Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: TAC Healthcare Group, Aberdeen

Service Provider: TAC Healthcare Group Ltd

12 September 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 26 August 2022

Recommendation

The service should ensure that controlled drugs are accurately recorded in a controlled drug register book.

Action taken

All controlled drugs the service used were accurately recorded in a controlled drug register book.

Recommendation

The service should ensure that the safety brief is documented for all staff to see.

Action taken

A documented safety brief was in place, discussed with all staff in the mornings and available for all staff to view.

Recommendation

The service should make sure that patient consent forms are fully completed.

Action taken

We saw that all patient consent forms were fully and accurately completed.

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 TAC Healthcare Group on Thursday 12 September 2024. We received feedback from eight patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Dyce, Aberdeen, TAC Healthcare Group 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 TAC Healthcare Group, 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's aim and objectives were displayed on its website. Regular, documented staff meetings and clinical governance meetings were held. The service should develop a strategic plan and senior management team meetings should be documented.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was sought and used to improve the service. Policies, procedures and treatment protocols helped the service deliver safe patient care. Clear systems and processes were in place to monitor and manage complaints, risk and accidents or incidents. An audit programme was in place. The service should regularly review and update its policies to keep them up to date with current standards, legislation and guidance.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Our survey results were positive and confirmed that patients felt safe and satisfied with the quality of care and treatment they received in the service. The clinic environment was clean and patient equipment was fit for purpose. We saw good compliance with infection control procedures. Patients had a full assessment to determine their suitability for treatment. Consent-to-treatment forms were fully completed. Appropriate pre-employment checks must be carried out for all staff, including those working under practicing privileges agreements.	✓✓ 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 TAC Healthcare Group 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 one requirement and four recommendations.

Direction	
Requirements	
	None
Recommendations	
a	The service should develop a strategic plan that sets out its strategic objectives, operational priorities and vision (see page 12). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
b	The service should record the agenda and minutes of senior management meetings and include any actions taken and those responsible for the actions (see page 14). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
	None
Recommendations	
c	The service should continue to review all its policies and procedures and ensure they are up to date with current standards, legislation and guidance (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
d	The service should ensure that when a key member of staff leaves, that a contingency plan is place to continuity of service (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

Results	
Requirement	
1	The provider must ensure that the safe recruitment of staff is completed in line with policy and national guidance, including the obtaining of two references and recording of PVG Disclosure numbers (see page 23). Timescale – by 12 December 2024 *Regulation 8 (1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) 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

TAC Healthcare Group Ltd, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at TAC Healthcare Group 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's aim and objectives were displayed on its website. Regular, documented staff meetings and clinical governance meetings were held.

The service should develop a strategic plan and senior management team meetings should be documented.

Clear vision and purpose

The service's aim was displayed on its website. It stated that it aimed to provide an all-encompassing service to better support patients' health needs and provide an efficient and friendly service to provide the best care possible. The provider's core values included:

- 'Best value - with passion and teamwork, we strive to deliver exceptional value to clients and patients.'
- 'Effective - we are committed to excellence, ensuring our treatments align with best quality practices.'
- 'Safe - through rigorous auditing of staff and treatments, we uphold the highest safety standards.'
- 'Treatment - we provide necessary. Timely care, serving our clients when they need us most.'

The service had key performance indicators (KPIs) in place, which it regularly reviewed. These included:

- efficacy of patient administration
- effective management of corporate contracts
- monitoring of medical correspondence to patients and clients, and
- monitoring of patient and staff satisfaction.

What needs to improve

The service did not have an overall strategic plan with a structured approach to improvement (recommendation a).

- No requirements.

Recommendation a

- The service should develop a strategic plan that sets out its strategic objectives, operational priorities and vision.

Leadership and culture

The service's staff was made up of:

- a service manager (registered with the Nursing and Midwifery Council)
- administrative staff including reception staff
- business support staff
- chief executive officer
- chief operating officer
- finance staff
- healthcare support workers
- human resource advisors
- IT support staff
- medical staff
- occupational health doctors
- occupational health manager
- occupational health nurses
- occupational health technicians
- payroll staff
- physiotherapy staff
- procurement staff
- quality and care staff
- registered general nurses, and
- training staff.

All staff told us they felt able to raise any concerns with the management team.

The service had a documented leadership structure in place with defined roles, responsibilities and support arrangements.

A clinical governance framework set out that the service would monitor the quality and safe delivery of care and treatment provided, according to its clinical governance policy. This included:

- clinical audits
- clinical governance and staff meetings
- education and training, and
- quality and risk.

Staff could access minutes of these meetings and the service's policies and procedures through the service's computer system.

The service manager engaged in regular continuing professional development (CDP) through their NMC registration and revalidation process.

We saw that monthly team meetings for admin, nursing and medical staff included an agenda and minutes.

We saw that the endoscopy unit had a safety brief in place. The safety brief was discussed with all staff in the morning and available for all staff to view.

We saw the service promoted a positive culture of staff engagement in a variety of ways, such as through:

- formal and informal opportunities for team discussion, and
- sharing information from patient feedback, audit results and training through emails, a staff noticeboard, staff one-to-ones and staff meetings.

An open-door policy helped to encourage open communication between the service manager and staff.

The service recognised its staff in a variety of ways, including through a staff recognition scheme. In this scheme, staff could nominate a colleague for good practice, the senior management team would discuss it and the recipient was given a voucher to spend. The service also provided a staff barbeque and a sometimes a fish and chip van. The service also recognised the importance of supporting charities and we saw that many staff regularly participated in fundraising. They would do this individually or as part of a team to draw attention to important causes, such as disadvantaged families and a food bank.

What needs to improve

We were told that the senior management team met at least weekly to discuss operation matters. However, we did not see any formal agendas or minutes recorded for this (recommendation b).

- No requirements.

Recommendation b

- The service should record the agenda and minutes of senior management meetings and include any actions taken and those responsible for the actions.

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

Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was sought and used to improve the service. Policies, procedures and treatment protocols helped the service deliver safe patient care. Clear systems and processes were in place to monitor and manage complaints, risk and accidents or incidents. An audit programme was in place.

The service should regularly review and update its policies to keep them up to date with current standards, legislation and guidance.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service had a participation policy in place. We saw that the service proactively sought patient feedback to learn from and improve. Service users could leave feedback through an online form. After each occupational health appointment, a member of staff would contact the business who had used the service for its employees to ask for feedback. NHS patients were given a feedback form to provide feedback to NHS Grampian. This gave patients an opportunity to give their feedback about the treatment and ask questions or raise any concerns they had.

We spoke with six members of staff, who all spoke positively about the service and of how supportive the senior management team was. All staff that we spoke with felt that they could raise any concerns if they had any and that they would be taken seriously.

We saw that feedback was analysed and used to inform service improvement, which was also discussed at staff meetings. For example, the service had introduced a GP primary care service and built more consulting or treatment rooms after receiving feedback.

The service's website contained information about the service, the treatments it offered and costs.

A staff survey called was carried out every year, which asked a comprehensive set of questions. Results from the most recent survey showed a good level of satisfaction, which had improved from previous year. Results were shared with staff, which included examples of feedback from staff and actions taken as a result. Minutes of monthly staff meetings demonstrated that staff could express their views freely. Staff we spoke with also confirmed this. We saw that staff had suggested sharing the responsibility of carrying out audits among members of staff groups. The service had implemented this change and it meant that audit activities were not person-dependent.

- 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 service had policies and procedures in place to support the delivery of person-centred care, available on the service's intranet for staff to access. The policies and procedures available included those for:

- complaints
- duty of candour
- emergency arrangements policy
- information management, and
- medication.

An infection prevention and control policy was in place and the service had a good awareness of infection prevention and control practices, including hand hygiene and clinical waste management. We saw that cleaning checklists were fully and accurately completed. All equipment used, including personal protective equipment (such as aprons and gloves) was single-use to prevent the risk of cross-infection.

All medication, including vaccines were in-date and we saw that medication checklists were fully and accurately completed.

Arrangements were in place to deal with medical emergencies. This included up-to-date training and first aid supplies.

Fire safety signage was displayed and fire safety equipment was serviced every year. Electrical equipment had been tested and safety certificates were in place for fixed electrical wiring and portable appliance testing (for electrical appliances and equipment to ensure they are safe to use). Maintenance contracts were in place for the audiology booth and spirometry equipment (used for a test to assess how well your lungs work). We saw good processes in place to test and monitor the endoscopy equipment. The service had a clinical waste contract in place and kept copies of waste consignment notes.

The service was aware of the notification process to Healthcare Improvement Scotland. During our inspection, we saw that the service had not experienced any events or incidents that should have been notified to Healthcare Improvement Scotland.

We saw that the service's website detailed how service users could make a complaint. The service had a complaints policy in place, which described the process for managing a complaint. The policy also provided information on how a patient could make a complaint to the service or directly to Healthcare Improvement Scotland at any stage of the complaints process.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with people when something goes wrong. The service had a duty of candour policy in place and displayed a yearly duty of candour report in the clinic.

Appropriate arrangements were in place to maintain patients' privacy and dignity. All consultations were appointment-only. Access to treatment rooms was controlled through reception. Window screening in the treatment room also helped make sure patient privacy was not compromised.

The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) and we saw that it worked in line with data protection regulations. Patient care records were stored electronically and password-protected, to help maintain patient confidentiality. All patients were provided with a face-to-face consultation to assess their suitability for treatment before a treatment plan was prepared or any treatment was administered. During their consultation appointment, patients discussed the risks and benefits, costs and likely outcome of the desired treatment.

Recruitment policies and processes were in place for all staff. Relevant pre-employment checks carried out for staff the service directly employed before they started working, including those for:

- Disclosure Scotland background checks
- proof of ID
- qualifications, and
- references.

We saw systems in place for the ongoing checks of clinical staff members' professional registration and revalidation.

We were told all new members of staff completed an induction to the service. This included an introduction to key members of staff and training on the service's policies and procedures.

Staff were expected to complete mandatory and refresher training on a range of topics relevant to their roles. This included training for:

- basic life support
- fire safety
- health and safety, and
- infection protection and control.

We saw that annual appraisals were carried out for all staff who had been employed for over 12 months.

What needs to improve

We saw that some of the service's policies lacked some specific details, such as the policies for:

- complaints
- infection prevention and control
- participation, and
- whistleblowing.

These policies did not state:

- that NHS patients could complain to their NHS board or the Scottish Public Services Ombudsman
- specific information on standard infection control procedures
- how feedback was obtained, and
- that NHS patients could contact the Independent National Whistleblowing Officer (recommendation c).

■ No requirements.

Recommendation c

■ The service should continue to review all its policies and procedures and ensure they are up to date with current standards, legislation and guidance.

Planning for quality

The service maintained a register of practice-associated risks and their impact to help manage risks. We saw a range of current risk assessments in place to protect patients and staff, such as for infection control and fire safety. Risk assessments were easy to follow and each risk assessment had a likelihood of occurrence attached. We saw that all necessary action plans were in place.

A business continuity policy was in place in the event that the service experienced a disruptive incident. The policy stated that, in such a scenario the service would establish alternative arrangements for patient treatments and prioritise critical functions.

The service carried out a comprehensive programme of audits regularly, including those for:

- infection control
- stock control, including medication
- training and education
- travel health vaccinations, and
- turnaround of referral management.

Action plans were produced to help make sure any improvements were addressed in specified timescales. For example, we saw that the service had

made sure that more than one member of staff could complete a medication audit and infection control audit to make sure the process was not person-dependent.

We were shown evidence that the service had achieved ISO 9001 accreditation. ISO 9001 is a recognised quality management system standard, established by the International Organisation for Standardization (ISO).

A quality improvement plan was in place, which measured the outcomes of service changes. This informed and directed service improvement activities from patient feedback analysis, previous inspections and audit results.

What needs to improve

We saw that some risk assessments had not been reviewed and updated. We discussed this with the management team, which told us that it was aware of this. The health and safety manager had recently left the service and would have been responsible for reviewing all risk assessments. The service was in the process of recruiting a new health and safety manager (recommendation d).

- No requirements.

Recommendation d

- The service should ensure that when a key member of staff leaves, that a contingency plan is place to continuity of service.

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

Our survey results were positive and confirmed that patients felt safe and satisfied with the quality of care and treatment they received in the service. The clinic environment was clean and patient equipment was fit for purpose. We saw good compliance with infection control procedures. Patients had a full assessment to determine their suitability for treatment. Consent-to-treatment forms were fully completed.

Appropriate pre-employment checks must be carried out for all staff, including those working under practicing privileges agreements.

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 satisfactory self-evaluation.

The clinic environment was clean and well maintained. Equipment used in the service was clean, well maintained and serviced regularly where required. Cleaning checklists were fully and accurately completed.

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

- ‘Clean space with good facilities.’
- ‘The facility is very clean.’
- ‘The room was clean and the equipment seemed to be well maintained.’

All five of the electronic patient care records we reviewed showed that consultation and assessments had been carried out before treatment started. Patient care records we reviewed included:

- comprehensive practitioner notes
- contact details for patients' next of kin or emergency contact
- consent
- GP details
- medical history (including details of any health conditions, allergies, medication and previous treatments), and
- treatment plans.

All patients who responded to our survey agreed they had been involved in decisions about their care and treatment. This helped to make sure patients had realistic expectations of the proposed treatment. Comments included:

- 'Doctor went through the pros n cons.'
- 'Everything explained in detail and great advice.'
- 'My opinion is asked after every question which makes me feel involved.'

We saw a safe system in place for the procurement, storing and prescribing of medicines and additional stock items used in the clinic. The medicines fridge was clean and in good working order. A temperature recording logbook was used to record fridge temperatures daily. This made sure medicines were stored at the correct temperature. The logbook was fully completed and up to date. All vaccines stored in the fridge were in-date.

We reviewed files of those staff the service directly employed. These staff files included evidence of appropriate initial and ongoing checks to help make sure staff were safe to work in the service. Staff had completed an induction process when starting in the service, as well as ongoing aesthetics training. We saw evidence of documented annual appraisals. Each staff member, including the manager (practitioner) had a learning and development folder with a yearly training-needs analysis and evidence of completed training.

What needs to improve

Staff working under practicing privileges is where staff are not employed directly by the provider but given permission to work in the service. We were told that the service was changing from a staffing model where consultants worked under practicing privileges to one where consultants are employed by the service. From the staff files of consultants working under practicing

privileges, we saw that the service did not record their PVG number from Disclosure Scotland and had not obtained two references (requirement 1).

Requirement 1 – Timescale: by 12 December 2024

- The provider must ensure that the safe recruitment of staff is completed in line with policy and national guidance, including the obtaining of two references and recording of PVG Disclosure numbers.

- 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
or email his.contactpublicinvolvement@nhs.scot

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