Lyca Health Canary Wharf Limited

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Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 7 November 2017 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Lyca Health Canary Wharf Limited provides diagnostic and imaging services, including MRI, ultrasound and X-Ray, from a purpose built location in Canary Wharf, London. The location includes 20 clinical rooms, which are used by consultants and other clinicians under practising privileges. The granting of practising privileges is an established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services. The organisation is based at Ground Floor, Devere Building, 1 Westferry Circus, London, E14 4HA.

Summary of findings

The service which commenced operations in 2016, is overseen by a Board of Directors which includes clinical and non-clinical members, including the Chief Executive Officer who is a consultant radiologist.

The Chief Operations Manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of inspection we collected 11 CQC comment cards filled in by patients. This information gave us a positive view of the service.

During the inspection we spoke with the chief executive officer, the Chief Operations Manager, one nurse, three clinical staff and members of the administration team. We looked at service policies and procedures and other records about how the service is managed.

Our key findings were:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- There were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R).
- Risks to staff and people who used the service were assessed and well managed.
- Staff assessed peoples' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- People who used the service said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and people who used the service, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- The service had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff.

There were areas where the provider could make improvements and should:

- Review infection prevention and control arrangements by following through with plans to review handwashing arrangements in the CT room.
- Review how information about the cost of procedures is presented on the service website.
- Ensure that Radiation Protection Audits and checks on lead aprons are undertaken regularly.
- Put steps in place to ensure Local Rules are reviewed regularly and changes made in line with regulations. Local Rules summarise the key working instructions intended to restrict exposure in radiation areas and include a description of the area covered by the Rules, its radiological designation and the radiological hazards which may be present in the area.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

We found one areas where improvements should be made relating to the safe provision of treatment. This was because handwashing arrangements in one clinical room were not in line with best practice.

- The service had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff.
- There were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R).
- Appropriate environmental measures, including signs, were in place to identify areas where radiological exposures were taking place in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- All staff received up-to-date safeguarding and safety training appropriate to their role.
- The service ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.
- On the day of the inspection, we noted that Local Rules were in place but were out of date. After the inspection, we were provided with evidence which showed that Local Rules had been reviewed and changes had been made to ensure that these were in line with regulations.
- Personal protective equipment (PPE), such as gloves, aprons as well as specialist x-ray protection PPE, including thyroid shields and lead aprons, were readily available for staff to use in all clinical areas.
- There were comprehensive risk assessments in relation to safety issues.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

- The service's policies and procedures referred to professional guidance produced by the National Institute for Health and Care Excellence (NICE), and the Royal College of Radiology.
- The service had a clinical audit programme in place which would ensure compliance with NICE guidelines.
- Clinical policies and procedures were available on the hospital's intranet and staff were aware of how to access them.
- The provider reviewed the effectiveness and appropriateness of the care provided. All staff were actively engaged in monitoring and improving quality and outcomes.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff had access to policies and guidance related to their roles
- The service shared relevant information with the person using the services' permission with other services.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Staff were sensitive to patients' personal, cultural, social and religious needs.
- People had access to chaperones during consultations and treatments and this was clearly advertised through signs in waiting areas and consulting rooms.
- Staff told us that people using the service were given time to ask questions about their procedures and were helped to understand what would happen.

Summary of findings

- Staff showed a clear understanding of the importance of providing emotional support to people undergoing procedures.
- Feedback received from people who used the service through the completed CQC patient comment cards told us that clinical staff took the time to involve them in their care

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

We found one area where improvements should be made relating to the responsive provision of treatment. This was because information about the cost of procedures was not clearly displayed on the service website.

- The service was located entirely on the ground floor of modern premises which had been designed specifically for the purpose of carrying out the services provided.
- The service had ensured that a wheelchair was available to assist people who found it difficult to move around the premises during their visit.
- Changing areas were spacious and allowed people to change safely and comfortably.
- There was a protocol in place to contact people with appointments in the event that equipment was not functioning.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- Leaders had the experience, capability and integrity to deliver the service's strategy and address risks to it.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff told us they were proud to be associated with a charitable foundation established by the provider, whose aim was to provide training opportunities in marginalised communities.
- The service was forward thinking and outward facing and helped improve the services it delivered by sharing innovation and learning.
- There was evidence of systems and processes for learning, continuous improvement and innovation.

Lyca Health Canary Wharf Limited

Detailed findings

Background to this inspection

Lyca Health Canary Wharf Limited provides diagnostic and imaging services, including MRI, ultrasound and X-Ray, from a purpose built location in Canary Wharf, London. The location includes 20 clinical rooms, which are used by consultants and other clinicians under practising privileges. The organisation is based at Ground Floor, Devere Building, 1 Westferry Circus, London, E14 4HA.

The service is overseen by a Board of Directors which includes clinical and non-clinical members, including the Chief Executive Officer who is a consultant radiologist. The Chief Medical Officer is also a partner in an NHS GP service. The Management Board is advised on clinical matters by a Clinical Board, two members of which are external advisors.

The service team consists of a chief operations manager, two nurses, four clinicians and seven administrative and reception staff.

The service is located entirely on the ground floor of modern premises which had been designed specifically for the purpose of carrying out the services provided.

The service is open for appointments between 8am and 8pm from Monday to Friday. Appointments can be booked in person, by telephone or by email.

The chief operations manager, who is a qualified radiographer, is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 completed comment cards where people using the service shared their views and experiences of the service. Patients spoke highly of the service; they described staff as professional, helpful and friendly. They told us that they felt listened to and would be happy to recommend the service to others.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Our inspection team consisted of a CQC Lead Inspector and a radiographer Specialist Advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

We found this service was providing safe services in accordance with the relevant regulations.The service had processes and services to minimise risks to client safety. We found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the service. Risk assessments relating to the health, safety and welfare of people using the service and people employed by the service, had been completed in full. The provider demonstrated that they understood their safeguarding responsibilities. The service had adequate arrangements to respond to emergencies and major incidents.

Safety systems and processes

The service had clear systems to keep patients safe and safeguarded from abuse.

- The service had a suite of safety policies including separate adult and child safeguarding policies which were regularly reviewed and communicated to staff. Staff received safety information for the service as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- There were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R).
- We were told that the Radiation Protection Committee (RPC) met bi-annually but on the day of the inspection, the service was unable to provide minutes to demonstrate what had been discussed at these meetings. Shortly after the inspection, we were provided with minutes of the most recent meeting of the RPC and we saw that the agenda had included items including reviews of the radiation incident reporting policy and radiation safety policy.
- At the time of our inspection, the service had not completed a Radiology Protection audit (RPA) against IR(ME)R standards since commencing service in 2015. We discussed this with the provider who told us they would arrange to have an audit carried out as a matter of urgency. Shortly after the inspection, we were provided with evidence which showed that an audit had been carried out by an external Radiation Protection Advisor on the same day as the inspection and we saw that an action plan had been put in place to bring about improvements where these were highlighted. For instance, the audit had identified a need to ensure Local Rules were updated in line with regulations and we saw that this had already been completed.
- Appropriate environmental measures, including signs, were in place to identify areas where radiological exposures were taking place in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- Electrical safety testing was undertaken every year, and we saw records confirming this. Staff we spoke with were clear on the procedure to follow if items of equipment were faulty or broken. Contractors completed all repair and servicing work for the x-ray equipment.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- There were cleaning schedules for consulting rooms, clinical equipment and patient facilities. These were fully completed by the cleaning team, overseen by the infection control lead and performance reviewed during quarterly review audits.
- There was a system to manage infection prevention and control although there were gaps. For instance, the CT scan room was not equipped with a sink. We asked the provider how they ensured staff were able to maintain appropriate levels of hand hygiene and were told that staff used a sink in the room directly adjacent to the CT room before and after every procedure and that a hand sanitiser had been placed in the room for additional hand cleansing during procedures. We were told this arrangement was being reviewed and a feasibility study had been commissioned with a view to identifying whether it was practicably possible to install hand washing facilities in the CT room.

Are services safe?

- During our inspection, we observed staff use hand sanitisers frequently. We saw that hand sanitiser gels were available in consulting rooms, reception desks and in all clinical areas.
- There were systems for safely managing healthcare waste.
- The service ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. All of the equipment used at the service had been procured as new when the service began operating in 2015.
- Personal protective equipment (PPE), such as gloves, aprons as well as specialist x-ray protection PPE, including thyroid shields and lead aprons, were readily available for staff to use in all clinical areas. We observed staff using them appropriately. We found that the PPE equipment we checked, including x-ray protection equipment were clean and in good condition. However, the service had not undertaken checks to ensure the integrity of lead coats were carried out in line with best practice. Guidance from the Royal College of Radiologists states that these should be checked annually. After the inspection, we were provided with evidence to show that the provider had carried out an audit of lead aprons and had put a process in place to ensure that checks would be carried out at regular intervals in the future.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods. The Chief Operations Manager was responsible for ensuring that staffing levels were appropriate for the services provided using professional judgement, speciality clinic requirements and knowledge of previous clinic attendances. Staff we spoke with said that staffing levels were adequate for the services that were delivered. During our inspection, we observed that staffing levels were adequate to meet the needs of patients, and there was an appropriate skill mix including clinical and administration staff.
- Consultants and radiologists worked under practising privileges with the service and attended the service on set days and times. This meant that the Chief Operations Manager knew in advance which consultant was attending and was able to allocate staff appropriately and could request additional staffing resources from another location managed by the provider when this was necessary.
- There was an effective induction system for temporary staff tailored to their role.
- The service was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- Although the service did not provide emergency care, reception staff told us if they identified any patients who were unwell they would call the nurse to see them urgently. However, they had said that this had never happened whilst they had been working there.
- The staff we spoke with were clear and knowledgeable about the procedures to follow if a patient deteriorated when using the services.
- The radiographers recorded the doses of radiation a patient received. The x-ray equipment gave a print out of the dose given, which we saw would be attached to the patient's referral form.
- There was a specific section on the radiology referral forms to complete for women of childbearing age. The hospital's policy required imaging staff to question a female of child bearing age about the possibility of pregnancy and sign a form to confirm this. The radiology staff we spoke with were confident about this process and we observed completed forms indicating this was being checked.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Are services safe?

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including local anaesthetic, medical gases, and emergency medicines and equipment minimised risks. The service had carried out an appropriate risk assessment to identify medicines that it should stock. The service kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Clinical staff we spoke with told us patients who were given any medicines were asked to remain at the location for one hour after their procedure and were checked by nursing staff before and after the procedure to ensure patients did not experience adverse reactions.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. We saw evidence that the service had carried out separate risk assessments for each item of clinical equipment.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The service had recorded seven incidents in 2017. We found that these had been managed in line with the policy. For instance, we saw a record of an incident when the CT scanner had failed to record the images taken during procedures. The incident had been reported to the Medicines and Healthcare products Regulatory Agency (MHRA) and the manufacturer of the equipment. The service had informed the person undergoing the procedure about the incident and had invited them to return for the procedure on a different day.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. Clinical staff we spoke with told us they were confident they could report any concerns about safety and that they would receive support in response to any incident. For instance, one person told us they had a concern that they had made a mistake recording information about a patient and informed their manager immediately. They told us their manager helped them to review the details and although no mistake had been made, they had received advice about how to avoid uncertainty arising in the future, for instance by recording information immediately.
- There was a system for receiving and acting on safety alerts. The service learned from external safety events as well as patient and medicine safety alerts. We saw records showing that the Chief Executive Officer, who was a qualified radiologist, reviewed and distributed alerts from a wide range of sources, including MHRA, NHS and the Royal College of Radiology.
- Staff told us they had received information and training on the duty of candour (DoC). Staff we spoke with were able to describe the principles of the DoC. They confirmed that they would contact a patient and provide truthful information if errors had been made, they were aware of the legal process that needed to be followed.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was providing effective care in accordance with the relevant regulations.The service provided evidence based care which was focussed on the needs of the people using the service.

Effective needs assessment, care and treatment

The service had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Although the majority of people using the service were referred by GPs and consultants, certain procedures, for instance, x-ray and ultrasound scans, were available to the public without a referral. People wishing to self-refer were required to complete a booking form which required contact details and a brief medical history to be provided. The person was then contacted by a clinician who would undertake a more detailed medical history review and discuss the reason for the procedure. If the clinician considered that the procedure was inappropriate or clinically unjustified, they would decline the booking.
- The service's policies and procedures referred to professional guidance produced by the National Institute for Health and Care Excellence (NICE), and the Royal College of Radiology.
- The service advised NICE guidance was reviewed by the Chief Executive Officer and disseminated to all the clinicians if relevant.
- The service had a clinical audit programme in place which would ensure compliance with NICE guidelines. They were not required to participate in national clinical audits.
- Clinical policies and procedures were available on the hospital's intranet and staff were aware of how to access them. We saw that all policies were dated, reviewed by their review date, or had a date for review. This meant that staff were working with policies and procedures that reflected the latest professional guidance.
- On the day of the inspection, we noted that Local Rules were in place but were out of date. This meant there was no assurance that all of the working services which must be followed to ensure staff are safe when working with radiation were effective or that they complied with the Ionising Radiations Regulations 1999 (IRR99). After the inspection, we were provided with evidence which showed that Local Rules had been reviewed and changes had been made to ensure that these were in line with regulations.

Monitoring care and treatment

The provider reviewed the effectiveness and appropriateness of the care provided. All staff were actively engaged in monitoring and improving quality and outcomes. Audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and patients' outcomes. We reviewed one audit which had been carried out to check whether people presenting for procedures had identity checks and whether female patients of child bearing age had been asked about the possibility of being pregnant. The service had a protocol which required that every person using the service should have their identity checked at each of three stages, namely, by administrative staff on arrival, by nursing staff during preparation and by clinicians before carrying out a procedure. This audit had found that although identity checks had been carried out during at least one stage for all patients, none had had checks at all three stages. The audit had also found that although clinicians had enquired about pregnancy with eligible female patients prior to every procedure, this check had not been carried out for any patient by administrative or nursing staff. The service had briefed all staff on the findings of the audit and had provided training to bring about improvements. We were told a second audit cycle would be undertaken to identify whether improvements had been made.

Effective staffing

- We found staff had the skills, knowledge and experience to deliver effective care and treatment. The service had an induction programme for newly appointed staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- We reviewed the in house training system and found staff had access to a variety of training. This included e-learning training modules and in-house training. Staff were required to undertake mandatory training and this was monitored to ensure staff were up to date. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.

Are services effective?

(for example, treatment is effective)

- Staff learning needs were identified through a system of meetings and appraisal which were linked to organisational development needs. Staff were supported through one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had received an appraisal within the last 12 months.
- There were 192 doctors and other clinicians practising under rules and privileges for the provider, all of which had their registration validated in the last 12 months. Practising privileges were granted to consultants who agreed to practise following the service's policies and provided evidence of appropriate skills and registration. Most of the consultants worked in the NHS and so received their appraisal and revalidation there and the information was forwarded on request to the provider. The service had a responsible officer in post to ensure those consultants not employed elsewhere and for validation purposes were suitably appraised and revalidated.
- Review of requirements for practising privileges was monitored by the service's Chief Operations Manager. When a clinician was due their appraisal they would receive written advice asking them to provide the required detail. A period of three months after the due date would be allowed but if the appraisal documentation was not received then the clinician would be suspended. Any complaints or incidents relating to the clinicians would also be reviewed as part of the process.

Coordinating patient care and information sharing

The service shared relevant information with the person using the services' permission with other services. For example, results from diagnostic procedures were sent to the clinician referring the person to the service. The service told us they aimed to provide results within 48 hours of a procedure being carried out but had not yet audited this to measure performance. Patients who self-referred were asked if they wished to have the results sent to a particular clinician or organisation.

Supporting patients to live healthier lives

The provider told us their services were designed to provide quicker access to diagnostic procedures which meant that people whose conditions meant they needed treatment were able to access this treatment more quickly. People using the service were provided with information and advice prior to and following their procedure; for instance, some procedures undertaken at the service involved administering a contrast media through a cannula into a vein. People having these procedures were advised to drink plenty of water to help flush the substance from their body and were given details of possible allergic reactions and details of who to contact in the event of any concerns.

Consent to care and treatment

Consent forms were used to ensure written consent was obtained where necessary. There was guidance and a protocol on consent available to staff. There was also a dedicated Mental Capacity Act (MCA) 2005 policy and guidance on the Gillick Competency (consent rights for patients under 16). No formal training was provided on the Gillick Competency on an ongoing basis but this was undertaken during induction.

We asked staff if they had access to policies and guidance related to their roles and they confirmed they did. Staff received training on consent and specifically the MCA 2005.

Are services caring?

Our findings

We found that this service was providing a caring service in accordance with the relevant regulations

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff were sensitive to patients' personal, cultural, social and religious needs. We discussed positive examples of care provided to people using the service and were told that many people undergoing procedures were especially nervous and that staff were conscious of high levels of anxiety and would help to put people at their ease, for instance by explaining about and providing reassurance around, the procedure to be undertaken.
- People had access to chaperones during consultations and treatments and this was clearly advertised through signs in waiting areas and consulting rooms.
- Staff told is that people using the service were given time to ask questions about their procedures and were helped to understood what would happen.
- Staff showed a clear understanding of the importance of providing emotional support to people undergoing procedures. Staff gave us examples of when carers had accompanied people during their procedure and they had taken additional time to provide reassurance to people who were anxious.

As part of the inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 completed comment cards, all were positive about the service experienced. Patients said they found staff professional and told us that they were treated with care, dignity and respect.

The provider carried out an online survey using a commercially available survey tool, although this had not been validated. The survey included asking people who had used the service to rate their satisfaction with the service on a scale of 1 to 5, with 1 representing the least satisfied and 5 being very satisfied. One hundred and five responses had been received and we saw data which showed that 95% of responses had scored the service as 4 or 5, indicating high levels of satisfaction. Respondents to the survey were also able to leave comments and we saw that these included references to the professionalism of staff, high standard of facilities and a calming atmosphere.

Involvement in decisions about care and treatment

Staff helped people who used the service to be involved in decisions about their care.

- Feedback received from people who used the service through the completed CQC patient comment cards told us that clinical staff took the time to involve them in their care. People said that they did not feel rushed during their procedures and felt listened to.
- We asked staff about facilities available to help patients be involved in decisions about their procedures where they may otherwise experience difficulties. They told us that they would arrange for an interpreter if requested but had not had a situation where language had been a barrier.
- Staff were aware of how they could obtain accessible information for example, easy read or information for patients who were visually impaired.
- People had access to information about clinicians working for the service, including details of languages other than English, spoken by clinicians.

Privacy and Dignity

Staff respected and promoted peoples' privacy and dignity.

- Reception staff knew that if people wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Privacy screens were provided in the consulting rooms to maintain peoples' privacy and dignity during examinations, investigations and treatments.
- Private changing room facilities and suitable gowns were provided for people who were required to undress for their procedures.
- The service was aware that some people visiting the service had additional privacy requirements and preferred not to enter via the main entrance. Arrangements were in place to provide access using a discrete entrance. People using this alternative entrance were accompanied through the building to their appointment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that this service was providing a responsive service in accordance with the relevant

Regulations.

Responding to and meeting people's needs

The service organised and delivered services to meet peoples' needs.

- The service was located entirely on the ground floor of modern premises which had been designed specifically for the purpose of carrying out the services provided. The premises were fully accessible to patients with mobility difficulties.
- The service had ensured that a wheelchair was available to assist people who found it difficult to move around the premises during their visit.
- All procedures and appointments were pre-booked and we were told that waiting times were minimal. However, if delays did arise because of technical issues or overrunning of earlier procedures, staff kept people informed and offered refreshments to people where appropriate.
- Changing areas were spacious and allowed people to change safely and comfortably.
- The location was well signposted and people using the service were accompanied to clinical areas and consultation rooms.
- Some of the services provided were available through self-referral, for instance, x-rays and ultrasound scans.
- There was a protocol in place to contact people with appointments in the event that equipment was not functioning. When this happened, people were offered appointments at another location managed by the provider or were offered alternative appointment times.
- All written information, including pre-appointment information and signs were in English. These were not available in other formats such as other languages, pictorial or braille. A translator service was available on request.
- Information about the cost of procedures was not clearly visible on the service website. We were told that most people using the service were doing so through their private health insurance policies, whilst others were referred by other private care providers who were responsible for the financial arrangements with the patient.

Timely access to the service

People were able to access care and treatment from the services in a timely manner.

- The service was open between 8am and 8pm from Monday to Friday.
- As well as arranging appointments through their referring care provider, people could book an appointment using the service's website, by telephone or by email.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated people who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Twelve complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way. For instance, one patient had been booked for a weight bearing foot x-ray, a procedure which the service had been unable to provide on the day. The person had complained and had received an apology, a full explanation and had their fee refunded.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. The service had identified that a number of complaints referred to the standard of customer service experienced by people visiting the location. Managers recognised that people using a private healthcare facility often had a different set of expectations around customer service and had arranged additional training for staff to reflect this.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We found that this service was providing a well-led service in accordance with the relevant regulations.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The organisation was overseen by a board of directors with clear overarching strategic responsibility and delegated operational responsibility that covered strategy plans, monitoring performance, and overseeing risk. The board consisted of members with clinical expertise as well as non-clinical members with business and technology backgrounds.
- The service was managed by a Chief Executive Officer who was also a consultant radiologist, supported by a Chief Operations Manager who also had a clinical background.
- Leaders had the experience, capability and integrity to deliver the service's strategy and address risks to it.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. The service developed its vision, values and strategy through consultation with staff, investors, external partners and with patients through survey activity,
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service planned its services to meet the needs of its perceived target audience.
- The service monitored progress against delivery of the strategy.

Culture

On the day of inspection the senior management team demonstrated they prioritised safe, high quality and compassionate care. Staff told us leaders and managers were approachable and always took the time to listen to all members of staff.

- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty.

The service had systems in place to ensure that when things went wrong with care and treatment:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management and were proud to work for the organisation:

- Staff said they felt respected, valued and supported by directors and the leadership and management team.
- Staff told us the service held regular team meetings and we saw evidence this was the case.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- The provider had established a charitable foundation, LycaHealth Gnanam Foundation, which was a humanitarian organisation operating in Eastern Europe, South East Asia, and Africa. Staff told us they were proud to be associated with the foundation, whose aim was to provide training opportunities in marginalised communities. .

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- We were told that the provider had made a significant donation to a research team at Cambridge University and this had been used to promote cardiovascular research in the vulnerable communities in Sri Lanka.

The service was forward thinking and outward facing and helped improve the services it delivered by sharing innovation and learning. For example, the service had developed social media channels in which staff could engage in learning conversations, as well as access important messages, alerts and safety information.

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Governance arrangements

The service had an overarching governance framework:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Service specific policies were in place and implemented, clearly catalogued and available to all staff via the corporate intranet system. We saw records which showed that there was a system to ensure that policies were reviewed regularly.
- There was a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Managing risks, issues and performance

The service was self-aware and ambitious to reduce errors and improve performance, particularly in response to patient feedback. For example, by improving communications with people who had booked appointments to ensure that the service was able to undertake the procedure which had been requested. The service responded to patient complaints by ensuring these were reviewed at senior management level and overseen at board level.

- The service had identified and planned against risks such as maintaining business resilience in light of equipment failure, and had developed a contingency plan to divert patients to an alternative location should clinical equipment malfunction.
- Risk assessments had been carried out for all clinical equipment in use at the service.
- The service leadership had oversight of safety, alerts, incidents and complaints.

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Appropriate and accurate information

We saw evidence appropriate and comprehensive assessments took place using clear pathways and protocols during our inspection.

- Anonymised assessments reviewed during our inspection outlined that individual needs and preferences including up to date medical history were available and recorded, as well as the purpose of the appointment, assessment and any onward referral information.
- Systems were in place to ensure that all personal information was stored and kept confidential. There were policies in place to protect the storage and use of all personal information IT systems were password protected and encrypted.

There were information governance and data protection protocols in place and staff completed regular training in these areas

Engagement with patients, the public, staff and external partners

The service encouraged and valued feedback from people who used the service and staff. It proactively sought peoples' and staff feedback and engaged staff in the delivery of the service.

- The service had gathered feedback from people who had used the service through surveys and complaints received.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. All staff were involved in discussions about how to run and develop the service, and the directors encouraged all members of staff to identify opportunities to improve the service. Staff told us they felt involved and engaged to improve how the service was run.
- All clinical staff had access to regular one to one meetings with the Chief Executive Officer and Chief Operations Manager.

Continuous improvement and innovation

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.