Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Nuffield Health Edinburgh Hospital, Edinburgh

Service Provider: Nuffield Health

4–5 September 2025

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 19–20 January 2022

Recommendation

The service should comply with national guidance to make sure that the appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical hand wash sinks.

Action taken

We saw evidence that all sanitary fittings, including clinical hand wash sinks were cleaned in line with national guidance.

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 unannounced inspection to Nuffield Health Edinburgh Hospital on Thursday 4 September and Friday 5 September 2025. We spoke with a number of staff and patients during the inspection. We received feedback from 28 staff members through an online survey we had asked the service to issue for us during the inspection.

Based in Edinburgh, Nuffield Health Edinburgh Hospital, is an independent hospital providing non-surgical and surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Nuffield Health Edinburgh Hospital, 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 hospital had a well-defined and measurable vision and purpose, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and purpose. Key performance indicators were regularly monitored and reported. Clear benchmarking was in place and continually monitored. A clear governance structure was in place. The hospital's leadership team was visible. Staff were empowered to speak up. The staff group was well established and long serving.	✓✓✓ 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. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes were in place for patient and staff safety. Improvement projects involved all departments. Staff surveys carried out every 6 months helped the service plan and develop staff. The quality improvement plan was maintained and updated regularly. The effectiveness of improvements made as a result of patient feedback were evaluated but not shared with patients.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The care environment and patient equipment was clean, equipment was fit for purpose and regularly maintained. Medicines management was good. Staff described the provider as a good employer and the hospital as a good place to work. Patients were very satisfied with their care and treatment.	✓✓ 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 Nuffield Health 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
Recommendations	
a	The service should share improvements or actions taken as a result of feedback with people using the service (see page 17). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8
b	The service should implement a formal process for clinical supervision of trained staff (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

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

We would like to thank all staff at Nuffield Health Edinburgh Hospital 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 hospital had a well-defined and measurable vision and purpose, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and purpose. Key performance indicators were regularly monitored and reported. Clear benchmarking was in place and continually monitored.

A clear governance structure was in place. The hospital's leadership team was visible. Staff were empowered to speak up. The staff group was well established and long serving.

Clear vision and purpose

The provider's purpose 'to build a healthier nation' was clearly set out in its strategic plan and yearly report. These documents detailed the provider's CARE values:

- connected
- aspirational
- responsive, and
- ethical.

The documents also stated the service's strategic vision and aims, its key performance indicators (KPIs) for the following year and direction over the next 5 years. The strategic plan and yearly report were comprehensive and set out clear and measurable indicators. We saw that the senior management team and the provider's senior leadership team regularly evaluated the indicators.

The provider set corporate KPIs for its services to meet. The provider monitored these KPIs through local performance and finance meetings and we saw them detailed in the business plan. Line managers and heads of department also set local KPIs as part of the appraisal process.

We also saw that the hospital committee and group meetings reported monthly performance dashboards, discussions and actions taken to make improvements where appropriate. For example, accreditation had been obtained with the Association for Perioperative Practice (AfPP) and front-facing staff had been trained in customer relations.

We saw evidence that KPIs reported in these dashboards benchmarked the service against the provider's other hospitals. This allowed the service to regularly monitor its performance in the hospital and compare it with other hospitals.

We were told that a programme of site visits helped monitor KPIs, such as site assurance visits and peer reviews with heads of departments and senior management teams. The visits used a 'find and fix' methodology to support services to follow policy and regulatory requirements.

We saw a holistic approach to healthcare that the service provided in line with provider's values and purpose. The service offered free 'flagship programmes' to help address national unmet health and wellbeing needs in the local community, widen access to its services and give more people the tools to live a healthy life. Examples of the local flagship programmes offered included:

- collaborating with the local NHS board to offer Nuffield Health's free joint pain programme
- delivering education and training to a local nursery and primary school children on infection prevention and control
- helping people living with joint pain, and
- helping young people understand and improve their own health.

The hospital carried out charity work in line with the provider's vision and purpose. As a registered charity, it had offered free health assessments at two local university campuses.

The service had also provided an open event at another of the provider's services. Attendees could get expert advice on how to manage hip and knee pain from one of the service's consultant surgeons for free. The provider also offered a joint pain programme to all its patients who wanted to self-manage their chronic joint pain and lead a more independent life. In line with the provider's charitable work, the service offered this programme for free for 12 weeks.

The service also supported staff to volunteer with local charities, including food bank collections and donated the proceeds of a secret Santa collection to a staff-nominated charity. During our inspection, we saw that the service held a bake sale and raffle in aid of local charity. Some staff were also taking part in a sponsored walk for another charity.

- No requirements.
- No recommendations.

Leadership and culture

The service had a highly skilled staffing resource, which included a mix of clinical and non-clinical staff, for example:

- administrative staff
- facilities staff
- healthcare support workers
- housekeeping staff
- imaging staff
- medical staff
- physiotherapists, and
- registered nurses.

The hospital is part of Nuffield Health, a UK-wide healthcare charity. Since our last inspection in 2022, the registered hospital manager had remained the same and some staff had been promoted into leadership team positions. The provider (Nuffield Health) had also changed its organisational structure into health regions instead of systems. This meant that all of the provider's hospitals in Scotland have separate functions from the fitness and wellbeing centres in Scotland.

A board of governors managed the provider. The board was responsible for setting strategy and making sure provider had the necessary financial, human and physical resources in place to meet its strategic aims.

The provider's board of governors was also responsible for monitoring performance and overseeing risk management. Responsibility for day-to-day oversight had been delegated to the group chief executive. Non-executive board members also held the board to account at yearly general meetings.

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

- director of clinical services
- director of operations, and
- the hospital director.

The SMT had well-defined roles, responsibilities and support arrangements. This helped to provide assurance of safe and consistent patient care and treatment. The hospital's governance framework detailed all the committees, which included:

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

The governance structure also set out how often the groups met (monthly, every 3 months, every 6 months). We saw a hospital meeting schedule spreadsheet, which showed all the internal groups and how often they met (monthly and every 3 months). We looked at recent agendas and minutes for all these meetings and saw a good representation from all staff groups.

We also saw that the hospital funded courses, such as those for training surgical first assistants and operating department practitioners (ODP) at universities for staff to attend. The hospital also funded professional memberships where appropriate, such as Infection Prevention Society membership for infection control champions.

The provider had recently introduced a staffing model for theatre which defined the staffing required, including the number of positions to be filled. We were told that hospital managers could use their professional judgement to alter the staffing if they could evidence safe, effective practice. The service told us it had good recruitment and retention levels and that a number of its student nurses applied to work in the service after they qualified, as they had a good experience while in training. The service operated its own staff bank, which meant it did not need to use agency staff.

A 'freedom to speak up' system was well established and embedded where staff could speak with a nominated freedom-to-speak-up 'guardian' or 'champion' in confidence if they had any concerns. A freedom to speak up board displayed who the speak up champions were, along with their contact information to

make it easy for staff to raise concerns or queries. The board also showed the dates of drop-in sessions for staff to attend. The speak-up guardians also met regularly with the provider's speak-up manager.

Staff we spoke with told us they found leaders at all levels to be visible and approachable. We saw that senior staff knew the names of staff as they walked round the site and the staff interacted with senior staff.

The service communicated with its staff in a variety of ways, including:

- intranet information
- local staff meetings
- meetings and huddles
- newsletters, and
- open forums, including a 'coffee and chat' with the hospital director.

Members of the senior management team, including the hospital director or their deputy and other senior hospital staff attended a daily huddle, as well as staff from:

- facilities
- heads of departments
- infection control nurse
- imaging
- outpatients
- stores
- theatre, and
- wards.

The huddle highlighted any hospital-wide updates and patient numbers for the day. Wards' daily safety briefs highlighted patient safety issues, such as patients with allergies, diabetes or those at risk of falls.

Staff had opportunities to meet to debrief after any incident or error that occurred. We saw examples of incidents, such as medication errors where staff were encouraged to reflect on and identify improvements in the processes and how to prevent any similar incidents.

Clinical staff also had access to link nurses in nominated 'champion' roles, such as those for cleanliness, cognitive impairment or pain management. Clinical staff

were encouraged to take responsibility for promoting best practice and improvements in these areas.

Staff we spoke with were clear about their roles and responsibilities and how to raise concerns if they had any. They told us they felt well supported by members of the senior leadership team.

- 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. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes were in place for patient and staff safety. Improvement projects involved all departments. Staff surveys carried out every 6 months helped the service plan and develop staff. The quality improvement plan was maintained and updated regularly. The effectiveness of improvements made as a result of patient feedback were evaluated but not shared with patients.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The hospital 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. Patients were given a feedback survey when they were discharged and a service users could leave online reviews through links and QR codes which were in place throughout the hospital.

Feedback was analysed every month and results were shared at staff meetings. Posters detailing how service users could leave feedback were also displayed throughout the hospital. We looked at results from the September 2025 and October 2025 surveys, which showed high levels of patient satisfaction, especially in patient care and individual staff members.

The provider benchmarked patient satisfaction outcomes across all its health regions UK-wide and this was reviewed at leadership meetings at service and provider levels. The outcomes of this benchmarking fed into the service's quality improvement plan.

We saw examples of service improvement, such as:

- the use of consulting room offered to ward patients for any private conversations with any member of staff
- updated information boards for patients and relatives, and
- wall protectors in the hospital corridors and theatre area to protect the walls.

An all-staff survey was carried out twice a year, seeking answers to a comprehensive set of questions. Results from the most recent survey showed a high level of satisfaction. 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 emails and monthly newsletters to keep them updated with any operational changes. The hospital director sent their own newsletter to staff every 3 months as part of their leadership approach. Staff told us they received information and training on new initiatives and policy updates and could attend leadership meetings and forums if they wished. This made sure staff felt part of the hospital and could discuss suggestions for improvement.

The hospital recognised its staff in a variety of ways. This included cards that acknowledged positive feedback received from patients and celebrating staff birthdays. The hospital also had a 'values recognition scheme' in place, where staff could nominate colleagues for demonstrating the provider's CARE values. A central team reviewed the nominations at the provider's head office. Recipients were given a gift voucher and greeting card containing messages from colleagues. A benefits programme was in place for staff, which included:

- access to savings schemes
- free gym access
- private GP access
- private healthcare, and
- wellbeing support.

What needs to improve

We saw evidence to demonstrate that the service listened to feedback and acted on any issues raised as a result. However, this information was not shared with patients (recommendation a).

- No requirements.

Recommendation a

- The service should share improvements or actions taken as a result of feedback with people using 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. For example:

- complaints management
- consent
- duty of candour
- emergency transfer of patients
- health and safety, and
- safeguarding.

A process was in place for writing all policies, submitting them to appropriate advisory 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 hospital's staff intranet.

The operations manager looked after the day-to-day management of the buildings and specialist equipment. An on-site maintenance team carried out all routine maintenance and repairs. Contracts were in place with external contractors for maintenance and repairs that the on-site team could not deal with, such as specialist equipment and machinery.

Comprehensive policies and procedures were in place to manage the facilities.

It also included more specialist risk assessments and operational plans for managing key building risks, such as legionella and ventilation. We saw that it also detailed any ongoing works, including current flooring works being carried out.

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

groups. The outcomes of the discussions from these meetings were fed back through regular staff meetings. We followed three incidents and saw that they had been reported and managed in a timely manner, including actions taken and learning shared.

The hospital'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 completed for all clinical areas. An infection control nurse participated in visual audits, formal audits and training opportunities on-site, as well as attending monthly infection prevention meetings.

The hospital had a detailed medicines management policy in place. All departments we visited had standard operating procedures (SOPs) and patient group directives (PGDs) in place for safety and compliance, including controlled drugs. The medicines and blood product fridges were checked regularly, including the contents and daily temperatures. The staff we spoke with knew the process for reporting faults.

The leadership team was aware of its duty to report certain matters to Healthcare Improvement Scotland as detailed in our notification guidance.

We saw the hospital's complaints procedure displayed prominently in the hospital and published on the provider's website. It included the timescale for addressing the complaint, the process of investigation and Healthcare Improvement Scotland (HIS) contact details. A clear process was in place for managing complaints.

We reviewed three current complaints in the service. These letters were comprehensive and answered the complaints in full, with the actions taken. An electronic system was used to monitor the progress of complaints. We were told that a weekly meeting with the hospital director discussed the progress of all complaints and identified any emerging themes.

Lessons learned were discussed at staff and management meetings. We saw evidence of changes made in the hospital after complaints had been made. The hospital 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 with fully understood their duty of candour responsibilities and had received training in it. The hospital had experienced candour events over

the past 12 months, which were reflected in its yearly duty of candour published report. We saw evidence that the hospital 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 and saw that these included:

- consent
- consultations including risks and benefits
- discharge planning and details of any follow-up
- next of kin and GP details
- surgical interventions, and
- treatment plans.

We saw good compliance with patient risk assessments, such as falls and venous thromboembolism (VTE).

The provider and service were 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.

We saw that patients were given aftercare instructions and information about any planned follow-up after their discharge. Hospital contact details were included in this information in case patients had any concerns or questions. Patients could contact a phone line that senior clinical staff managed at any time if they had concerns or questions. Staff also contacted all patients after discharge to check on their recovery and answer any questions they had. This was then recorded in the patient care records.

We saw that all emergency equipment was checked regularly. Emergency trolleys were kept in accessible locations and easily visible. Staff we spoke with were familiar with the location of the trolleys. We saw that individual staff were identified at the start of a shift to respond to emergencies.

We saw evidence of policies and procedures for emergency situations and for transferring patients to an acute NHS facility if required. Processes and procedures were also in place to identify patients with deteriorating conditions, which included:

- major haemorrhage protocol
- malignant hypothermia procedure
- national early warning score chart (NEWS 2), and
- 'sepsis 6' protocol.

The hospital had recently introduced a safe staffing model for the theatre department, which included the number of positions to be filled. We were told that the theatre manager could use their professional judgement to alter the staffing if they could evidence safe, effective practice.

For all other areas, a safe staffing tool was used to proactively manage the service's staffing compliment to make sure that an appropriate skill mix and safe number of staffing was always provided. We saw that the hospital used minimal agency and bank staff and only when clinically required to cover staffing gaps to maintain safe and effective staffing levels.

We were also told of initiatives aimed at improving the environmental impact of the service and its carbon footprint, including:

- co-ordinating with other hospitals to swap consumables before they expired, and
- using recycled, decontaminated sharps bins from a waste provider.

The hospital's recruitment policy described how staff would be appointed. Appropriate pre-employment checks were carried out for employed staff and healthcare professionals appointed under practising privileges (staff not employed directly by the provider but given permission to work in the hospital). Staff files contained a checklist to help make sure that appropriate recruitment checks had been carried out.

We reviewed files of both employed staff and individuals granted practising privileges. We saw evidence of job descriptions and appropriate recruitment checks, including:

- professional register checks and qualifications where appropriate
- professional registration status and indemnity cover every year
- Protecting Vulnerable Groups (PVG) status of the applicant (this was repeated every 3 years), and
- references, including one from the responsible medical officer.

A training needs analysis was carried out every year. Mandatory training and non-role specific training programmes were in place. Staff completed mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. Senior charge nurses, senior nurses and the SMT 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 for medical staff with practising privileges.

Staff completed an annual appraisal where aims, objectives and goals were identified and discussed. Progress against the identified aims and objectives was reviewed after 6 months and staff could share any issues or re-negotiate and amend the original details at that stage. 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.

What needs to improve

We saw no formal process in place for providing clinical supervision to nursing staff at the time of our inspection (recommendation b).

- No requirements.

Recommendation b

- The service should implement a formal process for clinical supervision of trained staff.

Planning for quality

The hospital's risk management system was comprehensive and included corporate and clinic risk registers. These documents detailed the actions that would be taken to mitigate risk and reduce harm. The hospital had recorded ongoing key business risks that it monitored regularly. These included:

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

Accidents and incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through the clinical governance framework. Learning was shared with staff in:

- e-mails
- staff huddles, and
- team meetings.

Managers were alerted to review dates and the provider's central team also reviewed the risks. A maintenance programme was in place for all equipment and areas in the hospital, which the director of operations managed. This included maintenance of medical and compressed gases, fire and electricity, as well as legionella risk assessments.

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.

The hospital had a detailed audit programme which helped make sure staff delivered consistent safe care and treatment for patients, identifying any areas for improvement. The infection control nurse and the governance lead carried out the audits. Action plans were produced to make sure any responses needed were taken forward. All areas were supported with any actions arising as a result.

The comprehensive audit programme included audits of:

- complaints
- infection prevention and control
- health and safety
- medication management, and
- patient care records.

The hospital had worked towards and achieved clinical accreditation from the Association for Perioperative Practice (AfPP) and it was working towards gold accreditation for ANTT status (aseptic non-touch technique used to prevent infection).

- 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, equipment was fit for purpose and regularly maintained. Medicines management was good. Staff described the provider as a good employer and the hospital as a good place to work. Patients we spoke were very satisfied with their care and treatment and felt that they could provide feedback to the service.

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.

We observed many examples of staff interacting positively with patients and other staff in a friendly and compassionate way with effective oversight from a supportive leadership team.

We saw that safe, person-centred care was delivered in a clean hospital environment and theatre suite with equipment that was fit for purpose and regularly maintained. The consulting or treatment rooms were in good condition, tidy and clean. The equipment we saw was clean and well maintained. Staff completed a checklist to record that the area was clean.

Toilets were provided throughout the hospital, including facilities for people with disabilities. We saw that housekeeping staff cleaned these facilities regularly and completed a checklist to record when they had been cleaned.

We saw that clinical handwash sinks were cleaned regularly in line with national guidance. Appropriate cleaning products were used to clean general equipment and the environment, including a locked area for materials under Control of Substances Hazardous to Health (COSHH). Clinical waste, including sharps was

managed in line with national guidance. We saw that all large clinical waste bins were locked and stored securely. Clean linen was stored correctly.
We saw appropriate personal protective equipment (PPE) and alcohol-based hand rub were readily available in the hospital.

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 are actually using). Controlled drugs were stored securely.

Controlled-drugs keys were kept separately from medication cupboard keys and were signed out. Medication used for sedation was stored in a locked cupboard.

The hospital's Home Office certificate for stocking and prescribing controlled drugs was valid and in-date and we saw a process in place for renewing this.

Take-home medication for patients was dispensed from a dedicated take-home medication cupboard. We saw appropriate systems and processes in place for the dispensing of this medication and the checking of stock levels.

Patients we spoke with stated the hospital was clean and tidy. Comments included

- 'Clean and tidy.'
- 'Very clean.'

We reviewed five patient records and saw they included patients':

- assessment and consultation
- GP details and patient consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate
- name, address and identifier number, and
- next of kin, including consent to share information.

All patient risk assessments were completed in patient care records we reviewed, along with the pre-operative health questionnaire. We saw the consultant and patients had signed and dated consent forms for different procedures carried out, with risks and benefits discussed.

The consultation letter was present in all patient care records we reviewed.

Consent forms we reviewed were fully and accurately completed. The patients and consultant surgeons had also signed the consent forms on the day of surgery. We saw evidence that treatment plans, options and aftercare had been discussed with patients before their discharge from the service.

During our inspection, we followed a patient's journey from admission through to theatre, recovery room and then discharge. 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 suitable member of staff accompanied patients to and from the theatre department. 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.

From our own observations of staff interactions, we saw a compassionate and co-ordinated approach to patient care and hospital delivery, with effective oversight from a supportive leadership team.

The service had a certified laser protection advisor, with a signed contract detailing dates of their contract with the hospital. All staff operating lasers had completed laser training and equipment training. This was kept on an electronic file and available to view on the day of our inspection. The laser protection supervisor worked closely and alongside the laser protection advisor to develop the local rules for all laser equipment being used. Local rules to be followed for the safe use of lasers were in place and we saw that the environment was fit for purpose.

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

- professional register checks and qualifications where appropriate
- Protecting Vulnerable Groups (PVG) status of the applicant, and
- references.

Pre-employment checks were carried out for employed staff. All 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.

As part of our inspection, we asked the hospital to circulate an anonymous staff survey which asked five 'yes or no' questions. The results for these questions showed that:

- all staff felt there was positive leadership at the highest level of the organisation
- all staff felt the hospital had a positive culture
- most staff felt they could influence how things were done in the hospital
- all staff felt their line manager took their concerns seriously, and
- all staff would recommend the hospital as a good place to work.

The final question of the survey asked for an overall view about what staff felt the hospital did really well and what could be improved. Comments were mostly positive and included:

- '....my department are very efficient.'
- 'Great teamwork over all departments.'
- 'There is nothing that stands out as needing dealt with out with our outlined improvement plan.'
- 'Improvements are always ongoing.'
- 'Great work culture and they look after their staff. Health care and gym is an excellent incentive.'

Patients we spoke with were extremely satisfied with the care and treatment they received from the hospital. They also stated that felt that they could provide feedback either verbally or via the various feedback channels. Comments included:

- 'Everyone has introduced themselves with a smile and have explained what will happen.'
- 'No complaints as I've been made to feel very welcome and put at ease.'
- 'I wouldn't go anywhere else'.

- 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
or email his.contactpublicinvolvement@nhs.scot

Healthcare Improvement Scotland

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