Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Waterfront Private Hospital, Edinburgh

Service Provider: Waterfront Private Hospital Ltd

12–13 August 2025

NHS SCOTLAND

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1 A summary of our inspection

Background

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

Our focus

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

About our inspection

We carried out an unannounced inspection to Waterfront Private Hospital on Tuesday 12 August and Wednesday 13 August 2025. We spoke with a number of staff and patients during the inspection. We received feedback from 18 staff members through an online survey we had asked the service to issue for us during the inspection. This was our first inspection to this service.

Based in Edinburgh, Waterfront Private Hospital is an independent hospital providing non-surgical and minor surgical treatments / providing non-surgical and surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Waterfront Private 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 aim. Values and principles were displayed in the hospital for staff and patients to see. Key performance indicators were reviewed. The leadership team worked well together and was open to ideas for improvement. Staff were empowered to speak up. Operational issues were managed appropriately in a clear governance structure. The service should display its objectives and key performance indicators. A record of all meetings with staff and any actions arising from them should be documented.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The hospital actively sought patient and staff feedback, using it to continually improve the way the service was delivered. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely. Systems were in place to manage risks. Policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to continuously improve service delivery. A formal process for reviewing patient feedback should be established. Nursing staff should be offered the opportunity to receive clinical supervision. A quality improvement plan should be implemented.	✓✓ 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. Practicing privilege contracts must be in place. PVG certificates should not be kept in staff files. A recruitment and induction checklist should be introduced		✓✓ 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 Waterfont Private Hospital 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 seven recommendations.

Direction	
Requirements	
	None
Recommendation	
a	The service should keep a record of all meetings with staff to capture discussions, actions and outcomes (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
	None
Recommendations	
b	The service should implement a structured approach to analysing all patient feedback to help continually improve the service (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8

Implementation and delivery (continued)	
Recommendations	
c	The service should develop and implement a process to actively seek the views of staff working within the service (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
d	The service should develop its own systems and processes and implement clinical supervision of trained staff, including formal recording of it (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
e	The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirements	
1	The provider must ensure that employment of practicing privileges contracts are introduced to ensure safe delivery of care with individual responsibility and accountability clearly identified (see page 27). Timescale – Immediate *Regulation 8* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
f	The service should securely destroy original Disclosure Scotland PVG records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff (see page 27). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

Results (continued)
Recommendations
g The service should ensure that a recruitment checklist is introduced and followed for all staff to ensure that the appropriate checks take place before and immediately after staff are recruited and begin working in the service (see page 27). 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

Waterfront Private Hospital 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 Waterfront Private Hospital for their assistance during the inspection.

2 What we found during our inspection

Key Focus Area: Direction

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

Our findings

The hospital had a well-defined and measurable vision and aim. Values and principles were displayed in the hospital for staff and patients to see. Key performance indicators were reviewed.

The leadership team worked well together and was open to ideas for improvement. Staff were empowered to speak up. Operational issues were managed appropriately in a clear governance structure. The service should display its objectives and key performance indicators. A record of all meetings with staff and any actions arising from them should be documented.

Clear vision and purpose

The service's business plan and strategy plan set out how the provider's vision would be achieved. The service aimed to provide patients with a: 'Unique, individualised treatment experience, focusing on safe, high-quality care in a calm and comfortable environment'. Its vison was to provide: 'High-quality care in beautiful, comfortable patient settings'. The service's aim and vision were displayed in the hospital and on its website.

The service's objectives were:

- Aiming to go 'beyond compliance' and achieve more than the minimum required.
- Commitment to transparency and continuous improvement.
- Co-ordinated and collaborative ways of working as an effective multidisciplinary team to achieve high-quality care standards.
- Providing personalised patient care and respecting the individual.

Key performance indicators (KPIs) helped to make sure the provider's vision was measurable. The business plan and strategy were reviewed at senior management team meetings and used to inform the next strategy. KPIs were continuously monitored in a variety of ways, including monthly reviews at the senior staff meeting, as well as through data analysis from:

- assurance tools
- business intelligence systems (monitoring workforce, audits, safety alerts, risk and incident reporting and complaints), and
- the service's clinical governance framework.

The hospital's strategy plan set out KPIs linked to the strategic objectives of patient experience and digital innovation and included issues, such as:

- 'Aftercare leaflet compliance.'
- 'Electronic consent form completion.'
- 'Increase patient satisfaction scores.'
- 'Reduction in complication rates.'

We saw that the service recorded progress against KPIs and reported this through the governance structure.

The strategy plan was reviewed every year and regularly discussed at leadership forums and team meetings. A comprehensive review of the plan had recently been carried out. From minutes of meetings we reviewed and staff we spoke with, we saw that the service was making good progress in achieving its KPIs. Values and principles were displayed throughout the hospital for staff and patients to see. Staff we spoke with were aware of the service's vision, purpose and values. The service's quality strategy document showed that it had identified its KPIs for 2026 and its strategic targets from 2026 onwards.

- No requirements.
- No recommendations.

Leadership and culture

The hospital's staffing resource was made up of:

- a clinical lead
- facilities staff
- healthcare support workers
- hospital support
- housekeepers
- medical staff (including consultant surgeons and anaesthetists)
- reception and administrative staff, and
- registered nurses.

An effective leadership structure was in place through the service's senior management team, made up of the two consultant surgeons (who were also company directors) and the clinical lead.

The service had recently implemented regular senior management team meetings and minutes we saw showed that information and strategic plan updates were shared at these meetings. Actions and updates on previously agreed actions were recorded. Service improvements were also discussed at the different management and governance meetings.

The hospital had a comprehensive and inclusive programme of department and staff meetings, including those for:

- clinical governance
- health and safety
- infection prevention and control
- managing patient care
- medicines management, and
- monitoring compliance with professional standards and legislation.

Staff we spoke with were clear in their roles and how they could impact change in the hospital. They reported that they felt the senior management team listened to and valued them.

The service proactively managed its staffing compliment based on a patient-dependency model to help make sure that an appropriate skill-mix and safe staffing was always provided.
We attended a daily huddle in the theatre department, which included the theatre staff and other appropriate staff from the hospital. The huddle discussed:

- a review of any issues from the previous day
- management of the equipment used
- staffing levels
- theatre lists and an overview of theatre cases, and
- whether it was safe to carry out the day's business.

No adverse incidents had been reported on the day we attended the huddle.

Staff we spoke with were clear about how they could raise any concerns they had and told us they had no concerns to raise. Staff also told us that they could speak to any member of the senior leadership team and felt supported and encouraged in their role.

Staff were kept up to date through:

- email
- safety briefs, and
- ward staff meetings every 2 months.

We were told that the service had started to include bank staff in staff meetings so they could raise anything to be discussed and keep up to date with information and developments.

The leadership team worked well together and was open to ideas for improvement. The team engaged well in the inspection process and shared all information we asked for. Staff told us they felt empowered to speak up and felt safe to do so.

What needs to improve

We saw that clinical staff had regular, documented staff meetings. However, administrative staff meetings were not held regularly or documented (recommendation a).

We saw evidence that the service was introducing a 'freedom to speak up' system, where staff could raise any concerns anonymously along with a 'speak-up champion'. We spoke with the speak up champion, who was clear about what their role would be. We will follow this up at our next inspection.

- No requirements.

Recommendation a

- The service should keep a record of all meetings with staff to capture discussions, actions and outcomes.

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

The hospital actively sought patient and staff feedback, using it to continually improve the way the service was delivered. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely. Systems were in place to manage risks. Policies and procedures supported staff to deliver safe, compassionate and person-centred care. Comprehensive risk management and quality assurance processes and a quality improvement plan helped staff to continuously improve service delivery.

A formal process for reviewing patient feedback should be established. Nursing staff should be offered the opportunity to receive clinical supervision. A quality improvement plan should be implemented.

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

We saw that the service had a participation policy in place that described how it would obtain feedback from patients. Patient feedback was gathered after consultations and treatments using a variety of methods, including QR codes and an automated email. Surgical patients also received a structured survey, as well as a follow-up call on day 2 after treatment. Other methods of gathering feedback included:

- online applications
- patient testimonials on the service's website
- social media, and
- verbally.

This information was used to help make improvements to the way the service was delivered, such as:

- better-tasting coffee
- improved signage for patient toilets
- staff talked to patients if their appointment was delayed, and
- the use of a label for patients to check that their details were correct, rather than discussing this at reception.

These improvements as a result of patient feedback were shared at staff meetings and the service's internal online information system. We looked at some feedback the service had gathered, which showed good levels of patient satisfaction.

We saw that the hospital recognised the importance of supporting charities. A charity hike had been planned, with many staff participating to raise money and support a nominated charity.

While the service did not have a formal staff recognition scheme in place, as way to show appreciation the management team would order in food from a local takeaway or bring in food, such as doughnuts for staff.

What needs to improve

While patient feedback was received in line with the service's participation policy, the service did not have a formal process in place for reviewing patient feedback (recommendation b).

Staff did not have a way to formally provide structured feedback about any improvements or changes that would benefit the service, such as an anonymised staff survey (recommendation c).

- No requirements.

Recommendation b

- The service should implement a structured approach to analysing all patient feedback to help continually improve the service.

Recommendation c

- The service should develop and implement a process to actively seek the views of staff working within 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.

Policies and procedures set out the way the hospital supported staff to deliver safe, compassionate, person-centred care. For example, policies and procedures in place included those for:

- complaints management
- consent
- duty of candour
- health and safety
- infection prevention and control
- medicines management, and
- safeguarding.

Policies and procedures were updated regularly or in response to changes in legislation, national and international guidance and best practice. The hospital was changing from paper-based policies to an electronic format, which was easily accessible to staff. The hospital was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights). We saw that patient care records were securely stored and password-protected.

The hospital support staff member was responsible for the day-to-day management of the building, which included its specialist equipment, engineering and maintenance and any repairs that staff reported.

We saw policies and procedures in place to manage the facilities. This included schedules for managing routine issues, such as:

- electrical safety
- fire safety, and
- medical gas safety
- water safety.

It also included more specialist risk assessments and operational plans for managing key building risks, such as legionella and ventilation.

The service's infection prevention and control policies and procedures were in line with Health Protection Scotland's *National Infection Prevention and Control Manual*. An identified infection control nurse participated in audits and training opportunities on-site.

The service's recruitment policies described how staff would be appointed.

All staff completed a 6-month probation period, which included a 'check in' with their line manager during weeks 4, 8 and 12 after starting employment. As well as completing a general induction programme, staff also completed a role-specific induction programme where appropriate.

Staff completed mandatory and role-specific online learning modules. Mandatory training included safeguarding of people and duty of candour. The theatre manager and service manager 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 practicing privileges (staff not employed directly by the provider but given permission to work in the service).

Staff completed an annual appraisal where aims, objectives and goals were identified and discussed. A process was in place to review progress made against the identified aims and objectives in the 6 months after they had been set. Staff had an opportunity at this stage to feedback any issues or change the original aims, objectives and goals. The appraisals we saw were comprehensively completed. Staff we spoke with told us their appraisals helped them feel valued and encouraged their career goals.

During our inspection, we reviewed six patient care records in paper and electronic formats. All consultations included details of the treatment risks and benefits discussed with patients. We saw evidence that treatment options had been discussed and that all patients had been given time to consider these. Patient care records we reviewed included:

- consent to treatment and sharing of information
- discharge letter and list of medicines provided
- medical history, with details of any health conditions
- options for surgical and non-surgical interventions, as well as a cooling-off period
- patient risk assessments, and
- support and aftercare.

We saw good compliance with patient risk assessments, including sepsis, peripheral venous access devices (cannulas) and venous thromboembolism (VTE).

We saw that patients were given written aftercare instructions when they were discharged and information about any recommended follow-up. Hospital contact details were provided on discharge which included out-of-hours contact details in case patients had any concerns or questions. Patients we spoke with told us they were clear about what to expect after discharge and could contact staff easily. Staff also contacted patients over the phone, usually within 48 hours after discharge to check how they felt and address any concerns they might have at that time.

The on-call contact service was a phone which staff took turns to monitor so that patients could contact the service out of hours. Calls were logged and discussed at the safety briefs the next day. Examples of actions taken as a result included:

- consultants contacted promptly so they could speak to the patient directly to discuss concerns
- next-day appointments arranged so patients could be seen quickly, and
- reassurance from staff to patients about their recovery.

The service was aware of the notification process to Healthcare Improvement Scotland. During the inspection, we saw that the service had submitted all incidents that should have been notified to Healthcare Improvement Scotland. The hospital complaints procedure was published on the provider's website. We saw how the hospital would manage a complaint in the event of one being received. The service had received no complaints since its registration with Healthcare Improvement Scotland in 2023.

The service had a duty of candour procedure in place (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). No duty of candour incidents had occurred since the service's registration and we saw a yearly duty of candour report was published on its website.

We saw emergency equipment was checked daily and kept in an accessible location. Staff we spoke with were familiar with the location of the equipment. We saw that staff who would respond to medical emergencies and in the event of a fire were identified at the start of a shift, during the daily huddle.

We saw policies and procedures in place for emergency situations and transferring patients to an acute NHS facility, if required. Since its registration, no incidents had occurred that would facilitate the need to transfer a patient to another hospital. Processes and procedures were also in place to identify patients with deteriorating conditions using the updated national early warning scoring (NEWS 2) system.

The hospital used a safe staffing tool and proactively managed its staffing complement to help make sure that an appropriate skill mix and safe staffing was always provided. We saw that staff rotas were completed and shared with staff weeks in advance. Staff could use a request book to ask for some shifts to fit in with their work-life balance. This book was monitored and audited and each person had a limit for the number of requests they could make. Any over-requesting was discussed directly with staff.

The variety of staff skills and knowledge allowed them to work across all areas when required, which meant the hospital could effectively manage short-notice absences. A large pool of identified bank staff also regularly worked in the hospital.

What needs to improve

While yearly appraisals were carried out, the service did not have a policy and process in place for clinical supervision. We saw no evidence of clinical supervision carried out at the time of our inspection (recommendation d).

The service had a staff induction process in place and we saw that it was introducing a competency framework for all staff involved in clinical care. We will follow this up at future inspections.

We were told that the hospital had recognised the increasing workload that the clinical lead managed. As a result, a deputy clinical lead had recently been recruited to support the clinical lead as part of the service delivery improvement work. We will follow this up at future inspections.

- No requirements.

Recommendation d

- The service should develop its own systems and processes and implement clinical supervision of trained staff, including formal recording of it.

Planning for quality

A risk register was in place, which included clinical and non-clinical risks. The clinical lead had oversight of risks, which were reviewed and discussed at safety briefs, staff meetings and 3-monthly governance meetings. A programme of maintenance was in place for all equipment and areas in the hospital, which the hospital support managed. This included maintenance of medical and compressed gases, fire and electricity and legionella risk assessments. We saw evidence that all equipment servicing and maintenance was up to date, including that for:

- clinical and medical equipment
- fire equipment
- fixed electrical installation
- medical gases, and
- portable appliance testing.

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

- closed electronic group discussions
- staff huddles, and
- team meetings.

We saw evidence of weekly fire alarm testing, unannounced fire drills and the most recent fire safety assessment had been carried out with any actions promptly addressed. No actions were outstanding at the time of our inspection.

The service had a detailed audit programme in place, which helped make sure it delivered consistent safe care and treatment for patients and identified any areas for improvement. Staff we spoke with participated in audits and were aware of when these were completed. Actions were included in the programme to make sure any actions needed were taken forward.

The audit programme included audits of:

- controlled drugs
- environment
- infection prevention and control
- medication, and
- patient care records.

A business continuity plan was in place which described what steps would be taken to protect patient care if an unexpected event happened, such as a major incident.

What needs to improve

We saw that the hospital had made improvements based on patient feedback, as well as ongoing improvement projects, such as:

- development of an AI-enabled chat system to provide information for patients
- recruitment of a new post to support the clinical lead, and
- the provision of better quality of beverages and snacks for patients in the waiting area.

However, these improvements were not recorded in a quality improvement plan. This would help to structure and record its improvement activities, record the outcomes and measure the impact of any future service change. This could include outcomes identified from:

- accidents and incidents
- audits
- complaints, and
- patient feedback.

This would allow the service to clearly demonstrate a culture of continuous quality improvement (recommendation e).

■ No requirements.

Recommendation e

- The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement.

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 were very satisfied with their care and treatment.

Practicing privilege contracts must be in place. PVG certificates should not be kept in staff files. A recruitment and induction checklist should be introduced.

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 hospital environment was clean and in a good state of repair. Clinical waste was managed effectively and laundry stored correctly. Sharps were managed appropriately and containers were safe, signed and dated when assembled for use. We saw appropriate personal protective equipment (PPE) and alcohol-based hand rub located throughout the hospital.

Toilets were provided in the hospital, including facilities for people with disabilities. Housekeeping staff regularly cleaned these facilities and carried out recorded checks during each day.

We saw appropriate cleaning solutions were available and used, including chlorine-based products for sanitary fixtures and fittings. All cleaning materials and equipment were stored in a designated area in the hospital, with limited access for staff only. This included a locked cupboard for materials under Control of Substances Hazardous to Health (COSHH).

Housekeepers used a cleaning matrix to identify areas and cleaning products used. We saw fully completed cleaning schedules and any issues arising were reported through the staff group or directly to the clinical lead. The clinical lead carried out daily walk-rounds of the environment at the start of the shift and at the end. No repairs or faults were outstanding at the time of our inspection.

The electronic patient care records we reviewed included appropriate documentation for patients, including:

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

We saw safety measures in place for patients having surgery, including:

- accountable items record
- discharge information
- peri-operative care
- pre-procedure checklist
- recovery notes, and
- theatre peri-operative care plans.

We saw evidence that treatments plans, options and aftercare had been discussed with the patient before their discharge from the hospital.

Patients we spoke with told us that they felt safe and well cared for and that the service was clean and relaxing. They felt listened to and that the service provided person-centred care. Comments included:

- ‘Very clean hospital.’
- ‘Beautiful and calm environment.’
- ‘Reassured.’
- ‘Well informed.’

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 take-home medication cupboard. We saw appropriate systems and processes in place for the dispensing of this medication and the checking of stock levels.

To help assess the safety culture in the clinic, 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. The patient was closely monitored while anaesthetised during the operation and then in the recovery room. 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.

We reviewed four files of employed staff and five files of individuals granted practicing privileges. All nine 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 the following:

- The majority of staff felt there was positive leadership at the highest level of the organisation.
- The majority of staff felt they could influence how things were done in the hospital.
- The majority of staff felt their line manager took their concerns seriously.
- The majority of 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:

- 'I think our interaction and patient experience are of a very high standard.'
- 'It is a workplace where you feel valued and part of something meaningful.'
- 'The business is relatively new and so a huge amount of work has gone on and continues to go on to ensure that standards are met to provide a safe environment for patients and the business complies with regulations and external agencies so it's a continual cycle of improvement.'
- 'Really hard to think of anything. I work both in the NHS and here and it always feels great coming into The Waterfront.'
- 'Provides a consistent high level of service even through periods of transition/change/unexpected reduced staffing levels.'

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

What needs to improve

Staff granted practicing privileges did not have practicing privileges contracts in place (requirement 1).

We saw that the service had not securely destroyed the original certificates received from Disclosure Scotland in line with current legislation for all members of staff recruited. A system should be introduced to record PVG scheme identification numbers for staff (recommendation f).

We were told that while qualification and registration were checked at the initial interview for employed staff, evidence of this was not recorded. We discussed introducing a recruitment checklist with the service to help make sure that the same process was followed for all staff recruited to the service (recommendation g).

Requirement 1 – Timescale: immediate

- The provider must ensure that employment of practicing privileges contracts are introduced to ensure safe delivery of care with individual responsibility and accountability clearly identified.

Recommendation f

- The service should securely destroy original Disclosure Scotland PVG records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff.

Recommendation g

- The service should ensure that a recruitment checklist is introduced and followed for all staff to ensure that the appropriate checks take place before and immediately after staff are recruited and begin working in the service.

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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