Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Unannounced Inspection Report: Independent Healthcare

Service: Elanic (Hospital), Glasgow

Service Provider: Elanic Ltd

11–12 February 2026

NHS SCOTLAND

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First published April 2026

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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 Elanic (Hospital) on Wednesday 11 and Thursday 12 February 2026. We spoke with a number of staff and patients during the inspection. We received feedback from 26 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 Glasgow, Elanic (Hospital) is an independent hospital providing surgical treatments.

The inspection team was made up of a senior inspector and two inspectors, along with a pharmacist and doctor.

What we found and inspection grades awarded

For Elanic (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 vision and purpose statement, strategic plan and key performance indicators were in place. A daily team meeting reviewed key performance indicators, operational flow, workforce capacity and any patient safety issues. All relevant documentation must be available to an authorised person when requested. Clear clinical governance structures must be in place that promote quality and safety through identified leadership. Appropriate procedures must be implemented to provide monitoring and oversight of safe patient care. The strategic plan should be reviewed. The vision and purpose statement should be shared with staff and patients.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patient experience was gathered, assessed and used to improve the service. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. All medications were in-date. Processes were in place to manage incidents. An audit programme was in place. Notifications must be submitted in a timely manner. Medicine management systems must be in place. The service must follow its complaints policy. Identified risks must be reviewed and documented. We saw no evidence of a quality Improvement plan.	✓ Satisfactory

Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Summary findings	**Grade awarded**
The care environment and patient equipment was clean. Equipment was fit for purpose, regularly checked and maintained. Staff followed World Health Organization guidelines for safe surgery for patients. Staff described the provider as a good employer and the service as a good place to work. Patients were very satisfied with their care and treatment. The service should complete and submit a self-evaluation. All new employees should have two references obtained an induction checklist should be implemented. An overnight cleaning schedule should be in place.	✓ Satisfactory

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 Elanic 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 seven requirements and 14 recommendations.

Direction	
Requirements	
1	The provider must ensure that all relevant documentation is available to view by an authorised person when requested, including Healthcare Improvement Scotland inspectors during an inspection (see page 14). Timescale – immediate *Regulation 5(2)(a)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011*
2	The provider must have clear governance structures in place that promote quality and safety through identified leadership that is both accountable and fully engaged in the service (see page 17). Timescale – immediate *Regulation 13(1)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011*

Direction (continued)	
Requirements	
3	The provider must ensure that appropriate clinical governance procedures are implemented to provide monitoring and oversight of safe patient care (see page 17). Timescale – immediate *Regulation 13 (2)(b)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011*
Recommendations	
a	The service should review its strategic plan and develop a strategic plan appropriate for the current service (see page 14). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
b	The service should share its vision and purpose statement with staff and patients (see page 14). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
4	The provider must notify Healthcare Improvement Scotland of certain matters as detailed in our notifications guidance and in a timely manner see page 24). Timescale – immediate *Regulation 5(1)(b)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Requirements	
5	The provider must ensure that medicine management systems are in place which demonstrate clear evidence of regulatory compliance and staff competency (see page 24). Timescale – immediate *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
6	The provider must ensure that all complaints are investigated in line with its complaints policy and that the complaints log is fully completed to reflect all complaints that involve the hospital (see page 24). Timescale – immediate *Regulation 15(3)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
7	The provider must have a process in place to ensure that all risks identified on the risk register and assessment framework have been assessed and reviewed by the service. This will ensure effective oversight of how the service is being delivered (see page 28). Timescale – by 11 May 2026 *Regulation 13(2)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
c	The service should demonstrate that improvements made after feedback from patients is communicated to the public (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery (continued)	
Recommendations	
d	The service should update its complaints policy to accurately reflect all aspects of the complaints process, including who investigates the complaint and how this is communicated to patients (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
e	The service should service should implement a formal process for clinical supervision of trained staff (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
f	The service should implement a competency framework for all staff working in the service (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
g	The service should amend its recruitment policies to make sure it sets out the recruitment process it will follow and contains the correct legislation and standards (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24
h	The service should develop a regular formal programme for non-clinical staff team meetings. These should be documented and include any actions taken and those responsible for the actions. Minutes of meetings should be shared with all staff involved to ensure issues discussed and decisions made are communicated to anyone unable to attend the meeting (see page 29). 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 (continued)	
Recommendations	
i	The service should develop a consistent format for recording one-to -one meetings between staff and their line manager which should be added to the individual's staff file (see page 29). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
j	The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (see page 29). 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	
	None
Recommendations	
k	The service should complete and submit a self-evaluation as requested by Healthcare Improvement Scotland (see page 34). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
l	The service should obtain two references for new members of staff, in line with safe recruitment practices (see page 34). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
m	The service should implement a formal documented induction process for self-employed staff, including those granted practicing privileges to work in the service (see page 34). 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 (continued)
Recommendations
n The service should ensure that cleaning schedules are fully and accurately completed for overnight cleaning and are available (see page 34). 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

Elanic Ltd, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Elanic (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 vision and purpose statement, strategic plan and key performance indicators were in place. A daily team meeting reviewed key performance indicators, operational flow, workforce capacity and any patient safety issues.

All relevant documentation must be available to an authorised person when requested. Clear clinical governance structures must be in place that promote quality and safety through identified leadership. Appropriate procedures must be implemented to provide monitoring and oversight of safe patient care. The strategic plan should be reviewed. The vision and purpose statement should be shared with staff and patients.

Clear vision and purpose

The service had a vision and purpose statement, 'To deliver high-quality, consultant-led surgical care that improves outcomes, accelerates recovery, and enables people to live better lives.'

We saw that the service had developed a 'Strategic Plan for Elanic Expansion' in January 2024 and we were told it planned to develop a single quality strategy document. We were told that strategic priorities were agreed through the board and included:

- financial sustainability
- growth
- quality, and
- workforce.

We saw that key performance indicators (KPIs) had been developed and included:

- financial sustainability and cashflow
- flow, scheduling and theatre utilisation
- patient demand and enquiry volumes
- patient experience
- patient safety, incidents, complaints and feedback, and
- workforce capacity and skill mix.

The senior management team reviewed the KPIs daily.

What needs to improve

While we were told that the board agreed on the strategic priorities, the service did not provide us with any evidence of this despite being asked to do so. This meant we were unable to confirm this decision-making process (requirement 1).

We saw no evidence that the January 2024 Strategic Plan for Elanic Expansion had been reviewed or that a new quality strategy had been developed (recommendation a).

While a vision and purpose statement was in place, it had not been shared with staff or patients at the time of our inspection and was not on the website or visible in the service (recommendation b).

Requirement 1 – Timescale: immediate

- The provider must ensure that all relevant documentation is available to view by an authorised person when requested, including Healthcare Improvement Scotland inspectors during an inspection.

Recommendation a

- The service should review its strategic plan and develop a strategic plan appropriate for the current service.

Recommendation b

- The service should share its vision and purpose statement with staff and patients.

Leadership and culture

The service was a small surgical hospital with staff, including:

- a housekeeper
- a pharmacist
- administration staff
- medical staff
- nursing staff
- operating department practitioners
- patient care co-ordinators, and
- sales and marketing.

The senior leadership team consisted of a:

- clinical services director
- director of strategy and operational excellence
- managing director, and
- medical director.

We saw that a daily senior leadership team meeting reviewed KPIs and had oversight of operational flow, workforce capacity and any patient safety issues in the service. At 10am daily, a multidisciplinary operational communication meeting included representatives from all teams.

The service had a non-clinical organisational chart showing the leads for each non-clinical area and we saw that a 'financial controller' had recently been appointed. We saw marketing steering group actions and reports for December 2025 and February 2026. We were also given an extract from a document which showed the overall clinical and non-clinical meeting governance structure of the service.

The service had recently appointed an improvement advisor, who was also acting as a theatre manager at the time of our inspection. The service's new theatre manager and a new quality and assurance manager were due to start in March 2026.

We saw evidence of three hospital transfusion committee meetings taking place since February 2025.

Staff we spoke with told us they found the leadership team to be visible and approachable. We saw that senior staff knew the names of staff as they walked round the site and we saw good staff interaction.

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

- local staff meetings
- meetings and huddles, and
- open forums.

Members of the senior management team and a variety of other senior staff for the hospital attended a daily huddle, including:

- admin staff
- facilities staff
- marketing executive
- medical co-ordinator lead
- procurement staff
- sales and marketing staff, and
- the outpatient and ward manager.

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

We also attended the early morning theatre huddle that all perioperative staff attended. This was used to make sure all theatres had the correct resources for the day, to identify any potential issues and pass on key information to the teams.

What needs to improve

While we were given the service meeting governance structure, it was unclear from the document who was responsible and accountable for the different clinical governance areas of the service (requirement 2).

We were told the last clinical governance meeting had been held in November 2025. The service's own clinical governance policy states that these meetings should be held monthly. Other meetings that should take place as part of the clinical governance structure of the hospital included the Medical Advisory Committee (MAC) and the medicine management meeting. The MAC was a specialised group of clinicians and experts that provided independent oversight,

clinical governance and strategic advice to an independent hospital board. While we were told that one initial meeting of the MAC had taken place in March 2025, no minutes were provided. No medicine management meetings had taken place as yet. This made it difficult to make sure that the hospital was providing safe, high-quality care. Services must have clear clinical governance structures in place and implemented to provide monitoring and oversight of safe patient care (requirement 3).

We were advised that the senior management team planned to meet monthly more formally. We will follow this up at future inspections.

Requirement 2 – Timescale: immediate

- The provider must have clear governance structures in place that promote quality and safety through identified leadership that is both accountable and fully engaged in the service.

Requirement 3 – Timescale: immediate

- The provider must ensure that appropriate clinical governance procedures are implemented to provide monitoring and oversight of safe patient care.

- No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Patient experience was gathered, assessed and used to improve the service. Appropriate policies and procedures supported staff to deliver safe, compassionate and person-centred care. All medications were in-date. Processes were in place to manage incidents. An audit programme was in place.

Notifications must be submitted in a timely manner. Medicine management systems must be in place. The service must follow its complaints policy. Identified risks must be reviewed and documented. We saw no evidence of a quality Improvement plan.

Co-design, co-production *(patients, staff and stakeholder engagement)*
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 within 48 hours after treatment. Other methods of gathering feedback included:

- online apps
- 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:

- changing food supplier
- implementing menu choices for patients to choose before an overnight stay
- introducing better-tasting coffee for patients, and
- purchasing orthopaedic chairs for patient bedrooms.

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

What needs to improve

We were told that patients were phoned about improvements made as result of their feedback. However, we saw no evidence that improvements were shared with the patients (recommendation c).

- No requirements.

Recommendation c

- The service should demonstrate that improvements made after feedback from patients is communicated to the patients.

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.

Patient care records were stored on a password-protected electronic database. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential patient information was safely stored.

Policies were in place that detailed safe recruitment and staffing, including recruitment and selection. A practicing privileges policy was also in place for staff not employed directly by the provider but given permission to work in the

service. These policies described how staff would be appointed to work in the service. They included the appropriate pre-employment checks to be carried out for employed staff and healthcare professionals appointed under practicing privileges. We also saw standard operating procedures in place for induction and training, appraisals and developing personal development plans.

A mandatory training framework for staff included online training on:

- health and safety principles
- infection control
- information governance
- moving and handling, and
- safeguarding of vulnerable adults.

We found that the majority of staff had not been in post for a year at the time of our inspection. In these cases, they had not had an annual appraisal where aims, objectives and goals could be identified and discussed. Staff we spoke with said they felt valued and had regular one-to-one meetings with their line managers, where they could raise issues.

A medicines management policy and protocols helped to make sure medicines were managed safely and effectively. Medicines were stored in locked cupboards and medicine fridges. The fridge temperatures were monitored to make sure medicines were stored at the appropriate temperature. Emergency medicines were easily accessible. We saw emergency equipment trolleys were checked daily and kept in accessible locations. Staff we spoke with were familiar with the location of the emergency equipment. We saw that the service carried out a controlled drug check regularly and recorded the checks in the controlled drug register.

A consent policy detailed how the service would make sure that informed consent was obtained from patients before any treatment was carried out. The surgeon shared information at consultations. When making an appointment, patients received a consent form with information about the treatment they had booked, including the risks.

Patients had to complete a medical history questionnaire before their appointment. A face-to-face consultation was then carried out with the practitioner and then a pre-assessment appointment before attending their treatment appointment. Discussions at the consultations included:

- expected outcomes of treatment
- full medical history
- risks and side effects, and
- the recommended aftercare.

This allowed the patient a cooling-off period and gave them time to consider the information received before going ahead with treatment.

Patients were given written aftercare instructions and information about any recommended follow-up at the point of discharge. Hospital contact details were also 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 service had a rota for the out of hours service. Patients could phone this service at any time out of hours. Calls were logged and discussed at the safety briefs the next day. Examples of actions taken as a result included 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 some incidents 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. Complaints were collated in a complaints log and we saw:

- evidence of investigation
- identified areas for improvement, and
- implementation of changes as a result.

The service had logged one complaint since its registration with Healthcare Improvement Scotland in 2025, which the hospital had investigated in line with its complaints policy.

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). Part of a provider's duty of candour responsibilities is to produce and publish duty of candour reports every year, even where no incidents occur requiring the need to implement the duty of candour procedure. A yearly duty of candour report was published on the service's website.

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 2 weeks in advance and we were told that the service planned to make this 1 month 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 each person had a limit for the number of requests they could make. Any over-requesting was discussed directly with staff.

What needs to improve

The service was aware of Healthcare Improvement Scotland's notifications guidance, which details specific events and circumstances which services are required to report to us. Some of the service's notifications submitted to Healthcare Improvement Scotland were submitted late and not in line with the timescales in our notifications guidance. We noted two significant events recorded on the service's clinical incident reporting system which were not reported to us (requirement 4).

The service had a medicines management policy and protocols in place. However, we saw no evidence of annual reviews, competency assessments or monitoring of staff adherence and compliance, demonstrating staff maintained the required knowledge and skills for medicines management. The service lacked medicines-specific audits, for example audits of:

- controlled drug management
- expiry and stock checks
- prescribing documentation, and
- storage compliance.

We also found no evidence of:

- near-miss logs
- peer review
- reflective practice around medicines governance, or
- shared learning.

Critical areas for improvement must include:

- clear and consistent record keeping
- clear evidence of standard operating procedure compliance and competency maintenance
- development of structured polypharmacy
- implementation of medicines-specific audit cycles
- introduction of incident and near-miss reporting mechanisms, and
- regularly documented stock, date and controlled drug checks (requirement 5).

We discussed three other complaints about Elanic (Hospital), which the outpatients team (based in Elanic clinic) was investigating. The hospital's complaints log did not record these complaints. Two of these complaints had not been investigated in the timescales detailed in the provider's complaints policy (requirement 6).

It was not clear how the decision of who would investigate the complaint (outpatients team) was made and whether this was communicated to patients. This process was not accurately reflected in the service's complaint policy (recommendation d).

While the service had an appraisal policy in place, it 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 e).

We saw a competency framework in place for ward staff. However, we saw no evidence of a competency framework in place for theatre or non-medical staff (recommendation f).

The service's policies for recruitment and selection, as well as practicing privileges referred to out-of-date legislation and standards (recommendation g).

Requirement 4 – Timescale: immediate

- The provider must notify Healthcare Improvement Scotland of certain matters as detailed in our notifications guidance and in a timely manner.

Requirement 5 – Timescale: immediate

- The provider must ensure that medicine management systems are in place which demonstrate clear evidence of regulatory compliance and staff competency.

Requirement 6 – Timescale: immediate

- The provider must ensure that all complaints are investigated in line with its complaints policy and that the complaints log is fully completed to reflect all complaints that involve the hospital.

Recommendation d

- The service should update its complaints policy to accurately reflect all aspects of the complaints process, including who investigates the complaint and how this is communicated to patients.

Recommendation e

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

Recommendation f

- The service should implement a competency framework for all staff working in the service.

Recommendation g

- The service should amend its recruitment policies to make sure it sets out the recruitment process it will follow and contains the correct legislation and standards.

Planning for quality

We saw that accidents and incidents were recorded and managed through an electronic incident management system. We were told these were reviewed and reported through the clinical governance framework and any learning was fed back to staff through:

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

We tracked an incident recorded on the system. From minutes of the clinical governance meeting, we saw this was discussed and a 'root cause analysis' investigation had been completed.

The service's risk management process included a combined corporate and clinical risk register, auditing and reporting system. This register detailed the actions taken to mitigate or reduce risk. The service carried out a variety of risk assessments to help identify and manage risk, including risk assessments for:

- compliance and regulatory risks
- environment and infrastructure
- financial risks
- patient safety, and
- staff and workforce.

We saw separate risk assessments for the patient services department, which included those for:

- fire
- lone working
- management of waste disposal
- moving and handling
- slips, trips and falls, and
- violence and aggression.

These risk assessments included control measures in place, the personnel involved and review dates.

The service used two external agencies for any unplanned work required, repairs to equipment and maintenance. The operations manager received a monthly update report from both agencies. 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.

Marketing steering group meetings were held every 2 months. Agendas included:

- customer satisfaction
- events updates
- marketing performance reviews
- planning ahead
- sales performance reviews, and
- stakeholder engagement.

We saw actions identified at these meetings generated action plans were assigned to particular members of staff and progress of actions were discussed at the next meeting. All heads of departments for non-clinical staff were involved in these meetings.

We saw evidence of monthly facilities and safety meetings and reports with:

- actions
- the people responsible for completing actions in a timeframe
- whether it had been achieved, and
- whether it was complete or had the next steps still outstanding.

The operations manager carried out weekly fire risk assessments and audits and monthly health and safety audits. This information was stored electronically. The hospital had not experienced any non-clinical accidents, incidents or

adverse events since registration with Healthcare Improvement Scotland on 6 February 2025.

We saw evidence of a non-clinical workforce planner, which included:

- identified actions
- mitigating actions
- personnel assigned to the actions
- review dates, and
- timeframes.

This included facilitating the increase in clinical activity and increased patient numbers. We saw that the service provider had submitted an application to Healthcare Improvement Scotland to register an additional service for consultation purposes only to accommodate the increased patient demand.

A business continuity plan described what steps would be taken to protect patient care if an unexpected event happened, such as power failure or a major incident. The operations manager and director reviewed this plan weekly. 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 in place, which helped make sure it 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 prevention and control nurse for the service carried out extensive audits in all departments and supported areas with any actions identified as a result.

Audits carried out included those for:

- health and safety
- infection prevention and control
- patient care records, and
- surgical briefs.

What needs to improve

The service had detailed risk assessments with review dates for two areas. However, the majority of the risks identified on the risk register and assessment framework had no detail of dates when the risk was identified or when the risk would be reviewed (requirement 7).

The operations manager told us that they met with their team regularly and had daily 'catch ups' with staff. However, we saw no evidence of formal team meetings taking place (recommendation h).

We saw the operations manager had recently started to review administrative staff performance through one-one meetings. This information was shared with each member of staff through e-mail correspondence. However, we saw no formal process in place to add details of these meeting to the member of staff's file (recommendation i).

The service did not have a formal quality improvement plan in place. A formal quality improvement plan would help the service to structure and record its improvement processes. This could include outcomes identified from:

- accidents and incidents
- audits
- complaints
- education and training events, and
- patient feedback (recommendation j).

While we saw that the service carried out a range of clinical audits, we were told that pharmacist was implementing an audit for medication management, including controlled drugs. We will follow this up at future inspections.

Requirement 7 – Timescale: by 11 May 2026

- The provider must have a process in place to ensure that all risks identified on the risk register and assessment framework have been assessed and reviewed by the service and are clearly documented. This will ensure effective oversight of how the service is being delivered.

Recommendation h

- The service should develop a regular formal programme for non-clinical staff team meetings. These should be documented and include any actions taken and those responsible for the actions. Minutes of meetings should be shared with all staff involved to ensure issues discussed and decisions made are communicated to anyone unable to attend the meeting.

Recommendation i

- The service should develop a consistent format for recording one-to - one meetings between staff and their line manager which should be added to the individual's staff file.

Recommendation j

- 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, regularly checked and maintained. Staff followed World Health Organization guidelines for safe surgery for patients. Staff described the provider as a good employer and the service as a good place to work. Patients were very satisfied with their care and treatment.

The service should complete and submit a self-evaluation. All new employees should have two references obtained an induction checklist should be implemented. An overnight cleaning schedule should be in place.

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.

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 housekeeping staff completed cleaning checklists. 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 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:

- ‘Very clean and tidy.’
- ‘Lovely clean environment.’
- ‘Very nice facility.’

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 patients before their discharge from the service.

During our inspection, we followed a patient's journey from the ward through theatre and into the recovery room. The service followed a two-stage consent process, which made sure patients made informed decisions through separating the initial consultation from final, legal consent. Stage one involved detailed discussion of risks, benefits and alternatives, with written information provided at an outpatient appointment. Stage two was when the surgeon checked for changes and reaffirmed consent near the time of the procedure. We observed the discussion with the patient and surgeon before signing the consent form. We saw that this process was carried out appropriately.

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 and a variety of staff introduced themselves and explained what was happening. The patient was closely monitored while anaesthetised during the operation and then in the recovery room. Patients' privacy and dignity was

always maintained. We saw effective multidisciplinary working, with informative staff handovers and communication at all stages in the patient journey.

We saw evidence of completed medicines reconciliation (the process of identifying an accurate list of the patient's current medicines and comparing it with what they are actually using).

The hospital's Home Office certificate for stocking, prescribing and dispensing controlled drugs was valid and in-date.

Safe and secure storage of medicines was observed during the inspection, with appropriate environmental controls and separation of medicines. Controlled drugs were stored appropriately.

Ward staff prepared take-home medication for patients in advance of their discharge.

Staff told us they felt the approachable leadership team valued and supported them well. Minutes of staff meetings 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:

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

- ‘Takes care of patients.’
- ‘Patients don't just feel like a number, there is close care from enquiry to treatment/admission to aftercare.’
- ‘I believe they care for their staff and listen to concerns and also positives we do well and recognised for them. Patient safety is always a priority and how we can improve this to the best of our ability to make the patient experience the best it can be.’

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 through the different feedback channels. Comments included:

- ‘Everything was lovely, staff were amazing and nothing to complain about.’
- ‘My physiotherapist recommended the surgeon and this hospital and it has been great.’

What needs to improve

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. While requested, the service did not submit a self-evaluation (recommendation k).

The service’s recruitment and selection, and practicing privileges, policies state that the service will take up two references. However, we found the following:

- While two references had been requested, only one reference had been received in five out the 10 staff files we reviewed. We also saw that a risk assessment had not been carried out for staff before starting their employment (recommendation l).

- While all of the recruited members of staff had a completed induction checklist, no staff granted practicing privileges had evidence of an induction checklist completed (recommendation m).

Housekeeping staff cleaned the hospital during the day and an external contractor cleaned additional areas of the hospital overnight. We saw that housekeeping staff had completed cleaning schedules during the day. While we asked for completed overnight cleaning schedules, these had not been provided (recommendation n).

We reviewed five files of employed staff members and five files of staff working under practicing privileges. We were told that the service was moving to a new human resources system and that staff files were being uploaded at the time of our inspection. We found that no interview notes were kept. We will follow this up at future inspections.

Recommendation k

- The service should complete and submit a self-evaluation as requested by Healthcare Improvement Scotland.

Recommendation l

- The service should obtain two references for new members of staff, in line with safe recruitment practices.

Recommendation m

- The service should implement a formal documented induction process for self-employed staff, including those granted practicing privileges to work in the service.

Recommendation n

- The service should ensure that cleaning schedules are fully and accurately completed for overnight cleaning and are available.

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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