence-based care and treatment

- The service provided care and treatment based on national guidance evidence of its effectiveness.
- The service based its policies and procedures on the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017). The local rules were up to date and reflected the equipment within the service, staff and local practices within the service.
- The services policies and procedures were subject to review by the medical physics expert team from St. Georges Hospital'; Radiological Protection Centre, providing Radiation Protection Advice in line with IR(ME)R 2017.
- The service applied the Public Health England guidance on the National Diagnostic Reference Levels when setting their local diagnostic reference levels (DRLs). These were based on national DRLs for dental radiography, for adults and children.
- Staff could access policies, procedures and guidelines via the services internal electronic resources.
- Staff followed NICE guideline QS61, Infection prevention and control – Quality standard 3: Hand decontamination.

- The service offered staff training in cone beam computed tomography (CBCT) for dentists who reported or referred on CBCT scans. This was in line with government guidance and European Congress of Dentomaxillofacial Radiology requirements, promoting safe practices in patient referrals.

Nutrition and hydration

- Patients had access to drinks whilst awaiting their scan.

Pain relief

- Staff did not provide pain relief to patients.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The manager explained the image quality self-audit undertaken by staff on 100% of images. One member of staff confirmed this process and demonstrated it on the system. Staff scored their scans as follows, 2D scans – score 1 – 3 i.e. excellent, acceptable, unacceptable, CBCT – score: acceptable, unacceptable.
- We reviewed the audit results for the period between January 2018 and June 2018. We found that the service had completed 2465 2d scans and 9250 CBCT scans. Of those 382 (3.3%) were repeated due to diagnostically unacceptable image quality. The most common reason for a repeat scan was due to patient movement.
- We found that 76% of images were 'scan only' this meant that the review of the scan would be undertaken by the dentist who referred the patient. 12% were reported on formally by a dental radiologist based in the UK and 12% were reported by a dental radiologist in the United States of America, who maintained an EU-US privacy shield registration which was recognised by the Information Commissioners Office. The policy was available for people to read and published on the website.
- The service did not hold quality documents for these radiologists; such documents would include practising privileges agreement, service level agreements, evidence of indemnity insurance, evidence of appraisal to include scope of practice and maintenance of competency.
- The service did conduct quality audits for images reported on by the dental radiologists in the UK or United States. We were told that the turnaround time for these reports was three to five days. The manager did not know if the reporters participated in discrepancy review. (a process to ensure data that falls outside of an expected range of values or is otherwise flagged during the edit check process as an error.)
- Patient feedback was captured electronically, following an attendance at the service an email was sent to the patient requesting feedback. The manager told us that this was reviewed regularly for London hub and satellite sites. The manager told us that they called dissatisfied service users to try and resolve issues. We noted that the majority of feedback was positive about the staff and the speed of access to the scan.

Competent staff

- The service did have processes in place to demonstrate that staff were competent for their roles
- We were told and the staff confirmed that they had received training on the use of the scanning equipment and all were Health and Care Professions Council (HCPC) registered and met standards to ensure delivery of safe and effective services to patients. Staff told and we saw evidence on internal systems that they were supported in their professional development .
- Both the manager and staff told us that their skills were assessed as part of the recruitment process and during their induction. Following on from this they would have their competency reviewed by the manager as part of their performance management. However, the service did not hold records of recruitment, induction or performance management.
- We were told that the service had informal meetings, which were not documented. This meant that the service lost opportunity for reviewing practice or disseminating information by not having formalised meetings.

Inadequate

Diagnostic imaging

- The manager told us that annually in March; the senior team discussed all the staff amongst themselves and made an assessment of their performance. Staff did not receive an appraisal or personal development plan. This meant that staff did not have a method in place to develop their skills and knowledge within the service.
- Following the inspection the provider has informed us of changes concerning its recruitment processes.

Multidisciplinary working

- Staff worked together as a team to benefit patients.
- Staff at the service worked closely with referrers to provide a seamless treatment pathway. Should concerns be identified these would be reviewed by the manager of the service and escalated to the referrer if necessary. The service could also refer to their medical physics expert team from St George's Hospital St. Georges'; Radiological Protection Centre.

Seven-day services

- The service was open Monday to Friday, 9am to 5pm; it did not provide a service at weekends.
- Appointments were flexible to meet the needs of patients; they were available at short notice.

Consent and Mental Capacity Act

- Staff demonstrated to us an understanding of their responsibility to obtain consent from patients prior to a scan. They told us that should a patient chose not to have a scan this decision would be respected.
- We observed staff informing and explaining procedures to patients and obtaining their verbal consent.
- The service was registered to provide services for children; they told us that they would ensure both the child and accompanying parent had provided verbal consent before any imaging.

  We were told that although the electronic patient record did not contain an area where consent could be marked, it would be recorded within the comments section. We reviewed at random a sample of patient records but we did not see that consent had been recorded.
- We found that staff had not received training in the Mental Capacity Act 2005, this meant that staff were not always aware about their responsibility in relation to adults who lacked mental capacity. They told us they had not had experience of supporting people assessed as lacking capacity to make decisions about the imagining procedure.
- The service did not have consent procedures in place for young people who were presumed to have sufficient capacity to decide on their own medical treatment, and provide consent to treatment, unless there was significant evidence to suggest otherwise. The manager told us that some of their service users were children with autism.
- Staff were unable to tell us about Gillick competence, this is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Following the inspection the provider informed us of changes they made to the recording of consent.

Are diagnostic imaging services caring?

Good

We rated caring good.

Compassionate care

- Staff cared for patients with compassion.
- Patients commented that staff treated them well and with kindness. We observed staff treating patients with dignity, courtesy and respect. We observed staff introduced themselves prior to the start of a patient's imaging scan, interacted well with patients and included patients during general conversation.
- Staff demonstrated a kind and caring attitude to patients. This was evident from the interactions we witnessed on inspection and the feedback provided by patients.
- Staff introduced themselves and explained their role and went on to explain what would happen next.

Inadequate

Diagnostic imaging

- Staff ensured that patient's privacy and dignity was maintained during their time in the service.
- Patient satisfaction was not formally measured although feedback via the service's website showed high levels of satisfaction with the service.

Emotional support

- Staff provided emotional support to patients to minimise any distress.
- We saw that when patients arrived for their scans, their treatment options had already been discussed with the referring clinician, who was able to communicate any needs via the referral form. Staff told us that if needs were identified they would telephone the patient prior to their attendance and provide if necessary support during their attendance at the service.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care.
- Staff communicated with patients so that they understood the reason for attending the unit. All patients were welcomed into the area and reassured about the procedure.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this.
- Patients understood the payment options and the cost of their procedures, we observed staff explaining this to patients.
- Information was available on the service's website explaining the service and referral process.

Are diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement.

Service delivery to meet the needs of local people

- The service was planned and designed to meet the needs of the patients. The equipment onsite enabled the service to offer special x-rays of the lower face, teeth and jaws mostly for orthodontic purposes.
- The service is open Monday to Friday, 9am to 5pm it operated a flexible online appointment system, dental referrals and walk-in service. The service was not open at weekends.
- Access to the service was by way established routes, with bus stops and the London underground short walks away.
- Patients with mobility needs had access to a lift to gain access to the scanning floors and ramps were available to gain entrance to the building.
- Patients were greeted when they entered the service and accessed a comfortable waiting area, there were toilet facilities available for people to use and there were hand washing facilities.
- The service's website gave people useful information about the service it provided, its other sites and the referral process.

Meeting people's individual needs

- There was no hearing loop installed within the service to support patients with hearing difficulties. The provider could provide large print literature on request.
- Imaging equipment was located within the service with itself was located on the second floor of the building; we were told that should people attend with wheelchairs then a ramp would be provided for the entrance for easy access. The lift within the building was too small for some wheelchairs; this meant staff would have to assist the person into the wheelchair they kept in the service. We found that the service could not satisfy itself that the wheelchair had been serviced in line with the manufacturer's recommendations and that staff had received appropriate training in transferring people between wheelchairs safely.

Inadequate

Diagnostic imaging

- Staff told us that they could provide translation services when required; interpreters could be available if the unit was informed prior to the appointment. This requirement would be highlighted on the referral information.
- Staff had not understanding of cultural, social and religious needs of the patient
- All patients received an appointment letter or email and were encouraged to contact the unit if they had any concerns or questions about their examination.

Access and flow

- Patients were seen quickly on the same day or soon after. They were offered a choice of time slot and many were seen via a walk-in service.Reports and images were returned to referring dentists within two days, patients could pay an additional fee for an express (same day) service.
- The service told us that it had upto 8000 referrers are on their referrer database.
- NHS contracts were in place and some NHS patients accessed the service including those on a two week wait pathway (A 'Two Week Wait' referral is a request from a General Practitioner (GP) requesting an urgent appointment, because symptoms may indicate cancer.) The manager told us that these patients were not treated any differently because the time to appointment was so short that a separate pathway was not required. If NHS patients could not be contacted by telephone the staff would send a letter asking them to get in touch with the service to make an appointment.
- If the radiographers saw some pathology which may be serious they escalated this to the manager. If the manager agreed, he informed the referring dentist or if the scan was due to be reported then the manager would escalate as urgent to the reporting radiologist.
- The manager told us some of their service users were children with autism. These children could have additional dental problems due to bruxism (excessive teeth grinding or jaw clenching). The service aimed to prioritise this group to minimise waiting times.

Learning from complaints and concerns

- The service had a complaint policy available for staff to refer.
- The manager told us patients could complain verbally, by email, letter or telephone call or via negative comments in the electronic feedback process. We noted that there was no information available within the service which informed patients of the services procedure toward complaint handling.
- We were told that the service had not received any formal complaints and complaints would be dealt with means of a telephone call to the complainant. We saw evidence where a a patient was inappropriately charged the 'express fee'. The manager apologised to the patient and refunded the fee, the patient was satisfied with the outcome.
- The service did not have a system of recording complaints was in place so opportunities for shared learning or for service improvement were lost.
- Staff were encouraged to resolve complaints and concerns locally or escalate a complainant to the manager of the service The service did not have any information directing people to the Public Health Service Ombudsman.
- Following the inspection the provider has informed us of changes they have made regarding how it intends to deal with complaints in the future.

Are diagnostic imaging services well-led?

Inadequate

We rated well-led as inadequate.

- The delivery of high-quality care was not always assured by the leadership and governance.

Leadership

- The registered manager did not demonstrate an understanding of the requirements of their registered manager registration.
- The services registered manager was also a director of the company and was responsible for overseeing the services other sites.

Inadequate

Diagnostic imaging

- Staff said the registered manager was supportive and was readily available. They all spoke positively about the management of the service.
- The registered manager had been in place since the service was first registered.

Vision and strategy

- The service did not have a mission statement which could be displayed within the service or on its website; subsequently staff did not understand the services values.
- The service did have a statement of purpose however this was not on display within the service for patients to read.
- Staff were invested in the service and committed to providing a patient focused service.

Culture

- The staff we spoke with were very positive and happy in their role and stated the service was a good place to work.
- Staff reported they felt supported, respected and valued by local managers and senior directors. Staff stated they felt empowered to make suggestions, make changes and improvements and this was actively encouraged.
- Staff demonstrated pride and positivity in their work and the service they delivered to patients. Staff were happy with the amount of time they had to support patients.
- A whistle blowing policy, duty of candour policy were in place although staff were unsure that these were in place.

Governance

- The governance arrangements and their purpose were not applied consistently. The information was not always used to monitor performance, make quality improvements or to make decisions was limited.
- There was a limited programme of internal audit to monitor quality and to make quality improvements.
- Staff had no received supervision or appraisal
- The service did not operate safe recruitment processes
- The service was not meeting intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.
- The services monitoring of mandatory training and records were not in place.
- Following the inspection the provider has informed us of changes concerning its governance processes.

Managing risks, issues and performance

- The service had risk assessments in place which covered hazards and precautions in relation to infection control, electrical safety, fire safety and substances hazardous to health.
- The service had a radiation risk assessment specific to the location. This covered the application of the Ionising Radiations Regulations 2017 to work with dental and medical x-ray equipment.
- There was a business continuity policy in place which highlighted key hazards and mitigations this included key contact details but the service did not have a risk register or quality dashboard in place.

Managing information

- Staff could access policies and resource material there were a number of computers in the service. This was sufficient to enable staff to access the system when they needed to.
- All staff we spoke with demonstrated they could locate and access relevant and key records very easily and this enabled them to carry out their day to day roles.
- Electronic patient records could be accessed easily but were kept secure to prevent unauthorised access to data. However, we
- Information from scans could be reviewed remotely by referrers to give timely advice and interpretation of results to determine appropriate patient care.

Engagement

Inadequate

Diagnostic imaging

- Patient satisfaction information was sought from patients via email. This feedback we saw on the internet was mostly positive. People said, ‘time and attention was given’ ‘confidence and trust in staff’ and ‘we were greeted on our arrival’.
- There was little evidence to suggest that the service had utilised the feedback to make positive actions when patients identified a concern.
- The service did not conduct staff satisfaction surveys due to the small number of people employed directly, but we could not identify any methods with which the service obtained feedback from staff.

Learning, continuous improvement and innovation

- The provider offered training to referring dentists on the software to view the cone bean computed tomography (CBCT) referrer training. This course provides the training required to refer patients for CBCT, following HPA-CRCE 010 guidelines and BSDMFR Core curriculum for dentists and dental care professionals.
- The service had been recently shortlisted as a finalist in the dental industry awards 2018 and was developing AI software to teach computers how to automate radiological diagnostics using learning.

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 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Consent Appropriate and accurate information was being effectively recorded in relation to consent. Although the electronic patient record did not contain an area where consent could be marked, it would be recorded within the comments section. We reviewed at random a sample of patient records but we did not see that consent had been recorded. Staff had not received training in the Mental Capacity Act 2005. This was in breach of Regulation 11 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The safeguarding policy in place was not in line with current guidance on the definitions of abuse. Not all staff were trained to recognise adults and children at risk. The service was not meeting intercollegiate guidance: Safeguarding Children and Young People: Roles and

Enforcement actions

competencies for Health Care Staff (March 2014). Guidance states all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers should be trained to level two.

There were no systems or processes in place in which the service could learn from safeguarding incidents.

This was in breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulation 15 HSCA (RA) Regulations 2014

Premises and equipment

There was no recorded evidence of routine cleaning in place.

Staff had access to a sink for hand washing in the staff area and in the toilet. We found one sink with paper notes that had been placed behind the pipes running to the sink in the staff area and did not have hand washing guides located above them as a reminder to staff. The taps and sink had visible scale. We found this not to be infection control compliant and was contrary to compliance criterion two, HSCA Act 2008 (Code of Practice on the prevention and control of infections) in that providers need to demonstrate a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

There was no hearing loop installed within the service to support patients with hearing difficulties.

We found that the service could not satisfy itself that the wheelchair had been serviced in line with the manufacturers' recommendations and that staff had received appropriate training in transferring people between wheelchairs safely.

Enforcement actions

This was in breach of Regulation 15 (1) (a) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints There was no information available within the service which informed patients of the services procedure toward complaint handling. The service did not have a system of recording complaints was in place so opportunities for shared learning or for service improvement were lost. This was in breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance arrangements and their purpose were not applied consistently. The information that was used to monitor performance, make quality improvements or to make decisions was limited. There was no structured incident reporting system in place.

This section is primarily information for the provider

Enforcement actions

The service did not hold quality documents for these radiologists; such documents would include practising privileges agreement, service level agreements, evidence of indemnity insurance, evidence of appraisal to include scope of practice and maintenance of competency.

The service did conduct quality audits for images reported on by the dental radiologists in the UK or United States.

There was a limited programme of internal audit to monitor quality and to make quality improvements.

Staff had not received supervision or appraisal.

This was in breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA (RA) Regulations 2014 Fit and proper person's employed The service had not recorded in radiographers' personnel files, such things as employment history, references or evidence of induction. This was in breach of Regulation 19 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.