Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Ross Hall Clinic Braehead, Glasgow

Service Provider: Circle Health Group Limited

23–24 January 2024

NHS SCOTLAND

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1 A summary of our inspection

Background

Healthcare Improvement Scotland is the regulator of independent healthcare services in Scotland. As a part of this role, we undertake risk-based and intelligence-led inspections of independent healthcare services.

Our focus

The focus of our inspections is to ensure each service is person-centred, safe and well led. We evaluate the service against the National Health Services (Scotland) Act 1978 and regulations or orders made under the Act, its conditions of registration and Healthcare Improvement Scotland's Quality Assurance Framework. We ask questions about the provider's direction, its processes for the implementation and delivery of the service, and its results.

About our inspection

We carried out an announced inspection to Ross Hall Clinic Braehead on Tuesday 23 and Wednesday 24 January 2024. We spoke with a number of staff, and patients during the inspection. We received feedback from 10 patients through an online survey we had asked the service to issue to its patients for us before the inspection. This was our first inspection to this service.

Based in Glasgow, Ross Hall Clinic Braehead is an independent clinic providing non-surgical and minor surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Ross Hall Clinic Braehead, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service had a clear vision and purpose. A comprehensive strategy and defined objectives with measurable key performance indicators for continuous improvement was in place. Leadership is visible and staff felt valued and supported. Effective governance arrangements were in place and accessible. Staff understood the governance arrangements.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experience was regularly assessed and used to continually inform how the service was delivered. A range of policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to monitor and improve service delivery. The service should develop a process to communicate to patients how patient feedback is used to inform service delivery.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The care environment and patient equipment was clean, and well maintained. Staff described the provider as a good employer and the service as a good place to work. Patients who completed the online survey were very satisfied with their care and treatment. The service should accurately record when the emergency trolley is checked.	✓✓ Good

Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Assurance Framework can also be found on our website at:
https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

What action we expect Circle Health Group Limited to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in no requirements and two recommendations.

Implementation and delivery	
Requirements	
	None
Recommendation	
a	The service should develop a process of keeping patients informed of the impact their feedback has on the service (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirements	
	None
Recommendation	
b	The service should accurately record when emergency equipment trolleys are checked (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

We would like to thank all staff at Ross Hall Clinic Braehead for their assistance during the inspection.

2 What we found during our inspection

Key Focus Area: Direction

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
How clear is the service's vision and purpose and how supportive is its leadership and culture?	

Our findings

The service had a clear vision and purpose. A comprehensive strategy and defined objectives with measurable key performance indicators for continuous improvement was in place. Leadership is visible and staff felt valued and supported. Effective governance arrangements were in place and accessible. Staff understood the governance arrangements.

Clear vision and purpose

Ross Hall Clinic Braehead is provided as part of Circle Health Group. We saw that the service's vision and values statement informed its strategic plan for 2023–2026. The vision was a statement of how it would provide care to patients.

The strategic plan also set out its key performance indicators for the following year and direction over the next 3 years. The plan was comprehensive and set out clear and measurable indicators. We saw that the senior management team (SMT) and the provider's senior leadership team regularly evaluated the indicators, separated into four main categories:

- clinical outcomes
- engaged staff
- optimal value, and
- patient experience.

Each category had specific, measurable objectives. Each objective was formally evaluated and any ongoing actions were identified and actioned, which helped to demonstrate a culture of continuous improvement. Reports were produced every month, documenting how well the service was performing against each of the objectives. This report was submitted to the clinical governance group.

- No requirements.
- No recommendations.

Leadership and culture

The service's staffing resource was made up of:

- reception staff
- house-keeping staff
- healthcare support workers
- registered nurses, and
- medical staff.

The clinic had an effective leadership structure in place through its senior management team (SMT), which consisted of the:

- executive director
- registered manager
- director of clinical services
- director of operations, and
- director of operations and business development.

The service's governance framework included a range of committees, which included:

- medical advisory committee (MAC)
- clinical governance committee
- quality forum and,
- heads of department meeting.

The governance structure also set out how often the groups met (monthly, every 3 months and every 6 months). From reviewing recent agendas and minutes for all these meetings, we saw good representation from all staff groups.

A leadership programme was available to staff.t This included online- and classroom-based training. At the time of our inspection, one nurse had completed the leadership course.

A daily huddle took place which we observed during the inspection. The huddles discussed a number of priorities, including:

- capacity
- flow
- incidents, and
- staffing.

A wide range of staff from both sites attended, including those from:

- estates
- heads of departments
- physiotherapy
- radiology, and
- senior management.

Staff had an opportunity to raise and discuss patient concerns during the daily staff safety huddle and we saw that the service addressed concerns.

A 'freedom to speak up' system had been introduced, where staff could speak with a nominated freedom-to-speak-up 'guardian' in confidence if they had any concerns. Staff we spoke with were clear about their roles, responsibilities and how they could raise any concerns they had.

- No requirements.
- No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Patient experience was regularly assessed and used to continually inform how the service was delivered. A range of policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to monitor and improve service delivery. The service should develop a process to communicate to patients how patient feedback is used to inform service delivery.

Co-design, co-production *(patients, staff and stakeholder engagement)*

The service had an up-to-date patient experience and engagement policy in place which described how feedback would be gathered, analysed and used to inform improvement activities.

The service actively sought feedback from patients about their experience of treatment and care and used this information to continually improve the way the service was delivered. Staff made a point of either calling patients or seeing patients at the clinic after their treatment to find out how they were and to provide an opportunity to raise any issues at the same time. QR codes detailing information about services provided were available throughout the service. Information leaflets were available for patients at the pre-assessment clinic. Patients were given a feedback survey to complete when discharged. We saw that patients could leave feedback on the service website, which the service then responded to directly. Feedback was analysed every month and results were shared at staff meetings. We looked at a selection of surveys the service had carried out, which showed high levels of patient satisfaction, especially in patient care and naming individual staff members for care and attention.

A staff survey called ‘b-heard’ was carried out every year, which asked a comprehensive set of questions. Results from the most recent survey showed a high level of satisfaction, which had improved from previous surveys and this had been acknowledged across the provider’s organisation. Results were shared with staff through a presentation that included examples of feedback from staff and actions taken as a result. Minutes of monthly staff meetings and daily team

briefs demonstrated that staff could express their views freely. Staff we spoke with also confirmed this.

Staff received regular newsletters, regular emails and could attend meetings and forums. This allowed staff to keep up to date with changes in the service, as well as Ross Hall Hospital. Staff told us they received information and training on new initiatives and when legislation changed, such as data protection. This made sure staff felt part of the service and could discuss improvement suggestions.

The service recognised its staff in a variety of ways, including cards acknowledging positive feedback from patients and celebrating staff birthdays. The service would also provide food treats as a reward for staff in view of their hard work. A 'long service award' was also given to staff that had worked in the service for 5 years or more. Recipients were given a certificate of recognition and a voucher to spend. Further awards were given with every extra 5 years of service. A benefits programme was in place for staff, which included private healthcare, access to savings schemes and wellbeing support.

The service had introduced other staff initiatives, including a 'freedom to speak' guardian. Staff could speak with this member of staff in confidence if they had any concerns about their work. Staff we spoke with knew of this initiative and how they could raise any concerns.

What needs to improve

We were told of a variety of service improvements discussed at the different management and governance meetings. However, we did not see any evidence to demonstrate how the improvements made after feedback were communicated to the public (recommendation a).

- No requirements.

Recommendation a

- The service should develop a process of keeping patients informed of the impact their feedback has on the service.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

Comprehensive policies and procedures set out the way the service was delivered and supported staff to deliver safe, compassionate, person-centred care. A process was in place for writing all policies, submitting them to appropriate corporate groups and approving them through the medical advisory committee. Policies and procedures were updated regularly or in response to changes in legislation, national and international guidance and best practice. To support effective version control and accessibility, policies were available electronically on the service's staff intranet.

The service's infection prevention and control policies and procedures were in line with Health Protection Scotland's National Infection Prevention and Control Manual. Procedures were in place to help prevent and control infection. Cleaning schedules were in place for all clinical areas.

Incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through the clinical governance framework.

The outcomes of the discussions from these meetings were fed back through regular staff meetings. Any incidents that an individual member of staff had been involved in were also discussed at the incident debrief, one-to-one meetings and at staff appraisals. Any trends identified were escalated for review to the executive director, to assess training needs.

The service was aware of the notification process to Healthcare Improvement Scotland. During the inspection, we saw that the service had submitted all incidents that should have been notified to Healthcare Improvement Scotland.

The service's complaints procedure was prominently displayed in the service and published on the provider's website. We saw evidence that complaints were well managed and lessons learned were discussed at staff and management meetings. The service was subscribed to the Independent Sector Complaints Adjudication Service (ISCAS), an independent adjudication service for complaints about the private healthcare sector.

A duty of candour procedure was in place (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). Staff we spoke to fully understood their duty of candour responsibilities and had received training in it. The service had published a yearly duty of candour report. We saw evidence that the service had followed its own procedure when dealing with these incidents and shared learning with staff and consultants.
We looked at five paper-based patient care records. Some patients had self-referred. All consultations included details of the treatment risks and benefits

discussed with patients. We saw evidence that treatment options had been discussed. All patient care records we reviewed included:

- aftercare and follow-up
- consent to treatment and sharing of information
- medical history, with details of any health conditions, and
- details of aftercare information.

The provider and service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights). We saw that patient care records were stored securely.

Staff told us that patients were given written aftercare instructions when they were discharged and information about any recommended follow-up. The service's contact details were provided on discharge included in this information in case patients had any concerns or questions. Patients we spoke to told us they were clear about what to expect after discharge. Patients were reviewed either the next day in-person or over the phone after discharge to check how they felt and address any concerns they might have at that time.

The medicines fridges were checked regularly, including its contents and daily temperatures. Staff we spoke with knew the process for reporting faults.
We saw emergency equipment was checked daily and these trolleys were kept in accessible locations. Staff we spoke with were familiar with the location of the trolleys. We saw that specific staff were identified at the start of a shift during the daily huddle to respond to medical emergencies and in the event of a fire.

The service's recruitment policies described how staff would be appointed. Appropriate pre-employment checks were carried out for employed staff and healthcare professionals appointed under practicing privileges (staff not employed directly by the provider but given permission to work in the service).

Staff files contained a checklist to help make sure that appropriate recruitment checks had been carried out.

The service proactively managed its staffing compliment to help make sure that an appropriate skill mix and safe staffing was always provided.

We reviewed five files of employed staff and five files of individuals granted practicing privileges. All 10 files were well organised and we saw evidence of clear job descriptions and that appropriate recruitment checks had been carried out, including:

- professional register checks and qualifications where appropriate
- Protecting Vulnerable Groups (PVG) status of the applicant (this was repeated every 3 years), and
- references.

All employed staff had completed an induction, which included an introduction to key members of staff in the service and mandatory training. All new staff we spoke with had completed an induction programme. We were told that new staff were allocated a mentor and the length of the mentorship depended on the skills, knowledge and experience of the new member of staff.

All staff were allocated mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. Team leaders, heads of departments and the senior management team used an online platform to monitor compliance with mandatory training completion. Staff told us they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training, including medical staff with practicing privileges.

The infection control and prevention nurse also delivered on-site training to staff. Staff told us time for training was usually protected.

Staff appraisals were carried out regularly and recorded on an online appraisal system. The appraisals we saw had been completed comprehensively and staff we spoke with told us their appraisals helped them feel valued and encouraged their career goals.

The service was in the process of implementing clinical supervision for trained nursing staff.

We were told that staff attended ward meetings and minutes of these were available in written form and sent in email to all staff. Staff were encouraged to attend these meetings and access was available in person or virtually to allow as many staff as possible to attend.

- No requirements.
- No recommendations.

Planning for quality

The service's risk management process included corporate and clinic risk registers, auditing and reporting systems. These detailed actions taken to mitigate or reduce risk. The service carried out a number of risk assessments to help identify and manage risk. These included risk assessments for:

- building security
- financial sustainability
- outbreak of infection due to failure of infection control systems and processes, and
- recruitment and retention.

The service also received 'flash alerts' from the provider's other services. The flash alerts detailed information and advice from incidents or identified risks, as well as steps to take to reduce or remove risk.

A business continuity plan described what steps would be taken to protect patient care if an unexpected event happened, such as power failure or a major incident. An arrangement was in place with another service in the provider's wider organisation in case evacuation of patients became necessary.

Circle Health Group Ltd had developed a quality and safety improvement programme called the 'circle operating system' (COS), which was used in the service. We were told that this was a process to make sure all staff were working in an evidence-based approach to care and we saw this included the service audit and review programmes.

The COS programme had systems in place to help staff consider the quality of service provided at all times. COS had four aspects it covered:

- clinical outcomes
- optimal value
- patient experience, and
- staff engagement.

As part of COS, senior staff told us that any member of staff regardless of grade could speak out safely about any practice if they had concerns. COS also allowed staff time to meet, reflect on the patient experience and learn from it. We saw the processes of COS were included in the agendas of staff safety briefs, senior management team meetings and the corporate board meetings. All staff we spoke with during our inspection were enthusiastic about COS.

Staff had opportunities to meet to de-brief after any incident or error that occurred.

The service had a detailed audit programme, which helped make sure the service delivered consistent safe care and treatment for patients and identified any areas for improvement. All staff we spoke to participated in audits and were aware of when these were completed. Action plans were produced to make sure any actions needed were taken forward. The infection control and prevention nurse for the service carried out extensive audits in all departments and supported areas with any actions arising as a result.

The audit programme included:

- clinical outcomes
- health and safety
- infection prevention and control
- medication, and
- patient care records.

The quality improvement plan took account of the service's objectives and included short-term goals and longer-term projects. For example, a short-term goal was following up of all eye surgery patients the day after surgery over the telephone or face-to-face. An example of a longer-term project was increasing the service's consultant base for specialties to give patients greater choice.

- No requirements.
- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

The care environment and patient equipment was clean, and well maintained. Staff described the provider as a good employer and the service as a good place to work. Patients who completed the online survey were very satisfied with their care and treatment. The service should accurately record when the emergency trolley is checked.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

The environment and equipment we saw were clean. We saw that cleaning checklists were completed. Patients we spoke with commented that the service and equipment was clean. Toilets were provided throughout the service, including facilities for people with disabilities. Housekeeping staff cleaned these facilities regularly. We saw that checks were carried out on these facilities regularly through the day and recorded.

Patients who responded to our online survey told us they felt safe and that the cleaning measures in place to reduce the risk of infection in the service were reassuring. All patients stated the clinic was clean and tidy. Some comments we received from patients included:

- ‘Lovely clean facility.’
- ‘Very hi tech - very clever.’
- ‘Everything from the reception area, to the toilets, to the treatment rooms and processes was first class.’
- ‘Facilities and equipment were as expected.’

Patients who responded to our online survey told us they were extremely satisfied with the care and treatment they received from the service and felt involved in the decisions about their care. Some comments we received included:

- ‘Staff were very knowledgeable and skilled - in particular the nurse who assisted consultant with subsequent procedure - glad to have it completed before Christmas holiday.’
- ‘Staff were knowledgeable and extremely helpful.’
- ‘Yes as they they outlined the process and what was going to happen, how and when, and why, and then the next steps.’
- ‘Staff and consultant provided the required information and explanations that I would have expected. I had confidence in the operation and post surgery has turned out well.’

The five electronic patient care records we reviewed showed that appropriate records had been kept for patients, including:

- assessment and consultation
- documentation of the discussion about the treatment plan, including the risks and benefits of each treatment offered, and
- patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate.

We also saw evidence that treatments plans, options and aftercare had been discussed with the patient before they were discharged from the service.

We saw evidence of good standards of medicines management. This included completed records of stock checks and medicines reconciliation (the process of identifying an accurate list of the patient’s current medicines and comparing it with what they’re actually using).

To help assess the safety culture in the clinic, we followed a patient’s journey from the admission area through theatre, recovery area and then to the discharge area. Before the patient arrived in theatre, we observed a pre-safety brief which made sure all staff in theatre were aware of the patient's details, journey and the procedure planned. We saw that staff followed World Health Organization guidelines, such as taking a ‘surgical pause’ before starting surgery to check they had the correct patient and equipment. We also observed staff following safe procedures for managing swabs and instruments in line with guidelines, including those for tracking and tracing instruments used.

A nurse or suitable member of staff accompanied patients to and from the theatre. Staff took time to talk and listen to the patient at each point in the journey, with various staff introducing themselves and explaining what was happening. Patients' privacy and dignity was maintained at all times. We saw effective multidisciplinary working with informative staff handovers and communication at all stages in the patient journey.

Staff told us the leadership team was approachable and they felt valued and well supported by them. Minutes of daily team briefs and monthly staff meetings showed that staff could express their views freely. From our own observations of staff interactions, we saw a compassionate and co-ordinated approach to patient care and treatment delivery, with effective oversight from a supportive leadership team.

What needs to improve

Each emergency trolley had a security tag in place, which made sure that the emergency equipment and medication was secure. While we were told that staff used a checklist to check these trolleys daily, the daily checks were not always recorded. For example, the daily checklist for one trolley only showed one entry in January 2024 (recommendation b).

- No requirements.

Recommendation b

- The service should accurately record when emergency equipment trolleys are checked.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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