Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Freedom From Torture, Glasgow

Service Provider: Freedom from Torture

4 June 2024

NHS SCOTLAND

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1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 25 February 2020

Recommendation

The service should remove all surplus equipment from the medical room and develop a structured cleaning schedule and update its infection prevention and control policy, in line with guidance in Health Protection Scotland's National Infection Prevention and Control Manual.

Action taken

All surplus equipment had been removed from the medical room. A detailed cleaning schedule had been developed with clinical staff who use the room and with the building cleaning services detailing who was responsible for specific tasks.

Recommendation

The service should record stock expiry dates on the audit checklist.

Action taken

A monthly check of stock expiry dates was now in place.

Recommendation

The service should introduce a system to obtain a Disclosure Scotland Protecting Vulnerable Groups (PVG) update for all staff and volunteers.

Action taken

The provider's human resources (HR) department ensured ongoing Protecting Vulnerable Groups (PVG) checks were carried out.

2 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 Freedom from Torture on Tuesday 4 June 2024. We spoke with a number of staff during the inspection. We had asked the service to issue an online feedback survey to its service users for us before the inspection. However, although the service had attempted to encourage service users to complete the survey, we received no responses.

Based in Glasgow, Freedom From Torture is an independent clinic providing rehabilitation services and psychological therapies to support asylum seekers and refugees who are survivors of torture.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Freedom From Torture, 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 values, with a comprehensive strategy and defined objectives with measurable key performance indicators to help continually improve performance. Leadership was visible and supportive, and staff felt valued. Governance arrangements and good communication with staff was evident.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Service users were supported and encouraged to be involved with their care and to help shape the service and policy. Care was person-centred and tailored to meet individual needs. Risk assessments and audits were in place for all environmental and clinical activities. A quality improvement plan also helped to support continuous improvement of the service. The complaints policy and processes were up to date and accessible to all service users. The duty of candour report must be made available to service users.	✓✓✓ Exceptional
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Service user care records demonstrated a person-centred approach and were comprehensively completed. Safe recruitment processes were followed. The environment was welcoming and therapeutic.	✓✓ 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: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect Freedom from Torture 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 one requirement.

Implementation and delivery
Requirement
1 The provider must publish an annual duty of candour report (see page 14). Timescale – immediate *Regulation 5(2)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011*
Recommendations
None

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website:
Find an independent healthcare provider or service – Healthcare Improvement Scotland

Freedom From Torture, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Freedom from Torture for their assistance during the inspection.

3 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 values, with a comprehensive strategy and defined objectives with measurable key performance indicators to help continually improve performance. Leadership was visible and supportive, and staff felt valued. Governance arrangements and good communication with staff was evident.

Clear vision and purpose

The service offered access to rehabilitation services and trauma-based therapies to service users who had experienced torture, as well as medical reports for those who need them for their asylum claim. The service had a clear published strategy for 2022-2025 which had been developed through service user engagement.

The service had a clear vision and values statement. The vision and values were stated on the provider's website. The vision was a statement of what services would be provided to service users. The values of compassion, empowerment, resolve and hope helped to inform the objectives clearly laid out in the strategy.

The service's strategy fed into four set objectives:

- changing lives, helping more survivors of torture
- changing the system, building support for the ban of torture
- survivors driving change, survivors leading and shaping the work of the service, and
- changing ourselves, becoming more agile to support survivors.

This allowed the service to form key performance indicators which included:

- number of service users accepted for treatment
- therapy hours offered, and
- improvement of service users' wellbeing using psychological measurement tools.

The key performance indicators were regularly reviewed though local and national governance processes. Reports were produced every 3 months documenting how well the service was performing against each key performance indicator. The senior management team and board of trustees also met regularly to ensure that all areas of the service continued to deliver the strategic objectives.

An impact report detailed the outcome of performance against the key performance indicators, the political work undertaken and achievements made to influence government policy.

- No requirements.
- No recommendations.

Leadership and culture

The service had a number of care co-ordinators with a background in social work as well as a cognitive behaviour therapist and psychotherapist. A GP provided support for any health-related concerns to service users in the northeast of England and Glasgow. The GP did not treat or prescribe but would link with service users' GPs and advise.

Clear governance processes were in place which demonstrated a supportive leadership culture with well-defined roles and lines of accountability. We saw minutes of weekly clinical governance meetings. Effective communication took place through clinical and line management structures to highlight any areas of concern, when required. There were weekly meetings of the senior management team, and the clinical operations and development board. The service also had meetings every 3 months that included:

- leadership forum
- clinical services managers, and
- clinical secretariat.

The clinical secretariat meetings discussed and reviewed key performance indicators, and learning identified from incidents and complaints. This was shared with all staff through the staff intranet.

All staff meetings were chaired by the chief executive officer where staff were given updates as well as having opportunities to raise concerns or questions. This was alongside all staff emails to share information and face-to-face staff meetings which gave staff the opportunity to speak 'in person' to the senior management team.

Weekly multidisciplinary meetings gave staff the opportunity to discuss clinical workloads. Local business meetings were also held every 6 weeks where staff could contribute to the agenda and discussions.

The service gathered staff feedback every 3 months through an online survey. Results were shared with staff, and an action and improvement plan was developed, if required.

Wellbeing and mental health support for staff was offered, including mental health first aiders and a 24-hour employee assistance programme. Clinical supervision was in place and all staff received supervision, with specialist supervision for therapists who delivered psychological interventions each month.

- 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

Service users were supported and encouraged to be involved with their care and to help shape the service and policy. Care was person centred and tailored to meet individual needs. Risk assessments and audits were in place for all environmental and clinical activities. A quality improvement plan also helped to support continuous improvement of the service. The complaints policy and processes were up to date and accessible to all service users. The duty of candour report must be made available to service users.

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

The service's participation policy detailed how it would actively engage with and encourage feedback from service users about their experience of the service, and how this feedback would be used to continually improve how the service was delivered.

The service sought stakeholder involvement in a variety of different ways. Stakeholders included staff and service users. The service had its own department to ensure service users' voices and feedback were heard and acted on. This department was made up of a range of individual departments, such as service user engagement, policy and survivor networks.

A local and national engagement programme included representation from different areas and met every 2 months. As well as formal groups, everyone using the service was asked if they would like to be involved in local or regional engagement opportunities. One recent example we were given was of a focus group providing feedback on the Scottish Government's refugee integration strategy consultation.

We were told that, in 2023, service users attended and participated in several meetings held in Scotland. This included discussion panels, visiting different service centres, recruitment and a national survey aimed at those accessing the service to help inform clinical pathways. This involvement led to several areas directly impacted as a result, including:

- equality, diversity and inclusion strategies
- clinical and legal advice and welfare service, and
- Christmas boxes/gifts to help fundraising.

As English is not a first language for a high percentage of service users, communication was supported by using interpreters. Information letters were produced in various languages and text messages were used for appointments to aid with translation. A wide range of written information in leaflets and posters was available to service users and families.

Staff were invited to regular online staff meetings led by the chief executive officer where time was allocated to share views and be heard. At a local level, staff were provided with various opportunities to shape how the service was delivered through attendance at team meetings, line management supervision and ongoing open conversations.

The head of clinical service met with partner agencies to listen to their experiences in accessing the service. This was an opportunity to strengthen working relationships with several human rights-based charities and have experience of multi-agency working both from a clinical and an advocacy perspective.

Following their attendance at clinical appointments, interpreters were offered debriefing opportunities due to the often-traumatic nature of some conversations, as well as having access to reflective practice online support.

The service helped to promote wellbeing among staff through protected mealtimes away from the working environment, paid training opportunities, promotional opportunities and team building events.

- No requirements.
- No recommendations.

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.

The registered manager understood the notification process to Healthcare Improvement Scotland, and we saw certain events were appropriately reported to us within the specified timeframes.

We saw evidence of policies and procedures to ensure the delivery of safe, person-centred care for:

- infection prevention and control
- information management, and
- safeguarding (public protection).

The landlord was responsible for general building maintenance, including fire safety equipment, the heating system and electrical appliances. Appropriate public and employer liability insurance cover was in place. Maintenance contracts for the fire safety equipment and fire detection system were up to date. A fire risk assessment was carried out every year. Fire safety signage was in place, and we saw a safety certificate for the fixed electrical wiring. There was weekly fire testing and staff carried out regular unannounced fire evacuation drills.

Incidents were recorded and managed through an electronic incident management system. A process of review and discussion was in place and any learning outcomes from incidents were discussed with staff. This enabled themes and organisational-wide learning to be identified. Key learnings, including best practice and areas for development, were then shared on the staff intranet.

The service had a detailed complaints policy available on its website. This explained the different stages of a complaint, included our contact details and stated that Healthcare Improvement Scotland could be contacted by the complainant at any time during the process.

Duty of candour is where healthcare organisations have a professional responsibility to be honest when something goes wrong. The service had a duty of candour policy. Staff also had training in duty of candour principles as part of their training schedule.

Service user consent was documented and signed by interpreters who were present if English was not the service user's first language. The service would only see those service users who had registered with a GP as they did not provide care for physical health issues. Their GP would then be informed if any issues or concerns were raised while the service user attended the service. The service also had links with the service users' community workers, welfare officers or any other relevant services, and information was passed to these services with the service user's consent. These often acted as official associates of the service users as most did not have a next of kin.

The service used an electronic care record system that was password protected. The service was registered with the Information Commissioner's Office (an independent authority for date protection and privacy rights) to make sure confidential information was safely stored.

Policies were in place for recruitment, induction and staff development. Systems were in place to ensure all staff had up-to-date Protecting Vulnerable Groups (PVG) background checks.

Staff performance and personal development was monitored through monthly supervision and twice-yearly appraisals. We saw appraisals were linked to the provider's values. Staff were asked to reflect on how they met the provider's values, and to set objectives and personal development goals for the year ahead. The appraisals we saw had been comprehensively completed.

What needs to improve

Part of a provider's duty of candour responsibilities is to produce and publish duty of candour reports every year, even where the duty of candour has not been invoked. Although a report had been produced, it had not been published or made available to service users (requirement 1).

Requirement 1 – Timescale: immediate

- The provider must publish an annual duty of candour report.

- No recommendations.

Planning for quality

We saw a risk register that demonstrated how the service managed risk. This included risk assessments for:

- infection prevention and control
- health and safety, and
- finance.

This involved identifying and grading the level of risk, what actions would be taken and the person responsible, as well as review dates. The clinic co-ordinator was responsible for keeping this up to date and implementing the new electronic risk management system. We were told that training on the new electronic system was planned for other staff members.

An audit programme helped to review the safe delivery and quality of the service. The findings were documented, and action plans completed, where required, and these were discussed at relevant staff meetings. Audits were completed thoroughly and included:

- service user care records
- clinic environment
- staff records
- fire safety, and
- emergency equipment.

The provider's leads for quality assurance visited all services every year to discuss incidents and complaints, undertake audits, and speak to staff and service users. This was documented and shared with all staff.

A business continuity plan was in place in case of events that may cause an emergency closure of the service, such as a power failure. We were told that, as no physical healthcare was carried out by the service, it would be able to pause therapy if this became necessary until other arrangements were made.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. We saw that audit actions, complaints and incidents fed into a service improvement plan and a development plan.

- 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

Service user care records demonstrated a person-centred approach and were comprehensively completed. Safe recruitment processes were followed. The environment was welcoming and therapeutic.

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 clinic environment was clean and well maintained. While the main areas were all secure and safe spaces, they also provided a friendly and welcoming environment. The designated therapy rooms were bright with many examples of therapeutic activities to encourage engagement and support through improved wellbeing. We saw cleaning schedules in place for clinical areas and a checklist completed for clinic rooms. The service was cleaned at the end of the day by the building's contracted cleaners.

Antibacterial hand wash and disposable paper hand towels were used to maintain good hand hygiene. Personal protective equipment such as disposable gloves and aprons was available, if needed. A waste management contract was in place for the safe disposal of sharps and other clinical waste.

No medicines were stored in the clinic and no prescribing was carried out by practitioners as part of the service provided. A clearly labelled emergency kit was available in reception for use in an emergency.

We reviewed five service user care records and found these were comprehensive and well organised. We saw evidence of multidisciplinary working and service user involvement. The care plans also included person-centred strategies for improving and maintaining good physical health.

We reviewed five staff files and found all contained the required background checks to show staff had been safely recruited. This included:

- professional registration checks and qualifications, where appropriate
- references, and
- Protecting Vulnerable Groups (PVG) status.

The staff files also included information on each staff member's induction, supervision and appraisals. We saw a process was in place to ensure ongoing reviews of professional registrations, and regular PVG checks were carried out, as required, to ensure staff remained safe to continue working in the service. Interpreters were checked by a company that the service used to ensure service user safety.

- No requirements.
- No recommendations.

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: [The quality assurance system and framework – Healthcare Improvement Scotland]

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

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.
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