

Ct Dent Ltd (London)


Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?		
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

Overall summary

Ct Dent Ltd (London) is operated by C.T. Dent Limited. The service provides diagnostic dental imaging services for patients referred by third-party dental and medical healthcare professionals.

The service provides 2D (dental panoramic, cephalometric and skull X-rays) and 3D (cone beam computed tomography) scanning services to both private

and NHS patients. Cephalometric analysis is the analysis of the dental and skeletal relationships of a human skull. It is frequently used by dentists, orthodontists, and oral and maxillofacial surgeons as a treatment planning tool.

Cone beam computed tomography (CBCT) is a low-dose medical imaging technique consisting of X-ray computed tomography where the X-rays are divergent, forming a cone. CBCT is used for dental and maxillofacial imaging for the purpose of treatment planning and diagnosis in

Summary of findings

implant dentistry. In addition, the service used CBCT for implant planning, orthodontics, endodontics, oral medicine, airway studies and temporomandibular joint imaging.

The service also provides intra-oral scanning service which uses light and imaging sensor technology, rather than X-rays, to create 3D surface models of dental and connective tissues.

The service operates a flexible online appointment system and walk-in service seeing both children and adults, referred by both private and NHS providers.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 25 July 2019. We previously inspected this service in October 2018 and rated the service inadequate overall.

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.

Services we rate

Our rating of this service improved. We rated it as **Good** overall.

We rated it as good because:

- The service had made improvements to address the areas of concern identified during the last inspection.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed

guidance. Staff monitored the effectiveness of care and treatment. Staff worked well together to make improvements and achieve good outcomes for the benefit of patients.

- 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.
- People could access the service when they needed it. The service planned care to meet the needs patients, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and 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 referral community to plan and manage services. Staff were committed to improving services continually.

However:

- The frequency of mandatory training updates and the quality and content of their policies on safeguarding did not meet with best practice recommendations.
- There was no specifically designated sink for clinical staff to wash their hands.
- The service did not have formal processes to provide ongoing review and assessment of staff competency.
- The service did not have any formal process to provide ongoing monitoring or management of service level agreements (SLAs) with third-parties.
- Although the service had effective systems and processes to identify and control risk, systems and processes for reviewing risks were relatively new and not yet fully embedded.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. 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

Diagnostic imaging

Rating

Good



Summary of each main service

Diagnostic imaging was the sole activity of the service. We rated this service as good because it was safe, caring, responsive and well-led. We do not rate the effective domain for this type of service.

Summary of findings

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Good 

Ct Dent Ltd (London)

Services we looked at: Diagnostic imaging

Summary of this inspection

Background to Ct Dent Ltd (London)

Ct Dent Ltd (London) is operated by C.T. Dent Limited. Ct Dent Ltd (London) began operating in March 2007. The company was created to provide third-party healthcare professionals with dental imaging and diagnostic scanning services.

The service has six satellite sites in the UK. These are in Manchester, Birmingham, Nottingham, Bristol, Leeds and Colchester. The London centre is the centralised location of the service handling all communication, data processing, document storage and it is where the senior management team is based. All satellite sites are managed from London.

Ct Dent Ltd (London) operates as a referral centre, accepting referrals from third-party healthcare

professionals for dental and maxillofacial diagnostic imaging, carrying out the imaging and returning the results to the referrer. It also provides a service for radiology reporting. The service receives referrals from healthcare professionals for both 2D and 3D imaging; often this is associated with treatment involving dental implants.

We previously inspected this service in October 2018 and rated the service inadequate overall. This was because we identified concerns around the safety and governance of the service. We issued the provider with a warning notice in response to breaches of regulation.

The service has had a registered manager in post since 2013.

Our inspection team

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

Why we carried out this inspection

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- During the inspection, we visited the London centre only. We spoke with three radiographers, one member of reception staff and the registered manager. We also spoke with two patients.

Activity (October 2018 to May 2019)

- In the reporting period, the service saw 19,537 patients in total across all seven of the UK locations.
- Of these patients, 97% were adults and 3% children and young people under 18 years of age.
- Of these, 95% were privately-funded and 5% NHS-funded patients.
- All patients were seen on an outpatients basis, the service did not provide any overnight beds.

- Staff in the service consisted of the registered manager (who was also the lead radiographer and managing director for the service) five other radiographers, two reception/administration staff and 10 other non-clinical staff who worked in sales, software and marketing (including two company directors). The service had access to radiologists for the purposes of reporting, this service was provided under a third-party contract arrangement.

Track record on safety

- No never events, serious injuries or deaths
- Clinical incidents: 85 in total, all 'no harm'.
- No serious injuries
- No reported incidences of hospital-acquired infection

Services provided at the hospital under service level agreement:

Summary of this inspection

- Housekeeping and facilities management
- Clinical and non-clinical waste removal
- Medical equipment provision and maintenance
- Medical physics expert and radiation protection advisor service
- Between October 2018 and June 2019, the service recorded six formal complaints

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?

Our rating of safe improved. We rated it as **Good** because:

Good



- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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 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.
- The design, maintenance and use of facilities, premises and equipment kept people safe and staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff knew what to do if patients became unwell.
- 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.
- 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.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with staff. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The frequency of mandatory training updates did not meet with best practice recommendations.
- Safeguarding policies needed to be updated to reflect best practice recommendations and provide clear guidance for staff
- There was no specifically designated clinical sink for staff to wash their hands.

Are services effective?

We do not rate effective for this type of service.

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

Summary of this inspection

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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.
- Patients had access to drinks while awaiting their scan.
- Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- 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.

However:

- The service did not have formal processes to provide ongoing review and assessment of staff competency.

Are services caring?

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand and make decisions about their care and treatment.

Good



Are services responsive?

Our rating of responsive improved. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of the patients they served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Good



Summary of this inspection

- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- 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. The service included patients in the investigation of their complaint.

However:

- Information on accessing the service was not readily available to patients with mobility issues.

Are services well-led?

Our rating of well-led improved. We rated it as **Good** because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, which it developed with input from staff and patients.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care
- 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 submitted to external organisations as required.
- The service engaged well with patients, referrers and staff to plan, manage and improve services.

Good



Summary of this inspection

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.
- The service had systems and processes to monitor and manage performance and to support quality improvement. 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.

However:

- The service did not have any formal process to provide ongoing monitoring or management of service level agreements (SLAs) with third-parties.
- Although the service had effective systems and processes to identify and control risk, systems and processes for reviewing risks were relatively new and not yet fully embedded. It was unclear how local risk management processes and risk assessments interacted with the corporate risk register to ensure the service had effective oversight and assurance on both local and corporate risk.





Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are diagnostic imaging services safe?

Good 

Our rating of safe improved. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, the frequency of mandatory training updates did not meet with best practice recommendations.

- The service now had a process to ensure all staff had completed appropriate mandatory training for their role. There was evidence that staff had read local rules and received training on radiation risks.
- At the time of this inspection, all staff had completed mandatory training in basic life support (BSL), fire safety, infection prevention, information governance, manual handling, radiation protection and safeguarding adults and children level 2, within the previous 12 months.
- Staff were required to complete mandatory training within the first three months of having their induction. Training was delivered through a combination of classroom-based training and e-learning.
- The service had updated its training and development policy in February 2019. The service's policy stated that staff were required to complete updates of all training modules every three years. However, this did not reflect professional guidelines, which recommended more frequent updates for some modules, including basic life support training. Skills for Health's Statutory/Mandatory Core Skills Training Framework (CSTF) recommends staff

receive annual updates for resuscitation, information governance and infection prevention and control. Fire safety training updates are recommended every two years as a minimum.

Safeguarding

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. However, safeguarding policies needed to be updated to reflect best practice recommendations and provide clear guidance for staff.

- The service now had a process to ensure all staff had completed appropriate safeguarding training.
- All staff had completed safeguarding adults and safeguarding children level 2. The service's registered manager who was also the safeguarding lead, had completed safeguarding children level 3.
- Staff we spoke with were aware that the registered manager was the service's safeguarding lead and could tell us what they would do if they had safeguarding concerns.
- The safeguarding lead had delivered a scenario-based training workshop to staff to help improve understanding of specific safeguarding concerns they needed to be aware of. Staff told us they found this helpful and that they felt confident in identifying patients at risk.
- Staff had access to contact telephone numbers for the relevant local safeguarding teams. These were available on the service's electronic system and in the paper copies of the provider's policies kept in a folder behind the reception area.

Diagnostic imaging

- The service had policies and procedures to safeguard children and vulnerable adults at risk of abuse. Although these policies had recently been reviewed and updated, we found the quality and content to be variable. For example, although policies listed types of abuse, they did not provide sufficient detail for staff to ensure they knew how to identify any patients at risk. We raised this with the registered manager during the inspection who said they would review these policies.
- Staff followed the Society and College of Radiographers (SCoR) 'pause and check' process to confirm patient's identity before carrying out any scans. If radiographers noticed any unexpected findings on the scan image, they would highlight their concerns to the manager.
- The service had not needed to report any safeguarding concerns to CQC in the 12 months prior to the inspection.

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. However, there was no specifically designated sink for clinical staff to wash their hands.

- The service now had a process to ensure staff kept appropriate cleaning records. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Radiographers carried out a weekly deep clean of scanning rooms and equipment.
- The environment and equipment was visibly clean, and staff followed infection prevention and control (IPC) policies and procedures.
- One of the radiographers was the designated IPC lead for the service and was responsible for carrying out monthly IPC audits, updating annual risk assessments and assessing staff compliance with hand hygiene processes. Audit results showed good compliance with IPC policies and procedures.
- Staff had access to handwashing facilities, hand gel sanitisers and personal protective equipment (PPE), including wall-mounted glove dispensers. Sanitising gel was available in all scanning rooms. We saw that staff used these appropriately.
- We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff followed appropriate waste segregation procedures.

- The Department of Health's professional standards for Health Building Note on Facilities for diagnostic imaging and interventional radiology are set out in Health Building Note 6 (HBN6). These recommend services have a specifically designated clinical sink for staff to wash their hands, within or adjacent to the examination room.
- Clinical staff had access to two sinks for handwashing, one in the staff kitchen, which was also used for food and drink preparation, and one in the third-floor bathroom, which was shared with non-clinical staff, visitors and patients. Handwashing guides were available for staff above both sinks. As neither sink was specifically designed as a clinical sink, there was a risk of cross contamination. However, due to the non-invasive nature of the services provided this risk was low and the service had reported no healthcare-acquired infections in the 12 months prior to our inspection.
- The registered manager told us that there were plans to redesign the unit later in 2019 and this would include a refurbishment of staff areas.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe and staff were trained to use them.

- The service's premises and facilities were appropriately maintained to keep people safe. There was secure access to the building via the ground floor reception. The service shared the building with other services and residential tenants. The service was based on the 2nd and 3rd floors accessible by stairs or lift. The lift was maintained by the building's landlord but was out of order on the day of our inspection. The reception and scanning rooms were located on the 2nd floor, with the 3rd floor used as office space.
- Staff carried out regular equipment safety checks to ensure they were safe and fit for purpose. The service had three items of ionising radiation equipment designed to produce images of dental and maxillofacial anatomy. We saw evidence that staff carried out quality assurance (QA) checks of equipment in line with the manufacturer's recommendations. Equipment was subject to annual planned maintenance checks.
- Staff carried out radiation risk assessments, we saw evidence these had recently been reviewed and

Diagnostic imaging

updated. Radiographers operated the equipment from outside the room and observed patients via CCTV. Each room had a separate monitor screen and emergency power shut off button outside.

- The centre had control measures including warning lights and signage to identify areas where radiological exposure was taking place as required by the ionising radiation regulations 2017. This ensured that staff and visitors did not accidentally enter a controlled zone such as X-ray when a procedure was in progress.
- Staff had access to appropriate related dental equipment; tongue depressors, plastic hygiene shields, and other supporting equipment. All rooms had clinical waste bins, glove dispensers, cleaning wipes and hand gel.
- The use personal protection equipment (PPE), such as lead aprons, were not required during dental radiography. Thyroid shields available within the centre but the manager told us these were used infrequently.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff knew what to do if patients became unwell.

- The service required that all third-party healthcare professionals wishing to refer patients to the service were registered doctors or dentists. Potential referrers were required to formally register to use the service, this was done via the provider's website.
- Staff carried out validation checks on all referrers to ensure they had valid professional registration. No non-medical staff were authorised to refer patients, and patients were not able to self-refer. Once registered, the referrer had access to the online portal to make referrals and view scan results.
- All patients required a completed referral form before any scan could go ahead. If any information was missing from the referral forms staff would contact the referrer. Referrers were required to provide appropriate information to allow for clinical justification for all scans or images. Radiographers would review this information against the service's referral criteria to ensure the type of requested scan was appropriate for each patient.

- The radiographer selected the scanning protocol for adults and children based upon recommended manufacturer settings and published research; there was an exposure chart in each scanning room showing estimated dose and diagnostic reference levels.
- The service used an electronic patient records system which formed part of the service's computer database and portal for referral, billing and patient records. The system had in-built checks to remind the radiographer to check patient identification and correct scan prior to progressing to the imaging.
- The service ensured that the right person got the right scan at the right time, by following the recommendation from the Society and College of Radiography to use a 'pause and check' system. This is a system of checks that need to be made when any diagnostic examination is undertaken. Radiographers used a three-point patient identification checking system. Radiographers described checking identification via: name, date of birth, referring dentist and scan area.
- There were processes to escalate unexpected or significant findings, both at the examination and upon reporting, which staff described. The service had a pathway for unexpected urgent clinical findings. If at time of examination, the radiographer identified anything unusual on the patient's scan they would escalate this to the lead radiographer who would then contact the referrer directly to make them aware. Where the referrer had requested a report from the service, the reporting radiologist was contacted by a member of staff to advise them of the urgent report to ensure it received prompt attention. For urgent referrals, images would be sent to the referrer via the image exchange portal within 24 hours or sooner.
- Pregnant patients were able to use the service if there was a clinical need for the scan. The service had prominent signs displayed in the waiting area asking patients to inform staff if they thought they may be pregnant. Staff told us that protective equipment was not necessary for pregnant patients as the risk of radiation exposure to the foetus was low.
- Patients attended the service for routine pre-planned non-invasive diagnostic procedures. the unit was not equipped with resuscitation equipment. All staff had completed basic life support training within the previous 12 months. Staff informed us, in the unlikely event a

Diagnostic imaging

patient deteriorated they would phone 999. Staff had also been trained to use the building's defibrillator. A defibrillator is a device that gives a high energy electric shock to the heart of someone who is in cardiac arrest.

- The service provided staff with life support updates every three years. Resuscitation Council (UK) recommends clinical staff should have at least annual updates in life support. The registered manager told us that they had considered this but as the service had very few medical emergencies they felt the training provided was sufficient to keep patients safe.
- The centre was registered with the Health and Safety Executive (HSE) in accordance with Ionising Radiation Regulations 2017 (IRR17). We viewed records that demonstrated access to a medical physics expert (MPE), and that a radiation protection advisor (RPA) and radiation protection supervisors (RPSs) had been appointed.

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.

- There were six radiographers employed by the service. Four worked at the London location, this included the registered manager who was also the lead radiographer. Two radiographers worked at the service's satellite locations in Bristol and Nottingham, the other four locations were staffed by third-party radiographers and receptionists as part of the rental contractual agreement. At the time of our inspection there were two vacancies for radiographers.
- The service did not use bank or agency staff. If staff were absent at short notice, the number of available appointment slots would be reduced. Staff had flexibility over their shifts and were given responsibility for managing their own rota.
- The service's electronic patient booking and management system allowed the service to ensure there was always enough staff to meet the demand for pre-booked and walk-in appointments, whilst ensuring there was flexibility to see any emergency referrals if needed.

- Radiologist services were provided by three third-party providers, under a contract agreement. The registered manager told us they were able to access advice and support when they needed it.
- The service had a policy on lone working. Radiographers working at satellite locations had access to support through the London centre and staff and patients were monitored remotely by senior management via the CCTV and computer system. The electronic system alerted senior staff to issues with patient-flow, for example where a member of staff was running late, or patients were waiting to be seen.

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.

- The system used for patient records was a bespoke computer portal used for referral, billing and patient records. Staff were able to access the system remotely when working from satellite location, as the system was password controlled for security.
- Referral information was received via the services electronic booking system or printed referral forms. Referral details were entered onto the provider's computer system and relevant information was noted against a patient's individual details. The referral form included areas where the type of imaging and the reasons for request were recorded. This ensured the referral was appropriate for the examination to proceed.
- Referrers were required to register online and set up a user account through the provider's website. This gave them access to a password-protected online portal to make referrals and receive scan results. Scan images and results could also be sent out on a CD via post.

Medicines

The service did not administer or store medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with staff. When things went wrong, staff apologised and gave patients honest information and suitable support.

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- Since our last inspection, the service had introduced a separate incident reporting function within their electronic patient records system. This system allowed any member of staff with access to the computer system to report an incident or near miss.
- The manager told us that to raise awareness and encourage learning, all staff were able to view the full details of all incidents reported. In addition, managers and senior staff reviewed the incidents each month to identify themes and opportunities for learning and improvement.
- The service had reported 85 incidents between October 2018 and June 2019. The manager told us that no patients had been harmed because of a patient safety incident. Incidents primarily related to radiography issues, including unintended patient exposure (usually where a scan had to be repeated) and incorrect patient information recorded by staff.
- The service recorded incidents of 'unintended patient exposure' where due to a technical or procedural error, the scan had to be repeated, for example of the wrong side of patient's jaw was scanned. The service manager confirmed there had been no incidents which met the radiation dose threshold for reporting to CQC. There had been no incidents where patients or staff had been accidentally exposed to a dose of radiation.
- The manager told us about actions that had been taken in response to incidents. These included reminding staff not to use mobile phones when in the scanning rooms to avoid distraction and putting up visible reminders of the Society and College of Radiographers (SCoR) pause and check process to confirm patient's identity before carrying out any scans.
- Senior staff discussed incidents at governance meetings. Learning in response to incidents was shared with staff during team meetings. Staff we spoke with were aware of their responsibilities to report incidents and knew about learning in response to incidents.
- Radiographers understood their responsibility to report any significant unintended or accidental exposure to ionising radiation. The manager knew that if exposure levels were too high, there was a requirement to report this to the CQC and Health and Safety Executive (HSE). They confirmed that this type of event had not occurred at the service.
- The duty of candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There had been no incidents which had required the service to use the statutory duty of candour since the service had opened. When things went wrong, staff apologised and gave patients honest information and suitable support.

- A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events reported since the service opened.

Are diagnostic imaging services effective?

We do not rate effective for this type of service.

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.

- The service based its policies and procedures on the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017). The local rules were up to date and reflected the equipment, staff and local practices within the service.
- Policies and procedures were subject to review by the medical physics expert (MPE) team and radiation protection advisor (RPA) in line with the requirements of IR(ME)R 2017.
- Staff could access policies, procedures and guidelines via the service's internal electronic resources. Paper copies of local protocols were in line with national guidance and readily available to staff.
- Staff had access to diagnostic reference levels (DRLs) which were displayed in all scanning rooms. The DRL is a measure of patient radiation dose and serves as a quantitative guide to optimisation of radiological protection. The service followed national guidance on DRLs.

Diagnostic imaging

Nutrition and hydration

Patients had access to drinks while awaiting their scan.

- Patients were able to help themselves to cold water from the water dispenser in the reception area.

Pain relief

The service did not provide pain relief to patients as it was not required for the imaging undertaken.

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 an audit programme to monitor the quality and safety of services provided and help achieve good outcomes for patients.
- Staff carried out an audit of image quality in accordance with the requirements of IR(ME)R 2017. The purpose of this audit was to assess the standard of diagnostic imaging thereby reducing the number of repeat images, increasing clinical efficiency and reducing the radiation dose to patients and staff.
- Staff carried out an image quality self-audit on all images. Staff scored their imaging as follows, 2D X-rays; score 1: excellent, score 2: acceptable, score 3: unacceptable and 3D scans either acceptable or unacceptable. The service set a target that 70% of images should score excellent for 2D images and that 95% of 3D scans should score as acceptable. Audit data for January to December 2018 demonstrated that these targets were consistently either met or exceeded.
- The lead radiographer carried out a monthly audit of radiology reports based on the Royal College of Radiologists (RCR) recommendations. They checked that reports matched RCR standards for the communication of radiological reports, including patient details, scan date, modality and narrative content. The audit results were shared with the radiologists.
- The service monitored patient experience as a measure of their effectiveness and used feedback to make improvements to systems and processes. The service

carried out an audit of patient feedback every four months. All patients received an email following their appointment with a request to provide feedback on their experience of using the service.

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. However, the service did not have formal processes to provide ongoing review and assessment of staff competency.

- The service had effective arrangements for supporting new staff, including an induction and supernumerary period during which clinical competencies were assessed. Staff underwent an initial competency assessment which covered key areas applicable across all roles including equipment, and clinical competency skills relevant to their job role and experience. Staff were satisfied with the induction and training process and how it prepared them for their role.
- During their probation, new radiographers were supervised and supported by a more senior radiographer to complete a range of competency assessments. Staff were required to complete competencies including the use of equipment, anatomy, patient explanation and dealing with anxious patients. Competency was assessed through supervision and scenario-based testing, for example, new staff would be asked to justify and protocol some dummy referrals, including some with deliberate mistakes. The clinical lead was responsible for signing off staff competencies once they were satisfied they were able to work unsupervised.
- We saw evidence that the registered manager had carried out recruitment checks for new staff, including CV, employment history, references and evidence of training and qualifications. All radiographers were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients.
- Since our last inspection, the service had introduced an annual appraisal process and all staff had received an appraisal. However, the manager told us that this was still a relatively informal process and staff were not required to provide evidence of continuous professional development (CPD) at their appraisals.

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- Although staff did not have formal one to one meetings with their manager, they told us that as they were a small team they were able to speak to senior staff informally at any time and felt supported in their training and professional development. Staff were given access to a range of resources to support their CPD for example, on the service's electronic database there was a range of clinical articles and other dental related information that staff could review. However, other than the annual appraisal process, the service did not keep formal records of performance management, CPD or other evidence of ongoing assessment of staff competency. The manager recognised this an area for improvement and told us they planned to introduce formal training days for staff.
- The service had contracts with radiologists providing radiology reporting services and carried out annual checks on registration and indemnity records to ensure they were fit to practice.

Multidisciplinary working

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

- The registered manager told us they were able to access radiation and radiology advice and support when they needed it.
- Staff at the service worked closely with referrers to provide a seamless treatment pathway. If staff identified any concerns would be reviewed by the manager of the service and escalated to the referrer. The service could also refer to their medical physics expert and radiation protection advisor for further advice and support if necessary.
- The service was proactive in supporting referrers, providing access to tools and resources to help raise awareness of cone beam computed tomography (CBCT), promoting safe practice with patient referral and to help with image interpretation.

Seven-day services

Key services were available to support timely patient care.

- The service was open Monday to Thursday 9am to 6pm and on Friday 9am to 5pm. The service also offered appointments on two weekday evenings until 7pm, and on Saturday 9am to 3pm. The service offered a flexible appointment system and a walk-in service.
- Staff told us the service would always try to accommodate any short notice and emergency patient referrals where possible.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

- Patients received an email prior to their appointment with information what the scan would entail and how to prepare. This included a link to a video demonstrating the scan process and further helpful information on the service's website.

Consent and Mental Capacity Act

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.

- Since the last inspection, the service had formalised their process for recording verbal consent. Staff followed a checklist prior to the scan, which asked them to confirm the patient had given their consent. The radiographer had to tick a box to confirm that patient had given consent in order to proceed with the scan.
- The referral form also required the referrer to provide confirmation that they had provided the patient with adequate information with regards to the benefits and risks of being exposed to radiation and that the patient had given their consent.
- Staff demonstrated to us an understanding of their responsibility to obtain consent from patients prior to a scan. They told us that should a patient chose not to have a scan this decision would be respected.
- We observed staff asking for a patient's consent before the scan took place and saw how this verbal consent was documented in patient records.

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- Staff were able to tell us about Gillick competence. This is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Staff had completed training in the Mental Capacity Act 2005 as part of their mandatory safeguarding training.

Are diagnostic imaging services caring?

Good 

Our rating of caring stayed the same. 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.

- Staff looked after patients in a kind and compassionate manner. Staff introduced themselves, explained their role and what to expect during the scan. This ensured that patients understood what was happening and felt able to ask questions.
- Staff were proactive in maintaining patient's privacy and dignity, for example they took care to ensure the monitoring screens, used to view the patient during the scan, were not visible to other patients in the waiting area.
- Patients were very positive about staff. Patients we spoke with said staff were "friendly", "wonderful", and "excellent". One patient told us they had arrived for their appointment earlier than planned and staff on reception had been friendly and had made them feel welcome by arranging for them to be seen sooner.
- Those patients who had provided the service with their email address, received an email following their appointment with a request to provide feedback on their experience of using the service. Patients were asked to rate their experience of using the service on a scale from 1 to 5, with 5 being the most positive. Between January and April 2019, 94% of patients rated their experience as either a 4 or a 5. This was based on 369 responses, which was 6.3% response rate.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff recognised that some patients were nervous or anxious and they made sure patients always had enough time to ask questions. Patients told us they felt supported and reassured by staff and had an opportunity to discuss any worries or concerns.
- Staff were considerate of patients' emotional needs and took the time to reassure those who were nervous or anxious about the scan. Staff told us that if a patient was claustrophobic they could offer them the scanning room with a window which often helped reduce their anxiety.
- Staff gave us examples of where they had accommodated patient's needs and allowed extra time for a scan where the patient needed more time to prepare themselves.
- We did not see any children using the service during the inspection, however, staff were able to tell us about what they did to reassure young patients. Staff gave us an example of using a teddy bear to demonstrate how the scan worked. If needed, a parent or guardian could stay in the room whilst the scan took place.

Understanding and involvement of patients and those close to them

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

- Communication between staff and patients was good. Patients told us they felt well-informed each step of the way and were given enough time to ask questions. Staff ensured patients understood what was happening and when they would receive the outcome of the scan or report.
- Staff made sure patients were made aware of payment options and provided information to referrers to share with patients in advance of their appointment. Where it was not possible to carry out an acceptable imaging procedure, for example if the patient had tremors due to a systemic illness, this was explained to the patient. The referrer would also be informed of this decision and the patient would not always be charged for the image.

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Are diagnostic imaging services responsive?

Good 

Our rating of responsive improved. We rated it as **good**.

Service delivery to meet the needs of patients

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

- Patients were referred by third-party healthcare professionals, primarily private dentists, as part of their planned dental treatment. The service also provided scans to a smaller number of NHS patients who were referred as part of their diagnostic investigation.
- Although the service had 10,933 registered referrers on their system, only 3,399 had actively referred any patients to the service in the 18 months prior to our inspection. Whilst the majority of referrers were dentists or doctors providing services to privately-funded patients, there were also 30 clinicians referring NHS patients to the service.
- The service recognised the importance of supporting referrers to make appropriate referrals and enable effective and accurate clinical evaluation of the images provided. The manager told us they were constantly working to identify new ways of improving clinical outcomes for patients by working closely with referrers to raise awareness and clinical skills. For example, they had developed a training package for referrers in cone beam computed tomography (CBCT) and shared best practice via the 'case of the month'.
- The service had six satellite sites in the UK. These were in Manchester, Birmingham, Nottingham, Bristol, Leeds and Colchester. All the satellite sites were managed from the London location which ensured there was a consistent and centralised process for communication, data processing and document storage. This allowed the senior management team central oversight of patient appointments and service delivery.
- The service was open six days a week including two weekday evenings and on Saturday 9am to 3pm and offered a flexible short-notice appointment system and

a walk-in service. The service would always try to accommodate any short notice and emergency patient referrals where possible. The service had recently reviewed its opening hours to increase patient capacity and provide flexibility.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- Staff demonstrated an understanding of patients with additional support needs. Referrers were asked to add detail to the patient's referral form to highlight if a patient had any complex needs such as mental capacity issues or learning disability. This allowed staff to prepare in advance for the patient. Staff told us they would contact referrers for more information if needed.
- Staff explained that children and patients with additional support needs were prioritised so they did not have to wait too long to be seen once they had arrived for their appointment.
- Since our previous inspection the service had introduced a hearing loop to help support patients with hearing impairment.
- Staff explained the referrer would inform them if interpretation services were required and they would organise this in advance. They stated that in most cases, patients were accompanied by a relative who could interpret for them, which was not best practice.
- The patient waiting area was patient-friendly, with comfortable seating and access to fresh water and magazines. There was information for patients on how to prepare for their scan and what to do if they wanted to complain. Due to the small size, and layout, of the service, adults and children used the same waiting areas. Although this is not best practice, staff told us that waiting areas were never left unsupervised and children were seen by staff as soon as they arrived.
- The service had ramp and lift access for those patients with reduced mobility, however the lift was small and unable to accommodate most standard wheelchairs, therefore not suitable for patients who were unable to walk short distances. Information on accessing the

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service was not readily available to referrers or patients with mobility issues. Following the inspection, the registered manager told us this information had been added to the provider's website.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

- Patients were seen promptly following their referral to the service. The service usually had appointment slots available on the same day if needed. Patients, and their referrers, were able to book appointments electronically via the provider's website or online portal, or they could phone to speak to staff directly. The service offered a wide choice of appointment times and a walk-in service.
- The service monitored in-clinic waiting times closely and patients usually had to wait no longer than 10 minutes to be seen for their appointment once they had checked in at reception.
- Staff recorded patients' arrival on the service's patient booking system notification system. If a patient is marked as arrived for longer than 25 minutes the senior management received a notification to check if there is a specific reason for the delay which may need to be dealt with. This allowed the central management team to remotely monitor waiting time performance at the service's satellite locations.
- Scans images were usually available to be returned to the referrer within 24 hours. Reports were available within three to five days. However, the referrer (or patient) could pay an additional fee for an express (same day) service. If the radiographer identified urgent concerns then this would be escalated to the referrer in real-time.

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. The service included patients in the investigation of their complaint.

- The service made it easy for people to give feedback and raise concerns. Information for patients on how to complain was visible in the main reception areas. The registered manager was the service's complaints lead and his contact details including phone number and email address were available. Details of an independent complaints service were also available should the patient not be happy with how the service has handled their concerns.
- The service treated concerns and complaints seriously, investigated them and took action to put things right. We saw examples of where complaints had been investigated and the patient had been provided with an apology and explanation of what had been done to address their concerns.
- The service now had a system to record complaints centrally which helped identify any reoccurring themes. Staff told us that they received feedback about complaints and gave us examples of where the service had made improvements and changes in practice in response to complaints and patient feedback, for example by improving signage.

Are diagnostic imaging services well-led?

Good 

Our rating of well-led improved. We rated it as **good**.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

- The service's senior management team consisted of the chief executive officer (CEO) and three directors. The managing director was the service's registered manager and lead radiographer. The managing director shared responsibility with the sales director and operation directors, and the CEO, for the governance, accountability and risk management of the organisation.
- The registered manager was also the service's clinical lead and had been with the organisation since 2011. They had received appropriate training for their role,

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including additional safeguarding training and a postgraduate qualification in advanced dental and maxillo-facial radiography. They were passionate about the quality and safety of services they provided and demonstrated a strong commitment to improving services in response to learning and feedback from staff, patients and referrers.

- Staff said they felt well-supported and felt confident in raising concerns. They were positive about the leadership of the service and told us their manager, and other senior staff within the service, were approachable and visible within the service.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, which it developed with input from staff and patients.

- The service's mission statement and vision was "to provide top quality, state-of-the-art digital scanning services, previously unavailable to dental professionals. It is a full spectrum imaging centre that strives to support the dentists in many phases of the patient's care."
- This vision was supported by the organisation's four strategic objectives of enhancing the patient experience, preventing harm, being responsive and being well led.
- The service had produced an annual plan for 2019-2020, setting out the proposed changes and improvements planned for the service over the next 12 months. These included plans to expand the service, increase appointment capacity and invest in new technology and equipment.
- The service had long-term plans to improve services through the introduction of new and innovative techniques. For example, they had recently developed a training package for referrers on CBCT and were working on development and introduction of artificial intelligence to improve diagnostic accuracy. The service was in the process of looking to replace scanners at the London and Manchester in centres to enable them to deliver high-quality images to clients with lower radiation dose.

Culture

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

- Staff felt supported, respected and valued by their colleagues and managers, and were proud to work at the service. They told us there was an open culture, which was centred on the needs and experience of people who used the service.
- Staff we met were welcoming, friendly and open in their discussions with us. It was evident that staff cared about patients and their colleagues, as well as the quality and safety of services they provided. There was a culture of challenging behaviours and practices to continue to improve patient experience and outcomes.
- Staff were actively involved in developing safe and effective practices and were encouraged to identify better and safer ways of working. The service held team meetings which provided staff with an opportunity to reflect, provide feedback and share learning.
- The registered manager told us that staff morale and welfare were of key importance and gave us several examples of where staff had been supported through personal challenges. The service offered flexible working to staff when needed and staff were able to take ownership of planning their working hours. The manager told us that this had led to a reduction in staff sickness.
- Staff told us that senior leaders responded positively to staff feedback and actively engaged staff in discussions about changes to the service. Staff told us they felt their views were respected and listened to.

Governance

The service had systems and processes to monitor and manage performance and to support quality improvement. 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. However, the service did not have any formal process to provide ongoing monitoring or management of service level agreements (SLAs) with third-parties.

- The service's leadership team consisted of four individuals (three directors and the CEO) therefore they

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were able to meet both formally and informally on a regular basis to discuss governance and performance issues. The managing director (who was also the registered manager and lead radiographer) shared responsibility with the sales and operation directors, for the governance, accountability and risk management of the organisation, with oversight by the CEO.

- The service's satellite sites were managed centrally from the London location which ensured there was a consistent and centralised process for managing quality and performance. All communication, data processing and document storage was managed centrally. This allowed the senior management team central oversight of service delivery.
- The registered manager told us that the leadership team met regularly to review performance and quality. Meeting minutes we reviewed demonstrated that the board had oversight of key performance and quality measures, including staffing, audit results, incidents, complaints and information governance. Although there was no formal timetable to these meetings, the board met on roughly on a quarterly-basis.
- The service had an audit programme to monitor the quality and safety of services provided and help achieve good outcomes for patients. Audit results were reviewed and discussed by the senior leadership team at governance meetings. The meeting minutes for the board meeting, which took place in May 2019, noted a review of audit results for January to April 2019. These included, clinical image quality, infection control and patient feedback. Areas for improvement were highlighted and discussed. Team meeting minutes evidence that this feedback was also shared with staff.
- The service shared information with staff via both face-to-face and electronic methods. Staff had access to information on the shared portal and via an electronic group messaging system. The manager told us that because some staff worked remotely, electronic communication methods had been received positively by staff as they ensured staff were able to keep up to date with changes in real-time.
- Medical physics expert (MPE) advice and radiation protection advisor (RPA) support was provided by service level agreement (SLA) from individuals who also worked for an external NHS trust. The department had access to the MPE and RPA via telephone or email, they could access their named individual or suitable

alternative anytime within normal working hours. The registered manager was the radiation protection supervisor (RPS) for the service and had received appropriate level of training for their role.

- The service did not have any formal process to provide ongoing monitoring or management of service level agreements (SLAs) with third-parties. The service required all referrers to formally register with them and sign a service level agree setting out their responsibilities under IR(ME)R 2017. Although the service carried out validity checks on all new referrers, there was no formal process to review SLAs once in place. The registered manager told us that the SLA was only reviewed and updated by them if there are any substantial changes to the service's referral criteria. In this case, the referrer would be automatically notified of the change when they logged into their online portal and asked to review and sign their agreement.
- Although the service had 10,933 registered referrers on their system, only 3,399 had actively referred any patients to the service in the 18 months prior to our inspection. Although the registered manager told us they regularly checked the general dental council (GDC) hearings list to identify any clinician who was no longer fit to practice and would remove their registration, the service relied on referrers to notify them if they moved on or retired from their current practice.
- The service did not routinely ask referrers to provide evidence that they had completed adequate training in dental CBCT appropriate to their IRMER role. Health Protection Agency (HPA) best practice guidelines recommend this should be requested and checked. HPA guidance also recommends annual reviews of SLAs to ensure they are kept up to date.

Managing risks, issues and performance

Although the service had effective systems and processes to identify and control risk, systems and processes for reviewing risks were relatively new and not yet fully embedded. It was unclear how local risk management processes and risk assessments interacted with the corporate risk register to ensure the service had effective oversight and assurance on both local and corporate risk.

- The service had processes to identify and manage risks relevant to the service. The board was responsible for the corporate risk register which recorded high-level

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risks to the organisation including staffing and recruitment, financial risks and data security. Senior staff were responsible for local risk management through the monthly review of all patient safety incidents. Other staff, including the health and safety and infection control leads, were responsible for completing risk assessments to ensure effective controls were in place to mitigate risks. All staff were actively encouraged to participate in risk identification by reporting incidents and near misses.

- The service's risk register had been reviewed and updated in February 2019. Although each risk had a risk rating and documented controls in order to mitigate them, the risk register did not record when the next review date was or if there were any outstanding actions for completion. The registered manager told us that the risk register was reviewed annually by the board. Although the February 2019 board meeting minutes referenced the corporate risk register, there was no standing agenda item specifically related to identifying or reviewing risks. It was unclear how the local risk management process and the corporate risk register interacted to ensure the service had comprehensive oversight of both local and corporate risk.
- The service's incident policy set out the process for local risk management. The senior team carried out a monthly risk-review of all incidents reported for that period. Incidents were categorised and colour-coded to indicate the level of risk and action required. Incidents rated on a scale from one (no harm) to five (major risk). Although incident themes were reviewed and discussed at board and staff meetings, it was unclear how risks would be escalated to the risk register if necessary.
- The service carried out an annual health and safety risk assessment. We saw this had been completed in April 2019. The assessment identified hazards within the service, including the risk of trips or falls, manual handling, fire, lone working and radiation exposure. Potential harm, and controls to mitigate the risk, as well as ongoing actions were documented.
- Staff told us they had been consulted about improvement plans and had opportunities to raise concerns and provide feedback on any risk that may impact the service. For example, staff had been consulted on plans to refurbish the London centre.
- The service had a comprehensive business continuity plan detailing mitigation plans in the event of a disaster or emergency situation.

Managing information

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 submitted to external organisations as required.

- Staff were able to access information to help them perform their role. There was a shared drive available to all staff, which contained links to current guidelines, policies and procedures. Staff knew how to access this, and the information contained within. All staff of all levels in the company were able to view reported safety incidents, the manager told us this was to encourage openness, transparency, and service improvement.
- Staff completed training on information governance and data protection as part of their mandatory training and were supported by the registered manager in their role as Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.
- The service had taken action to ensure compliance with the introduction of the General Data Protection Regulation (GDPR). The registered manager had carried out an audit against the ISO 27001 standards to provide assurance that processes and systems manage the collection, storage and transfer data were secure. ISO 27001 is an international standard for an information security management system. In response to the audit, the service had introduced several improvements to ensure they were following best practice on information security. These included adding an additional data back-up system to enable better management of internal data storage and transfer processes.

Engagement

The service engaged well with patients, referrers and staff to plan, manage and improve services.

- The service recognised the importance of gathering the views of stakeholders including staff and patients to help drive improvement in the quality and safety of services being delivered.

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- The service used a mobile phone application to set up communication groups for different groups of staff. This ensured that even staff working remotely were kept up to date with changes and new information.
- Formal staff meetings were held annually. Minutes of these meetings were recorded and stored centrally so that staff could refer to these if necessary. Staff told us they also held more frequent informal 'catch-up' meetings with each other and shared information via the communication groups and electronic portal.
- The registered manager told us that there were plans to redesign the London centre later in 2019 and this would include a refurbishment of the 2nd floor clinical and staff areas. Staff told us they had been consulted on these plans and there had been a group exercise where they had been encouraged to suggest ideas for how the new layout would look.
- The service was proactive in supporting referrers and responding to feedback. For example, in redesigning welcome packs for new clients, condensing relevant information into a small brochure with extra information. Staff had been consulted and asked to provide suggestions for improvements to ensure the information was fit for purpose.
- Those patients who had provided the service with their email address, received an email following their appointment with a request to provide feedback on their experience of using the service. Patients were asked to rate their experience of using the service on a scale from 1 to 5, with 5 being the most positive. Where patients scored their experience poorly, the manager would follow this up to find out why. Staff were automatically copied in to any feedback where they were mentioned by name. Staff said they found this helpful.
- The provider took action to improve services based on patient feedback. For example, patients said they had difficulty finding the lift, so a sign had been added to provide direction. Staff were copied in to any feedback where they were mentioned by name.

- The service was responsive to feedback from both patients and referrers and was constantly updating and improving their electronic system to reflect this. New functions added in response to feedback included, an automated invoice system and patient waiting-time monitoring and notification systems.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The service was committed to improving services in response to learning and feedback from staff, patients and referrers.
- The service was able to remotely monitor patient in-clinic waiting time performance at the service's satellite locations. Staff recorded patients' arrival on the service's patient booking system notification system. If a patient is marked as arrived for longer than 25 minutes the senior management received a notification to check if there is a specific reason for the delay which may need to be dealt with.
- The service was proactive in supporting healthcare professionals who referred their patients to the service. The service had worked with a radiologist to produce learning materials including an e-learning training module for dentists to ensure they were able to meet the requirements for CBCT referral and clinical evaluation. The lead and senior radiographer chose a 'case of the month' to share with referrers on the provider's website.
- The service was actively involved in the development and introduction of artificial intelligence (AI) in dental radiology. It was intended that AI software would be able to teach computers how to automate radiological diagnostics using machine learning. This would help locate and identify anomalies within images, providing a faster, more accurate diagnostic evaluation.

Outstanding practice and areas for improvement

Outstanding practice

- The service had invested in innovative information systems and processes to help improve outcomes for patients. For example, they provided support and training tools for referrers, to help with clinical evaluation of images.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should consider reviewing how frequently staff receive mandatory and statutory training updates to ensure this meets with best practice recommendations.
- The provider should review their safeguarding policies to ensure they reflect best practice recommendations and provide clear guidance for staff.
- The provider should review hand washing facilities available for clinical staff.
- The provider should review their processes for providing ongoing assurance of staff competency.
- The provider should review information available to the public on accessing the services with mobility issues.
- The provider should review their arrangements to provide ongoing monitoring or management of service level agreements with third-parties.
- The provider should review their systems and processes for reviewing and escalating risks to ensure effective oversight and assurance of both local and corporate risk.