3BEAM Ltd

3BEAM

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The service had not been rated before. We rated it as requires improvement because:

Staff did not have training in paediatric basis life support.

The service did not have a deteriorating adult or child policy in place.

The service did not undertake DBS checks on all staff members.

The service did not provide information in an accessible format for all.

Leaders did not have a contractual agreement in place for the sub-letting of the treatment room within the service.

The service did not have a strategy to demonstrate its commitment to ongoing quality patient care.

Risks identified by the service, and actions taken to mitigate these risks, where not recorded.

However,

The service had enough staff to care for patients. Staff understood how to protect patients from abuse. The service controlled infection risk well. Staff kept good care records. The service managed safety incidents well and learned lessons from them.

Staff provided good care and treatment, gave patients enough to eat and drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment

Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Requires Improvement 	This service has not been rated before. We rated it as requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to 3BEAM

The service provides dental, ear, nose, throat and maxillofacial scanning for patients aged six and above. Cone beam computerised tomography (CBCT), orthopantomogram X-ray (panoramic image) and Cephalometric X-rays (side profile image) facial scans are taken.

The service has been registered to carry out the regulated activity of diagnostic and screening procedures since December 2020 since this time a registered manager has been in post. The service has not previously been inspected.

Between June 2021 and June 2022 3671 patients were seen by the service, of this, 281 were aged below 16 years of age and 38 were aged between 16 and 18 years of age.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected this service using our comprehensive inspection methodology. One inspector and one specialist advisor, with support from an offsite inspection manager, carried out the inspection on 12 July 2022 which was overseen by the head on hospital inspections.

During the inspection we reviewed a range of documents related to running the service including, several policies and procedures, a training matrix, independent website browser platform and servicing records of equipment. We spoke with three members of staff including the registered manager and three patients who had used the service. We also reviewed patient and staff records.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that appropriate paediatric training including basic life support is completed in line with statutory requirements and that suitable procedures to manage deteriorating patient put into place. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2)(c)
- The service must ensure that information about candidates set out in Schedule 3 of the regulations is confirmed before they are employed including front office staff. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 (2)(b)
- The service must ensure that appropriate contractual agreements arrangements including, who is responsible for the provision of safe care and treatment of patients is in place. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2)(d)

Summary of this inspection

Action the service SHOULD take to improve:

- The service should ensure that it has a robust method of recording identified risks within the service. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2)(b)
- The service should ensure monthly equipment/environmental quality assurance assessments are carried out. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (2)(h)
- The service should ensure access to a variety of communication methods are available to help patients become partners in their care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (1)

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Diagnostic and screening services

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic and screening services safe?

Requires Improvement

This service has not been rated before. We rated it as requires improvement.

Mandatory training

The service did not provide paediatric mandatory training in key skills to all staff, however, were compliant with other mandatory training.

The service did not train staff in paediatric basic life support despite undertaking diagnostic testing on children as young as six years old. One newly recruited member of staff had undertaken paediatric advanced life support at a previous place of employment; however, we saw that this had expired in September 2021. This was a concern because research shows that early, effective and up to date methods of resuscitation can save lives. Nor was it in line with the national core skills framework which sets out that "staff with clinical care responsibilities including all qualified healthcare professionals working with paediatric patients should undertake training in paediatric basic life support."

Staff received and kept up-to-date with all other mandatory training. The compliance rate for the service was 100%. Modules included health and safety, manual handling and fire safety and adult basic life support.

Mandatory training modules in autism and learning disabilities were being procured at the time of the inspection in line with Skills for Health Core skills framework.

The registered manager for the service had created a training matrix so that training compliance could be monitored and managed appropriately.

Safeguarding

Not all patient facing staff had appropriate pre-employment checks completed. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had undertaken the relevant pre-employment checks including disclosure and barring service checks (DBS) for registered healthcare professionals. Risk assessments for front office assistants justifying why the service had not

applied for a DBS check had been undertaken by the service. These demonstrated the level of risk and what other checks had been completed such as references and identity checks. However, this was not in line with schedule 3 requirements of the Health and Social Care Act 2008 which sets out that patient facing staff members should be subject to a disclosure barring service check.

Staff received training specific for their role on how to recognise and report abuse. This included level two training in both adult and children safeguarding for staff. The registered manager of the service was the designated safeguarding lead. Both the registered manager and the nominated individual had completed level three adult and children safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. No referrals had been identified; however, safeguarding policies for adults included details about how and where to make a referral.

The children and young people's safeguarding policy contained information on female genital mutilation, modern slavery and child trafficking.

A chaperone policy was in place within the service and both receptionists had undertaken training on how to be a chaperone. A notice about the availability of a chaperone was visible to patients attending the clinic.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were visibly clean and had suitable furnishings. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly in line with the services' cleaning schedule and also the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections.

Staff followed infection control principles including hand hygiene and the use of personal protective equipment (PPE) which was readily available. Between May and June 2022, the service achieved 100% compliance in its hand hygiene audit which included the five key moments and bare below the elbow checks. Staff also washed their hands regularly, which was in line with the National Institute for Health and Care Excellence guidance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning products were kept in a locked cupboard meaning they could not easily be tampered with or pose a risk to health and safety of patients and visitors

Environment and equipment

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

The service had enough suitable equipment to help them to safely care for patients. Equipment was maintained and regularly serviced by both the manufacturer and supplier on the manufacturer’s behalf. Contractual agreements were in place for both. Remote software updates could be carried out and we saw that the manufacturer had completed a service of the equipment in April 2022.

The cone beam CT equipment was leased in 2020 and was expected to have a lifespan of between ten and 15 years. The service had a business plan in place for the purchase of a second scanner soon.

Signage was displayed outside of the scanning room door advising it was a radiation-controlled area. A skull and cross bone meant that there was a visual prompt for people that may have been unable to read the written warning.

The service had a process for monthly equipment quality assessment (QA) assessments to be undertaken, however these assessments had not been completed for March, April and May 2022. This was not in line with professional guidance by the Society of Radiographers

Clinical waste was kept securely and was removed fortnightly by a specialist company.

Staff received training on the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and hazardous substances such as cleaning materials were kept in a locked cupboard.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. The service had a policy in place to advise staff on how to quickly act upon patients at risk of deterioration.

The service has an emergency care policy, which meant staff were able to identify or respond appropriately to the changing risk and situation in the event of a patient or visitor deteriorating and becoming acutely unwell.

Staff completed risk assessments for each patient on arrival. This included checks about pregnancy and patient identity. A pause and check poster from the Society of Radiographers was displayed in the scanning room, which prompted the radiographer to check the patient, anatomy, user checks, exposure and draw to close checks. This included checking the patient had not had any similar examinations recently, there were no contraindications to radiological exposure and that the patients correct anatomical area was indicated.

Justification for scan was reviewed at the time of referral by the referrer and again immediately before the scan was undertaken.

Personal protective equipment such as staff dosimeters for staff and gonad shielding for patients and lead aprons for carers were not required due to the low dose omitted from the scanning machine. The room where the scanner was based was lead-lined and a lead screen with a window was between the patient and radiographer. This meant the patient could always be monitored and the test stopped immediately if a problem was detected.

An emergency first aid kit was kept within the service in the event of an accident occurring. Anaphylaxis medication was not required as no contrast dye was administered by the service.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe. Appointment slots were released based on staff availability and the service was able to flex these to match the level of cover.

Requires Improvement

Diagnostic and screening services

All clinical staff were registered allied health care practitioners in line with Schedule 2 of the Health and Social Care Act and the Ionising Radiation (medical exposure) regulations IR(ME)R 2017 regulations which entitles the practitioner to take responsibility for an individual's exposure.

Plans were in place to cover unexpected absences which included the use of agency staff. A local induction checklist had been created to ensure that agency staff had access to the appropriate information, policies and procedures within the service. No agency staff had been used by the service at the time of inspection.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily electronically. Records were stored securely in a cloud-based storage in line with the Department of Health and Social Care code of practice for record management.

Three records were reviewed at the time of the inspection, they were comprehensive and appropriately completed.

Medicines

The service did not use medications

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Staff knew how to apologise if things went wrong. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. There was an electronic form for reporting which all staff had access to.

Incidents were discussed at regular meetings held by all staff and patient safety alerts were shared from the radiation protection advisor with the service.

No never events or serious incidents had occurred in the last twelve months.

Mangers had a process for undertaking duty of candour and staff and managers could tell us what it was and how to apply it. No incidents had required a duty of candour notification over the last twelve months.

Are Diagnostic and screening services effective?

Inspected but not rated

This service has not been rated before. We do not rate effective domain.

Evidence-based care and treatment

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

Requires Improvement

Diagnostic and screening services

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This included an emergency care policy, lone worker policy and records management policy. All policies were within review date.

The clinical leader within the service was a member of the society of radiographers which meant they were alerted to any specific changes in radiology practice through the society and in addition, the service monitored dental radiology updates. These updates were shared with staff via an electronic staff portal meaning that all staff had access to important updates and changes to practices.

The service was registered to receive Medicines and Healthcare products Regulation Agency (MHRA) alters and subscribed to the National Institute of Health and Clinical Excellence (NICE).

Nutrition and hydration

Staff gave patients food and drink when needed.

The service did not routinely provide food for patients using the service, however there were a range of soft drinks available for patients and food could be sourced if a patient requested it specifically.

Pain relief

The service did not use pain relief as it was not required in this type of service.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service had undertaken a clinical image audit in May 2022. The audit was undertaken by a consultant dental radiologist and reviewed 74 images taken by the service. There was 100% of the images classed as 'diagnostically acceptable' using the European Commission's Radiation Protection No 172 guidelines on Cone beam CT for dental and maxillofacial radiology. This meant the service had oversight of the quality and effectiveness of the diagnostic imaging carried out by the service.

Managers and staff used the results to improve patients' outcomes; for example, two members of staff had been supported to extend their knowledge in maxillofacial anatomy following the clinical image audit.

Staff worked with a private radiation protection advisor (RPA) and medical physics expert (MPE) who provided the service with radiation protection advice and assistance to support the service in meeting the Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017.

The service had worked with its radiation protection advisor to establish that patients undergoing diagnostic assessments at the service were given doses in line or below the national database levels. In all areas of this study carried out in January 2022, the service was adequate or satisfactory meaning that patient radiation dosage was in line with the national average.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Requires Improvement

Diagnostic and screening services

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. An induction policy was in place, this was in date and set out the requirements of new members of staff as well as what they could expect in terms of support and guidance.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge and managers made sure staff received any specialist training for their role for example staff had undertaken a specialised cone beam CT scanning course to ensure they had the specialist knowledge for type of scanning undertaken and a dental nurse was undergoing accredited training in dental radiology.

Professional registration checks were undertaken by the registered manager annually at the time of appraisal. There was 100% of the four staff members appraisals completed and were within review date at the time of the inspection.

The service did not have any staff working under practising privileges; however the service monitored the professional registration and annual appraisal of the consultant radiologist who was also a non-executive director for the service. This meant the service could be assured that the correct skills level and registration was in place.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The last team meeting held on the 8th July 2022 saw three of the four members of staff in attendance. The minutes of these meetings were stored electronically and available for all staff to access so that those unable to attend important meetings could be kept up to date with key pieces of information.

Multidisciplinary working

Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The requirement for multidisciplinary working was limited due to the nature of the service. However, the service worked with subject matter experts such as oral surgeons and consultant radiologists and liaised closely with the professionals making referrals.

Seven-day services

Key services were available to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

The service operated between Monday and Friday 10am to 5pm and Saturday 9am to 4pm. Same day appointments were offered to patients to support timely patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Requires Improvement

Diagnostic and screening services

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Consent was initially gained by the referrer and then again in person by the service immediately prior to the scan taking place. This was in line with Regulation 11 (Need for consent) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training on Gillick competence was provided as part of the annual Mental Capacity Act mandatory training which all four members of staff had completed.

The service had an in date consent policy and staff we spoke with told us that if they had concerns about the capacity of a patient to give consent the diagnostic assessment would not take place and the patient would be referred back to the initial referrer. This would be documented as a best interest decision. No instances of this had occurred at the time of the inspection.

Are Diagnostic and screening services caring?

Good

This service has not been rated before. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During the inspection we spoke to three patients who all were pleased with their care and treatment. They spoke positively about their care and felt they had been informed and involved suitably about their assessments.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Patients were not hurried, and staff kept patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. This included a chaperone policy and appointment bookings at a time to best suit the patient's needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff could explain how they would support patients who became distressed and they understood the emotional impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand and took time to explain the procedures.

Requires Improvement

Diagnostic and screening services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. This was monitored by the service and consistently positive feedback was received. Patients made comments such as "calm, superb, reassuring and first class".

The service did not charge individuals for their assessments, this was done through the individual dental provider.

Are Diagnostic and screening services responsive?

Good

This service has not been rated before. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. For example, the service offered same day scanning for patients in the London area to enable rapid diagnosis and treatment for patients with dental and ear, nose and throat problems.

Managers visited dental practices within the area personally to explain their service and provided written literature to the dentists.

The service minimised the number of times patients needed to attend the service, by ensuring patients had access to the required staff and tests on one occasion.

The service had identified a high concentration of dental practices within the area which had good transport links, including buses and the tube. Car parking spaces were directly outside of the building. A map could be found on the service website to show people where to go and in addition the patient received an SMS message prior to their appointment which also had a link to a map of the service.

Managers monitored and took action to minimise missed appointments and patients that did not attend, including telephone calls to the patient and referrer. Additional appointments were offered to the patient.

The service was provided for private patients at the time of the inspection.

Meeting people's individual needs

The service was not always inclusive or took account of patients' individual needs and preferences. The service could not make reasonable adjustments to help patients access services.

Facilities and premises were appropriate for the services being delivered; however, they did not cater for patients with mobility issues as the service was located on the first floor of a listed building. The service told inspectors that information detailing this was listed on the referral portal so that the referring clinician could make alternative arrangements for people with mobility issues.

Requires Improvement

Diagnostic and screening services

Staff did not have access to communication aids such as large print, non-electronic methods of patient communication or information leaflets in different languages other than English to help patients become partners in their care and treatment. This was not in line with the Equality Act 2010 or the accessible information standard which is designed to support people with information or communication needs relating to a disability, impairment or sensory loss including people who are deaf, blind, deafblind or who have autism, learning disability or a mental health condition which affects their ability to communicate. This meant that the service could not be sure that it catered appropriately for everyone and that access to the service may not be equitable.

The service could access a telephone based translation service when required.

The service did have a hearing loop in place for patients wearing a hearing aid. This is a devise that helps to reduce background noise.

The service provided a separate internet connection and mobile charging points for patients meaning they could continue with work whilst waiting to be called in for their appointment.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes, often this was the same day as the referral was made.

Managers monitored the number of appointments where a patient did not attend. Often this was due to a patient changing their mind about a planned procedure such as dental implants and therefore the scan was no longer required. The service contacted all patients that did not attend and offered another appointment. Information was fed back to the referrer.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Information was available on the website and the patient portal used by anyone accessing the service.

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and had a process to identify themes. A complaints dashboard was used by the service. This demonstrated that two complaints had been received since April 2022. Neither related to patient care or safety in the service, for example one related to staff in a different part of the shared building. Both were responded to within five days, had been resolved and were discussed at the regular meeting attended by the team.

A complaint policy was available to all staff on the website.

Are Diagnostic and screening services well-led?

Requires Improvement

Diagnostic and screening services

Requires Improvement

This service has not been rated before. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They had recognised and managed some priorities issues the service had identified but not others. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders within the service were visible and approachable to staff. They understood some of the challenges they faced and were working to overcome them; for example, ensuring full capacity was utilized. However, they had not identified others such as accessible information for all and resuscitation requirements for paediatric patients.

The service had a whistleblowing policy which staff were aware of and although small staff could approach either of the two managers in confidence if required. Staff felt they could raise concerns without fear of retribution.

Leaders supported staff to develop their skills and take on more senior roles. For example, one member of staff was supported in training in dental radiology. This supported the service in terms of staffing retention, sustainability, and also the individual development and succession planning within the service.

Vision and Strategy

The service had a vision for what it wanted to achieve but no realistic strategy to turn it into action. The vision did not appear to be focused on sustainability of services or aligned to local plans within the wider health economy.

The service had a clear vision to capture the London market although it was not clear how this vision reflected quality patient care as a priority.

Progress against the implementation of measures to achieve this, such as visiting dental surgeries, were monitored regularly at performance and scheduling meetings held between the managers of the service. However, there was lack of a robust strategy or priorities for delivering good quality sustainable care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported, valued and proud to work for the organisation. We saw interactions between managers and staff that were respectful, friendly and kind. Staff were supported to develop their skills and could raise concerns without fear of retribution.

Equality, diversity and inclusion featured as part of mandatory training undertaken by staff.

Patients could raise concerns and information on how to do so was available on the patient portal used by all patients accessing the service.

Requires Improvement

Diagnostic and screening services

Governance

Leaders did not always operate effective governance processes with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service did not always have systems of accountability to support good quality patient care. For example, an arrangement with a third-party provider that used a treatment room at 3BEAM location was in place, and a copy of the treatment room contact was provided following inspection. However, this did not set out clear governance and patient safety information such as what to do in an emergency and who would investigate and carry out duty of candour if an incident occurred. The contract was essentially blank, it did not have a name of the co-occupant, there was no agreement start date, no review date and was unsigned by either party. This meant the service had no assurance that good quality patient centred care was being provided.

Service level agreements were in place with the radiation protection advisory company and teleradiology company. These contracts were signed and in date and set out clear terms of expectations. For example. Radiation protection and scientific advice and x-ray equipment safety and performance checks to support the statutory requirements set out by the Ionising Radiations Regulations (Medical exposure) Regulations 2017.

Service level agreements between the dental referrers were in place and professional register checks were undertaken prior to the referral being accepted by the service.

Liability and indemnity insurance were in place within the service and due for renewal in March 2023.

A medical advisory committee meeting took place quarterly at the service. This was attended by the registered manager and nominated individual as well as an oral surgeon and consultant radiologist. Clinical advice and external feedback were discussed at this meeting.

Managers from the service met fortnightly to discuss a set agenda which included scheduling, staffing and incidents. Meeting minutes were reviewed from the 8th July: equipment, training, safeguarding, complaints, IT issues and AOB were discussed. The meetings prior to this had taken place on the 23rd May 2022, 3rd May 2022 and 14th April 2022.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. The service did not keep comprehensive records of identified risks and issues and could not provide evidence of identified actions to reduce their impact. The service had plans to cope with unexpected events.

The service could not demonstrate it had an appropriate method of recording risk. It identified risks at a regular weekly meeting held between managers. Managers spoken with during the inspection could articulate the top risks to the service. However, these risks, and the actions taken to mitigate them or monitoring of them, were not recorded. Therefore, we were not assured that systems relating to risk were fully developed.

Contingency arrangements were in place to cope with system failures both electronic and radiological. This included rescheduling appointments and when required patients being scanned at different organisations.

Requires Improvement

Diagnostic and screening services

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had worked to ensure it was compliant with data and information management including general data protection regulations (GDPR). An external subject expert had been consulted and supported the service to be compliant with statutory requirements.

Documentation was electronic for staff, patients and referrers. This was password protected and meant that the system could not be accessed by those unauthorised to do so.

Information was kept securely on a cloud-based system meaning that it was easily accessible and kept securely.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Peoples' views and experiences were gathered via a public electronic platform and by requesting feedback from people accessing and booking with the clinic. This was then acted on to shape and improve the services. For example, the service had identified through engagement with referrers that the ability to offer two CT scanners from different manufacturers meant that patients from different specialties, such as maxillofacial and ear nose and throat, could receive the most appropriate scanning images.

A newsletter was being produced to share developments in dental scanning this was planned to be distributed to dentists in the local area. No date for completion was available at the time of the inspection.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was committed to continually learning and improving its services. Subject matter experts had been consulted, such as the GDPR specialist, to work alongside the service in supporting them with compliance. The registered manager was undertaking an accredited qualification in information technology so that he could work easily with the electronic systems used by the service. Clinical image audits with external specialists meant that the service was outwardly looking in terms of improvement, and feedback was analysed to help shape the service in the future.

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 17 HSCA (RA) Regulations 2014 Good governance Contractual arrangements for the sub letting of room within the service were not in place.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Disclosure barring service checks had not been undertaken for all patient facing staff members.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Paediatric resuscitation was not in place for staff to use within the service.