Unannounced Inspection Report: Independent Healthcare

**Service:** Ross Hall Hospital, Glasgow

**Service Provider:** Circle Health Group Limited

14–15 March 2023
Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot
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1 A summary of our inspection

The focus of our inspections is to ensure each service is person-centred, safe and well led. Therefore, we only evaluate the service against key quality indicators which apply across all services. However, depending on the scope and nature of the service, we may look at additional quality indicators.

About our inspection

We carried out an unannounced inspection to Ross Hall Hospital on Tuesday 15 and Wednesday 15 March 2023. We spoke with a number of staff and patients during the inspection.

The inspection team was made up of four inspectors (one of whom was observing).

As part of the inspection process, we asked the service to submit a self-evaluation. The questions in the self-evaluation are based on our Quality Framework and ask the service to tell us what it does well, what improvements could be made and how it intends to make those improvements. The service submitted a comprehensive self-evaluation.

What we found and inspection grades awarded

For Ross Hall Hospital, the following grades have been applied to the key quality indicators inspected.

<table>
<thead>
<tr>
<th>Key quality indicators inspected</th>
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<tr>
<td><strong>Domain 2 – Impact on people experiencing care, carers and families</strong></td>
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<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
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<tr>
<td>2.1 - People’s experience of care and the involvement of carers and families</td>
<td>Processes were in place to make sure patients are fully informed of the treatments available. A comprehensive process of gathering patient feedback was in place. Feedback was reviewed daily and used to develop the service.</td>
<td>✓✓ Good</td>
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Domain 5 – Delivery of safe, effective, compassionate and person-centred care

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<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
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<tr>
<td>5.1 - Safe delivery of care</td>
<td>Systems were in place to allow staff to provide safe and effective care. The service had a proactive approach to risk management and health and safety. Staff we spoke with were aware of their responsibilities in delivering safe care. Effective monitoring of infection prevention and control compliance was in place. Equipment we saw was well maintained and clean.</td>
<td>☑️ Good</td>
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Domain 9 – Quality improvement-focused leadership

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<tr>
<th>Quality indicator</th>
<th>Summary findings</th>
<th>Grade awarded</th>
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<tr>
<td>9.4 - Leadership of improvement and change</td>
<td>We saw evidence of a quality improvement focused leadership. The provider had developed a process of quality systems which were embedded throughout the organisation. Leadership at all levels was visible and approachable.</td>
<td>☑️ Good</td>
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The following additional quality indicators were inspected against during this inspection.

**Additional quality indicators inspected (ungraded)**

**Domain 3 – Impact on staff**

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<th>Summary findings</th>
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<tr>
<td>3.1 - The involvement of staff in the work of the organisation</td>
<td>Staff were positive about their work and their working relationships with colleagues. They felt they had enough training to carry out their job and a system was in place to make sure regular appraisals were carried out.</td>
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**Domain 5 – Delivery of safe, effective, compassionate and person-centred care**

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<tr>
<td>5.2 - Assessment and management of people experiencing care</td>
<td>Patient care records were comprehensive and contained all relevant information.</td>
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Domain 7 – Workforce management and support

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<td>7.1 - Staff recruitment, training</td>
<td>Systems and processes were in place to help make sure staff recruitment was safe and effective. Induction and appraisal programmes were in place. Staff were clear about the reporting structures in the service. The service should make sure that PVG certificates are not kept in staff files.</td>
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<td>and development</td>
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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:
http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Framework can also be found on our website at:

What action we expect Circle Health Group Limited to take after our inspection

This inspection resulted in one recommendation. See Appendix 1 for the recommendation.

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website:
www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

We would like to thank all staff at Ross Hall Hospital for their assistance during the inspection.
2 What we found during our inspection

Outcomes and impact

This section is where we report on how well the service meets people’s needs.

Domain 2 – Impact on people experiencing care, carers and families

High performing healthcare organisations deliver services that meet the needs and expectations of the people who use them.

Our findings

Quality indicator 2.1 - People’s experience of care and the involvement of carers and families

Processes were in place to make sure patients are fully informed of the treatments available. A comprehensive process of gathering patient feedback was in place. Feedback was reviewed daily and used to develop the service.

The service had a process in place to make sure patients were fully informed of the treatments available and the costs involved. This included their risks and benefits and was accessible on the service’s social media platforms and website. Patients had a consultation with a consultant where decisions were made about which treatment was most suitable. After this, patients were given patient information leaflets which detailed:

- a quote for the cost of the treatment
- the admission process, and
- the procedure.

Patients could also be given a quote for the cost when only enquiring about a treatment.

Patients could attend treatment-specific patient forums, for cancer or weight loss management where patients with similar conditions could meet and support each other.

The service had an up-to-date patient experience and engagement policy in place which described how feedback would be gathered, analysed and used to inform improvement activities. We saw this had been embedded into the daily activities of patient care in the service. For example, questionnaires were available for patients to complete at different times during their experience of
the service, including after admission and discharge. Patients were also regularly asked to give their feedback on other parts of the service, such as:

- catering
- if they had enough time with the consultant
- pharmacy, and
- theatre staff.

Staff had an opportunity to raise and discuss patient concerns during the daily staff safety huddle and we saw that the service addressed concerns highlighted from feedback daily. The results of feedback were also regularly discussed at the weekly and monthly meetings. Noticeboards, which were accessible to staff and patients highlighted feedback and included the service’s responses.

The provider had processes in place to make sure that all patient experiences were captured in its quality processes. For example, the service had recently developed a ‘patient voice champion’ staff role carried out by an appropriately trained healthcare assistant. Patients could talk through their experience with the patient voice champion face-to-face, or over the telephone if they had been discharged from the service. We saw that these experiences were discussed during a ‘patient hour’ at regular staff meetings. The patient hour was used to reflect on and develop learning outcomes from the feedback gathered. This included the teams involved, the service and the service provider. The patient hour was also a standing item on the various clinical governance committees in the service and we saw good documentation of this process.

We were told that the service planned to engage with external dementia services and visual impairment charity about the environment as part of the refurbishment programme. It planned to work with the services to help make the environment supportive of people with cognitive impairment. The service had already worked with these services to raise awareness and education of supporting people with cognitive impairment.

The service also provided treatments for children. We saw completed patient experience questionnaires that staff had recently developed and were piloting for children to complete. Staff that we spoke with felt this had been very informative.

We also saw that staff looking after children would hang children’s drawings on patient room walls to make the rooms more welcoming to children.
Duty of candour is where healthcare organisations have a responsibility to be honest with patients if something goes wrong. The service had up to date duty of candour policy in place and had published a yearly report on its website.

We also saw the service had safeguarding policies for vulnerable adults and children in place and staff were trained in how to use the policies.

The service’s complaints policy included the timescale for addressing the complaint, a process of investigation and Healthcare Improvement Scotland (HIS) contact details. The complaints process was available on the website and also included HIS contact details. We reviewed three current complaints in the service. The service was also a member of the Independent Sector Complaints adjudication service (ISCAS), an external service available to patients wishing to make a complaint.

Staff we spoke to told us they had training in the duty of candour and the complaints process.

Comments from patients we spoke with during the inspection included:

- ‘Very informative.’
- ‘Everything was well explained.’
- ‘I couldn’t be happier with everyone’.

**What needs to improve**

We saw posters in the service informing patients on how to provide feedback about their experience. However, we found that leaflets describing how patients could make a complaint were not readily available in the ward areas. We discussed this with the service manager and will follow this up at future inspections.

- No requirements.
- No recommendations.
Domain 3 – Impact on staff
High performing healthcare organisations value their people and create a culture and an environment that supports them to deliver high quality care.

Our findings

Quality indicator 3.1 - The involvement of staff in the work of the organisation

Staff were positive about their work and their working relationships with colleagues. They felt they had enough training to carry out their job and a system was in place to make sure regular appraisals were carried out.

The most recent colleague survey was completed in 2022. Responses were generally positive about how interesting and fulfilling the jobs were, making good use of skills and staff said they felt trusted to do their job. Each department had developed an action plan to address issues identified in the survey. For example, inviting a member of the senior management team to the department’s staff meeting and providing monthly education for healthcare assistants.

We sent out an anonymous survey which asked five ‘yes or no’ questions, along with one question on staff views for what the service did really well and what could be improved. The results showed the following:

- The majority of staff said that the highest level of the organisation had positive leadership.
- The majority of staff said that the service had a positive culture.
- Not all staff felt that they could influence how things were done in this service.
- The majority of staff said their line manager took their concerns seriously.
- The majority of staff said that they would recommend this organisation as a good place to work.

Staff comments received from our survey were mixed. However, in general staff we spoke with were positive about the hospital. Comments included:

- ‘The senior management team communicate well with the hospital staff, and they are very approachable. We have an excellent SACT service, and the care patients receive is excellent.’
- ‘We work in a professional, inclusive and friendly hospital that continually strives to meet the needs of the patients in the Independent sector.’
• ‘Staff are supported and I feel patients have a great service in imaging.’

Staff received monthly and 3-monthly newsletters, emails and could attend meetings and forums to keep up to date with changes in the hospital. Staff told us they received information and training on new initiatives and when legislation changed, for example data protection. This made sure staff felt part of the service and could discuss improvement suggestions.

The provider held an awards ceremony every year for all of its hospitals in England and Scotland. Ross Hall Hospital had won the provider’s hospital of the year award in 2023.

The service recognised its staff in a variety of ways, including cards that recognised positive feedback received from patients and staff birthdays. Staff were given a ‘long service award’ for every 5 years of service, where staff received a certificate of recognition and a voucher to spend. The service would also provide food treats as a reward for staff in view of their hard work. A benefits programme was also in place for staff, which included private healthcare, access to savings schemes and wellbeing support.

The service had introduced other staff initiatives, including a ‘freedom to speak’ guardian. Staff could speak with this member of staff in confidence if they had any concerns about their work. Staff we spoke with knew of this initiative and how they could raise any concerns.

■ No requirements.
■ No recommendations.
Service delivery

This section is where we report on how safe the service is.

Domain 5 – Delivery of safe, effective, compassionate and person-centred care

High performing healthcare organisations are focused on safety and learning to take forward improvements, and put in place appropriate controls to manage risks. They provide care that is respectful and responsive to people’s individual needs, preferences and values delivered through appropriate clinical and operational planning, processes and procedures.

Our findings

Quality indicator 5.1 - Safe delivery of care

Systems were in place to allow staff to provide safe and effective care. The service had a proactive approach to risk management and health and safety. Staff we spoke with were aware of their responsibilities in delivering safe care. Effective monitoring of infection prevention and control compliance was in place. Equipment we saw was well maintained and clean.

Systems were in place to help prevent and control infection in the hospital. For example, we saw where stickers had been applied to equipment after it had been cleaned so that staff knew it was ready for use. We saw that staff demonstrated good compliance with infection prevention and control policies and procedures.

The service was in the process of a significant refurbishment project and this had resulted in a change of patient access to the building, a reduction in bed capacity and ward areas closing. We saw that staff and patients were kept informed of the different phases of the refurbishment on public noticeboards. We were told that the service had made sure that patients were made aware of the temporary changes to the building. We were told that the refurbishment was on schedule at the time of our inspection.

We saw clinical areas were uncluttered and clean. Equipment used in these areas was clean and we saw records of regular maintenance checks.

Cleaning schedules were in place in all areas, sanitary fittings were cleaned using chlorine-based products and a current waste contract was in place.

We spoke with the infection control lead for the hospital, who oversaw a programme of audits and training for staff. They also told us that they were part...
of a multidisciplinary approach to monitoring safe care, which involved regular visits to wards for a visual audit. The director of operations led these visits, which were usually unannounced.

We found an open and transparent approach to risk management and health and safety in the service. For example, we saw information boards in the public corridors that showed performance and improvement actions taken.

The service had an electronic risk register and each area had oversight of its top risks, while the senior management team had oversight of all the service’s risks. In our discussion, it was clear the team was aware of the current risks to the service. Regular meetings, such as the health and safety committee meeting which were held and was well attended. Minutes from these meetings were recorded and shared with the wider team.

The risk register included a recent and detailed fire risk assessment with actions, all of which were either completed or being addressed at the time of our inspection.

We saw that staff were taking measures to minimise the impact of the noise from the refurbishment work during our inspection and inform patients. We were told that the work was limited to certain times of the day and signage had been altered to reflect the changing environment.

To help assess the safety culture in the service, we followed a patient’s journey from the ward through theatre, recovery room and then to the high dependency unit. 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 nurse or other suitable member of staff accompanied patients to and from the theatre department. Staff took time to talk and listen to the patient at each point in the journey, with various staff introducing themselves and explaining what was happening. The patient was closely monitored while anaesthetised during the operation and then in the recovery room. Patients’ privacy and dignity was maintained at all times. We saw effective multidisciplinary working with informative staff handovers and communication at all stages in the patient journey.
No requirements.
No recommendations.

Our findings

Quality indicator 5.2 - Assessment and management of people experiencing care

Patient care records were comprehensive and contained all relevant information.

We reviewed eight patient care records. Patient care records were in paper form, easily located and well organised. Entries were legible, signed and dated.

All consultations had clear details of the treatment risks and benefits discussed with patients. We also saw evidence that treatment options had been discussed. All patient care records we reviewed had consent forms in place, along with pre-assessment information, aftercare and follow-up plan. The majority of the patient care record was in the form of a care pathway with a standardised layout and assessments. They included:

- aftercare and follow-up
- consent to treatment and sharing of information
- medical history, with details of any health conditions, and
- patient risk assessments.

We saw that patients had appropriate care immediately after their treatments in the recovery area and this was recorded in the patient care records. Evidence of the planned follow-up was found in the operation notes the consultant had written in the patient care record.

Medicine prescription charts and medicines administration records were well completed.

No requirements.
No recommendations.
Domain 7 – Workforce management and support
High performing healthcare organisations have a proactive approach to workforce planning and management, and value their people supporting them to deliver safe and high quality care.

Our findings

Quality indicator 7.1 - Staff recruitment, training and development

Systems and processes were in place to help make sure staff recruitment was safe and effective. Induction and appraisal programmes were in place. Staff were clear about the reporting structures in the service. The service should make sure that PVG certificates are not kept in staff files.

Like other services, the service was finding recruiting staff to be challenging. The service was actively trying to recruit to vacancies and to recruit more than the minimum amount of staff needed as a contingency and to provide some flexibility. We were told that the service used minimal agency and bank staff and only when clinically required to cover staffing gaps to ensure safe and effective staffing. The service had also recently recruited some staff nurses from overseas and had supported them with:

- further advanced training
- registering on the Nursing and Midwifery Council (NMC), and
- settling in the area.

The service had a recruitment policy in place, as well as a practicing privileges policy. The service carried out the appropriate pre-employment checks and had a written agreement with staff working under practicing privileges.

We reviewed six staff files and four files for those granted practicing privileges. The 10 electronic staff files we reviewed were well organised. We saw evidence of effective recruitment in all staff files and any gaps in the staff files were highlighted at the time of our inspection. Recruitment checks included:

- checking professional registration and qualifications where appropriate
- checking the protecting vulnerable groups (PVG) status of the applicant, and
- obtaining references.

Staff files had a checklist to help make sure that appropriate recruitment checks had been carried out.
All employed staff had completed an induction, which included:

- an introduction to key members of staff in the service
- mandatory and statutory training, and
- role-specific training.

We saw a staff induction process in place for new staff. All new staff we spoke with had a period of induction and had completed an induction programme. Staff kept their own induction document and updated it with their progress. We were told that new staff were allocated a mentor and the length of the mentorship depended on the skills, knowledge and experience of the new member of staff.

We saw clear job descriptions for each role detailed roles and responsibilities. Clinical staff had link nurse or ‘champion’ roles for different areas, such as cleanliness or pain management. Clinical staff were also encouraged to take responsibility for promoting best practice and improvements in these areas.

Mandatory and optional staff training was monitored using an online platform. All staff were allocated a number of mandatory online learning modules and then allocated role-specific modules, some of which may have been mandatory for their role. Mandatory training covered safeguarding of people and duty of candour (where healthcare organisations have a professional responsibility to be honest with patients when things go wrong). Team leaders, heads of departments and the senior management team could monitor compliance with mandatory training. We were told that the service was working on how to make the reporting of training data more accurate and meaningful. We saw that the majority of staff had fully completed their mandatory training for the year ending March 2022.

We saw that appraisals had been carried out for all staff for the previous year, with new objectives set for 2022. Appraisals for 2023 had started at the time of our inspection. We saw completed staff appraisals on the online appraisal system. Staff we spoke with stated that these helped with their career goals and to feel valued. Staff said they received enough training to carry out their role. We saw evidence in staff files and training reports of completed mandatory training. This included medical staff not employed directly by the provider but given permission to work in the service with practicing privileges.

Staff we spoke with were clear about their roles and the reporting structures in the service.
What needs to improve
From the staff files we reviewed of consultants working within the terms of practicing privileges, we saw that the service had not securely destroyed the original certificates received from Disclosure Scotland in line with current legislation. A system should be introduced to record PVG scheme identification numbers for staff (recommendation a).

- No requirements.

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

This section is where we report on how well the service is led.

Domain 9 – Quality improvement-focused leadership

High performing healthcare organisations are focused on quality improvement. The leaders and managers in the organisation drive the delivery of high quality, safe, person-centred care by supporting and promoting an open and fair culture of continuous learning and improvement.

Our findings

Quality indicator 9.4 - Leadership of improvement and change

We saw evidence of a quality improvement focused leadership. The provider had developed a process of quality systems which were embedded throughout the organisation. Leadership at all levels was visible and approachable.

Since the last inspection, the service provider had changed to Circle Health Group Ltd. We saw detailed processes in place, as part of the Circle Health Group Ltd corporate processes to make sure that quality improvement was embedded in the service’s daily activities.

Staff that we spoke to during the inspection told us they felt that managers at all levels supported them, from the senior staff in the ward to the senior management team. They also told us that all levels of management were visible and approachable.

The operating board, which included the chief executive officer, the chief financial officer and the chief medical officer met monthly and at other times as required with the service. The meeting included the organisational objectives and subjects discussed included:

- development and training
- property and facilities management
- health and safety
- quality assurance processes, such as patient satisfaction and clinical audit results, and
- workforce issues, such as job vacancies.
The senior management team, which included the services executive director, director of clinical services and quality and risk manager met monthly and more often informally. The meetings included any changes in the service locally or nationally, key performance indicators, patient experience and workforce issues.

The heads of departments met formally monthly and informally more regularly. At this meeting, the service’s executive director would report new business objectives and any significant changes locally or in the organisation. All heads of department gave an update on their department. This was then fed back to staff in each department. We saw appropriate agendas, minutes and associated action plans in place for these meetings.

The corporate and local integrated governance committees of the operating board met monthly and addressed issues locally and nationally. Sub-committees met monthly, these sub-committees included:

- health and safety
- infection prevention and control
- medical governance, and
- operational governance.

We saw agendas and minutes for these meetings.

We saw that the service had online meetings with the provider’s other Scottish hospitals. These were arranged as required and had previously involved discussions about issues impacting on Scottish legislation and regulation. In addition, the service was a member of the Independent Hospitals Provider Network (IHPN), where they meet regularly with all other IHPN member hospitals in Scotland.

A performance driven electronic management system was in place that addressed all the key performance indicators (KPI) in the service, such as:

- bed capacity
- patient reviews, and
- staffing vacancies.

This system allowed the service to benchmark its performance with the provider’s other similar services. In the electronic management system, we saw a local and corporate risk register as well as an ongoing programme of clinical
and organisational audits. The up-to-date KPIs were part of the agenda for the regular senior management team meetings.

The provider organisation had carried out an internal peer review of Ross Hall Hospital in February 2023. We were told that the peer review had provided constructive and useful feedback and the service had developed an action plan.

Circle Health Group Ltd had developed a quality and safety improvement programme called the ‘circle operating system’ (COS), which was used in the service. We were told that this was a process to make sure all staff were working in an evidence-based approach to care and we saw this included the service audit and review programmes. The audit programme had a variety of audits, including checking the process of patient discharge and capturing the patient’s experience in the service. Safety audits included clinical review of the management of certain clinical aspects, such as sepsis and fasting before surgery.

The COS programme had systems in place to help staff consider the quality of service provided at all times. This aimed to make sure that, as part of the daily activities in the service the patient experience was addressed, staff had a voice and staff could meet with specific patient concerns. COS had four aspects it covered:

- clinical outcomes
- optimal value
- patient experience, and
- staff engagement.

As part of COS, senior staff told us that staff could speak out safely about practice if they had concerns, which could mean the process was stopped while it was reviewed. We were told of a member of staff collecting a bag of blood for transfusion had concerns about the accuracy of the labelling, they raised their concerns and the process was stopped. COS also allowed staff time to meet, reflect on patient experience and learn from it. Staff we spoke with during our inspection were enthusiastic about COS.

Staff had opportunities to meet to de-brief after any incident or error that occurred. We observed a de-brief following the false activation of the fire alarms the day before our inspection.

We saw the processes of COS were included in the agendas of staff safety briefs, senior management team meetings and the corporate board meetings. We
were told that individual staff members were being trained as champions in COS, with the aim that each department would have a champion to support staff.

Staff that we spoke to told us the service supported them to introduce new initiatives, such as the development of the children’s questionnaire and illustrated information book.

We were told staff were supported to develop in the service. For example, operating department practitioners had been supported through their training and a staff member had been promoted to deputy service manager. Some staff who had retired had returned to the service in a different role in nurse education.

- No requirements.
- No recommendations.
Appendix 1 – Requirements and recommendations

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 at the discretion of Healthcare Improvement Scotland.

- **Recommendation**: A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Domain 7 – Workforce management and support

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<th>Requirements</th>
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<tr>
<td>a The service should securely destroy original Disclosure Scotland PVG records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff (see page 17).</td>
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Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24
Appendix 2 – About our inspections

Our quality of care approach and the quality framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach 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.

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.

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.

More information about our approach can be found on our website:

Healthcare Improvement Scotland Unannounced Inspection Report
Ross Hall Hospital, Circle Health Group Limited: 13-14 March 2023
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

Telephone: 0131 623 4300

Email: his.ihcregulation@nhs.scot