Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: St Ellen's Daycase Hospital

Service Provider: Cosmedicare UK Ltd

6–7 October 2025

NHS SCOTLAND

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Contents

1 A summary of our inspection 4

2 What we found during our inspection 9

Appendix 1 – About our inspections 27

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 announced inspection to St. Ellen's Daycase Hospital between Monday 6 and Tuesday 7 October 2025. We spoke with a number of staff during the inspection. We telephoned two patients after the inspection who had received treatment at the service. This was our first inspection to this service.

Based in Glasgow, St. Ellen's Daycase 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 St. Ellen's Daycase 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**
A clear vision and purpose was displayed in the service and on its website. A strategic plan was in place that to included aims, objectives and measurable key performance indicators. Clinical governance systems and processes were in place along with regular staff meetings. Staff told us leadership was approachable and proactive. Patient-focused objectives should be developed.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient and staff feedback was actively sought and used to continuously improve the service. We saw good levels of patient and staff satisfaction. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely. Systems were in place to manage risks. A range of 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 were in place. The service should develop a process to communicate the impact of improvements made after patient feedback.	✓✓ 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, regularly checked and 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. Sanitary fittings should be cleaned in line with national guidance.	✓✓ 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 Cosmedicare UK Ltd to take after our inspection

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the National Health Services (Scotland) Act 1978, regulations or a condition of registration. Where there are breaches of the Act, regulations or conditions, a requirement must be made. Requirements are enforceable.
- **Recommendation:** A recommendation is a statement which sets out what a service should do in order to align with relevant standards and guidance.

This inspection resulted in no requirements and five recommendations.

Direction	
Requirements	
	None
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 10). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
b	The service should record the 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

Implementation and delivery	
Requirements	
	None
Recommendations	
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
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

Results	
Requirements	
	None
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

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 St. Ellen's 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

A clear vision and purpose was displayed in the service and on its website. A strategic plan was in place that to included aims, objectives and measurable key performance indicators. Clinical governance systems and processes were in place along with regular staff meetings. Staff told us leadership was approachable and proactive. Patient-focused objectives should be developed.

Clear vision and purpose

The service's vision was a commitment to being 'the most trusted and accessible private health care provider in Scotland.' This vision was reinforced through its mission and purpose of providing access to affordable, private healthcare, delivering safe and compassionate treatment to the communities it served.

The service had further developed the provider's values to expand on its vision and purpose. These values were:

- 'Integrity – upholding professional and ethical standards in a trusting and nurturing environment that promotes personal growth, transparency and accountability.'
- 'Compassion – delivering patient-centred care with professionalism and kindness while safeguarding patient dignity, autonomy and preferences.'
- Respect – considering and serving patients and colleagues in a way that values their humanity and uniqueness, treating individuals with honour, privacy, and empathy.'
- 'Teamship - collaborating, communicating and coordinating our efforts to deliver the highest quality of patient care, prioritising patient safety, efficiency, and positive outcomes by leveraging each team member's distinct skills and perspectives.'

The managing director had developed a strategic plan, which set out the service's vision over the next 5 years. This was a live document that was updated regularly and discussed at senior management team and clinical governance meetings. The strategic plan included key performance indicators (KPIs), which included:

- audit compliance
- complaints
- employee satisfaction
- patient satisfaction, and
- staff training and development.

KPIs were 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.

We saw evidence of regular monitoring, recording and reporting through appropriate governance structures. We saw that the service recorded progress against KPIs and reported this through the governance structure.

KPIs were also reviewed and discussed regularly at leadership forums and senior management team (SMT) meetings every 3 months. We saw that the service was making good progress in achieving its KPIs from minutes of meetings we reviewed and staff we spoke with. Values and principles were displayed in the hospital for staff and patients to see. Staff we spoke with were aware of the service's vision, purpose and values.

What needs to improve

The service's business strategy did not include any patient-focused objectives or KPIs (recommendation a).

- No requirements.

Recommendation 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.

Leadership and culture

The hospital's staffing resource was made up of:

- external facilities staff
- healthcare support workers
- housekeeper
- medical staff, including consultant surgeons and anaesthetists
- pharmacist
- reception and administrative staff, and
- registered nurses.

The hospital had a senior leadership structure in place through its senior management team, which was made up of the:

- clinical manager
- compliance manager
- deputy clinical manager
- finance manager (who was also the service manager)
- managing director
- medical clinical directors
- non-executive director, and
- pharmacist.

Regular senior management team meetings were held and minutes showed that information and strategic plan updates were shared at these meetings. Actions and updates on previously agreed actions were recorded. Service improvements and complaints were also discussed at the different management and governance meetings.

The leadership team consisted of the:

- clinical manager
- compliance manager, and
- deputy clinical manager.

We also saw minutes of meetings between the leadership team and the managing director.

The weekly multidisciplinary clinical team consisted of the clinical manager or deputy clinical manager, the lead clinical co-ordinator and a health care support worker. The outcomes of this meeting were discussed with the service pharmacist and shared with the consultant medical staff as required. Weekly theatre staff meetings included discussions about staffing levels, equipment and theatre kit requirements. Minutes of all meetings were available to view during our inspection.

At the time of our inspection, the service was experiencing a period of change and was not providing any major surgery. A plan was in place to safely reintroduce this. The service was also appointing a new service manager.

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

- clinical governance
- health and safety
- medical advisory committee, and
- quality improvement.

Staff were kept up to date through:

- email
- online applications, and
- staff meetings every 2 months.

Staff we spoke with were clear about 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.

Staff told us that they knew who to speak to confidentially if they had any concerns about their work. The service had several ‘speak-up champions.’ Posters were clearly displayed around the hospital detailing who the speak-up champions were. Staff we spoke with also told us that they could speak to any member of the senior leadership team and they felt supported and encouraged in their role.

We saw that the compliance manager and quality improvement facilitator were currently working on updating the continuity plan and developing a disaster recovery plan for the service.

What needs to improve

We were told that on the days that multiple staff were on duty, a daily huddle discussed:

- any hospital-wide updates
- patient numbers for the day
- staffing, any issues and
- whether the hospital was safe to start.

However, we did not see any evidence that these huddles or actions arising from them were formally recorded (recommendation b).

- No requirements.

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.

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 and staff feedback was actively sought and used to continuously improve the service. We saw good levels of patient and staff satisfaction. Patient feedback outcomes were shared and staff received regular feedback. Staff were recruited safely. Systems were in place to manage risks. A range of 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 were in place.

The service should develop a process to communicate the impact of improvements made after patient feedback.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service had an up-to-date patient participation policy in place which described how feedback would be gathered, analysed and used to inform improvement activities.

The service actively sought feedback from patients about their experience of treatment and care and used this information to continuously improve how it was delivered.

Patients were given a feedback survey to complete when discharged. We saw that patients could leave feedback on the service's website, which the service then responded to directly. Staff called patients if they noted an issue or concern in their feedback. Patients were also checked at the clinic after their treatment and given an opportunity to raise any issues.

Feedback was analysed regularly and results were shared at staff meetings, including those from patient surveys the service had carried out. The surveys we reviewed showed high levels of patient satisfaction with their care and we saw individual staff members named for their level of care and attention. The service had introduced a named person that patients could leave feedback with daily as a result of patient feedback.

Other methods of gathering patient feedback included:

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

This information was used to improve the way the service was delivered. For example, the service had:

- introduced music in the waiting area
- provided a discount voucher for parking in the city centre, and
- provided patients with access to free wi-fi.

We saw that this information was displayed for patients in a 'you said, we did' format.

Staff meetings were held every month. A formal staff survey was carried out twice a year, which asked a comprehensive set of questions. Results from the most recent survey were discussed at the staff meeting and any changes made to the service were shared. Minutes of these meetings demonstrated that staff could express their views freely and staff we spoke with agreed. Improvements we saw included weekend or evening working to suit patient and staff preferences, as well as an increase in staffing numbers for the patient co-ordinator team. This information was also displayed in a 'you said, we did' format.

Staff told us they received information and training on new initiatives and when legislation changed, such as data protection. This made sure staff felt part of the service and could discuss improvement suggestions.

The service had recently employed a quality improvement facilitator. This role facilitates improvement for clinical and non-clinical staff. The service had developed a dashboard for the patient care co-ordinator team (non-clinical staff). KPIs had been identified for this team, which included:

- enquiry-to-booking conversion rates
- first-response timeframes
- follow-up compliance
- patient engagement quality
- patient re-engagement options
- task completion rates, and
- team collaboration and efficiency.

Monthly meetings for this staff group were documented and from the minutes, we saw that the agenda included:

- actions
- decisions
- improvements made to the service as a result of staff feedback
- key discussion points, and
- staff feedback.

The service had implemented 'Feedback Friday', where staff were told of positive comments from patients and other staff about members of staff. The service was also developing a staff initiative scheme, where staff would have access to more benefits and be recognised for their contributions to service delivery.

When staff worked late, the service would order food from a local takeaway for staff.

What needs to improve

We were told of a variety of service improvements discussed at the different management and governance meetings. However, we did not see any evidence to demonstrate how the impact of improvements made after feedback was communicated to the public (recommendation c).

- No requirements.

Recommendation c

- The service should develop a process of keeping patients informed of the impact their feedback has on 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.

A detailed medicines management policy was in place, which included the use of controlled drugs. The service did not hold stock of medication. However, we saw a process in place for the safe delivery and receipt of medication, including take-home medication for patients who received treatment at the hospital.

The service had a Home Office license for storing and delivering controlled drugs. At the time of our inspection, we saw that all controlled drugs had been disposed of safely or transferred through to the provider's other hospital in Livingston. We spoke with the service's pharmacist who described these processes.

Appropriate policies and procedures set out the way the service was delivered and supported staff to deliver safe, compassionate, person-centred care. A process was in place for writing all policies and approving them through the clinical governance group and 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 service's online system.

The service'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 in place for all clinical and non-clinical areas.

The service was aware of the notification process to Healthcare Improvement Scotland. During our inspection, we saw that the service had submitted all incidents that should have been notified to Healthcare Improvement Scotland.

The outcomes of the discussions from these meetings were shared in regular staff meetings. Any incidents that an individual member of staff had been involved in were also discussed at the incident debrief, one-to-one meetings and at staff appraisals. Any trends identified were escalated to senior management for review, to assess training needs.

All staff completed 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 practising privileges (staff not employed directly by the provider but given permission to work in the service). The infection control and prevention nurse also delivered on-site training to staff. Staff told us time for training was usually protected.

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.

The service's complaints procedure was prominently displayed and published on the provider's website. We were told that when someone made a complaint, they:

- received an acknowledgement letter with a full description of the complaint
- then received a follow-up letter when the complaint had been fully investigated, with the outcome of the investigation, and
- were offered a face-to-face with a member of the senior management team.

We saw evidence that complaints were well managed and lessons learned were discussed at staff and management meetings. An electronic system was used to monitor the progress of complaints. Complaints were discussed at the leadership team meetings and governance meetings.

The service subscribed to 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 service had published a yearly duty of candour

report. We saw evidence that the service had followed its own procedure when dealing with these incidents and shared learning with staff and consultants.

The provider and service was 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 patients received electronic aftercare instructions and information about any recommended follow-up when discharged. This information could be provided to patients in paper copies if required. We saw evidence of this recorded in the patient care record. The service's contact details were provided on discharge in case patients had any concerns or queries. Patients we spoke with told us they were clear about what to expect after discharge.

Patients were reviewed either the next day in-person or over the phone after discharge to check how they felt and address any concerns they might have at that time.

The medicines fridges were checked regularly, including its contents and daily temperatures. Staff we spoke with knew the process for reporting faults. We saw that the emergency equipment trolley was checked regularly in line with the service's opening times and kept in accessible locations. Staff we spoke with were familiar with the location of the emergency equipment.

We saw that the service had a deteriorating patient protocol, which included a:

- major haemorrhage protocol
- national early warning score chart (NEWS 2), and
- transfer out to NHS facility if required.

The service's recruitment policies described how staff would be appointed. Appropriate pre-employment checks were carried out for employed staff and healthcare professionals appointed under practising privileges.

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

- professional register checks and qualifications where appropriate
- Protecting Vulnerable Groups (PVG) status of the applicant (this was repeated every 3 years), and
- references.

Staff files contained a checklist to help make sure that appropriate recruitment checks were carried out.

The service proactively managed its staffing complement to help make sure that an appropriate skill mix and safe staffing was always provided.

We were told that staff attended ward meetings and minutes of these were available in written form and sent in email to all staff. Staff were encouraged to attend these meetings and access was available in-person or virtually to allow as many staff as possible to attend.

What needs to improve

The service did not have a formal policy or standard operating procedure in place for clinical supervision. We saw no evidence of clinical supervision taking place at the time of our inspection (recommendation d).

- 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

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 fed back to staff through:

- e-mails
- one-to-one meetings
- theatre huddles, and
- team meetings.

The service's risk management process included corporate and clinic risk registers, auditing and reporting systems. These detailed the actions taken to mitigate or reduce risk. The service carried out a variety of risk assessments to help identify and manage risk. These included risk assessments for:

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

The service used external agencies for any unplanned work required. We were told that it was exploring the possibility of registering with a facilities management company for future works. An equipment asset register had been established to track when each item of equipment was due to be serviced or maintained. We saw evidence that all equipment servicing and maintenance was up to date. Examples included:

- clinical and medical equipment
- fire equipment
- gas boilers,
- medical gases, and
- the fixed electrical installation.

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. An arrangement was in place with another service in the provider's wider organisation in case evacuation of patients became necessary.

Processes were in place to manage the service's water safety, including a legionella risk assessment.

The service had a detailed audit programme, which helped make sure the service delivered consistent safe care and treatment for patients and identified any areas for improvement. All staff we spoke with participated in audits and were aware of when these were completed. Action plans were produced to make sure any actions needed were progressed. The infection control and prevention nurse for the service carried out extensive audits in all departments and supported areas with any actions arising as a result.

Audits carried out included those for:

- health and safety
- infection prevention and control
- medication management including controlled drugs
- patient care records, and
- surgical briefs.

The quality improvement team had oversight of the quality improvement plan, which considered the service's objectives and included short-term goals and longer-term projects. For example, a short-term goal was to increase the number of treatment options and operations available in the service. An example of a longer-term project was to introduce hormone therapy for transgender patients.

- 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, regularly checked and 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.

Sanitary fittings should be cleaned in line with national guidance.

Every year, we ask the service to submit an annual return. This gives us essential information about the service such as composition, activities, incidents and accidents, and staffing details. The service submitted an annual return, as requested. As part of the inspection process, we ask the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Assurance Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a satisfactory self-evaluation.

The environment and equipment we saw were clean. We saw that care was delivered in a clean hospital environment and theatre suites with equipment that was fit for purpose and regularly maintained. The consulting or treatment rooms and minor surgery rooms were in good condition, tidy and clean. We saw that cleaning checklists were completed. Patients we spoke with commented that the service and equipment was clean. Toilets were provided throughout the service, including facilities for people with disabilities. Housekeeping staff cleaned these facilities regularly.

Clinical waste was managed in line with national guidance and clean linen was stored correctly.

The equipment we saw was clean and well maintained. Patients we spoke with told us that they felt safe and that the cleaning measures in place to reduce the risk of infection in the service were reassuring. All patients stated the clinic was clean and tidy. Comments included:

- ‘Spotlessly clean.’
- ‘Absolutely spotless and well maintained.’

We looked at five patient care records and saw they all included the patients’ name, address and next of kin. Patient care records also included:

- details of their assessment and consultation
- documentation of the discussion about the treatment plan, including the risks and benefits of each treatment offered
- patients consent to treatment and to share information with their GP or other relevant healthcare professional where appropriate, and
- post-treatment aftercare discussions with patients before their discharge from the service.

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 using the updated national early warning scoring (NEWS 2) system.

We also saw evidence that treatments plans, options and aftercare had been discussed with the patient before they were discharged from the service.

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). We saw that controlled drugs were stored securely. While the service was not fully functioning at the time of our inspection, the service told us that the controlled-drugs keys were kept separately from medication cupboard keys and were signed out. We saw that 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.

Take-home medication for patients was ordered in advance of their discharge. The pharmacist had oversight of this and reviewed all prescriptions before dispensing any medication.

Staff told us they felt the approachable leadership team valued and supported them well. Minutes of staff meetings and the staff survey showed that staff could express their views freely. 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.

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:

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

- 'Patient safety and care is of the highest standard, transparent service that educates patients from start to finish.'
- 'Patient care. Going the extra mile to make people feel comfortable. Being flexible with staff and patients to work around life's challenges.'
- 'Do our best, for everyone, staff and patients alike - we treat everyone as if they are a member of our own family or how we would want to be treated ourselves.'
- 'We are very good at all departments coming together when needed to ensure a positive outcome for our patients.'

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:

- 'Everything was lovely, staff were amazing and nothing to complain about.'
- 'Really good experience and I have gone back for more surgery.'

What needs to improve

The service's sanitary fittings, including sinks, were not cleaned with the appropriate cleaning solution, in line with current guidance (recommendation e).

- No requirements.

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.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.

Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.

During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.

After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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