Action Plan

Service Name:	St. Ellen's Daycase Hospital
Service number:	02507
Service Provider:	Cosmedicare UK Ltd
Address:	410 Sauchiehall Street, Glasgow, G2 3JD
Date Inspection Concluded:	6-7 October 2025

Requirements and Recommendations	Action Planned	Timescale	Responsible Person
Recommendations a: The service should develop patient-facing objectives with measurable key performance indicators to help monitor how well the service is being delivered. These should be made available to patients (see page 11). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19	Actions Taken: • Developed 10 patient-facing objectives with explanations, measures and linked improvement work. • Published 5 priority objectives on website. • Early improvements delivered (plain-English T&Cs; patient-centred complaints policy; enhanced discharge information; Zen Room upgrades; improved waiting areas; Get Well Cards with patient surveys via QR code; structured feedback via post-op calls; daily "feedback lead" identified). • Regular patient experience walk-rounds already in place. • Patient feedback displayed on digital screens and "You Said, We Did" posters. • Key staff trained to update website content regularly. Actions Planned: • Finalise and publish KPIs for the 5 published objectives. • Establish monthly data-collection cycle and quarterly reporting.	 Dec-25 Jan-26	Compliance Manager (Lead), Clinical Manager, Deputy Clinical Lead, PCC Lead

	• Introduce quick micro-surveys in waiting rooms to capture real-time patient experience feedback. • Expand patient-facing updates via website, waiting rooms and social media. • Complete full patient-information library and environment refresh. • Phase in additional objectives with KPIs from the full list. • Launch public-facing KPI dashboard on website.	Mar-26 Mar-26 May-26 May-26 Jun-26	
Recommendation b: The service should record the outcomes of discussions and decisions reached at the daily huddles, including the staff responsible for taking forward any actions (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	Actions Taken: The service has now implemented documented daily hospital safety huddles at both sites. Huddles take place at 10:00 each morning, led by the most senior clinician present onsite at that time (for example, Clinical Manager, Deputy Clinical Manager, or senior registered nurse). A structured Daily Safety Huddle Form has been created and is completed at each huddle. The form captures: • hospital staffing and skill mix • daily activity overview (procedure numbers only, no patient identifiers) • environmental or equipment issues • operational updates for the day • any safety concerns, incidents, or near misses from the previous 24 hours • agreed actions and responsible person • escalations required • sign-off by the huddle lead Completed forms are filed in paper format in the PCC Team Office and, at month end, are scanned into the digital governance folder. The physical copies are shredded once digitised. Any adverse or non-compliant audit outcomes automatically trigger a RiskMate incident. A monthly huddle audit has been introduced, following the same scoring method used for the surgical brief/debrief audits (completion, quality of information, action assignment, action	Implemented 08 October 2025 Full audit cycle established by November 2025 Ongoing monthly reporting and review	PCC Team Lead – monthly audit and dashboard updates Compliance Manager – oversight, trend analysis, governance reporting Most Senior Clinician Onsite – leads daily huddle and completes form

	closure). Audit responsibility sits with the PCC Team Lead and the Compliance Manager. Actions Planned: The huddle compliance results will be: • displayed on monthly staff dashboards • reviewed at PCC and Clinical Team Meetings, Clinical Governance Meetings, and SMT meetings • included within the monthly internal audit summary • escalated via RiskMate where audit findings require follow-up Notes: This system now ensures consistent, structured communication across non-clinical and non-surgical teams, complementing the existing clinical surgical briefs and debriefs, which continue to be documented, audited monthly by the HCA Lead and Compliance Manager, and discussed at clinical meetings.		
Recommendation c: The service should develop a process of keeping patients informed of the impact their feedback has on 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 4.19	Existing Measures (Already in Place): • Get Well Cards with QR codes • 7-day post-op nursing calls with structured feedback prompts • PROMS (bariatrics, elective where relevant) • online feedback via website • email/phone feedback (informal) • complaints, compliments, observations, and recommendations for improvement • "You Said, We Did" posters and digital displays • patient experience walkrounds • updated discharge materials with feedback request prompts Actions Planned: • introduce micro-surveys in waiting areas • use social media to communicate improvement updates • refresh website content regularly to highlight patient experience themes and improvements	Dashboard and reporting structure fully operational: Jan 2026 First quarterly public update: March 2026	Compliance Manager – oversight of data capture and feedback dissemination Deputy Clinical Lead, PCC Team Lead, Compliance Manager and media consultant – website and social media updates SMT – review and approval of public updates and Quality Report

	• biannual formal public updates on themes and improvements, with continuous updates where possible via website and social media • KPI publication to commence after three months of validated data; reporting will focus on themes and improvements rather than raw statistics • Annual Quality Report summarising patient experience themes, improvements, and priorities Staff currently receives feedback via: • monthly Clinical Team Meetings • staff dashboards • SMT meetings • email cascades / internal chat channels Patients currently receive feedback via: • website – Mission Statement and Testimonials / Patient Experience sections • reception digital screens • "You Said, We Did" posters in patient areas • social media posts Notes: KPI publication requires several months of data capture to ensure accuracy and meaningful interpretation.		
Recommendation d: The service should develop its own systems and processes and implement clinical supervision of trained staff, including formal recording of it (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14	Actions Taken: A Clinical Supervision and Peer Review SOP has been created and approved (17 October 2025) to establish a structured, supportive, and confidential framework for clinical supervision and peer review across all clinical disciplines. The SOP covers: • clinical supervision for all clinical staff, with guidance on frequency, appointment of supervisors, and documentation. • peer review meetings within clinical departments, including review of anonymised case notes, outcomes, incidents, and patient feedback	SOP approved: 17 October 2025 Rollout and initial implementation: commenced October 2025, ongoing First review of compliance and audit: 31	Clinical Manager – oversight of rollout, supervision, and escalation of significant findings SMT – monitoring, reporting, and quality improvement integration Supervisors and peer reviewers – delivery of supervision and peer review sessions

	• formal recording of supervision and peer review sessions using designated templates • oversight by the Clinical Manager and the rest of the SMT • confidentiality, professional conduct, reflective practice, and integration into governance processes Actions Planned: • Rollout and implementation of the SOP is ongoing across all clinical areas of St Ellen's Hospitals. • Staff are being introduced to the SOP through induction sessions and direct communication. • Supervisors and peer reviewers will receive relevant training in reflective practice and constructive feedback as part of the phased implementation. • Compliance and effectiveness will be monitored through audits and review of supervision and peer review documentation. • Themes, risks, and learning identified through supervision and peer review will be reported to the SMT and used to inform quality improvement initiatives. Notes / Clarifications for HIS: The SOP has been developed and is actively being implemented; formal recording processes are now in place, but the programme is still in its early stages. As rollout progresses, all clinical staff will participate in supervision and peer review sessions in line with the SOP guidance.	December 2025 Annual audit and SOP review: next audit by 31 December 2026	

Recommendation e: The service should ensure that appropriate cleaning products are used for the cleaning of all sanitary fittings, including sinks, in line with national guidance (see page 26). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19	The service identified that the chlorine dilution used for cleaning sanitary fittings was not in line with current guidance. Corrective action has been taken immediately to ensure the correct dilution is applied across all clinical areas. A system to monitor updates to Infection Prevention and Control (IPC) guidance will be implemented, operating similarly to the MHRA automated alerts currently used for medication and medical device safety. A designated group within the Clinical Governance Team will receive notifications of all relevant IPC updates, legislative changes, and national guidance. All cleaning products and protocols will be cross-checked against updated guidance whenever changes occur, ensuring continued compliance. Staff involved in cleaning and infection prevention activities will receive training and updates on revised protocols and safe product use, including correct dilution procedures for chlorine-based products.	Corrected cleaning practice implemented immediately (October 2025) IPC monitoring system operational: by 31 December 2025 Staff training and cross-checking processes: by 31 December 2025	Deputy Clinical Lead (who is our Infection Prevention and Control (IPC) Lead) – oversight of cleaning protocol compliance, staff training, and guidance monitoring Clinical Manager, Deputy Clinical Lead and Compliance Manager - receiving updates and ensuring dissemination to relevant staff

Name	Gill Hutton		
Designation	Compliance Manager		
Signature		Date	17/11/2025

Guidance on completing the action plan.

- **Action Planned**: This must be a relevant to the requirement or recommendation. It must be measurable and focussed with a well-defined description of how the requirement/recommendation will be (or has been) met. Including the tasks and steps required.
- **Timescales** for some requirements can be immediate. If you identify a requirement/recommendation timescale that you feel needs to be extended, include the reason why.
- **Person Responsible**: Please do not name individuals or an easily identifiable person. Use Job Titles.
- Please do not name individuals in the document.
- If you have any questions about your inspection, the requirements/recommendations or how to complete this action plan, please contact the lead inspector for your inspection.