Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: NY Skin Clinic, Aberdeen

Service Provider: NY Skin Clinic Limited

20 March 2025

This report is embargoed until 10.00am on Friday 16 May 2025

NHS SCOTLAND

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

First published May 2025

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 27 June 2022

Requirement

The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff.

Action taken

The service had implemented systems for managing risks, including developing clinical risk assessments. **This requirement is met**.

Requirement

The provider must ensure that Protecting Vulnerable Groups (PVG) checks are carried out in line with current legislation and best practice guidance to make sure it does not employ any person that is unfit.

Action taken

Appropriate PVG checks had been carried out for staff. **This requirement is met**.

What the service had done to meet the recommendations we made at our last inspection on 27 June 2022

Recommendation

The service should share improvements or actions taken as a result of feedback with patients to show how this was being used to improve the quality of care provided and how the service was delivered.

Action taken

The service had not made any improvements as a direct result of patient feedback since our last inspection. However, we discussed a current improvement it was making from patient feedback and how this could be shared with patients once implemented.

Recommendation

The service should develop a programme of regular audits to cover key aspects of care and treatment. Audits must be documented, and improvement action plans implemented.

Action taken

The service had introduced an audit programme in 2023. These included audits of infection prevention and control, patient care records, laser treatments. Each audit included recommendations and an action plan.

Recommendation

The service should develop cleaning schedules for the general environment and patient equipment in line with best practice guidance.

Action taken

Cleaning schedules were in place in the service.

Recommendation

The service should comply with national guidance to make sure that the appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical hand wash sinks.

Action taken

We saw that the service used appropriate equipment and cleaning products in line with best practice.

Recommendation

The service should develop and implement a quality improvement plan.

Action taken

The service had developed and implemented a quality improvement plan. This recommendation is reported in Domain 5: Planning for quality (see recommendation f on page 21).

What the provider had done to meet the requirements we made at our complaint investigation on 16 August 2023

Requirement

The provider must ensure that a record of the face-to-face consultations with patients and the prescriber for prescription only treatments is documented in their patient care record.

Action taken

The prescriber's face-to-face consultation was documented in each patient care record reviewed where patients received prescription-only treatments. **This requirement is met**.

Requirement

The provider must ensure that a suitably qualified health care professional is present in the independent healthcare service to assess, prescribe and administer prescription only medicine to patients as part of a response to complications and/or an emergency, if required.

Action taken

Suitably qualified staff were present in the clinic when patients were receiving certain treatments. **This requirement is met**.

2 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 NY Skin Clinic on Thursday 20 March 2025. We spoke with a number of staff during the inspection. We received feedback from 28 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Aberdeen, NY Skin Clinic is an independent clinic providing non-surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For NY Skin Clinic, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
The service's website detailed its aim. Leadership was visible, approachable and open to staff ideas for improving the service. Formalised aims and objectives with measurable key performance indicators should be developed and implemented.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
A process was in place for patients to give feedback. Staff told us they enjoyed working for the provider. Processes were in place to make sure the service was safe. Risk assessments and a regular audit programme were in place. Staff providing laser treatments must complete the core of knowledge laser training. Policies and procedures should be reviewed and made clear for staff to follow. The quality improvement plan should include actions and timelines.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The service was clean and in a good state of repair. Effective processes were in place to maintain a clean environment. Patients told us they found the service welcoming and professional. The provider must manage medicines in line with the manufacturer's guidance. A yearly duty of candour report must be published and accessible to patients. A recruitment and induction checklist should be developed to demonstrate all appropriate checks are completed.	✓ 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 NY Skin Clinic Limited 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 three requirements and 11 recommendations.

Direction	
Requirements	
	None
Recommendations	
a	The service should develop formalised aims and objectives with measurable key performance indicators to help monitor how well the service is being delivered (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 review its whistleblowing policy to ensure that it addresses the stated aims of the policy (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.22

Implementation and delivery	
Requirement	
1	The provider must ensure that all staff involved in providing laser treatments have completed 'Core of Knowledge' laser training and complete refresher training at least every 5 years (see page 20). Timescale – immediate *Regulation 3(d)(v)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
c	The service should ensure that all policies and procedures are thoroughly reviewed to ensure that they are accurate, clear for staff and reflect practice in the service (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
d	The service should ensure that the practicing privileges agreement in place with the GP is reviewed and updated to reflect the current working arrangements (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
e	The service should further develop its risk assessments to include non-clinical risk and develop a risk register (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
f	The service should further develop its quality improvement plan to include specific actions, timelines and staff names (see page 21). 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)	
g	The service should develop a contingency plan in the event the service has to close (see page 21). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.12

Results	
Requirements	
2	The provider must ensure that, once reconstituted, the botulinum toxin vial is only used for a single patient, during a single treatment session, and that any unused solution is discarded to comply with the manufacturer's guidance for botulinum toxin (see page 24). Timescale – immediate *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must produce and publish a duty of candour report every year (see page 24). Timescale – immediate *Regulation 5(2)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011*
Recommendations	
h	The service should ensure that a recruitment and induction checklist is introduced and followed for all staff to ensure that the appropriate checks take place before and immediately after staff are recruited and begin working in the service (see page 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

Results (continued)	
i	The service should ensure that a system is in place to make sure that staff are subject to ongoing professional registration and indemnity insurance checks (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
j	The service should ensure that patients are asked to consent to share information with the GP and next of kin in the event of an emergency and asked to consent to take photographs (see page 25). Health and Social Care Standards: My support, my life. I am fully involved in all decisions about my care and support. Statement 2.14
k	The service should ensure that a system is in place to make sure that all single-use equipment and medicines remain in-date (see page 25). 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

NY Skin Clinic Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at NY Skin Clinic for their assistance during the inspection.

3 What we found during our inspection

Key Focus Area: Direction

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

Our findings

The service's website detailed its aim. Leadership was visible, approachable and open to staff ideas for improving the service.

Formalised aims and objectives with measurable key performance indicators should be developed and implemented.

Clear vision and purpose

The service's website stated that its main aim is its patients' wellbeing and satisfaction. Through caring and detailed consultation, the service worked closely with its patients to help identify the best treatments for patients to achieve their goals. The service also described its vision to provide safe and effective treatments in a professional setting.

What needs to improve

While the website detailed its aim, the service did not have objectives in place to describe how it would achieve this. We saw no evidence that the service had a process in place to measure its performance against aims or objectives (recommendation a).

Recommendation a

- The service should develop formalised aims and objectives with measurable key performance indicators to help monitor how well the service is being delivered.

Leadership and culture

The service was owned and managed by an independent nurse prescriber registered with the Nursing and Midwifery Council (NMC), who was also an experienced aesthetics practitioner.

The service employed three part-time receptionists and two aestheticians. A GP also worked in the service under practicing privileges.

We saw monthly staff meetings were held, with an agenda set before the meeting and minutes produced from them. The part-time receptionists had a diary where they detailed a handover for their colleagues at the end of a shift.

Staff we spoke with told us the service manager was always visible. As it was a small service and team, they felt able to approach the manager directly with any concerns. Staff told us that they were encouraged to make suggestions as to how to improve the service. We saw a staff suggestion box in place in the staff kitchen allowing for anonymous suggestions to be made at any time.

What needs to improve

The service's whistleblowing policy stated its aims clearly. However, the detail of the policy itself did not set out ways to achieve the stated aims (recommendation b).

Recommendation b

- The service should review its whistleblowing policy to ensure that it addresses the stated aims of the policy.

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

A process was in place for patients to give feedback. Staff told us they enjoyed working for the provider. Processes were in place to make sure the service was safe. Risk assessments and a regular audit programme were in place.

Staff providing laser treatments must complete the core of knowledge laser training. Policies and procedures should be reviewed and made clear for staff to follow. The quality improvement plan should include actions and timelines.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service's website provided information about the treatments offered and costs. Information on treatments available was also available in the service. Patients could contact the service directly over the telephone, through email or social media. A patient suggestion box was available in the patient vanity area, to allow patients to make anonymous suggestions.

We were told that patients could give feedback about their experience in the service directly to the practitioner verbally, through a feedback email link or leave messages on the service's social media account. The service's website also gave patients an opportunity to leave an online review.

From the minutes of staff meetings, we saw that staff feedback was discussed and staff told us they looked at patient reviews and suggestions as they were received. We were told that the service was implementing a recent suggestion for patients to be sent an email offering a follow-up treatment 6 months after their initial treatment.

Patients who completed our online survey told us they felt fully informed:

- '[The practitioner] is very thorough with the process, the aftercare and the expected outcomes.'
- 'Took time to thoroughly explain everything and followed up with after care.'
- 'Taken through everything from first consultation and after each treatment after care advice given every time.'
- 'Everything explained clearly, and risks discussion taken seriously.'

Staff we spoke to told us they felt they were a valued member of staff and enjoyed working in the service.

What needs to improve

The service told us that the website was being updated at the time of our inspection. We discussed with the service that the website did not include information about what to do if the patient was dissatisfied with the service and wished to make a complaint. The service told us it would consider this when updating the website. We will follow this up at future inspections.

- No requirements.
- No recommendations.

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.

The service manager was aware of the process of notifying Healthcare Improvement Scotland of any changes occurring in the service.

A variety of policies and procedures were in place to support the delivery of person-centred care.

The service's infection prevention and control policy referred to the standard infection control precautions in place to prevent the risk of infection. This included hand hygiene, sharps management and the use of personal protective equipment (such as gloves, aprons and face masks). A good supply of single-use equipment was available to prevent the risk of cross-infection. A contract was in place with a waste management company for the collection and safe disposal of clinical waste, used syringes and needles.

A process of managing incidents and accidents was in place in the service, which was easily accessible for all staff. We noted that the service had experienced no incidents and accidents since its registration with Healthcare Improvement Scotland.

The complaints policy included Healthcare Improvement Scotland contact details and was displayed clearly in the service.

We saw a duty of candour policy in place in the service. This is where organisations have a duty to be open and honest with patients when something goes wrong. We noted that no duty of candour incidents had occurred in the last 12 months.

All medications used in the service were ordered from appropriately registered suppliers and ordered for individual patients. Medicine fridges were in use in the service to store medicines, the temperature of the fridge was regularly recorded. We saw that all medicines, including a small number of emergency medicines held in stock, were in-date and stored securely.

The service offered treatments using lasers. We saw appropriate policies, processes and local rules in place addressing patient and staff safety, this was available to staff registered to carry out laser treatments. The room used for laser treatments was suitably equipped.

Consultations in the service were appointment-only. We were told that patients had face-to-face consultations and were appropriately assessed, consented and given information about aftercare and follow-up. Following their initial consultation, patients were given a ‘cooling-off’ period to consider the treatment options available to them.

All patient care records were securely stored electronically on a password-protected system. The service was registered with the Information Commissioner’s Office (ICO), an independent authority for data protection and privacy rights.

We saw that all staff working in the service had been enrolled in the Protecting Vulnerable Groups (PVG) scheme. All staff had annual appraisals, and we saw these documented and detailed for each staff member, including the doctor working on practicing privileges.

The service manager was a member of the Complications in Medical Aesthetics Collaborative and the British Association of Medical Aesthetic Nurses. The manager and the aestheticians also attended a variety of training courses every year to help keep up to date with developments in the sector.

Staff told us they had staff training nights over the year, where they could experience treatments themselves in order that they could then discuss these with patients knowledgably.

What needs to improve

While we saw evidence of appropriate processes and procedures in place for laser treatments, we saw no evidence that staff had completed 'Core of Knowledge' training on the day of our inspection. The service manager appeared to be unaware of this training. Medicines and Healthcare products Regulatory Agency (MHRA) recognises core of knowledge training as a minimum training standard for all staff involved in laser treatments. The training focuses on safety, risks and hazards of laser equipment.

Following our inspection, we were sent core-of-knowledge certificates for two staff offering laser treatments. However, this did not include the service manager, who was listed as an authorised laser user and the designated laser protection supervisor (requirement 1).

We saw a variety of policies and procedures in place to support the safe delivery of patient care. However, we saw that some of the service's policies and procedures did not reflect its practice or did not give staff enough detail about the actions they should take. These included the following:

- The infection control policy made reference to infection control precautions in place during the Covid-19 pandemic and no longer applied.
- The practicing privilege policy made no reference to PVG checks, which we saw had been carried out.
- The safeguarding and protecting people from abuse policy did not guide staff on how to manage vulnerable patients or include details of external local authorities to be contacted.

We saw a practicing privileges agreement in place for emergency cover for the GP. However, this did not cover working in the service routinely, which the GP did. We discussed making sure that the agreement made clear who had responsibility for different aspects of care with the service, such as:

- whether the GP or the service provided the medicines that the GP used, and
- who was responsible for complaints about the service that the GP provided and how this was communicated to patients (recommendation d).

Requirement 1 – Timescale: immediate

- The provider must ensure that all staff involved in providing laser treatments have completed 'Core of Knowledge' laser training and complete refresher training at least every 5 years.

Recommendation c

- The service should ensure that all policies and procedures are thoroughly reviewed to ensure that they are accurate, clear for staff and reflect practice in the service.

Recommendation d

- The service should ensure that the practicing privileges agreement in place with the GP is reviewed and updated to reflect the current working arrangements.

Planning for quality

The service had a risk management policy in place, which referred to:

- a risk register
- corporate and operational risk
- strategic risk, and
- team risks.

Risk assessments were in place for fire safety, ventilation and trips and falls. These had been reviewed and updated recently.

An audit programme has been in place since 2023, which included audits of:

- laser and IPL treatments
- medicine management
- patient care records, and
- the environment.

The audit programme was ongoing and clearly demonstrated when audits were due. Each audit resulted in recommendations and actions. The results of audits were discussed at the regular staff meetings.

What needs to improve

The service should consider developing more risk assessments in line with the risk management policy and include non-clinical risk assessment, such as

corporate risk assessments. These could then become part of a risk register demonstrating an ongoing review of the service risks (recommendation e).

The service had a quality improvement plan and an 'annual evaluation of the quality improvement plan.' However, the quality improvement plan and the evaluation of the plan did not include actions, timelines or names of the person or people responsible for achieving actions. Including these details would make the document more effective as a quality improvement plan (recommendation f).

During our inspection, we spoke with the owner (manager) about what the contingency plan would be, should the service have to close. The service did not have a formal contingency plan in place (recommendation g).

- No requirements.

Recommendation e

- The service should further develop its risk assessments to include non-clinical risk and develop a risk register.

Recommendation f

- The service should further develop its quality improvement plan to include specific actions, timelines and staff names.

Recommendation g

- The service should develop a contingency plan in the event the service has to close.

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 service was clean and in a good state of repair. Effective processes were in place to maintain a clean environment. Patients told us they found the service welcoming and professional.

The provider must manage medicines in line with the manufacturer's guidance. A yearly duty of candour report must be published and accessible to patients. A recruitment and induction checklist should be developed to demonstrate all appropriate checks are completed.

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 limited self-evaluation.

The environment was clean and in a good state of repair. We saw daily cleaning checklists were in place in each room and appropriate cleaning equipment and products were being used. We saw a checklist that demonstrated a deep clean was carried out weekly.

We saw a good supply of personal protective equipment in place including aprons and gloves. Single-use equipment (such as syringes and needles) was in place to help manage the risk of cross infection.

We reviewed five patient care records and saw that each one included the patient's name, contact details and date of birth. A medical questionnaire had been completed and signed by the patient. This included information on past medical history, allergies and current medications. We saw that the questionnaire included detailed questions on the reasons for the treatment and addressed issues of the patient's wellbeing.

Patients who completed our online survey told us:

- ‘I find my visits are both professional and friendly. I always feel at ease with the explanation and the treatment itself.’
- ‘I am always made to feel welcomed and comfortable.’
- ‘The clinic is spotless, comfortable and well laid out.’
- ‘The clinic is so nice and the staff all so friendly. It’s just a happy place to visit.’

What needs to improve

Staff told us that they would sometimes retain a re-constituted, patient-specific vial of botulinum toxin injection for the patient’s review appointment 2 weeks later. The manufacturer’s guidance states that such a vial can only be retained for 24 hours. The service must always follow manufacturers’ guidance (requirement 2).

While the service had a duty of candour policy, the provider had not published an annual duty of candour report. The provider must publish a duty of candour report every year and make it available to patients, even when it has not been triggered (requirement 3).

We saw that each staff member had a staff file, which included some of the pre-employment checks. However, this was not consistently completed. For example, we saw:

- not all staff had an initial confirmation of employment letter
- not all staff had two references
- no evidence that qualifications had been checked for the aestheticians, and
- only the doctor had their identity checked.

We discussed introducing a recruitment and induction checklist with the service to help make sure that the same process was followed for all staff. The service told us that it was considering purchasing an HR package which would address these points (recommendation g).

No yearly checks had been recorded in the staff file for the GP to make sure that the individual was fit to continue working in the service, such as for indemnity insurance and GMC registration (recommendation h).

Some parts of the patient care records we reviewed were not complete. This included:

- no evidence of patient consenting to having their photographs taken, and
- while the service obtained GP and next of kin contact details, we saw no evidence that patients consented to sharing this in the event of an emergency (recommendation i).

We saw checklists demonstrating regular checks on expiry dates of emergency medicines. This should be developed further to include similar checklists capturing expiry dates of single-use equipment and other medicines in use (recommendation j).

We saw a system in place to make sure that staff were enrolled in the PVG scheme. While the system had space for it to be stated for every staff member's file, not all staff had a date of starting recorded. We discussed the importance of completing this and informing the umbrella body it used for Disclosure Scotland checks when someone leaves employment with the service. We will follow this up at the next inspection.

Requirement 2 – Timescale: immediate

- The provider must ensure that, once reconstituted, the botulinum toxin vial is only used for a single patient, during a single treatment session, and that any unused solution is discarded to comply with the manufacturer's guidance for botulinum toxin.

Requirement 3 – Timescale: immediate

- The provider must publish a duty of candour report every year.

Recommendation h

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

Recommendation i

- The service should ensure that a system is in place to make sure that staff are subject to ongoing professional registration and indemnity insurance checks.

Recommendation j

- The service should ensure that patients are asked to consent to share information with the GP and next of kin in the event of an emergency and asked to consent to take photographs.

Recommendation k

- The service should ensure that a system is in place to make sure that all single-use equipment and medicines remain in-date.

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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