360 Visualise - Ilkley

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	Good
Are services safe?	Good
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

We rated it as good because:

- 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 and managed safety incidents well.
- Managers made sure staff had the knowledge, skills and experience to undertake their role. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- 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 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 operated some governance processes throughout the service. We saw limited evidence of clinical and internal audit to monitor quality and operational processes in place. Some risks to the service were identified, although, plans were not in place to cope with unexpected events. The service had recently identified a vision or values. Leaders supported staff to develop their skills and staff felt respected, supported, and valued and were generally clear about their roles and accountabilities. Staff were focused on the needs of patients receiving care.

However:

- We did not see any formal monitoring of mandatory training in place.
- The non-wipeable sofa was raised as a potential infection risk to the registered manager.
- There was no sink in the clinic room.
- We observed that the door to the clinical room was unlocked on one occasion during the inspection and alerted the registered manager.
- The radiation dosage chart was available, however, was not displayed in the room the scanner was in which meant staff did not have immediate access to the information.
- The dental nurse had no access to a senior dental nurse for support.
- There was no evidence of a written consent in the patients notes.
- A complaints register was not in place.
- The service did not have a formalised clinical audit schedule in place.
- To date, no pause and check audits had taken place.
- There was no formal feedback process by the referring dentists with regards to the quality of the scans undertaken to ensure that the quality of scans was satisfactory.
- We did not see how progress against the business plan was going to be monitored.
- A business continuity plan was not in place in case of failure of essential services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic and screening services	Good 	See the summary above for details. We rated this service as good because it was safe, caring, and responsive, although leadership required improvement. We do not rate effective.

Summary of findings

Contents

Summary of this inspection

Background to 360 Visualise - Ilkley

360 Visualise is based in the market town of Ilkley and is registered to provide diagnostic and screening services for clients aged 18 and above. Service provision is through private referrals, no NHS patients are seen at this location. Weekly activity is approximately five diagnostic and screening procedures.

The service specialises in 3- dimensional images and the images help dentists see internal anatomy of the face that cannot be diagnosed externally. The images also enable dentists and dental implant clinicians to accurately plan treatment and analyse the position of critical structures such as nerves and teeth.

The registered manager is Mr Peter Donnelly, and the service was registered on the 7 July 2011 to provide diagnostic and screening services. Since registration this service was inspected in 2013 where the service achieved compliance against all five key lines of enquiry. The service became dormant in 2022 and reopened in November 2022, but did not recommence its service until the new dental nurse commenced early 2023.

How we carried out this inspection

During the inspection visit, the inspection team included: the lead inspector Sue Stanton and a second inspector and was overseen by Sarah Dronsfield Deputy Director of Operations.

- Looked at the quality of the overall environment and observed how staff were caring for patients.
- We collected information from the site.
- Spoke with the Registered Manager and Dental Nurse
- Reviewed three patient care records and treatment records.
- Attended two patient consultations.
- Reviewed policies, procedures and other documents which related to the running of the service.

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 a clinical audit schedule is in place which includes the introduction of pause and check audits. (Regulation 17 (1) (2) (a))
- The service must ensure there is a formal feedback process by the referring dentists with regards to the quality of the scans undertaken to ensure that the quality of scans was satisfactory. (Regulation 17 (1) (2) (a))
- The service must ensure a complaints register is in place. (Regulation 16)
- The service must ensure there is a business continuity plan in case of failure of essential services. (Regulation 12 (1)(2)(d) (e)

Summary of this inspection

Action the service SHOULD take to improve:

- The service should ensure that the non-wipeable sofa was raised as a potential infection risk to the registered manager. (Regulation 12)
- The service should ensure that the door to the clinical room remains locked at all times. (Regulation 15)
- The service should ensure that documentation of patients' consent is captured in their records prior to the scanning procedure and auditing of consent takes place. (Regulation 11)
- The service should consider putting formal monitoring of mandatory training in place.
- The service should consider displaying the radiation dosage chart in the clinical room so that staff had immediate access to the information.
- The service should consider ensuring that the dental nurse had access to a senior dental nurse for support.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic and screening services

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

Is the service safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The training policy (DPR06) identified training requirements which included mandatory training completion.

Staff told us that the provider had registered them with an online mandatory training course provider by an external provider to ensure their mandatory training needs were met. In total two staff worked within this service, one, of which was the registered manager.

The training matrix confirmed completion of training in the following areas for 2022/23: safeguarding adults and children (L3), infection control and decontamination, information governance / general data protection regulation, Ionizing radiation (medical exposure) regulations training, basic life support and automated emergency defibrillator training, complaints, law and ethics and fire safety.

Staff we spoke with identified that the continuous professional development website they accessed had all of the necessary core skills training available to them, for example, first aid, resuscitation, safeguarding, lone working, modern slavery, cross infection. We saw a screenshot of training attended which confirmed completion of the core skills training. However, staff were not clear as to the frequency required when completing some mandatory training sessions.

The clinical lead had completed training on recognizing and responding to patients with learning disabilities and autism awareness as part of core training through their recently held NHS post and we saw the CPD website did include these courses. We saw that the training policy had also identified the importance of staff completion of training in learning disabilities and autism.

We did not see any formal monitoring of mandatory training in place; however, we were shown the training records for the new staff member who had joined the service in 2023. The registered manager said they would check the nurses training attendance through the quarterly one to one sessions and at annual appraisals.

Good

Diagnostic and screening services

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.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said there had been no safeguarding referrals in the last 12 months.

The registered manager said the newly employed clinical lead would take on the safeguarding lead role within the service. Discussions with this person confirmed they thought the safeguarding lead was currently, either the registered manager or operations manager. The new clinical lead had completed level three adult and children's safeguarding training.

Following the inspection, the registered manager confirmed they had completed an online level three adult safeguarding course. We saw evidence of completion as the adult safeguarding training completion certificate was submitted as evidence.

Staff were informed by the local authority adult safeguarding lead which process would be followed should a safeguarding concern be identified. A safeguarding adult's poster was displayed on the wall of the clinical room which identified the contact details such as the local police and local authority.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff said patients with specific needs or characteristics were identified through the referral process. These characteristics and / or needs were identified on their patient record and referral forms. We reviewed patient records including three referral forms and saw if needed that protected characteristics could be identified in relation to the patient.

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.

The infection prevention and control lead at the clinic was the clinical lead nurse.

The clinical room was visibly clean and had suitable furnishings which were clean and well-maintained. We observed there was no sink in the clinical room and the sofa present was not wipeable. The non-wipeable sofa was raised as a potential infection risk to the registered manager.

Staff followed infection control principles including the use of personal protective equipment (PPE).

The service had a Covid 19 policy in place which was now due for review. The policy was last amended on the 23 March 2022. We were told that staff no longer performed lateral flow testing for Covid 19 regularly.

Patients could wear face masks if this was their preference.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. No compliance issues were noted, and cleaning audits confirmed 100% compliance. Monthly deep cleans of the scanning room took place, the last deep clean took place on the 13 February 2023.

We observed the dental nurse wore gloves and disinfected the equipment between patients. Hand gel was located available for the use of staff and patients. Clinical staff's arms were also bare beneath the elbows. Staff advised they would physically wash their hands in the shared toilet facilities between each patient. Key moments for hand hygiene and hand hygiene technique for staff posters were seen.

Training records confirmed that all staff had completed infection prevention and control training.

Hand hygiene audits confirmed compliance. However, the audit was not signed or dated by the auditor. A second audit, the hand hygiene tool for general practice was completed, signed, and dated 3 May 2021.

The decontamination audit although complete and showed no evidence of non-compliance was not dated or signed by the auditor.

The last environmental annual checklist audit took place on the 3 May 2021 and was not repeated in 2022 as the service was closed.

Staff confirmed that the building manager for the landlord ensured legionella testing took place. The service did not have a copy of the Health and Safety Executive Legionella risk assessments and had requested this from the landlord.

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.

Patients were collected from the main reception area and on arrival called the clinic from a designated phone to inform them of their arrival. Staff from the clinic would collect the patient from the main reception area and take them to the clinical room which had a lockable door. However, we observed that the door to the clinical room was unlocked on one occasion during the inspection and alerted the registered manager.

The building was compliant against the Equality Act 2010, for example, a designated disabled toilet area was located on the ground floor of the building and a lift was available should the patient require this facility which could accommodate patients with physical disabilities. The lift's last service took place on the 22 February 2023. Three recommendations were made from the lift service although, it was not clear whether all the recommendations were completed.

Additional toilet facilities were located on the first floor of the building.

The clinical room allowed for patient privacy.

Environmental risk assessments were in place.

The clinic room was visibly clean and had waste bins present in two areas. However, there was no sink in the room. The nearest sink was in shared toilet facilities on the same floor as the clinic room. We observed that the sink in the shared facilities had the six-step handwashing procedure displayed on the wall.

We saw completed documentation which confirmed staff had received training and updates in the use of the scanner.

Good

Diagnostic and screening services

The three-yearly critical report for the scanner was completed by the radiation protection adviser on the 20 March 2020. A pass was awarded at this safety inspection.

Documentation confirmed that Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) checks had been completed for the scanner and the next check due was booked for late March 2023.

Staff carried out weekly safety checks of the x-ray scanner equipment and a quality assurance check monthly. The checklist was kept on paper records and stored on the computer.

The 2022/23 monthly calibration results for the scanner confirmed the machine had passed these checks. The machine was three years old, and we saw the last annual service was dated 17 June 2022. The annual service certificate was displayed on the wall next to the scanner.

The clinical lead was aware of the radiation policy and (IR(ME)R) policy and guidance around following lowest possible dose principles.

An automated external defibrillator and a first aid kit could be accessed by staff should a patient collapse. We saw documented weekly checks of the automated external defibrillator and first aid kits had taken place.

The fire extinguisher was last checked on the 19 January 2023. Staff said weekly fire alarm testing took place. Fire assembly points were displayed on a poster.

If staff were concerned about safety in relation to any patient attending, they asked for a second person to be either in the clinic area or around outside of the room.

Business continuity plans were not in place. However, staff said two engineers based in the building could be called to fix the scanner if the scanner broke down.

Staff disposed of clinical waste safely. The provider had a service contract with a waste company who removed used gloves and patient bite sheaves two weekly. This waste was stored in a bin in the scanning room until removal.

Controlled substances hazardous to health wipes (COSHH) were in a separate drawer within the locked clinical room. Alcohol gels were also stored in the clinic room cupboards which were locked overnight. There was a COSHH file and evidence of the COSHH checklist dated November 2021 which was due an annual update. The staff member was informed at the visit that the COSHH checklist required review. Following inspection, the provider confirmed that the wipes safety sheets had been reviewed, printed, and filed and risk assessments completed on the 9 March 2023. However, the updated wipes safety sheets or risk assessments were not provided as evidence.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff confirmed the imaging service could access the radiation protection advisor (RPA) by email or phone when needed.

The clinical lead was the radiation protection supervisor at the clinic.

Good

Diagnostic and screening services

Staff shared key information to keep patients safe when handing over their care to others.

Should a patient deteriorate suddenly staff would call 999.

An automated external defibrillator and a first aid kit were available for use should a patient collapse.

Staff training records confirmed the clinical lead had completed annual basic life support and defibrillator training.

Staff confirmed that women (including staff) who are or may be pregnant would be asked to inform a member of staff before they were exposed to any radiation in accordance with Ionizing Radiation (Medical Exposure) Regulations.

An undated patient identification policy confirmed the checks which took place to ensure that the right person received the right radiological scan at the right time.

Staff confirmed and we observed during two patients' consultations that the 'pause and check' and three points of identification were used to identify the patient. To date no pause and check audits had taken place.

Patients' details were checked at the start of the appointment and included an additional check to confirm which dentist had referred them to ensure confirmation of the right patient. Additional checks included was the patient pregnant, the patients understanding of the procedure due to take place and they were aware the procedure involved exposure to a small amount of radiation. The local rules we saw recognised precautions for pregnant women.

Staff confirmed the scanner position was checked and said that if the scanner was not positioned correctly a red light would appear and the scan would not take place.

Following the inspection, the service introduced guidance which informed staff of the Royal College of Radiographers standards for the communication of radiological reports and fail-safe alert notifications.

The 360 Visualise terms, conditions and service level agreement document confirmed the process and options for the referring dentist in relation to the reporting of patients scans.

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.

The service had staff to keep patients safe. The service employed one whole time equivalent (wte) dental nurse who had been in post one month and was supported by the registered manager. We were told that the dental nurse was the clinical lead for this service location.

The service also shared administration staff with another company who directly employed these people.

The service recruitment and retention policy detailed the recruitment process and the required checks the potential employee went through prior to a job offer. We saw that the nurse's registration status was checked, and this information was held by the company. Both staff had completed disclosure and baring checks. We reviewed the staff members personal file which confirmed the necessary checks were completed.

Staff completed an induction process. We did not see the completed induction document as this person was still going through their induction process.

Managers said they did not use bank and agency staff.

No staff were employed through practicing privileges arrangements.

The radiation protection adviser was employed through a local NHS Trust who provided support and advice to the service.

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.

Records were stored securely and encrypted and were accessed through a designated password/pass card.

The providers website and patients' scans were backed up locally and on computer. Patients' scans were also stored in the cloud.

Staff said patients' scans were immediately sent to the dentist post scan in the presence of the patient. A notification was sent to the dentist for them to access the website and securely access the scan images. Dentists had to agree to terms and conditions when they joined the website.

The patient's dentist could log onto the website and download the patient's scan.

Patients could access their own scans if they created an account.

We reviewed three patients records from referral to post scan completion. We saw information regarding the contact made for appointment booking and the follow up calls if no response after first call. An additional free text box on the form ensured the nurse could add detail such as medical conditions, access and equality support needs and safeguarding concerns if needed. The information present on the referral identified the patients name, date of birth and contact details. A tick box was present and completed which identified the patient was happy with the terms and conditions associated with the service.

Staff confirmed that audits of referral information received from dentists took place to ensure they had all necessary information before proceeding with care. The last audit took place on the 2 March 2023. The audit outcome confirmed most referrals contained all required information. Occasionally, a practice was able to refer without including the name of the practice or telephone number. The action required was to amend the referral website to make it mandatory so that all fields were completed prior to submission.

Good

Diagnostic and screening services

Medicines

The service did not provide medicines or keep medicines at this location.

Incidents

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

An incident policy and procedure were available to staff. Staff knew what incidents to report and how to report them. We asked staff about their knowledge of the 'Duty of Candor' and staff were aware of what it meant and how to implement this. Staff told us that they completed 'Duty of Candor' training as part of their induction to the service. Staff knew this meant they were open and transparent and gave patients and families a full explanation when things went wrong.

The service had not had any never events or serious incidents. Staff reported incidents clearly and in line with the service's policy. Managers said they would debrief and support staff after any serious incident.

Staff said an incident register was in place.

Staff said there had been no incidents in the last 12 months. If there had been staff said the incident would also be documented in the patients notes.

Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Inspected but not rated

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. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All protocols were stored on the company's shared drive and had been reviewed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff said and we saw that patients with specific needs or characteristics were identified through the referral process.

Staff said they would ensure that patients' needs were identified prior to their appointment through the referral and appointment process so that they could ensure patients' needs were being met. For example, the anxious patient or those patients with a learning disability, staff would familiarise the patient with the local environment, show them how the scanner worked and what to expect from the scanner process prior to their appointment.

For those patients who have mobility issues or use a wheelchair they could access the service via a lift from ground to first floor. A disabled toilet was available on the ground floor for use by the patient if required.

Good

Diagnostic and screening services

The service ensured that radiation doses were kept as low as reasonably practicable by monitoring staff exposure. Staff radiation doses were audited. We saw the last radiation doses audit dated the 15 February 2023 which comprised of five dose assessment audits which included the engineers dose readings and confirmed staff were not at risk. We observed that the audit document did not summarise the outcome of the audit results.

A radiation folder contained guidelines and other information pertinent to the service, for example, the Radiation Protection Adviser contract, dosimetry, staff training certificates, Health and Safety Executives registrations, risk assessments and the scanner's local rules.

The radiation dosage chart was available, however, was not displayed in the room the scanner was in which meant staff did not have immediate access to the information.

Radiation checks were carried out on staff completing scans. Staff carried a radiation monitor which was reviewed three monthly to ensure radiation levels for that staff member were within the recommended limits.

The latest local rules were dated 8 March 2023. The local rules for the scanner were displayed in scan room.

Nutrition and hydration

Staff gave patients food and drink when needed. Patients could access specialist dietry advice and support.

The service did not provide food or drink to patients as the patients' appointment time generally did not last longer than five minutes and patients were seen immediately on arrival.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

No tools were used at the site; staff said the patient would be accompanied by a chaperone if needed.

During our observations of two patient consultations, we observed that staff made sure they were comfortable before proceeding with their diagnostic investigation.

Pain management audits were not completed by the 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 been accredited under relevant clinical accreditation schemes.

The service did not participate in relevant national clinical audits.

Quality of the scans was audited. The last scan quality audit took place on the 2 March 2023 in which radiographs for each clinician for each x-ray type were reviewed. The audits included orthopantomogram (OPT) which is a panoramic

single image radiograph of the mandible, maxilla, and teeth. The second audit was the core beam computed tomography (CBCT) method that allowed accurate three-dimensional imaging of hard tissue structures. The outcome of both audits confirmed that all x-rays taken were graded A (diagnostically acceptable); patients were positioned well, and referrals adhered to. The next audit was planned for the 2 September 2023.

The provider did not participate in the Quality Standards for Imaging.

The service ensured that radiation doses were kept as low as reasonably practicable by monitoring staff exposure. Staff radiation doses were audited. We saw the last radiation doses audit dated the 15 February 2023 which comprised of five dose assessment audits which included the engineers dose readings and confirmed staff were not at risk. We observed the audit document did not summarise the outcome of the audit results.

A patient referral audit of 20 patient referrals took place on the 29 November 2021. The outcome of the audit showed that three dentist referrals were returned due to lacking information. The action from this audit identified there would be talks with the website team to improve referrals and make more user friendly.

The service was responsible only for taking the scan and did no diagnostic follow up. The referring dentist by making the referral had agreed to take full responsibility for acting on any image and / or report.

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.

Managers gave all new staff a full induction tailored to their role before they started work. New staff confirmed they had completed an induction over two weeks. We saw the induction programme, however, did not see the completed documentation which confirmed this induction was fully completed.

The service had an induction policy and procedure in place which was last amended on the 1 April 2023.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role. We saw evidence that clinical staff had received training appropriate for their role and registrations were in date.

The clinical lead identified that they could access the continuous professional development website and the courses provided through this site were sufficient to support the revalidation of her registration.

Clinical staff had no access to a senior dental nurse for support.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers said they had informal staff meetings and as such spoke daily about issues when they arose.

The manager said they supported staff to develop through yearly, constructive appraisals of their work. The service had one staff member who was currently within their induction period and would have a formal appraisal after they had been in post a year.

Good

Diagnostic and screening services

The registered manager when asked said they did not have a yearly appraisal but said they would have discussions with their business partner if required.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients.

Multi-disciplinary meetings took place with the NHS based radiation protection adviser and the other business partners. The minutes of the meeting confirmed that the last meeting had taken place on the 11 February 2022. No concerns were raised at this meeting and the current service contract was discussed.

Seven-day services

Key services were available to support timely patient care.

The service operated Monday to Friday and diagnostic and screening sessions were performed over three days.

Staff could call for support from dentists and other disciplines.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure that patients consented to treatment based on all the information available.

The consent policy gave detail of needing to evidence that patient had given full consent; however, there was no written completed consent form currently in use, although, the consent policy confirmed a consent document was in place.

Staff said the dentist was expected to gain consent and this was provided by the dentist when they completed the electronic referral form. However, the referral form did not have a clear statement to confirm consent, which meant no signed consent was evident. Staff said the consent was identified through the electronic referral process; however, we did not see evidence of this, or audits having taken place of consent processes at the clinic.

Staff said scans would not proceed if they had any concerns about the patients understanding of the scan about to be undertaken.

Staff said they would expect the referring dentist would advise if the patient had a learning disability or dementia like conditions. However, there was not an area on the referral form where this information could be added.

Good

Diagnostic and screening services

Staff spoke with the patient and / or carer at the start of their appointment to ascertain whether they understood why they were there. Where concerns about a patient's capacity existed, staff rang and spoke to the referring dentist; the scan would not be undertaken until all questions were answered.

On the machine there was a test facility which allowed a test run to take place without radiation. This was especially useful when patients may have autism, learning disabilities or dementia like conditions so that the patient could experience what the scan was like.

Training documentation confirmed the clinical lead had completed training in complaint handling, law and ethics, consent, Mental Capacity Act following the inspection on the 17 April 2023.

Is the service caring?

Good

Compassionate care

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

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

Chaperones were also available for patients if they felt they needed additional support.

We spoke with two patients who said they had been treated with respect and felt fully informed, understood the procedure and what to expect following their procedure.

We observed two patient consultation sessions and observed the clinician was respectful and respected the patient's dignity.

Staff checked the patient's comfort and condition throughout their diagnostic test.

Staff had completed equality and diversity training so they could support the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when needed.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

Good

Diagnostic and screening services

We observed two patient consultation sessions and saw the patient appeared at ease and comfortable to ask questions. The clinician answered the patient's questions and was seen to reassure the patient throughout their consultation.

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 diagnostic procedure.

Staff talked with patients, families, and carers in a way they could understand.

Both patients gave positive feedback about the service. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Both patients said it had been easy to book an appointment and the booking process was straightforward.

Is the service responsive?

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.

Facilities and premises were appropriate for the services being delivered. Staff confirmed that provision for disabled and able-bodied people was available, and this included large corridors, disabled access and toilet facilities and the use of a lift.

The service minimised the number of times patients needed to attend the hospital and worked with the patient to agree dates and times of the appointment so that patients had access to the required staff and tests on one occasion.

The service did not provide an out of hours service; the last planned appointment was at 4.30pm.

Accessible information standards were applied to the service. Staff said information was provided to patients in accessible formats before appointments if required. Information was saved in a portable document format which meant it could be printed larger. However, information was not provided in alternative languages.

Managers monitored and took action to minimise missed appointments. Staff said there had been no patients who did not arrival. Staff said they would phone the patient and the dental practice if the patient was not contactable and then refer the patient back to their dentist.

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.

Good

Diagnostic and screening services

Staff ensured that those patients who had additional needs were identified at the initial referral stage so that additional time could be allowed at and prior to these appointments so that the patient was reassured and comfortable with the equipment, scanning process and staff member.

Staff said patients could access online booking facilities.

Staff understood how to meet the communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. These requests were often initiated by the patient's dentist so that this support would be in place for when the patient came to their appointment.

Staff said that patient information could be provided in alternative languages on request.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

The provider confirmed they did not receive referrals for urgent cancer cases.

Referrals were submitted by dentists via the web site which meant referrals were sent directly to the company.

Staff said they would try to confirm the day prior to the patient's appointment that the patient was going to attend and also answer any questions the patient had. Patients would also be advised to remove jewellery prior to their scan.

Patient referrals commenced when their dentist referred them to the clinic. Staff said following the referral patients were seen and scanned within a week of referral.

Staff confirmed patients were offered a choice of appointments. We observed on the day of inspection that a patient arrived two hours early and was scanned immediately.

Reporting of images was sometimes completed by an external provider based at an NHS Teaching Hospital in London. Staff said not all scans were reported; reports were completed only if the dentist asked for this service.

The provider confirmed they had no key performance indicators for report turnaround times as any reporting of patients' scans were undertaken by an external provider if requested by the patient's dentist. Staff confirmed that patients' scans would be sent direct to the referring dentist prior to the patient leaving the scanner room.

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.

Patients, relatives, and carers knew how to complain or raise concerns. The complaints leaflet advised patients on how to raise concerns.

Good

Diagnostic and screening services

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff.

The service had received no complaints in the last 12-months.

Patients could either feedback their experiences of the service online or through the feedback form they were given to complete. This feedback was reviewed by the registered manager. The last patient feedback took place in May 2021 and the feedback audit asked questions in six areas. No concerns were identified from patients following the May 2021 audit. Future patient feedback was due to be collected in May 2023.

A complaints register was not in place.

Is the service well-led?

Requires Improvement

Leadership

Leaders had the 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. They supported staff to develop their skills and take on more senior roles.

Leaders were seen to be visible and approachable.

The senior team comprised of the registered manager and nominated individual.

A consultant radiologist from a local NHS Hospital Trust provided expert advice.

Staff confirmed an awareness of the local whistleblowing policy and procedure and who to approach should they have any concerns.

Staff could access leadership development programmes and mentoring through their annual appraisal process. We saw an example of this having taken place when we reviewed a staff members training records.

Vision and Strategy

The service had a business plan for what it wanted to achieve; however, it was not clear how the plan was going to be monitored. A new service vision and strategy had been identified since the inspection.

The service has an identified business plan is in place which identified future plans for service development.

Replacement of high-cost equipment was factored into the service capital replacement programme. After five-years the scanner would be sold and replaced with a new machine.

The service had not identified a service specific strategy which identified how the business plan / vision would be turned into action. We did not see how progress against the business plan was going to be monitored.

Following the inspection, the provider produced a service vision and strategy document dated 23 March 2023. Implementation and monitoring of this document were to be identified.

Culture

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

Throughout the inspection we observed, and two staff identified that the team worked well together. One staff member confirmed they had felt supported within their role since starting at the organization.

Staff could access the whistle blowing and Duty of Candor policies.

The registered manager was the service freedom to speak up guardian had protected time to carry out the role when needed. The whistle blowing policy and procedure was last amended on the 4 December 2022. Staff could also raise concerns directly with the General Dental Council should they not want to approach the registered manager. Staff knew who to approach should they have any concerns and where to access the freedom to speak up policy and procedure.

Clinical staff registration fees were paid for by the company and to ensure ongoing core skills training is maintained the company have paid for access to a Continuous Professional Development website so staff can access all required core training. Staff confirmed this training support was sufficient for them to maintain registration.

The equality and diversity policy and procedure were last amended on the 9 May 2022. This document supported and advised staff in relation to the promotion of equality and diversity within and beyond the organisation. Staff said there had been no concerns raised by staff in these areas.

Grievance policy and procedure in place last amended 19 October 2022

Staff confirmed appraisal processes were in place for all staff, although, with a change in staff recently, staff appraisals would need to be completed. Staffing was limited to the dental nurse and registered manager. We were told that following a staff members probationary period their first appraisal took place at the end of their first year of employment. Prior to the appraisal the staff member met regularly with the registered manager for ongoing support.

Governance

Leaders operated some governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

The clinical governance lead was identified to be the clinical lead.

There was no formal feedback process by the referring dentists with regards to the quality of the scans undertaken to ensure that the quality of scans was satisfactory.

The service did not have a clinical audit schedule in place, although, we saw that the quality of scans was audited.

Good

Diagnostic and screening services

Guidance in the form of the clinical governance policy and procedure last amended 3 October 2022 and quality assurance policy and procedure (DQQ07) last reviewed on the 30 January 2023 was in place. The quality assurance policy identified regular quality control audits of the service would take place and listed some examples of these audits. However, we only saw limited examples of auditing having taken place as described in the patients' outcomes and cleanliness, infection control and hygiene sections of this report.

The service had introduced a 'Pause and Check' audits policy dated 17 April 2023 which identified audits proposed for the future.

Staff were assured the machine would identify if the scanner was not positioned correctly as a red light showed if the positioning was not correct, and the scan would not take place.

Business governance was managed by the registered manager, for example, the two directors of the company ensured that records were submitted to companies' house.

Staff said when policies were due for review, they flagged on the information technology portal they were stored on. Staff showed us this process in action which ensured that all guidance was current and followed relevant guidance.

The provider had service level agreements (SLA) with third parties, for example, an SLA was in place with the local NHS Trust that the radiation protection adviser was based in. The SLA was between the local NHS Trust and the provider for the supply of radiation protection services for dental radiology dated 13 July 2020 (v8). The contract was signed and dated by both parties.

Staff confirmed ongoing engagement with the radiation protection adviser via zoom; the last meeting took place in February 2022. We saw that meeting minutes were produced by the radiation protection adviser following this meeting.

The provider had a rolling contract with the waste company dated 14 May 2021.

We saw evidence of checks having taken place when we reviewed the new staff members documentation checks.

Management of risk, issues, and performance

We saw limited evidence of a systematic programme of clinical and internal audit to monitor quality and operational processes in place or what systems were used to identify where action should be taken. Some risks to the service were identified, although, plans were not in place to cope with unexpected events.

We saw some evidence of clinical and internal audit to monitor quality and operational processes in place and systems used to identify where action should be taken.

The service did not have a formalized clinical audit schedule in place.

Six- monthly radiography audits took place; the outcomes of the last audit are described in the patient's outcome section of this report.

The service risk management policy and procedure (DCR02) was amended on the 29 March 2022.

The service risk register was identified as a tool within the risk management policy.

Good

Diagnostic and screening services

A risk matrix which the provider identified as the risk register identified risk assessments pertaining to eight areas were completed. These risk assessments were for control of substances hazardous to health, radiation, slips, trips and falls, lone working, electrical, medical emergency, fire, manual handling.

There was not a business continuity plan or emergency generators in case of failure of essential services.

Annual reviews by the radiation protection adviser of the local rules for the scanner had taken place. The latest local rules were dated 8 March 2023.

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.

Information security guidance was available on how to maintain information security.

Records could only be accessed through a designated password/pass card.

The data protection lead was identified amongst the senior team. The Data Protection Registration Certificate was due to expire on the 17 Jan 2024. Staff completed training on data protection which included the General Data Protection Regulation.

Staff told us that when patients were contacted the clinical lead contacted them from the scanning room so that conversations could not be overheard.

Staff said private patients received a statement that includes terms and conditions of the services being provided to the person and the amount and method of payment of fees. This was provided via email when the session was booked, and fees were identified for the scan, so patients were aware.

Patients could access their scan results electronically. Staff confirmed they shared scan results immediately with the patient's dentist.

Staff said that currently there were no clear and robust service performance measures, which are reported and monitored and that these performance measures were to be developed.

Arrangements to ensure that data or notifications were submitted to external bodies were managed either by the clinical lead for clinical notifications or the registered manager where notifications related to the Information Commissioners Office.

Training records confirmed that the clinical lead had completed the annual information governance training.

Engagement

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

Good

Diagnostic and screening services

Staff confirmed they had regular, daily discussions about the service.

There had not been a staff survey.

Discussions and meetings had taken place with the radiation protection adviser to ensure that service provision was safe and to agree the ongoing service contract.

Patients could either feedback their experiences of the service online or through the feedback form they were given to complete. Please refer to the complaints section of the report for the most recent patient feedback.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff said a new website was created which had improved dentist access to the referral areas and access to scans once taken.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure there is a business continuity plan in case of failure of essential services.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints • The service must ensure a complaints register is in place. (Regulation 16)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that a clinical audit schedule is in place which includes the introduction of pause and check audits. (Regulation 17 (1) (2) (a))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

- The service must ensure there is a formal feedback process by the referring dentists with regards to the quality of the scans undertaken to ensure that the quality of scans was satisfactory. (Regulation 17 (1) (2) (a))