Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Scottish Vein Centre, Edinburgh

Service Provider: Scottish Vein Centre Ltd

28 May 2024

NHS SCOTLAND

Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 9 January 2020

Requirement

The provider must ensure that staff employed in the provision of the independent healthcare service receive regular individual performance reviews and appraisals.

Action taken

The provider was able to demonstrate that staff employed in the provision of the independent healthcare service had regular performance reviews and appraisals. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 9 January 2020

Recommendation

The service should introduce a system to obtain a Disclosure Scotland PVG update for all staff at regular intervals. This will ensure that staff remain safe to work in the service.

Action taken

The service demonstrated it had a system in place to check all staff had a linked Disclosure Scotland PVG and this was regularly checked.

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 Scottish Vein Centre on Tuesday 28 May 2024. We spoke with four members of staff, including the service manager who was also a doctor and practitioner. We received feedback from 24 patients through an online survey we had asked the service to issue for us before the inspection.

Based in Edinburgh, Scottish Vein Centre is an independent clinic providing non-surgical treatments.

The inspection team was made up of one inspector and an observer.

What we found and inspection grades awarded

For Scottish Vein Centre, 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, with a comprehensive strategic direction and key performance indicators for continued improvement. Governance processes were in place with visible and supportive leadership. Staff felt supported and valued. The service is going through a period of change which will result in new leadership due to the current director and practice manager retiring.	✓✓✓ Exceptional
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 improve how the service was delivered. Detailed policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes, including an audit programme and quality improvement plan, helped staff to continuously improve how the service was delivered. Patient and staff feedback was actively sought and improvements were continuously being made to progress the service.	✓✓✓ Exceptional
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The care environment and patient equipment were clean, equipment was fit for purpose and was regularly maintained. Staff had comprehensive employment checks carried out to make sure they were safe to work in the service. Patient care records were detailed and consent was recorded. Patients were very satisfied with their care and treatment and said they felt safe and well informed.	✓✓✓ Exceptional

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 Scottish Vein Centre Ltd 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 no recommendations.

We would like to thank all staff at Scottish Vein Centre 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 purpose, with a comprehensive strategic direction and key performance indicators for continued improvement. Governance processes were in place with visible and supportive leadership. Staff felt supported and valued. The service is going through a period of change implementation which will result in new leadership due to the current director and practice manager retiring.

Clear vision and purpose

We saw that the service's vision and purpose was at the forefront of service delivery and continued to be people-centred and measurable. The service offered treatments that involved patient informed choice and personal preference, using evidence-based research. The service offered alternative approaches for treatment compared to the more traditional methods. Information on the service's vision and purpose was provided on the service's detailed website.

The service key performance indicators (KPIs) helped measure and evaluate how well it was doing. KPIs allowed identification of the service's strengths and weaknesses while promoting continuous improvement, in the short- and longer-term goals of the service. The KPIs included:

- audit and compliance
- complaints
- incident and accident reporting
- financial reports
- missed patient appointments
- feedback from patients and staff
- reported outcomes from service users, and
- staff sickness absence monitoring.

We saw that the service reviewed and revised the KPIs as appropriate and shared any developments with staff.

The service had a continued active role in a benchmarking project that the College of Phlebology had developed, called the national venous registry. This is a live, online registry that involved the service collecting detailed data, including outcomes that were:

- clinical
- from different demographics
- from treatment, and
- patient-reported.

Data was collected after consent had been obtained and documented. It was collected through a patient questionnaire that the practitioner had designed in line with peer-reviewed and published methodology to record patient outcomes. This allowed the service to benchmark its performance nationally with other similar services in the UK.

The service had a long-standing shared premises agreement with the resident, registered, private GP practice. This continued to be a positive partnership that clearly demonstrated a proactive partnership. For example, the practitioner had regular meetings with the GP practice lead. We also saw ongoing shared ownership of some policies, such as those for health and safety and patient-centred care.

The service had a clear and current strategic plan in place, which was regularly reviewed and included:

- analysis, development and progression of staff roles and responsibilities
- moving from paper-based to electronic records
- succession planning and future-proofing, and
- upgrading of existing website.

- No requirements.
- No recommendations.

Leadership and culture

The medical director was a doctor registered with the General Medical Council (GMC), a former NHS consultant in vascular surgery and interventional radiologist with 30 years' experience in this field. The practitioner was also an active advocate for improvement. For example, they had contributed to the development of new techniques and innovative practice using evidence-based research and national guidance for alternative approaches to traditional varicose vein surgery.

The team had well defined roles and responsibilities. It included one member with practicing privileges (staff not employed directly by the provider but given permission to work in the service) and a practice manager working remotely. The practice manager's responsibilities included managing the bookings and calls. This was a well-established team and the majority of staff had worked in the service since its registration. Staff we spoke with were positive about the support they received from the medical director and in the team. All staff we spoke to were fully aware of their role and enjoyed working in the service.

The morning staff meeting held in the service provided an opportunity to discuss patients and any issues. Incentives for staff included:

- flexible working
- funded training opportunities for professional development, and
- progression.

We were told of one example where a staff member had been involved in the re-evaluation of their role. A new job description had been developed as a result of data collection and feedback, which the staff member was fully involved in. Staff were also involved in the development and review of policies and were encouraged to provide feedback. Minutes of staff meetings regularly covered:

- complaints and concerns
- equipment maintenance schedules
- governance
- minutes of previous meeting
- training, and
- staffing.

Staff were encouraged during these meetings to share their views, ideas and contribute to service improvement.

We saw a variety of examples of the service making improvements from its continuous performance monitoring, including recent changes to an electronic system to store patient care records. The service had introduced the use of a smartphone app for better communication and access to the staff duty rota. Staff were positive about these improvements.

The service had developed a comprehensive quality improvement framework to monitor and improve the quality of care and treatment it delivered to patients. A variety of key outcome measures meant the service could evaluate and improve clinical and environmental risks, treatment outcomes and patient reported outcomes.

- 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 improve how the service was delivered. Detailed policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes, including an audit programme and quality improvement plan, helped staff to continuously improve how the service was delivered. Patient and staff feedback was actively sought and improvements were continuously being made to progress the service.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service's participation policy detailed how it would encourage and actively engage with feedback from patients about their experience of treatment and care. The policy also set out how this feedback would be used to continually improve the way the service was delivered.

The service sought stakeholder involvement in a variety of different ways. For example, online surveys and direct feedback were asked for 6 months and a year post-treatment. The results from the surveys and feedback showed consistently high levels of satisfaction. The service carried out comparisons with previously-received patient feedback and shared the comparisons on its website. Feedback was used to inform improvement activities, such as changing the signage in the service to improve wayfinding for patients using the clinic. The service has also had many new patients attending because of the positive reviews read on the website and word-of-mouth from existing patients. Any changes made were evaluated to determine how effective they had been.

We saw recent patient feedback and patient survey results, which showed a high level of satisfaction and trust in the service received.

The service shared information with patients in a variety of ways and kept patients well informed of any changes. The website included a wide range of information on all treatments available in the service. The proposed changes of leadership had also been explained to existing patients and how these changes would affect their treatment.

After booking an appointment, patients received a welcome pack and information about the treatment requested. The pack and website:

- clearly explained the service's vision and values
- introduced all members of the team
- provided before- and aftercare advice, and
- shared information on how to provide feedback or complaints and directions on how to get to the service.

Patient comments about the information they received included confirmation that the website was informative, they received further information at consultation and in the patient information they took away. Costs were also included at consultation and the website had a comparison for costs, which some patients commented on as helpful.

- 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.

Governance structures and comprehensive policies and procedures helped support the delivery of safe, person-centred care. Policies were reviewed regularly or in response to changes in legislation, national guidance and best practice. Examples of key policies included those for:

- clinical governance
- duty of candour
- health and safety
- infection prevention and control
- medicines management, and
- safeguarding.

An external cleaning company regularly cleaned the service. However, staff carried out sessional cleaning and daily checks were completed that demonstrated appropriate cleaning had been completed, including the use of chlorine-releasing agents for sanitary fixtures and fittings.

A medicines governance audit tool was used to regularly monitor the safe, effective and secure use of medicines in line with its safe medicines policy, legal requirements and best practice. Patient care records documented the medicines administered to patients as part of their treatment was in line with best practice.

The service had a detailed and comprehensive risk assessment and risk management policy, some aspects of which were shared with the other registered service in the building.

An up-to-date complaints policy was published on the service's website and in the patient welcome pack. This included information on how to make a complaint and details of how to contact Healthcare Improvement Scotland, at any time. We saw evidence that the one complaint the service had received had led to the development of an action plan, key learning and training needs identified and a change in practice. This had then been shared with the team. We saw that complaints, concerns and lessons learned were part of the rolling agenda at the staff meetings. The service had not had any complaints in the previous 12 months.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. The service had a duty of candour policy in place and a current report was available on its website.

The service was in the process of moving to electronic record keeping, as well as an upgrade of the website as part of continuing service development. While this changeover was still in transition, all paper patient care records were stored safely and we saw that electronic patient information was stored on a password-protected electronic device. This helped to protect confidential information in line with the service's information management policy, which had been updated. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) and we saw that it followed appropriate date protection regulations.

Patients completed the initial booking request online or they could call and speak to the practice manager directly. The practice manager was the first point of contact for the service and was also a registered nurse. The current role of the practice manager was to manage all the calls, bookings, follow-ups and offer advice if required.

All patients had an initial discussion at the first call and a comprehensive clinical assessment to assess their suitability for treatment including past medical

history, risks and benefits and possible side effects. Patients were offered an out-of-hours contact number for support as well as planned follow-up appointments 6 months and a year after treatment. All patients had a patient care pathway in place from start of treatment to completion of their care.

The service's recruitment policies were in line with safer staffing guidance. This helped make sure that suitably qualified staff were recruited.

The service had a programme of mandatory training and the practice manager had responsibility for making sure that staff had completed this. Examples of training topics included:

- anaphylaxis
- basic and advanced life support
- duty of candour
- equality and diversity
- fire safety, and
- laser safety training (Core of Knowledge).

A process was in place to make sure ongoing reviews of professional registrations, professional indemnity insurance and regular PVG checks were carried out for all healthcare professionals. This included those granted practicing privileges.

Yearly appraisals were carried out for all staff employed in the service. Clinicians contracted to work under practicing privileges had to provide evidence of their:

- continued professional development
- supervision arrangements, and
- yearly appraisal.

This made sure they maintained their contractual agreements.

- No requirements
- No recommendations.

Planning for quality

Systems were in place to proactively assess and manage risks to staff and patients. This included:

- auditing
- minuted staff meetings, and
- risk assessments.

This helped to make sure that care and treatment was delivered in a safe environment. The service's risk register was regularly reviewed and covered organisational risks and detailed actions taken to mitigate or reduce the risks. Risks on the register included:

- building failure
- IT management, and
- staffing and recruitment.

The service had an up-to-date fire risk assessment and we saw that appropriate fire safety equipment and signage was in place.

A programme of audits was carried out at regular intervals. This helped make sure the service delivered consistent safe care and treatment to patients. Examples of clinical audits carried out included those for:

- infection control
- medicines management, and
- patient care records.

We saw a detailed quality improvement plan in place, which set out how the service used information gathered from patients, staff and stakeholders to continually improve service delivery and patient outcomes. For example, the service now used more digitally-based patients care records to support effective communication and service provision.

- 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 were clean, equipment was fit for purpose and was regularly maintained. Staff had comprehensive employment checks carried out to make sure they were safe to work in the service. Patient care records were detailed, and consent was recorded. Patients were very satisfied with their care and treatment and said they felt safe and well informed.

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 service is in a quiet, accessible area. The main entrance area was clean and well equipped with a bright, comfortable reception area for patients. The clinic was on the upper floor and accessed by a set of stairs. Patients with mobility difficulties could use the fire exit door at the side of the building to gain direct access to the clinic if this was required. We saw the treatment room was clean, comfortable and fit for purpose. Our online survey results confirmed that respondents were extremely satisfied with the cleanliness of the environment and stated:

- ‘The treatment area was very calm, clean and comfortable.’
- ‘Venue was very convenient to get to and equipped for purpose.’
- ‘Small, but clean and tidy room.’
- ‘Excellent.’

The lead nurse was key in managing infection prevention and control in the clinic. Audits of hand hygiene and cleaning protocols were carried out in line

with the service's infection control policy, which followed national guidance. The service had an appropriate waste contract in place for the safe disposal of sharp and clinical waste. Personal protective equipment, such as disposable gloves and aprons were available. Medical devices, such as needles, syringes and laser probes were all single use. Disposable sterile procedure packs were used during laser procedures and aseptic techniques were followed to further reduce infection risks to patients.

We reviewed five patient care records which were fully completed and contained comprehensive information including consent. This included:

- a health questionnaire
- areas identified to be treated
- before and after photos
- consent to share information with GP or other healthcare professionals
- consultation notes for each care episode
- information about the risks and benefits of treatment, as well as the cooling-off period, and
- prescriptions and areas treated.

Arrangements were in place to make sure the team could support patients in the event of a medical emergency or any complications from treatment. This included mandatory staff training and provision of first aid supplies in the clinic. The service was registered with the Medicines and Healthcare Products Regulatory Agency (MHRA) to receive medical alerts and report any adverse incidents.

The procedures performed in the clinic involved using laser technology. The practitioner was the laser safety supervisor and one of two authorised users of the equipment. We saw the laser was regularly maintained to make sure it remained fit for purpose. The most recent report from the laser protection advisor's yearly review was carried out in January 2024 and confirmed the service was fully compliant with its laser protection obligations. All relevant staff have completed their core of knowledge training.

The service reviewed its policies every year or when legislation changed. For example, all policies we reviewed had been reviewed and updated to make sure the service followed current legislation and guidance, where necessary. Patients who used the service and who responded to our online survey told us that they felt safe and well cared for. Comments included:

- ‘Expertly treated. Condition discussed and course of treatment advised and the probable outcome.’
- ‘All procedures, after care and communication excellent.’
- ‘Everything including costs were explained well. Medical treatments and after care excellent.’
- ‘I felt fully informed and received answers to my questions.’
- ‘I know I made the right choice for me, and I cannot rate the treatment I received any higher than excellent.’

    - 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.
Please contact our Equality and Diversity Advisor on 0141 225 6999
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