Cavendish Imaging Birmingham

Quality Report

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Date of inspection visit: 27 February 2019
Date of publication: 31/07/2019

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Overall summary

Cavendish Imaging Birmingham is operated by Cavendish Imaging Ltd. The imaging centre has one imaging room with one cone beam CT scanner and one other imaging machine capable of producing orthopantomogram (OPG) and cephalometric x-ray images. OPG imaging is mainly used to take panoramic images of the jaw and mouth. Cephalometric imaging is used in the treatment of

Summary of findings

orthodontic conditions, and by ear, nose and throat specialists to image the airway of patients with, for example, sleep apnoea. The service had no beds or operating theatres.

The imaging centre provides diagnostic imaging only.

The service saw several thousand patients in 2018, with a mix of NHS funded and other funded. The service undertakes imaging on all ages of patients, including children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 27 February 2019, giving the provider 24 hours notice to allow key staff to be available and travel to the location.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we rate

We rated it as **Requires improvement** overall.

We found areas of practice that require improvement in diagnostic imaging:

- **Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Policies did not support staff to safeguard patients from abuse and harm.** However, staff understood how to protect patients from abuse and staff had training on how to recognise and report abuse, and they knew how to apply it.
- **Staff did not always have the right skills and competencies to respond to patient risks.** However, staff kept clear records and asked for support when necessary.
- **Imaging staff did not always have the right skills, training and experience to provide the right care and treatment to children and young people.** However, the service had enough imaging staff with the right imaging qualifications to keep people safe from avoidable harm.
- **Managers did not regularly or robustly monitor the effectiveness of care and treatment or use the findings to improve them. Participation in external audits and benchmarking was limited. Staff did not use the results of monitoring to effectively improve the quality of care.**
- **The service did not ensure staff had the right skills, knowledge and experience to deliver care to all patients, including children and young people.** However, the service appraised staff's work performance.
- **We found staff did not understand how to assess capacity in children and young people.** However, staff understood how and when to assess whether an adult patient had the capacity to make decisions about their care. They followed the service policy and procedures when an adult patient could not give consent.
- **Managers at all levels in the service did not consistently have the right skills, knowledge and abilities to run a service providing high-quality sustainable care.**
- **The service did not demonstrate workable plans to turn its vision and strategy into action.** However, the service had a vision for what it wanted to achieve.
- **The service did not have a systematic approach to improving service quality and safeguarding high standards of care.**
- **The service did not have good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- **The service did not analyse, manage and use information well to support all its activities.** However, the service did collect information and used secure electronic systems with security safeguards.

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- **The service had a limited approach to obtaining the views of staff, people who use the service, external partners and other stakeholders.** However, the leadership team did share positive feedback with individual staff.

We found good practice in relation to diagnostic imaging:

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean.
- **The service had suitable premises and equipment and looked after them well.**
- **The service had enough radiography staff with the right qualifications to keep people safe from avoidable harm.** However, radiography staff did not always have the right skills, training and experience to provide the right care and treatment to children and young people.
- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to staff providing care.
- **The service could describe how it would manage patient safety incidents.** Staff could explain what incidents should be reported and how. Managers described the process for investigating and reporting on incidents, both clinical and non-clinical.
- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- **Staff assessed patients to see if they were in pain.**
- **Staff of different professions worked well together as a team to benefit the patient.** Doctors, nurses and other healthcare professions supported each other to provide good care.
- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- **Staff provided emotional support to patients to minimise their distress.**
- **Staff involved patients and those close to them in decision about their care and treatment.**
- **The service planned and delivered services to meet the majority of the needs of local people.** However, we found the service did not consistently plan services to meet the needs of children, young people and those close to them.
- **The service took account of the individual needs of adult patients.** However, the service did not consistently meet the individual needs of children, young people and those close to them.
- **People could access the service when they needed it.** However, the service had no process to monitor the referral to scan times of patients.
- **The service could describe how they would treat concerns and complaints, investigated them and learn lessons from the results, and shared these with all staff.**
- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** However, we found inconsistencies in the application of this.
- **The service demonstrated some commitment to improving services, promoting training, research and innovation.** However, the learning from incidents was not always clear and communicated well within meeting minutes.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even

Summary of findings

though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected Cavendish Imaging Birmingham. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires improvement 	Cavendish Imaging Birmingham is operated by Cavendish Imaging Ltd. The imaging centre has one imaging room with one cone beam CT scanner, and no beds or operating theatres. The imaging centre provides diagnostic imaging only. The service saw several thousand patients in 2018, with a mix of NHS funded and other funded. The service undertakes imaging on all ages of patients, including children and young people. We have rated the service as requires improvement overall. We have rated safe and well-led as requires improvement, and responsive and caring as good. We do not currently have a legal duty to rate the effective key question in diagnostic imaging services.

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Requires improvement

Cavendish Imaging Birmingham

Services we looked at: Diagnostic imaging

Summary of this inspection

Background to Cavendish Imaging Birmingham

Cavendish Imaging Birmingham is operated by Cavendish Imaging Ltd. The imaging centre opened in 2009. It is a private imaging centre in Birmingham, West Midlands. The imaging centre primarily serves the communities of Birmingham City. It also accepts patient referrals from outside this area.

The imaging has had a registered manager in post since February 2012.

Our inspection team

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

Information about Cavendish Imaging Birmingham

The imaging centre is registered to provide the following regulated activities:

- Diagnostic and screening procedures

During the inspection, we spoke with three staff including radiographers and senior managers. We spoke with two patients and one relative. During our inspection, we reviewed three sets of patient 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. This was the services second inspection since registration with CQC. The previous inspection in 2013 found that the service was meeting all standards of quality and safety it was inspected against.

Activity (January to December 2018)

- In the reporting period January to December 2018, the service saw several thousand patients. Of these, 4.1% were for children and young people and the remaining patients were over the age of 18 years. Of all the patients seen, 10.7% were NHS funded, with the remaining 89.3% were other funded patients.

One radiologist worked at the imaging centre under practising privileges. Cavendish Imaging Birmingham employed two radiographers, as well as utilising staff from other locations around England.

Track record on safety

- Zero Never events
- Clinical incidents: zero moderate harm, zero severe harm, zero death
- Zero serious injuries
- Zero Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incidents

Track record on hospital acquired infections

- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli

Track record on complaints

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- Zero complaints

Services provided at the imaging centre under service level agreement:

- Cleaning and waste disposal
- Management and provision of emergency equipment
- Building maintenance

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?

Requires improvement 

We rated it as **Requires improvement** because:

- **Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Policies did not support staff to safeguard patients from abuse and harm.** However, staff understood how to protect patients from abuse and staff had training on how to recognise and report abuse, and they knew how to apply it.
- **Staff did not always have the right skills and competencies to respond to patient risks.** However, staff kept clear records and asked for support when necessary.
- **Imaging staff did not always have the right skills, training and experience to provide the right care and treatment to children and young people.** However, the service had enough imaging staff with the right imaging qualifications to keep people safe from avoidable harm.

However:

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean.
- **The service had suitable premises and equipment and looked after them well.**
- **The service had enough radiography staff with the right qualifications to keep people safe from avoidable harm.** However, radiography staff did not always have the right skills, training and experience to provide the right care and treatment to children and young people.
- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to staff providing care.
- **The service could describe how it would manage patient safety incidents.** Staff could explain what incidents should be reported and how. Managers described the process for investigating and reporting on incidents, both clinical and non-clinical.

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Are services effective?

We do not currently have a legal duty to rate this key question for diagnostic imaging services.

During the inspection we found:

- **Managers did not regularly or robustly monitor the effectiveness of care and treatment or use the findings to improve them. Participation in external audits and benchmarking was limited. Staff did not use the results of monitoring to effectively improve the quality of care.**
- **The service did not ensure staff had the right skills, knowledge and experience to delivery care to all patients, including children and young people.** However, the service appraised staff's work performance.
- **We found staff did not understand how to assess capacity in children and young people.** However, staff understood how and when to assess whether an adult patient had the capacity to make decisions about their care. They followed the service policy and procedures when an adult patient could not give consent.

However:

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- **Staff assessed patients to see if they were in pain.**
- **Staff of different professions worked well together as a team to benefit the patient.** Doctors, nurses and other healthcare professions supported each other to provide good care.

Are services caring?

Good

We rated it as **Good** because:

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- **Staff provided emotional support to patients to minimise their distress.**
- **Staff involved patients and those close to them in decision about their care and treatment.**

Are services responsive?

Good

We rated it as **Good** because:

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- **The service planned and delivered services to meet the majority of the needs of local people.** However, we found the service did not consistently plan services to meet the needs of children, young people and those close to them.
- **The service took account of the individual needs of adult patients.** However, the service did not consistently meet the individual needs of children, young people and those close to them.
- **People could access the service when they needed it.** However, the service had no process to monitor the referral to scan times of patients.
- **The service could describe how they would treat concerns and complaints, investigated them and learn lessons from the results, and shared these with all staff.**

Are services well-led?

Requires improvement

We rated it as **Requires improvement** because:

- **Managers at all levels in the service did not consistently have the right skills, knowledge and abilities to run a service providing high-quality sustainable care.**
- **The service did not demonstrate workable plans to turn its vision and strategy into action.** However, the service had a vision for what it wanted to achieve.
- **The service did not have a systematic approach to improving service quality and safeguarding high standards of care.**
- **The service did not have good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- **The service did not analyse, manage and use information well to support all its activities.** However, the service did collect information and used secure electronic systems with security safeguards.
- **The service had a limited approach to obtaining the views of staff, people who use the service, external partners and other stakeholders.** However, the leadership team did share positive feedback with individual staff.

However:

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** However, we found inconsistencies in the application of this.

Summary of this inspection

- **The service demonstrated some commitment to improving services, promoting training, research and innovation.** However, the learning from incidents was not always clear and communicated well within meeting minutes.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

We do not currently have a legal duty to rate the Effective key question for diagnostic imaging services.

Requires improvement

Diagnostic imaging

Safe	Requires improvement
Effective	
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are diagnostic imaging services safe?

Requires improvement

We rated it as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The service provided mandatory training, and update training, to all staff. The mandatory training provided covered a range of areas, including: infection control, basic life support, consent, information governance and safeguarding (adults and children).
- We found 100% of staff were compliant with all 33 mandatory training modules.
- We reviewed training records for three members of staff, including two senior managers. We found the service had detailed records of completion of mandatory training, and when staff needed to update their training.
- The service used an external company to provide mandatory training in an online format. Staff told us they get time to complete mandatory training and the training met their needs.
- We asked three members of staff about their mandatory training and they told us they had completed the required training and were given time to complete training.
- The leadership team had a good oversight of the training completed by each member of staff, and who had not completed particular modules. The leadership team knew when each member of staff was next due an update of each mandatory training module.

Safeguarding

- **Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Policies did not support staff to safeguard patients from abuse and harm.** However, staff understood how to protect patients from abuse and staff had training on how to recognise and report abuse, and they knew how to apply it.
- The provider had a safeguarding policy in place, which the service used. We reviewed the policy and found it lacked detail and did not support staff in taking the actions required where safeguarding concerns were raised. We found the policy had not been adapted to reflect local processes, for example, including contact details for the local authorities within the Birmingham area. The policy did not clearly set out the process that staff should follow if they had safeguarding concerns.
- The policy did not have any explanations of what abuse was or the types of abuse. The policy listed some additional considerations, including child sexual exploitation (CSE), female genital mutilation (FGM) and modern slavery. However, the policy did not provide any explanations in relation to these or provide any further guidance to staff on dealing with suspected CSE, FGM or modern slavery situations.
- During the inspection, we found some additional contact details on display in the scanning room for staff to refer to. We spoke with one member of staff,

who primarily worked at the Birmingham location, who could explain their responsibilities in relation to safeguarding, and had a good knowledge of safeguarding children and adults.

- The senior management team told us of their commitment to safeguard patients; however, we were not assured that the support mechanisms supported staff at all levels to safely escalate, both internally and externally, where concerns were highlighted. This posed a risk to children, young people and adults at risk of abuse not receiving the support required.
- The service had a designated person who was the safeguarding lead within the organisation. We found the safeguarding lead had completed children's safeguarding level three training, in line with the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).
- The safeguarding lead had completed adult safeguarding level two. However, this was not in line with duties being undertaken, as described in the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018). Staff whose duties would include advising others on appropriate information sharing, applying lessons learnt from audit and case reviews to improve practice or would contribute to case reviews, panels, internal partnerships and local forums of review where safeguarding concerns were raised should be level three trained.
- Following the inspection, the leadership team told us they were working with their chosen training provider to ensure suitable training was available as soon as possible to meet the requirements of the adult safeguarding: roles and competencies for health care staff document.
- All other staff had received children's safeguarding level two training and adult safeguarding level two training within the last 12 months.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean.
- The service had a designated infection control lead at corporate level covering all Cavendish Imaging locations across England.
- The environment was visibly clean throughout, including waiting areas and treatment rooms.
- Staff were knowledgeable about the need to clean equipment to reduce the risk of cross infection. However, we found the service did not have a way of clearly marking when equipment had been cleaned, such as 'I am clean' stickers or records of equipment cleaning.
- Staff demonstrated a thorough level of hand hygiene throughout the inspection. We observed staff washing their hands between each patient, which reduced the risk of cross contamination and spread of infection. We observed that all staff complied with being 'bare below the elbows', not wearing watches or rings, and wearing short sleeve tops. Staff had access to personal protective equipment where required.
- The service reported no healthcare acquired infections, including methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile. between November 2017 and November 2018.
- The service undertook an infection control audit in November 2018. We reviewed the latest audit undertaken in November 2018 and found the service was compliant in all areas. The audit linked to the previous audit undertaken and detailed actions taken in respect of areas to improve.
- The service had a service level agreement in place for the cleaning of all areas, except clinical equipment, including floors, toilets and waiting rooms.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- We found the environment was suitable for the purposes for which it was being used. The service had one treatment room, where staff undertook all scans. The service utilised a waiting room area for patients to wait before staff called them through for their scan.
- We found all equipment was available, in date and accessible.

- The service had access to a resuscitation trolley, maintained and managed by another provider within the building. The service had a service level agreement (SLA) in place for the building owners to maintain the resuscitation equipment. We found the service did not request or have assurance of the checks undertaken by the building owners.
- The scanning room was fit for purpose and contained required safety features, including radiation warning signs.
- The service managed substances covered by the Control of Substances Hazardous to Health (COSHH) Regulations well. A third-party company managed the majority of the cleaning agents for the service.

Assessing and responding to patient risk

- **Staff did not always have the right skills and competencies to respond to patient risks.** However, staff kept clear records and asked for support when necessary.
- The service planned for emergencies and staff understood what to do in the event of an emergency situation.
- The service used the corporate responding to patient risk policy. However, the policy was limited in detail and did not clearly set out the steps for staff to undertake in the event of a medical emergency. However, all three staff asked during the inspection did know the procedures to follow in the event of an emergency.
- The service had access to resuscitation equipment. The resuscitation equipment was portable enabling staff to take the equipment upstairs should a patient collapse and require resuscitation.
- All staff completed adult basic life support training. However, we found that none of the staff at the Birmingham location undertook basic life support training for children and young people. Children and young people accounted for around 4% of the total patients between January and December 2018. This posed a risk should a child or young person become unwell whilst receiving treatment within the service.
- The service had a service level agreement (SLA) in place with the other providers within the building in the event of a medical emergency. The SLA detailed that other staff within the building would take the lead in an emergency. However, the leadership team had not gained assurance of the level of training or competence of other staff in the provision of care, such as training in basic life support for children.
- The service followed national guidance on diagnostic reference levels (DRLs) when taking 2D x-ray images. There were no DRLs for cone beam CT; however, the service had developed local DRLs. These were set in line with common practice and the manufacturers guidelines, as recommended by the radiation protection advisor and medical physics expert. The service audited these levels to check they maintained high-quality standards.

Radiography and imaging staffing

- **Imaging staff did not always have the right skills, training and experience to provide the right care and treatment to children and young people.** However, the service had enough imaging staff with the right imaging qualifications to keep people safe from avoidable harm.
- None of the imaging staff working at the Birmingham location had the skills, training or experience to deliver cone beam CT to children and young people. The service did not have access to imaging staff that had specific competencies and skills in treating children and young people. Therefore, the service was unable to plan for specific staff with the skills and competencies to be available when children and young people were undergoing cone beam CT scans.
- The service employed two members of staff to work at the Birmingham location. One member of staff was a radiographer and the second was a dental nurse with additional qualifications in radiography. The provider had flexibility to utilise staff from other locations to cover in the event of sickness or leave.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

Requires improvement

Diagnostic imaging

- The service employed one radiologist at the Birmingham location to review and report on images. The service employed the radiologist on a practicing privileges basis. The radiologist reviewed and reported on images where the referrer requested this to happen. Referrers could also make their own arrangements for the review of images.
- The radiologist employed to review the Birmingham location images worked at a local NHS Trust and had a demonstrable clinical record of working with similar imagery and the skills to report on scans of a similar type.
- Referrals were received from medical practitioners employed by other services.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to staff providing care.
- We reviewed three records during the inspection. We found all records reviewed were detailed and contained all the information required.
- Referrers completed a referral form, detailing the scan required. Staff ensured this was present and matched the expectations of the patient before continuing.
- The service had an electronic patient record system for storing images. The electronic system was encrypted and only staff that required access to images had access. The service issued referrers with specific login information to allow them to access the information about their specific patients. This ensured that patient records and information was kept safe and secure.

Medicines

- The service did not order, store, prescribe or administer any medicines or controlled drugs as part of its services.
- The service did not record medication allergies of patients due to not administering or using medication that may cause allergies.

Incidents

- **The service could describe how it would manage patient safety incidents.** Staff could explain what incidents should be reported and how. Managers described the process for investigating and reporting on incidents, both clinical and non-clinical.
- The service reported no serious incidents and no never events between November 2017 and November 2018.
- Never events are serious, largely preventable patient safety incidents that should not happen if the available preventative measures have been used, so any 'never event' reported could indicate unsafe care.
- The service reported no incidents relating to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) between November 2017 and November 2018.
- The service had an incident reporting policy in place. We reviewed the policy, which the provider had implemented in August 2018, and found it contained an implementation date, date for review and version control.
- However, we found the policy to be brief and lacked some detail. We found the policy provided some guidance to staff in how to report an incident; however, lacked detail in the information that should be supplied as part of the process. We asked the leadership team about this, and they told us this was the only policy or guidance for staff on how to report an incident. The leadership team acknowledged our feedback and told us they would look at the policy and any improvements that could be made.
- Staff were aware of what to report and how to report this. For example, staff knew to inform both Cavendish Imaging and the host provider where a patient suffered a slip, trip or fall on the premises. Staff knew to raise an incident if, for example, the cone beam CT machine stopped working, or staff delivered a higher than expected dose of radiation to a patient.
- We asked two members of staff about duty of candour and both knew about the regulation and could explain what duty of candour meant. The service had had no incidents requiring duty of candour in the reporting period of January to December 2018.

Requires improvement

Diagnostic imaging

Are diagnostic imaging services effective?

We do not currently have a legal duty to rate this key question for diagnostic imaging services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- We found the service complied with the requirements of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017.
- The service used the Sedentexct guidance to help shape the services provided. The Sedentexct guidelines provide an evidence-based approach to the use of cone beam CT in dentistry, including referral criteria and quality assurance.
- The leadership team had been involved in research to establish the evidence-base around cone beam CT scans. The research had been published and the service had used the results to inform other clinicians about cone beam CT and the benefits of the technology.
- The research looked at the use of cone beam CT as an alternative scan to conventional CT for other maxillofacial conditions.
- Staff were aware of the evidence-base behind the dosage levels to be delivered in cone beam CT scanning to create an equivalent quality image for the referrer.
- We observed staff complying with the Society of Radiographers 'pause and check' guidelines. This ensures that the correct patient is receiving the correct imaging. Staff were seen checking the identity of patient and checking what imaging the patient understood they were going to receive.
- The senior leadership team were aware of other providers of cone beam CT within the West Midlands; however, when asked, the leadership team told us they had not engaged with other providers to ensure the most effective, evidence-based approach to delivering cone beam CT.
- The service had a number of policies in place, such as the responding to patient risk policy. We found all policies reviewed reflected current best practice; however, lacked detail and references to current best practice for staff to follow up.

Nutrition and hydration

- Patients had access to a water fountain within the waiting room.
- The service did not assess or monitor the nutrition and hydration needs of patients.

Pain relief

- **Staff assessed patients to see if they were in pain.**
- We observed staff ask patients if they were in pain or discomfort before commencing the cone beam CT scan.
- Staff did not have access to pain relief as part of the services delivered. Staff would ensure that the referrer was informed if patients expressed pain whilst having the scan completed.

Patient outcomes

- **Managers did not regularly or robustly monitor the effectiveness of care and treatment or use the findings to improve them. Participation in external audits and benchmarking was limited. Staff did not use the results of monitoring to effectively improve the quality of care.**
- The service did not monitor referral to treatment times to review the effectiveness of cone beam CT scans against wait times from referral.
- The service did not audit reporting times to ensure an effective, timely reporting process. The leadership team told us they aimed for five days reporting for standard imaging and one day for urgent images. The leadership told us they had not received any incident reports relating to breaches of the five-day or one-day reporting timeframes between January and December

2018. However, the service had no mechanism for formally monitoring and recording this. The system was reliant on staff raising a concern where an image was not returned in a timely manner.

- The senior leadership team told us they did not report on images where the referrer was competent to report themselves. However, the leadership team told us the service did not always receive a report back from referrers reporting on their own images. Therefore, the service was unable to measure the effectiveness of all images or track the outcomes of patients based on these images.
- The service had an image review process in place, which was undertaken externally. The three radiologists employed by the provider, plus a radiographer, met every two months to review performance, in line with the Royal College of Radiologists learning from discrepancies standards. During the inspection, the leadership team told us that these meetings were not minuted and could not give examples or improvements or changes made because of these meetings.
- However, following the onsite inspection, the leadership team informed us that the first meeting took place on 26 February, the day before the onsite inspection activity. The leadership team sent us minutes from this meeting for review.
- The senior leadership team told us they were aware of other providers of cone beam CT within the West Midlands; however, when asked, the leadership team told us they had not engaged with any other provider to compare outcomes or work collectively to ensure the most effective imagery for the patient.

Competent staff

- **The service did not ensure staff had the right skills, knowledge and experience to delivery care to all patients, including children and young people.** However, the service appraised staff's work performance.
- Children and young people received care from staff who did not have the skills or experience needed to deliver effective care.
- We found that the service did not provide any additional training or competencies in the care and treatment of children and young people. Staff did demonstrate some understanding of how to care for children and young people; however, the lack of specific training or awareness of how to care for a child or young person could result in staff being unable to capture sufficient images. This posed a risk of the potential for needing repeat imagery and exposure to radiation.
- For example, staff did not have training in paediatric life support, and the service did not have a clear structure of assurance about the skills and training of other staff within the building. Staff did not have training or sufficient knowledge in how to take consent from children, young people and their legal guardians. The service did not provide any training or guidance to staff in how to communicate with children and young people, or techniques such as distraction therapy to support children to remain still during imaging.
- Staff did have the competencies and skills required to deliver cone beam CT scans to patients over the age of 18 years.
- We found staff knowledgeable about the services and scans provided. We reviewed the person specification for the role of operator and radiographer. The role descriptors clearly set out the requirements of both an operator and of the radiographer. The service had clear requirements that all employees must have before being employed by Cavendish Imaging Limited.
- We reviewed the personnel files of four members of staff during the inspection, including an operator, a radiographer, a radiologist under practicing privileges and a senior manager. We found each file contained relevant training and competency updates, including in relation to the operation of the scanning machinery (where applicable to their role).
- The personnel files contained information in relation to the professional registration of each member of staff, such as with the Healthcare Professional Council and the General Dental Council. Senior managers checked the registration of staff every six months to ensure compliance.
- Each member of staff had an appraisal within the last 12 months. Appraisals were recorded and contained information on performance and development,

including clear objectives for the next 12 months. We found the radiologist had had an appraisal undertaken within their NHS Trust and a copy stored within their file.

Multidisciplinary working

- **Staff of different professions worked well together as a team to benefit the patient.** Doctors, nurses and other healthcare professions supported each other to provide good care.
- We found good working relationships between the staff undertaking the scans and the referrers. Staff communicated well with the referrers to ensure good working relationships.
- Staff told us that the strong work relationships between the Cavendish Imaging staff and the host provider's staff and referrers ensured a smooth journey for patients.
- Staff told us that they would highlight to referrers where the patient had had exposure to radiation in the recent past, to ensure that exposure was required at this time.
- We found that the Cavendish Imaging staff did not attend any multidisciplinary discussions with local referrers or other organisations to provide learning and service development opportunities.
- However, the leadership team told us after the onsite inspection that staff do attend national multidisciplinary discussions, such as at conference and radiography congresses.

Seven-day services

- The service did not operate seven-days a week. The service was available four days a week for pre-booked appointments and same day referrals from clinicians within the same building.
- The service did not operate on Thursdays, as this was used for staff training and updates.
- Patients could contact the service Monday to Friday either by phone or email to discuss their appointment.

Consent and Mental Capacity Act

- **We found staff did not understand how to assess capacity in children and young people.** However, staff understood how and when to assess whether an adult patient had the capacity to make decisions about their care. They followed the service policy and procedures when an adult patient could not give consent.
- We asked two members of staff about the Mental Capacity Act 2005. Both staff could describe their responsibilities in relation to assessing mental capacity of patients undergoing imaging procedures.
- The leadership team had recognised the service had limited resources to support patients that lacked the capacity to consent to treatment to maintain their safety and wellbeing and this would be reviewed on a patient by patient basis. The service did not accept patients that were unable to consent to treatment themselves due to a lack of capacity.
- We asked one member of staff about consent. The staff member could describe their responsibilities in relation to gaining consent before undertaking any intervention. We observed staff taking verbal consent prior to undertaking a cone beam CT scan.
- The service did not take written consent from patients routinely. Consent would be documented within care records where a patient was pregnant, or potentially pregnant, but consented to continuing with the procedure. The provider had trialled taking written consent at another Cavendish Imaging location. At the time of the inspection, the provider had not made a decision about implementing written consent across all locations.
- The service had a consent policy in place that detailed how staff should take consent from adults, young people and children. However, staff were unable to describe the principles of Gillick competence. Gillick competence are guidelines in relation to gaining consent from children and young people.
- Following the inspection, the provider ensured that staff undertook further training in consent, including Gillick competence for consenting children and young people.

Are diagnostic imaging services caring?

Requires improvement

Diagnostic imaging

Good

We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- We spoke to two patients and one relative during the inspection.
- We observed staff delivering treatment to patients during the inspection. Staff treated patients with dignity and respect in all observed care.
- We reviewed feedback given by patients about the service and staff. We found that the feedback was positive and reflected the care we observed. We found no patient feedback that was negative between January and December 2018.
- We reviewed three letters that had been sent to Cavendish Imaging about the service provided at the Birmingham location. We found all three patients were very positive about the care received. One patient described the staff as "pleasant and professional". Another patient stated that staff had "given good information" during the scanning process.
- Patient feedback was gathered informally on the day of the procedure, but also using email after the procedure.
- Patients had access to a chaperone if they wanted; however, we found staff did not offer this routinely.
- We found pricing was made clear to patients before the treatment and was clearly displayed within the waiting area. We found payment options were explained on the services website.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff booked 30 minutes appointment times that allowed patients sufficient time to undergo the scan without feeling rushed and pressured. It allowed staff time to provide reassurance to patients before, during and after the scan.
- During scans, we observed staff talking to patients and providing reassurance throughout the scanning process.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decision about their care and treatment.**
- We observed staff involve patients as much as possible in the process of undertaking a diagnostic image.
- We observed staff explaining the procedure to patients and check the patient was aware of the scan they had come for. Patients were given time to ask questions before and after the procedure, and staff answered any questions calmly and confidently.
- Where staff were unable to answer a question, they would refer the patient back to the referring consultant for clarity.
- Staff provided support and information to referrers about cone beam CT scans to ensure that patients were fully informed about the benefits and risks of the procedure before agreeing.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and delivered services to meet the majority of the needs of local people.** However, we found the service did not consistently plan services to meet the needs of children, young people and those close to them.

Requires improvement

Diagnostic imaging

- The service was planned in a way to allow patients to come at a time convenient to them, or, where already at the location for an outpatient appointment, to undertake the imagery at the same time.
- The service had planned the booked appointments for 30 minutes, which was significantly longer than required. This allowed staff to build a relationship with the patient and ensure that the patient had sufficient time to ask any questions.
- The service would see patients of any age, so long as they were able to sit still for long enough for the scan to be undertaken. However, we found that the service had not taken into account the additional needs of children and young people. For example, staff did not have training or guidance in how to communicate with children and young people, or techniques such as distraction therapy to support children to remain still during imaging.
- The service worked closely with other local independent health providers to provide services under service level agreements. The service did provide services to some NHS providers within the local area; however, this was done on a patient by patient basis and no service level agreement was in place with the local NHS.
- The service had not engaged with local clinical commissioning groups with regards the provision of services to the NHS.
- The senior leadership team told us they were aware of other independent providers of cone beam CT within the West Midlands; however, when asked, the leadership team told us they had not engaged with any other independent provider to work collectively to ensure the best outcomes for patients and accessibility into services.
- The service did work collaboratively with a local NHS trust that provided cone beam CT on any issues arising and collectively to provide continuous professional development for NHS and Cavendish Imaging staff.
- The leadership team displayed a good knowledge of the requirements under the Equality Act 2010. They explained the need to meet the ever changing and growing diversity within Birmingham and the surrounding areas.

Meeting people's individual needs

- **The service took account of the individual needs of adult patients.** However, the service did not consistently meet the individual needs of children, young people and those close to them.
- The service was located on the first floor in the building it operated from, with access only via a set of steps. The leadership team had recognised that the service was not accessible to those patients requiring lift access or with conditions affecting their ability to climb stairs safely. However, the leadership team made all referrers aware of the limited access, and this was made clear on the service's public website for all patients.
- The service had access to a verbal translation service, and this would be booked in advance of the patient attending. Staff and the leadership team told us that the procedure would not go ahead where staff were unable to take verbal consent for the patient due to them not being able to communicate clearly with the patient.
- Staff gave an example of a patient with a visual impairment attending for a scan. Staff allowed extra time for the patient and supported them with positioning of their head to ensure an accurate image was taken.
- We asked staff about how they would support patients religious and cultural needs. Staff told us that they had recently had a patient who wore a turban. Staff explained how they supported the patient within the scanning room to continue to wear their turban, but also to get an accurate and effective image.
- The service provided a limited number of toys for children to use as distraction during scanning.

Access and flow

- **People could access the service when they needed it.** However, the service had no process to monitor the referral to scan times of patients.

Requires improvement

Diagnostic imaging

- The service saw several thousand patients between January and December 2018. Of these, 4.1% were for children and young people and the remaining patients were over the age of 18 years. Of all the patients seen, 10.7% were NHS funded, with the remaining 89.3% were other funded patients.
- Referring clinicians contacted the imaging centre to arrange appointments. This was done through the provider's head office or via an online portal system.
- The service did not have a waiting list for cone beam CT scanning at the time of the inspection. The service told us the service was operating at around 35% capacity.
- However, the leadership told us they did not have a formal referral to scan target for patients, and they did not formally monitor and report on this internally. The leadership team told us they did not have a referral to scan target or monitor referral to scan times as they did not have the volume of patients that would require this to be in place.
- The service did not monitor 'did not attend' rates amongst patients and did not use this information to improve and plan services.
- The service did not cancel any pre-planned clinics between January and December 2018. Staff from other Cavendish Imaging locations covered for any periods of absence of the routine staff at Cavendish Imaging Birmingham.

Learning from complaints and concerns

- **The service could describe how they would treat concerns and complaints, investigated them and learn lessons from the results, and shared these with all staff.**
- The service had received no complaints in the reporting period January to December 2018.
- The service used the provider wide corporate complaints management policy. We reviewed the policy, which the provider implemented in August 2018, and found it contained an implementation date, review date and version control. The policy referenced applicable external bodies, such as CQC and professional bodies, and had clear methodology for resolving both informal complaints and formal complaints.
- The complaints policy set out the requirements under the duty of candour regulations and signposted staff to further support and guidance on complying with the duty of candour regulation.
- The service had complaints leaflets in place for both adults and children and young people. The children's complaints leaflet used simpler language and supported children and young people to leave their own thoughts about the service.

Are diagnostic imaging services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership

- **Managers at all levels in the service did not consistently have the right skills, knowledge and abilities to run a service providing high-quality sustainable care.**
- The provider and service had a clear organisational structure. The registered manager had responsibility for the running and management of Cavendish Imaging Birmingham. However, the registered manager was not present on a daily basis due to being the registered manager for all four Cavendish Imaging locations across England and was based in London.
- The staff at the Birmingham location managed the day-to-day running of the clinics and delivery of the service. However, we found a reliance on the local knowledge of one person, which increased the risk of a single point of failure. We were not assured that should the staff that worked at the Birmingham location require sudden leave, the service would run as smoothly.
- Cavendish staff told us that the registered manager attended the Birmingham location once a month at most. The host provider's staff told us they did not see or interact with the leadership team from Cavendish

Imaging. Following the onsite inspection, the leadership team told us that they interact at a senior level with their counterparts within the host provider, and local staff interact with the host providers local staff as required.

- The leadership team showed a lack of understanding of the requirements of the fit and proper person regulations (FPPR). The FPPR provides a regulatory framework to ensure that registered managers and other senior staff are fit to hold those positions. We explained the regulatory requirements under FPPR; however, the leadership team were unable to provide assurance of knowledge of the regulation.
- We reviewed the personnel file of the registered manager and found that it contained most of the requirements of the fit and proper person regulation. However, we found details of the employment history and references were missing from the personnel file. The registered manager was able to provide verbal assurance that these could be obtained.
- Following the inspection, the leadership team provided written assurance of meeting the fit and proper person regulation.

Vision and strategy

- **The service did not demonstrate workable plans to turn its vision and strategy into action.** However, the service had a vision for what it wanted to achieve.
- We requested the service's vision and strategy. Both were provider wide and held and managed centrally by the provider wide leadership team. We found no local vision or strategy for Cavendish Imaging Birmingham.
- The vision for the service was based around the providers statement of purpose, which consisted of six points. The statement of purpose included the service providing high quality specialist imaging, use evidence-based guidelines to tailor imaging procedures to minimise radiation exposure to patients, an aim to be helpful to both patients and referrers through a consistent approach to patient care and embedding a human rights approach in all systems and processes.
- The service provided a set of principles it had adopted as part of the service's vision. These were:
  - Care with kindness
  - Effective leadership and clear direction
  - Clear roles, responsibilities and authority
  - Efficient and effective use of resources
  - Appropriate scrutiny, oversight and supervision
  - Effective management of risk and performance
- We reviewed the strategy for the service, which consisted of three priorities:
  - Focus on improvement, innovation and sustainability of services
  - To ensure evidence-led approach in developing the service.
  - To promote quality in the sector.
- The strategy, as sent by the provider, included some measures, which the provider told us were developed to show when they had succeeded in the above three priorities. However, we found the measures were not evidence-based.
- We found two of the seven measures did not provide assurance of achievement. One of these was around CQC regulating all cone beam CT services in the same way, and the second around an increase in the number of referrals for cone beam CT scans. Neither of these two measures were within the control of the organisation. Therefore, it would be difficult for the organisation to implement strategies to achieve these and show when and how the organisation had achieved them. Also, not achieving these two outcomes may not be evidence of a lack of achievement within the organisation, as the organisation did not hold the ability to influence them.
- The strategy did not have an implementation date or a review date. We found the strategy did not have outcomes that staff could measure in a way that would provide constructive information to guide improvements. We reviewed governance meeting minutes from December 2017 and March, June and September 2018. We found the service did not discuss the vision and strategy at these meetings. This,

combined with the lack of review information within the strategy, did not provide assurance that the provider reviewed the progress against the strategy on a regular basis.

- The strategy contained a priority around promoting quality in the sector. One of the points under this heading was to promote a shared vision of quality in the cone beam CT sector by engaging with clinicians, other provider and regulators. Although we found engagement with regulators to be ongoing and productive, the leadership team made is clear during the inspection they currently did not engage with other independent providers of cone beam CT services within the Birmingham area. The leadership team told us they did not engage with other independent providers of cone beam CT providers as this could put Cavendish Imaging at a commercial disadvantage. We were not assured the service would be able to meet its strategic commitments when it currently did not engage with other independent cone beam CT providers.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** However, we found inconsistencies in the application of this.
- We found a positive culture across the service. We spoke with three members of staff, including two managers, during the inspection. All staff told us that they felt well supported by the leadership team.
- We were told, and we observed that staff of all grades would help with all tasks, such as administrative and reception tasks, to ensure the patients had the best experience they could.
- All staff spoken with told us that the service wanted to provide high-quality care to patients, and this is what they strived to achieve. We observed this during the inspection.
- However, we found that staff did not consistently have access to the same level of support as colleagues in other locations provided by Cavendish Imaging Limited. Staff told us that staff working at the Birmingham location did not attend staff meetings in London due to the distance required to travel. The senior leadership team visited the Birmingham office around once a month.
- The leadership team told us that staff did not meet without the leadership team to provide peer-to-peer support. When asked the leadership team told us they did not see the need for this due to the overall low number of non-leadership staff within the wider organisation.

Governance

- **The service did not have a systematic approach to improving service quality and safeguarding high standards of care.**
- We found the governance arrangements and their purpose were unclear. The service had not undertaken a recent review of the governance arrangements, the strategy or improvement plans.
- Before the inspection we requested the service's governance structure, and we reviewed this on site with the leadership team. The service's governance structure did not provide assurance of sufficient oversight and decision-making processes in relation to the service.
- The governance structure used by the service did not detail any groups or committees in relation to specific aspects of the service, for example audit or quality and safety. The leadership team could not provide a structure or evidence of how decisions within the service or wider organisation were taken, and who held the accountability for decision making.
- The leadership team told us that due to being a small organisation, they had not formulated such a structure as they did not see the benefit of formalising the governance arrangements.
- The service held weekly team meeting, and quarterly governance meetings.
- We reviewed governance meeting minutes from December 2017 and March, June and September 2018. We found the minutes lacked clarity and detail. The

minutes did not detail actions from the meeting, or who was responsible for them. The meetings did not include a review of previous minutes and updates from the previous meeting.

- We found there was a reliance on a non-structured approach across the organisation. We were not assured that the service had sufficient governance arrangements in place to promote the safety and quality of care in a robust way.
- We found policies and procedures to support staff in their work were not always detailed. We found policies lacked detail, for example within the safeguarding policy no local contact details were available. The leadership team had not implemented local procedures to support the organisation wide policy.
- We found policies did reflect current best practice; however, they did not reference this within the policies and procedures. This meant staff did not have quick access to the supporting information should they require further information.

Managing risks, issues and performance

- **The service did not have good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- We found the risk management approach was not linked effectively into planning processes. Risk registers and action plans were rarely reviewed or updated.
- We requested a copy of the corporate and local risk registers for the service before the inspection. The service provided us with the business continuity policy.
- During the inspection we asked the senior leadership team about risk oversight, management and recording. The senior leadership team told us the business continuity policy was their version of a corporate risk register. The senior leadership team could not provide assurance that this was reviewed regularly and updated in accordance to changes.
- The risks identified within the business continuity policy were not reflective of the risks found during the inspection. The risks that had been identified had limited mitigation, and no reassessment of the risk following mitigation. For example, failure of phone lines was identified as a risk. The service had identified one mitigation, which was listed as the provider of the phone service.
- During the onsite inspection, we identified additional risks that the service had not taken into account or recognised. This included the ability to evacuate people from the first floor in the event of a fire. The service had no fire evacuation plan in place, or a risk assessment in the event of a fire.
- The senior leadership team told us that they were developing a new way of recording risks; however, this was still under development and they were not yet fully using it.
- We found no formalised approach to reviewing risks, both at a corporate level or locally.
- We asked the senior leadership team what the main risks were within the service provided at Cavendish Imaging Birmingham; however, the senior leadership team were unable to confidently explain the main risks for the service and what, if any, mitigation had been put in place.
- Following the onsite inspection, the service provided us with a fire policy and fire risk assessment undertaken by the main healthcare provider within the building. However, the risk assessment did not mention Cavendish Imaging, or specifically patients attending Cavendish Imaging for imaging services. The risk assessment details all other areas of the first floor but fails to include Cavendish Imaging.
- As the policy was written by another provider, it references other policies related to the third-party provider. However, Cavendish Imaging staff did not have access to these policies. The third-party risk assessment and policy, along with the lack of identification of fire as a risk on Cavendish Imaging's own risk register, did not provide assurance of adequate oversight of the risk of fire.

Managing information

- **The service did not analyse, manage and use information well to support all its activities.** However, the service did collect information and used secure electronic systems with security safeguards.

Requires improvement

Diagnostic imaging

- The service collected a limited amount of information about the outcomes of patients and the accessibility of the service for patients. We found staff used the information that was collected to measure assurance, with less importance given to improving services. This was evident across all areas of the service.
- The service recorded risks for assurance; however, did not review these routinely to ensure improvements or a reduction in risk was achieved. The service had a performance measure to report on routine images within five days; however, did not have a monitoring system in place to highlight areas of concern to guide improvements. The service wanted patients to access the service as quickly as possible; however, did not measure the average referral to appointment time to ensure they were achieving this.
- We reviewed weekly team meeting minutes from September and October 2018. We found that the meetings did not have a set agenda and we found limited evidence of follow up of actions. We found in the 23 October 2018 meeting minutes an action with a completion date of 16 October 2018, before the meeting date. Meetings did not consist of standard agenda items, such as risk, complaints or training; therefore, we were unable to establish that quality and sustainability of the service was given enough priority at team meeting.
- However, we found that the minutes did have actions noted and these were assigned to an individual to lead on. We found that where a concern had been identified, this was discussed with the team. For example, in the 9 October 2018 meeting minutes, a discussion happened regarding a small increase in the number of re-scans taking place.
- The service did not have clearly defined or robust service performance measures in place that were monitored and reported on. The information collected by staff, and the lack of detailed and measurable outcomes within the strategy, did not provide assurance that the service used information well to monitor and measure performance. The service was unable to demonstrate that it produced reports on the service to provide its own internal assurance around performance.
- For example, the service did not monitor wait times for the service, and the impact of these on outcomes. The service did not have a robust system in place to monitor patients who did not attend their appointments. The service did not have a robust system in place for the monitoring of the quality of images reviewed only by the referrer.
- We found that staff did have access to the information they required to undertake their roles. All staff had access to the online system containing policies and procedures. Staff had access to an online video and chat system to enable rapid access to other staff for information and support.
- The service had a well-integrated technology system in place to store and distribute images securely. The leadership team described the cloud-based storage systems it had in place, and how the service can provide individualised access for referrers to access their own patients' images.
- The service had well-integrated back-up systems in place to mitigate in the event of the failure of the technology systems. The leadership team could clearly articulate this process.
- The leadership team showed a clear understanding of the requirements under the Data Protection Act 2018 and the General Data Protection Regulations 2018 in respect of confidentiality and sharing of personal information.
- The provider had obtained and maintained ISO27001 accreditation. The standard is designed to support organisations to manage their information security processes in line with international best practice.

Engagement

- **The service had a limited approach to obtaining the views of staff, people who use the service, external partners and other stakeholders.** However, the leadership team did share positive feedback with individual staff.
- The service had limited engagement with patients. The service engaged with patients though feedback forms. However, feedback forms were available for both adults and children, to encourage feedback from children and young people too.

Requires improvement

Diagnostic imaging

- The leadership team acknowledged that they did not receive feedback from children and young people as there was a reliance on the child or young person completing this at the time of the appointment. The service did not send a child friendly version out to parents via email following appointments to try and gather more feedback from children and young people.
- The leadership team told us when specific feedback about a member of staff is received, they would inform that member of staff. The leadership team shared some individual patient feedback with us during the onsite inspection. Staff confirmed that the leadership did share this feedback with individual members of staff.
- The leadership team did review feedback and produced a report each year to demonstrate the feedback given about specific members of staff and locations. We reviewed this information and found that the majority of responses for the Birmingham location were positive.
- The leadership team encouraged staff to participate and engage with the service and the development of the service. One member of staff we spoke to wanted to increase the service's presence on social media. The leadership team supported this and gave the member of staff the resources to undertake the work.
- The education lead for Cavendish Imaging Limited was based at the Birmingham location. The education lead engaged with the referrers of patients to provide guidance, support and education around what cone beam CT was and the benefits and risks to patients. The leadership team told us that through the education of referrers, referrals were now more appropriate for the services offered at Cavendish Imaging Birmingham.
- The service worked well with the other providers in the premises where the Birmingham location was situated. We found good engagement between the regular staff working at the Birmingham location and the reception staff and referring consultants.
- However, we found limited engagement between the service and other providers of cone beam CT services within the Birmingham area.

Learning, continuous improvement and innovation

- **The service demonstrated some commitment to improving services, promoting training, research and innovation.** However, the learning from incidents was not always clear and communicated well within meeting minutes.
- The service had undertaken research into the exposure risks associated with plain film x-ray, CT and cone beam CT. The research had been published and used to inform and educate referrers into the benefits of the lower radiation exposure, when compared to plain film or conventional CT. This research included working with local NHS trusts.
- The leadership team had supported a member of staff to undertake further training in social media use in order to improve and promote the service on a wider variety of platforms.
- The education lead for the service had provided training to referrers across the West Midlands to educate on when cone beam CT would be appropriate, vs conventional CT or plain film x-ray.
- Following the onsite inspection, the leadership told us and provided evidence of additional research and participation in national conferences. The provider had undertaken research into cone beam CT, along with partner agencies including NHS providers, and was due to present this at the upcoming UK Imaging and Oncology Conference.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff understand how to gain consent from children and young people, and what to do when this is not possible. Regulation 11: Consent 11(1)
- The provider must ensure that suitable risk assessments are in place to support the safe delivery of care and treatment to patients, including those related to premises, equipment, staff training, processes and practices. Regulation 12: Safe care and treatment 12(2)(b)
- The provider must ensure that staff have the skills and resources to respond effectively and in a timely manner to deteriorating patients, including suitable methods to summon additional help. Regulation 12: Safe care and treatment 12(2)(c)
- The provider must ensure that the lead for safeguarding has the required level of safeguarding training in line with national guidance and best practice. Regulation 13: Safeguarding service users from abuse and improper treatment 13(2)
- The provider must ensure systems and processes are established and operated to provide a structured approach to governance to support the delivery of good quality, sustainable services. Regulation 17: Good governance 17(1)
- The provider must have systems and processes in place to assess, monitor and improve the quality and safety of the services provided, including accurate, complete and contemporaneous risk assessments. Regulation 17: Good governance 17(2)(a)
- The provider must ensure it collects relevant information about the service and uses this to inform and guide service improvements. Regulation 17: Good governance 17(2)(a)
- The provider must ensure it has a clear vision and strategy, with measurable outcomes, that is monitored, reviewed and updated. Regulation 17: Good governance 17(2)(a)
- The provider must ensure there is enough staff with the right skills and training to provide care to children and young people. Regulation 18: Staffing 18(1)

Action the provider SHOULD take to improve

- The provider should ensure it has oversight of the time taken for patient to access the service.
- The provider should ensure suitable processes to allow staff to be fully engaged in all aspects of the service, including team meetings, regardless of geographical location.
- The provider should ensure that it has sufficient oversight of safety checks undertaken as part of service level agreements.
- The provider should ensure that policies and procedures support staff to undertake their role.
- The provider should ensure that staff have access to peer support, away from senior leaders.
- The provider should ensure that it has knowledge and oversight of the training and competence of staff not employed by Cavendish Imaging Birmingham that would provide support in the event of an emergency.
- The provider should review how it engages with stakeholders in relation to multidisciplinary discussions and sharing learning and knowledge.
- The provider should review how it stores and reviews information in relation to the meeting of the fit and proper person regulation to ensure compliance with the regulation.
- The provider should ensure those employed by the service to manage the carrying on of a regulated activity are of good character, and have the qualifications, skills and experience necessary for the work to be performed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment The provider must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The provider must do all that is reasonably practicable to mitigate risks. Staff did not receive training or competencies in the delivery of care and treatment to children or young people. Staff did not receive paediatric life support training. Staff did not receive training or understand how to gain consent from children and young people, the process to undertake where this was not possible. Regulation 12(2)(b)(c)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure the quality and safety of the services provided. The provider did not have a structured approach to governance to support the delivery of good quality, sustainable services.

This section is primarily information for the provider

Requirement notices

The provider did not have robust arrangements for identifying, recording and managing risks, issues and mitigating actions. The provider did not have a single point of recording risks associated with the provider or the Birmingham location.

Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Persons employed by the service provider must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The provider did not deliver or provide access to training or competencies for staff to care for children and young people. Staff did not have the skills or competence to meet the needs of children and young people accessing the service. Staff did not have access to peer-to-peer support, away from the senior leadership team. Regulation 18(1)(2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

The provider must ensure that staff taking consent from patients have the knowledge and understanding of the relevant national legislation and guidance surrounding the taking of consent, and assessment of mental capacity.

The provider must ensure that staff taking consent from children, young people and their legal guardians have the knowledge and skills to assess the capacity of children and young people to consent for themselves.

Regulation 11(1)