Island Osteoscan

Quality Report

Mill Court
Furrlongs
Newport
Isle of Wight
PO30 2AA
Tel:01983 559256
Website:www.islandosteoscan.co.uk

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Island Osteoscan is operated by the registered provider, Miss Vivien White. The service provides dual-energy X-ray absorptiometry (DEXA) scans to measure bone density. The service is contracted by the local clinical commissioning group to carry out DEXA scans for the local NHS trust osteoporosis service. The service does not employ any staff. The provider, Miss Vivien White, carries out all the DEXA scans provided by the service.

A bone density scanning clinic is held at Island Osteoscan clinic approximately twice a week. Patients attending the bone density scanning clinics are mainly NHS patients. Patients attending the clinic receive bone density scans that are provided by Island Osteoscan. However, the overall running and organisation of the Island's osteoporosis service, which includes the bone density scanning clinic, is carried out by the local NHS trust osteoporosis specialist nurse. The NHS trust specialist nurse receives all referrals for DEXA scans, reviews and triages the referrals and plans the clinic attendance list. Appointment letters are sent to patients by the NHS trust specialist nurse. Island Osteoscan does not carry out DEXA scans on children and young people under the age of 18.

Both the provider and the NHS trust specialist nurse are present at all bone density scanning clinics, with the clinic being led by the NHS trust specialist nurse. Patients are received into the clinic by the NHS trust's specialist nurse where she reviews the patient's clinical information, the patient then has their DEXA scan, carried out by Island Osteoscan, in an adjoining room, following which they return to see the specialist nurse to receive their results and any treatment plans.

Island Osteoscan also carry out two to three private DEXA scans per year. The provider has an agreement with an independent consultant who is present at all private scans and who interprets and provides scan results to patients.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 22 August 2019.

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

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

Services we rate

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

We found areas of practice that require improvement

- The provider did not operate a formalised governance process. The provider did not have documented policies and procedures to support the delivery of the service. There were no service specific policies and procedures to support the running of the service, Island Osteoscan. There was no process to manage incidents relating to the delivery of the service, no policy about mandatory training of the provider or other staff attending the clinic, no policy about managing the safety of the environment and equipment and no policy about managing the risk of cross infection. The provider had not acted to fulfil their contractual agreement with the local clinical commissioning group.
- Other than the quality assurance process for the safety of the scanning machine, the provider had no processes to monitor the quality and performance and manage risks of the DEXA scanning service they provided.
- The provider did not have a formal process to manage complaints about the service.

Summary of findings

- The provider did not consider national guidance to determine what level of children's and young people's safeguarding training they needed to complete.

However, we found areas of good practice:

- The service provided DEXA scans based on national guidance and evidence-based practice.
- The provider and the NHS specialist nurse worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- The provider supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

The design, maintenance and use of facilities, premises and equipment kept people safe and the provider was trained to use them.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The provider planned and provided the service in a way to meet the needs of local people and the communities served. The provider made reasonable adjustments to help patients access the service.
- Clinics ran to time and patients received results of their scans during their clinic appointment.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. We told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected Island Osteoscan. Details are at the end of the report.

Nigel Acheson
Deputy Chief Inspector of Hospitals (London and south)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	**Requires improvement** 	Island Osteoscan provided dual-energy X-ray absorptiometry (DEXA) scans to measure bone density for NHS patients over the age of 18. The service also carried out a very small number of private DEXA scans (two to three) per year. We rated this service as requires improvement. We rated the safe, responsive and well led domains as requiring improvement and the caring domain as good. We do not rate the effective domain for this type of service.

Summary of findings

Contents

Requires improvement

Island Osteoscan

Services we looked at: Diagnostic imaging

Summary of this inspection

Background to Island Osteoscan

Island Osteoscan is operated by the registered provider, Miss Vivien White. The service operates from a business complex in central Newport. The service provides dual-energy X-ray absorptiometry (DEXA) scans to measure bone density. The service is contracted by the local clinical commissioning group (CCG) to carry out DEXA scans for the local NHS trust osteoporosis service. The service does not employ any staff. The registered provider, Miss Vivien White, carries out all the DEXA scans provided by the service.

The service is not required to have a registered manager. This is because the registered provider is an individual and manages the day to day running of the service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the Island Osteoscan clinic. We spoke with the registered provider, Miss Vivien White, who carries out the DEXA scans. We also spoke with the NHS trust osteoporosis specialist nurse. This was because Island Osteoscan worked in partnership with the NHS trust specialist nurse to deliver the NHS trust's bone density scanning service. We spoke with three patients and one relative. During our inspection, we observed the interactions between the provider and patients and reviewed a sample of documents about to the running of the service.

Information about Island Osteoscan

Island Osteoscan provides dual-energy X-ray absorptiometry (DEXA) scans to measure bone density. The service is contracted by the local clinical commissioning group (CCG) to carry out DEXA scans for the local NHS trust osteoporosis service. The service carries out a small number (two to three) of private DEXA scans per year.

The service is registered to provide the following regulated activity:

- Diagnostic and screening procedures.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected two times, and the most recent inspection took place in January 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Island Osteoscan is contracted by the Isle of Wight clinical commissioning group to carry out 1,100 DEXA scans a year. Arrangements were in place and followed to ensure this figure was always met.

Island Osteoscan employed no staff, all DEXA scans were carried out by the registered provider, Miss Vivien White who is a qualified radiographer.

Track record on safety.

Summary of this inspection

The service reported they had had no never events, no clinical incidents and no complaints in the twelve months preceding the inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- The provider did not complete safeguarding training in line with national guidance.
- The provider did not identify any mandatory training in key skills that they needed to complete.
- The service had no formal infection control processes. The lack of a sink in the clinic area did not support effective infection control processes.
- There was no formal process to manage incidents.

However, we also found the following areas of good practice:

- The service 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 the equipment.
- The service had enough staff with the right qualifications to provide the right care and treatment.
- Patient records held by Island Osteoscan were stored securely.

Are services effective?

Not sufficient evidence to rate

We found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence-based practice.
- The provider was competent for their professional role.
- The provider and the NHS specialist nurse worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- The provider supported patients to make informed decisions about their care and treatment.

However, we also found the following issues that the service provider needs to improve:

- There was limited monitoring of the effectiveness of the service.
- There were no formalised arrangements for appraisal or supervision to provide support and development for the provider.

Are services caring?

Good

We rated it as **Good** because:

Summary of this inspection

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided support to patients to minimise their anxiety.

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

Are services responsive?

Requires improvement

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

- Waiting times from referral to scan were worse than the target set by commissioners.
- The provider did not have a formal process to manage complaints.

However, we also found the following areas of good practice:

- The provider planned and provided care in a way to meet the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs.
- Clinics ran to time and patients received results of their scans during their clinic appointment.

Are services well-led?

Requires improvement

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

- Although the provider had the skills, knowledge, and experience to manage a DEXA scanning service, they did not fully consider their individual responsibility as a registered provider about meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider did not operate a formalised governance process, including the management of risks, processes to monitor the quality and performance of the DEXA scanning service, processes to identify any required mandatory training and processes to identify and implement essential service specific policies and procedures needed to support the safe and effective delivery of the service

However, we also found the following areas of good practice:

- The provider had an informal vision for the service and an informal strategy to turn it into action.
- Patient feedback was encouraged.

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Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

Mandatory training

The provider did not identify any mandatory training in key skills that they needed to complete.

The registered provider, who was the sole worker, had not identified any areas of mandatory training to ensure they had up to date knowledge of key safety skills. There was no policy statement about mandatory training to evidence the need for mandatory training in key skills had been considered for the provider or any other staff attending the clinic.

To lessen risk for patients associated with the lack of mandatory training, the registered provider said they would always seek advice from the NHS trust osteoporosis specialist nurse who worked alongside them for any updates about key safety issues. The NHS trust specialist nurse confirmed to us that she had completed all mandatory training required by the NHS trust.

Safeguarding

The provider did not complete safeguarding training in line with national guidance.

The provider had completed adult safeguarding level 1 training. However, she had not completed safeguarding children level 1 training. The provider described there was no need for her to complete this training, because the service did not treat people under the age of 18. This did not meet the national guidance in the 'Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document third edition: March 2014.' This document details that all staff working in health care settings should have safeguarding children level 1 training, even if they do not treat children. Following the inspection, the registered provider submitted information to CQC that showed they had completed safeguarding children (level 1) training in October 2019.

The provider did not have a policy statement about safeguarding. However, conversation with the provider showed they understood their roles and responsibilities regarding safeguarding vulnerable people. They said they would use the local NHS trust's safeguarding process if they had any safeguarding concerns about patients. However, this was not detailed in any document held by the provider. They described that the NHS trust specialist nurse they worked with would make the necessary safeguarding alerts to the local NHS trust's safeguarding team. Our review of the provider's contract with the CCG showed that the contract required the provider to have a safeguarding policy.

Cleanliness, infection control and hygiene

The service had no formal infection control processes. The lack of a sink in the clinic area did not support effective infection control processes. However, the service kept equipment and the premises visibly clean and staff used informal control measures to protect patients, themselves and others from infection.

There was no evidence to show the provider had taken account of their responsibilities towards the "Code of Practice on the prevention and control of infections and

related guidance." This guidance describes the actions different types of providers registered with the Health and Social Care at 2008 should take to reduce the risk of cross infection between patients, including policies they should have to support infection prevention and control practices.

There were no written policies for the management of cleanliness, hygiene and infection control. There was no consideration about what action the service should take to reduce risk of cross contamination if a patient had an obvious infection or an open wound. The provider considered that there was a low risk of patients being at risk of ill health due to cross infection, because all patients were out patients, were not unwell and wore their outside clothes for the scanning process.

There was no hand basin facility in the scanning room or the consulting room. The nearest hand basin facility was in the lady's toilet room in the patient waiting area. The provider had not formally assessed the risk this may pose to patients. However, the provider had access to and used hand gel before and after contact with patients.

The provider followed a process to ensure all equipment was clean, which included cleaning the equipment before and after scanning sessions and wiping equipment with 'cleaning wipes' between each patient. The provider used fresh paper towelling to cover the scanning couch and pillow for each patient.

The provider was responsible for cleaning of the clinic and consulting room environment, which were visibly clean at the time of the inspection. The environment of the clinic area was visibly clean.

Personal protective equipment, such as disposable gloves and aprons were available to use in the event of an unexpected body spillage, such as vomit.

Environment and equipment

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

The provider had one DEXA scanner that had been installed in 2017. We saw evidence that the provider, who was the only person who carried out the scans, had completed training about how to use the scanner. The training was by the manufacturer of the scanner when the scanner was first received. The manufacturer did not provide update training.

The provider had a contract for servicing of the scanner every six months. Service records evidenced six monthly servicing of the equipment was carried out.

The provider carried out quality checks on the scanner before each scanning session. The quality checks were built into the switching on programme for the equipment. To ensure the scanner was not used if there was a fault, the built-in quality checking system did not allow the scanner to be fully turned on, until all quality checks were passed. This protected patients from being scanned by faulty equipment, which may provide incorrect readings.

The environment in which the scans were performed was well-lit and arranged for its use.

The provider had an informal agreement for use of clinical waste bins with another service located in the same building. However, the provider said, there had been no occurrence when this had to be used.

The waiting area and entrance to the building was maintained by the building landlord. This included the provisions and maintenance of the seating and décor in the waiting area and the toilet areas.

Assessing and responding to patient risk

Arrangements were in place to manage risks to patients.

The provider had a set of local rules that were in date, referenced national guidance and were signed by the provider. Local rules are a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Ionising Radiations Regulations (IRR) 2017 which require services to have local rules relevant to the radiation risk and nature of the service provided.

Patients were informed about the level of radiation risk from the DEXA scan in their initial appointment letter from the local NHS trust and from a notice displayed at the entrance to the consulting room.

The provider was the radiation protection supervisor for the service. The provider had a contract with a radiation protection adviser (RPA) and a medical physics expert. Services that use ionising radiation are required by the

Requires improvement

Diagnostic imaging

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) to have annual inspections carried out by a RPA. Our review of records showed the service received annual inspections by the RPA. This included a critical examination and commissioning report on the scanning equipment after it was installed in June 2017.

The provider was the appointed first aider. The provider had completed life support training. However, our review of training certificates showed that the renewal date for this training had expired. This meant that they did not have any current and up to date life support training. The provider had carried out a health and safety executive risk assessment that, due to having no employed staff, had identified the service only required an appointed first aider.

The provider had considered meeting the needs of patients in a medical emergency. The service had an automated defibrillator in working order and the acute NHS specialist nurse who worked in partnership with the provider had completed life support training with the acute trust. In the event of a clinical emergency, the provider's process was to call the emergency ambulance service. However, there was no written policy or procedure that detailed this.

Referrals for scans we received by the local NHS trust specialist nurse from primary or secondary care medical professionals. The NHS specialist nurse reviewed and triaged all the referrals. The provider understood the nurse had the appropriate skills and training to carry out triage of the referrals.

Both the NHS specialist nurse and the provider checked three points of patient identification prior to carrying out the scan. The provider, who carried out the scan, checked the referral to ensure the bone density scan was appropriate for the patient. These checks ensured the correct patient received the correct scan, reducing risks associated with exposure to X rays.

Staffing

The service had enough staff with the right qualifications to provide the right care and treatment.

The provider did not employ staff and it was only the provider who carried out the DEXA scans. Clinics were planned around the availability of both the provider and the NHS trust specialist nurse. This ensured both were present at all bone scanning clinics.

Records

Patient records held by Island Osteoscan were stored securely.

The only patient records held by Island Osteoscan were patient referral forms. These were stored in the scanning room which was locked and not accessible to unauthorised persons when the clinic was not open.

Patients' individual care and treatment records were held electronically by the local NHS trust. This was because patients scanned at Island Osteoscan were trust patients and their care and treatment was planned and delivered by the trust.

For the few private scans carried out by the service, the patient records were held by the medical professional, with the service retaining only the referral forms following the same practice as for NHS patients.

Medicines

The provider did not hold or manage medicines.

Incidents

There was no formal process to manage incidents.

The registered provider had not considered the need to have a formal process for managing incidents. They said, that as patients were patients of the local NHS trust, they would use the trust process for reporting incidents. Both the provider and the NHS specialist nurse confirmed there had been no incidents that required reporting in the time they had worked in partnership.

However, there was no documented process that detailed how the local NHS trust policy and procedure for reporting and investigating incidents would be followed. There was no documented process for managing incidents that were not related to the provision of the NHS service, such as relating to DEXA imaging equipment, the registered provider or the environment and building.

Requires improvement

Diagnostic imaging

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The service based its imaging processes on the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017). The local rules were up to date and reflected the equipment and practices at this location.

The provider's processes for scanning were subject to review by the radiation protection advisor and the medical physics expert, in line with IR(ME)R 2017 requirements. The most recent RPA report showed no concerns with the processes or local rules used by the provider.

Pain relief

The provider advised patients that the imaging was pain free, though there may be momentary discomfort when moving position to enable the imaging to be carried out. No formal monitoring of pain and no pain relief was provided by the service.

Patient outcomes

There was limited monitoring of the effectiveness of the service.

The provider stated that as patients were patients of the local NHS trust, the trust monitored the effectiveness and outcomes for patients rather than herself. The provider did not have a programme of audits to support measurement of the effectiveness of the service or outcomes for people using the scanning service.

However, conversations with the provider evidenced there was shared monitoring, with the local NHS trust, of patient attendances. The 'did not attend rate' for the 12 months prior to our inspection ranged from 5% to 10% per month.

Reporting on the scans was the responsibility of the NHS specialist nurse. Reporting was carried out at the time of the scan. For the occasional private patients, reporting was carried out by an independent consultant who directly reported the findings to the patient.

Competent staff

The provider was competent for their professional role. However, there were no formalised arrangements for appraisal or supervision to provide support and development for the provider.

The provider who carried out the DEXA scans, was a trained radiographer, with a Health and Care Professional Council (HCPC) registration.

Records evidenced she maintained her professional competency through continuous professional development both in the role of a radiographer and in the specialist role of a DEXA scanner operator for an osteoporosis service. This included attending the biannual national osteoporosis conference.

However, the provider had not considered making any arrangements for formal clinical supervision or appraisal. Informal supervision and support was carried out between the NHS specialist nurse and the provider. There was no arrangement for clinical supervision with a relevant health care profession, such as another radiographer.

Multidisciplinary working

The provider and the NHS specialist nurse worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

The provider and the NHS specialist nurse worked closely together to provide a seamless bone scanning service. The close working relationship meant patients had their scan carried out by the provider, received their results, treatment plans, health advice and future osteoporosis clinic appointments from the NHS specialist nurse within a 15 minute appointment.

Seven-day services

The service was planned to meet their contractual requirements. This meant the service mostly operated two days a week.

Requires improvement

Diagnostic imaging

Health promotion

Although the provider did not deliver any health promotion, patients attending the bone scanning clinic received advice and support about their conditions from the NHS trust specialist nurse.

Consent and Mental Capacity Act

The provider supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

The provider understood their responsibility to gain consent for imaging from patients. They recognised and respected a patient's choice if they chose not to have any imaging when they arrived for their appointment.

The NHS specialist nurse and the provider explained the imaging procedure to patients and the provider obtained verbal consent before proceeding.

The provider was aware about their responsibility in relation to patients who lacked mental capacity. They said the NHS specialist nurse normally provided them with information about a patient's capacity, in the referral process. If there were any concerns about a patient's capacity to understand and agree to the scan, the scan was not carried out.

Discussion with the provider, showed that although there was no evidence of training about the Mental Capacity Act 2005, they had a good understanding about their responsibilities towards the Mental Capacity Act 2005.

Are diagnostic imaging services caring?

Good

Compassionate care

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

Feedback from patients we spoke with confirmed that staff treated them well and with kindness.

With patient's permission, we observed the patient journey through their clinic appointment including the scanning process. We observed the provider treated patients with kindness and respect. The process for being seen by the specialist nurse and having the scan carried out meant, that only one patient was in the clinical area at a time. This meant patient's privacy and confidentiality was protected.

Approximately 10% of patients scanned were males. Male patients were scanned by the provider, there was no provision of a male radiographer to scan the patient. The provider said there had been no complaints or comments received from male patients regarding the lack of a male radiographer. They commented that as patients remained fully clothed during the scanning process, their dignity and privacy was protected. The provider did not provide a chaperoning service. However, patients' relatives and /or carers were allowed in the scanning room to support patients and promote their dignity.

We reviewed some of the comments received from patients through the provider's satisfaction comment cards. There were many comments about the kindness of the staff, thought there was no distinction between the provider and the NHS specialist nurse.

Emotional support

Staff provided emotional support to patients to minimise their anxiety.

When patients arrived for their scans, to reduce anxiety, they had already received written information from the NHS specialist nurse about what to expect at the appointment, including a description about the scanning process.

We observed the provider gave clear explanations to patients about what to expect during the scanning process.

Understanding and involvement of patients and those close to them

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

Patients said the appointment letter and the radiographer described the scanning process in a way they understood.

Requires improvement

Diagnostic imaging

Information about the scanning process and radiation levels were displayed in the clinic waiting area, on the provider's website and in the appointment letter.

The provider's patient satisfaction comment cards included comments that all questions were answered simply and that there was good explanation of the scanning process.

For the few patients who self-funded their DEXA scans, information about costs was displayed on the providers website.

Are diagnostic imaging services responsive?

Requires improvement

Service delivery to meet the needs of local people

The provider planned and provided care in a way to meet the needs of local people and the communities served. They also worked with others in the wider system to plan care.

The provider was contracted by the clinical commissioning group (CCG) to carry out 1,100 DEXA scans annually for the local NHS trust. The provider worked with the local NHS trust specialist osteoporosis to plan and deliver the 1,100 DEXA scans. Clinics were held approximately twice a week to ensure the contracted target was met.

The clinic environment was managed by the provider and was appropriate and comfortable for patients.

The communal areas of the building, including the clinic waiting area and seating, was managed by the building landlord. There were enough seats in the waiting area. However, these were all low seats and had the potential to pose a difficulty for patients with some mobility problems to get in and out of. The provider said there were infrequent meetings with the landlord to provide opportunity to influence the general environment of the building, including the seating in the clinic waiting area.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs. The provider made reasonable adjustments to help patients access services.

The scanning equipment was located on the first floor of the building. The building had ramp access and a lift which made the clinic accessible to patients with limited mobility.

The provider had a small number of mobilising aids, such as a walking frame and steps up to the scanning machine. There was no hoist facility. If patients who needed a hoist to transfer required investigations into bone density the NHS trust specialist nurse considered other options to measure their bone density that did not require a scan.

The scanning table had a weight limit. The NHS trust specialist nurse identified at referral patients whose weight made then not suitable for the DEXA scan and offered them alternative investigations to measure bone density.

The provider used the local NHS trust's translation service for patients whose first language was not English. This was coordinated by the NHS trust specialist nurse during the referral and clinic planning process. The provider also accessed British Sign Language interpreters for patients who were deaf or hearing-impaired through the local NHS trust.

The service made reasonable adjustments to allow family members or carers accompany and support patients with conditions such as dementia or a learning disability in the treatment and x-ray rooms.

The provider was not commissioned to carry out DEXA scans on children and young people.

Access and flow

Clinics ran to time and patients received results of their scans during their clinic appointment. However, waiting times from referral to scan were worse than the target set by commissioners.

Once patients received their appointment and arrived at the clinic, clinics ran to schedule with minimal delays. Patients we spoke with said appointments were on time. The provider's patient satisfaction survey cards included comments that clinics were efficient, and appointments were on time.

Requires improvement

Diagnostic imaging

Patients received the results of their scan from the NHS trust specialist nurse at the same appointment as their scan. This included treatment advice and dates of future clinic appointments.

Patients experienced delays in receiving their bone density scans. The provider's contract with the CCG stipulated a maximum of a six week wait from referral for DEXA scan to completion of the scan. At the time of the inspection there was a waiting time of three months for a scan from the time of referral. There had been a waiting time of three months for a scan for the ten months prior to our inspection of the service.

The provider, in partnership with the NHS trust specialist nurse, had alerted the CCG about the extended waiting time. In partnership with the NHS trust specialist nurse, a business case was being developed to put forward to the CCG to increase the number of bone density scanning clinics to meet the demand.

Learning from complaints and concerns

The provider did not have a formal process to manage complaints.

The provider did not have a documented complaints process. There was no information for patients about how to raise a complaint or concern about the provider. However, the provider's website did include directions about how to contact the service.

The provider said that as the patients were trust patients, the trust's complaint process would be used. This was not detailed in any document held by the provider. However, our review of the providers contract with the CCG showed the provider was contractually required to maintain and operate a complaints procedure.

The provider carried out two to three private scans a year. The provider described the process she would follow to investigate any complaints from a private patient. This included documenting the complaint, acknowledging receipt of the complaint to the complainant, investigating and informing the complaint about the outcome of the complaint investigation. However, this process was not detailed in any document held by the provider.

The provider had not received any complaints in the 12 months preceding the inspection.

Are diagnostic imaging services well-led?

Requires improvement

Leadership

Although the provider had the skills, knowledge, and experience to manage a DEXA scanning service, they did not fully consider their individual responsibility as a registered provider about meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Island Osteoscan was managed by the provider, Miss Vivien White, who also carried out all the DEXA scans. No staff were employed by the provider, so she did not have any staff to manage or lead. Island Osteoscan was contracted by the local clinical commissioning group (CCG) to carry out all the DEXA scans for the local NHS trust osteoporosis service. The osteoporosis service was led by the NHS trust's specialist osteoporosis nurse, who managed the coordination of the clinic lists, reviewed and triaged all referrals, reported on the scans and prescribed treatment plans for patients.

The provider described their role as just carrying out the scans with no other input into the delivery of the osteoporosis service. The provider said they relied on use of the NHS trust policies and procedures to support the running of the service. However, the provider could not access these policies and procedures herself, she had to rely on the NHS trust specialist nurse to access them.

The provider had not fully considered the requirements of the Health and Social Care Act regulations that required her to have systems and processes to ensure safe and effective care and treatment to patients.

Vision and strategy

The provider had an informal vision for the service and an informal strategy to turn it into action.

The provider's vision for the service, was for it to continue to meet the needs of the local population, including the increased demand for the service. Her strategy for turning the vision into action, was to continue to work with the

local NHS trust specialist nurse to deliver the service and develop the business case to increase the number of bone density scanning clinics to meet the need of the local population.

Culture

The provider's culture was focused on the needs of patients attending the clinic for scans.

Observation and discussion with the provider and the NHS trust specialist nurse showed the provider had promoted a collaborative working culture, with both persons focused on the needs of patients attending the clinic.

Governance

The provider did not operate a formalised governance process.

As a sole provider and sole radiographer, the provider held all the professional responsibility and accountability for the delivery of the DEXA scans.

The delivery of the osteoporosis service, of which Island Osteoscan was commissioned to carry out the DEXA scans for, was governed and managed by the local NHS trust.

The provider did not have documented policies and procedures to support the delivery of the service. There were no policies and procedures to support the running of the service, Island Osteoscan. For example, there were no policies for managing the safety of the environment and equipment, there were no policies for managing complaints about Island Osteoscan and there were no policies about managing the risk of cross infection. The service had not considered the need to have any formal processes to follow to ensure all patients were safe on the premises, including the few private patients they carried out scans on each year.

Managing risks, issues and performance

The provider had no formal processes to monitor the quality and performance and manage risks of the DEXA scanning service they provided.

The provider had no formal processes to monitor the quality and performance of the DEXA scanning service they provided, other than the quality assurance process followed at the beginning of each scanning session to ensure the safe working of the scanning machine. They relied on the clinical commissioning group's contract monitoring and informal feedback from the local NHS trust's specialist nurse to identify any improvements needed in quality and performance.

The provider did not manage the risk of not meeting their contractual requirements with the clinical commissioning group. They did not have policies and procedures in place, as required by their contract. The provider had not completed all safe guarding training, as required by their contract.

The provider had no formal process to identify, monitor and manage risks to the service. However, when asked, she described the top three risks as power failure, extreme weather causing disruption and unexpected non-availability of the provider to carry out the scanning. Discussion with the provider showed that, in partnership with the NHS specialist nurse, there was an unwritten plan to manage these situations. However, the provider did not have a documented business continuity plan.

The provider had no documentary evidence to show they had fully considered the risk of patients receiving care and treatment from staff who did not have the relevant skills, competencies and experience. The provider did have documented assurance that the NHS trust specialist nurse, who worked in partnership with the service, had completed the trust's' mandatory training and had the relevant skills and competencies for their role.

However, discussion with the provider and the NHS specialist nurse showed they both understood the challenges faced by the service and were working together to resolve the challenges. This included communicating with clinical commissioning group about additional clinics to resolve the waiting list for scans and liaising with the building landlord to improve signage in the building.

Managing information

The provider held minimal patient information.

The only patient information held by the provider were the paper referral for scan forms. All other patient information, including time for referral to scan and treatment records were held electronically by the local NHS trust. Image results were managed by the NHS trust, including providing patient's GPs with results.

Requires improvement

Diagnostic imaging

The provider carried out a small number (two to three) private scans a year. The providers website gave detail about the cost of a private DEXA scan.

Information about the running of the service, such as contractual agreements with the CCG , radiation protection advisor reports and local rules were easily accessible in the clinic rooms.

Engagement

Patient feedback was encouraged.

Patient feedback was encouraged using patient feedback forms. Patient feedback forms were available to patients in the clinic waiting area.

The completed forms were reviewed by the provider and the NHS trust specialist nurse, as the feedback was not specific to the imaging service but to the whole bone density screening clinic experience. Although review did not include analysis of themes and trends, the service acted where needed. One example included improving the signage in the building to the Island Osteoscan clinic in response to patient feedback.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must have a process to manage any complaints received about their service. (Regulation 16 (1)(2) of the HSCA 2008 (Regulated Activities) Regulations 2014)
- The provider must operate an effective governance system, including but not limited to processes to identify, monitor and manage risks, processes to monitor the quality and performance of the DEXA scanning service, processes to identify any required mandatory training and processes to identify essential policies and procedures needed to support the safe and effective delivery of the service. (Regulation 17(1)(2) of the HSCA 2008 (Regulated Activities) Regulations 2014)

Action the provider SHOULD take to improve

- The provider should continue to make sure they complete safeguarding training that meets the national guidance.
- The provider should consider and act on their responsibilities towards the Code of Practice on the prevention and control of infections and related guidance.
- The provider should consider a formal supervision process.
- The provider should continue to work in partnership with the NHS trust specialist nurse to develop a business plan to improve the three month waiting list for DEXA scans in order to meet the needs of patients as per the contractual agreement.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not have a process to manage any complaints received about their service.**

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have an effective governance system, to identify, monitor and manage risks to the service and people using the service, to monitor the quality and performance of the DEXA scanning service, to identify any required mandatory training and to identify essential policies and procedures needed to support the safe and effective delivery of the service.**