Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: YourGP, Edinburgh

Service Provider: YourGP Group Ltd

12 June 2025

NHS SCOTLAND

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www.healthcareimprovementscotland.scot

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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 12 December 2022

Requirement

The provider must ensure that the prescription pad is locked away securely and accessed only by authorised staff.

Action taken

The prescription pad was now locked away in a dedicated digital safe, and medical staff had to request keys from authorised staff. **This requirement is met.**

Requirement

The provider must ensure that appropriate cleaning products are used for the cleaning of all sanitary fittings, including clinical wash hand basins, in line with national guidance. The service should risk assess the continued use of non-compliant clinical hand wash basins.

Action taken

Appropriate cleaning products, in line with national infection prevention and control guidance, were now being used to clean the sanitary fittings. Risk assessments were also in place for use of the non-compliant clinical hand wash basins. **This requirement is met.**

Requirement

The provider must appoint a medical lead to provide effective clinical oversight and leadership to medical staff and medical services offered by the service.

Action taken

Two clinical leads had been appointed to work in the service since our previous inspection in December 2022. One clinical lead was responsible for the gender identity service, and the other clinical lead was responsible for the GP service and other services provided to patients. They provided leadership to the other medical staff, including carrying out their appraisals, and ensured the service's policies and processes were being followed to support safe care. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 12 December 2022

Recommendation

The service should ensure all clinical staff are trained in the principles of duty of candour and consent.

Action taken

Medical staff now completed mandatory duty of candour training. All policies, including consent and duty of candour, were signed by staff to confirm they had read and understood the policies.

Recommendation

The service should follow national guidance for the selection and use of gloves.

Action taken

All gloves used in the service were appropriate for the task they were used for, in line with national infection prevention and control guidance.

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

A programme of audits had been developed and implemented. Where actions were required, these were documented in an action plan and also added to the service's quality improvement plan. Audit findings were shared with staff.

Recommendation

The service should review the shared care protocols and include more detail so the responsibilities of all parties involved in a shared care pathway agreement are clear.

Action taken

A detailed 'standards of care for transgender and gender diverse patients' protocol was now in place. This included pathways, monitoring, prescribing, hormone consent and shared care arrangements. The document was regularly reviewed and updated by the gender identity clinical lead.

Recommendation

The service should ensure that the patients' emergency contact, GP and allergy information are documented in the patient care record or a reason given.

Action taken

Patient care records we reviewed included patients' emergency contact and GP details, and any allergy information.

Recommendation

The service should retain occupational health records, including immunisation status, for all staff recruited and employed in the service.

Action taken

Staff records we reviewed showed that occupational health records were now available for all relevant staff.

Recommendation

The service should retain records of ongoing training undertaken by staff under a practicing privileges arrangement.

Action taken

Training records for those staff working under a practicing privileges arrangement (staff not employed directly by the provider but given permission to work in the service) were kept and reviewed annually.

Recommendation

The service should develop and implement a staff survey to actively seek the views of staff working within the service.

Action taken

A staff feedback survey had recently been issued. Responses were still being submitted and, therefore, they had not yet been reviewed. We were told that staff would be asked to complete the survey annually.

Recommendation

The service should develop a quality improvement plan to formalise and direct the way it drives and measures improvement.

Action taken

A comprehensive quality improvement plan was now in place. We saw that findings from our last inspection had been added and actioned. We noted that the managing director continued to add actions to the plan to be taken forward during this inspection as areas for improvement were identified.

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 YourGP on Thursday 12 June 2025. We received feedback from eight patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Edinburgh, YourGP is an independent clinic providing non-surgical and minor surgical treatments, and a gender identity clinic.

The inspection team was made up of one inspector.

What we found and inspection grades awarded

For YourGP, 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 shared its aims and objectives with patients and staff. A programme of staff meetings ensured good communication. Staff were able to contribute to developing and improving the service. Key performance indicators should include monitoring the safe care and treatment of patients.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Policies and procedures set out the way the service delivered safe care. An audit programme and detailed quality improvement plan helped to support the service to continuously improve. A proactive approach to managing risks was evident. Feedback was actively encouraged from patients, staff and clients. Gender identity training should be provided to staff.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
Patients had confidence in the staff and the service. The clinic environment and equipment were clean and well maintained. Patient care records were well completed. Recruitment processes and ongoing checks of staff helped to make sure they remained safe to work in the service. Good medicines governance must be followed when using unlicensed medicines for treatment, including obtaining informed consent from patients.	✓✓ Good

Grades may change after this inspection due to other regulatory activity. For example, if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

More information about grading can be found on our website at: Guidance for independent healthcare service providers – Healthcare Improvement Scotland

Further information about the Quality Assurance Framework can also be found on our website at: The quality assurance system and framework – Healthcare Improvement Scotland

What action we expect YourGP Group 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 one requirement and two recommendations.

Direction	
Requirements	
None	
Recommendation	
a	The service should further develop the key performance indicators to include monitoring the safe care and treatment of patients (see page 12). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery
Requirements
None
Recommendation
b The service should ensure that relevant staff have received basic gender identity training (see page 19). 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
Requirement
1 The provider must ensure that when unlicensed medicines are used that appropriate medicine governance arrangements are in place, including a documented rationale for use and informed patient consent (see page 23). Timescale – immediate *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations
None

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

YourGP Group Ltd, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at YourGP 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 shared its aims and objectives with patients and staff. A programme of staff meetings ensured good communication. Staff were able to contribute to developing and improving the service. Key performance indicators should include monitoring the safe care and treatment of patients.

Clear vision and purpose

A statement of purpose included the service's aims and objectives and was displayed in the clinic for staff and patients to see. These included providing a high quality, person-centred and safe service that was compliant with the legal requirements of an independent healthcare service.

Key performance indicators helped the service to measure how well it was performing and the effectiveness of the quality of the service provided. The service's key performance indicators included:

- financial
- complaints, and
- performance (numbers of patients, returning patients).

An individual key performance indicator report was produced for each indicator to provide an overview of how the service had performed. A recent key performance indicators review had found that the service should encourage more returning patients, rather than one-off treatments or consultations. As a result, a patient membership scheme was being implemented. Patients who joined would receive benefits, including a full health assessment, and discounted appointments and laboratory tests. We were told the success of the new membership scheme would be monitored and reported on as part of the key performance indicator about the service's performance.

What needs to improve

The key performance indicators did not include monitoring the safe care and treatment of patients, such as adverse events and compliance with clinical audits (recommendation a).

The service planned to update its website to better publicise its statement of purpose. This had been added to its quality improvement plan as an action to be taken forward. We will follow this up at the next inspection.

- No requirements.

Recommendation a

- The service should further develop the key performance indicators to include monitoring the safe care and treatment of patients.

Leadership and culture

The managing director provided visible leadership and was responsible for the overall management of the service. The nursing and administrative staff were directly employed by the service. Medical staff worked under a practicing privileges arrangement (staff not employed directly by the provider but given permission to work in the service). Two clinical leads were appointed to provide governance and assurance of all clinical-related matters in the service. One clinical lead was responsible for the gender identity service and the other was responsible for the GP service and all other treatments.

A programme of meetings provided a clear communication and reporting structure. We saw evidence of agendas and minutes of a range of weekly meetings, including:

- management - with one of the clinical leads attending, alternating each meeting
- reception staff
- medical secretaries, and
- nurses and healthcare assistant.

As the medical staff worked under a practicing privileges arrangement and had commitments to their NHS roles, it was difficult to hold regular meetings with them. However, the service held an annual comprehensive full day doctors meeting to discuss business developments, performance and future planning. Outwith this event, medical staff were kept regularly updated through emails and a secure online messaging group.

Outwith their weekly meetings, clinical and administrative staff also used online messaging groups for informal communication.

From minutes of meetings we reviewed, we saw evidence that staff suggested changes and improvements to the service. We were told staff were encouraged to highlight anything, such as improving processes they thought could benefit the service and its patients. Other opportunities for staff to provide feedback included their one-to-one meeting held every 3 months with their line manager, annual appraisals and exit interviews.

As well as having the opportunity to contribute to staff meetings, a whistleblowing policy was in place that described how staff could raise a concern about patient safety or practice.

- No requirements.
- 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

Policies and procedures set out the way the service delivered safe care. An audit programme and detailed quality improvement plan helped to support the service to continuously improve. A proactive approach to managing risks was evident. Feedback was actively encouraged from patients, staff and clients. Gender identity training should be provided to staff.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service's participation policy stated how it would proactively seek and use feedback from patients to help the service to develop. Patients were encouraged to complete a feedback questionnaire and post it in a box at reception or leave a review on an online review website. A link to an online survey was emailed every year to patients who had given their consent to receiving it. The survey asked questions relating to:

- appointment availability and waiting times
- confidence in staff, and
- areas for improvement, and additional services that could be offered.

We saw that feedback was monitored by the managing director, responded to, reviewed and collated. Feedback was discussed in team meetings for staff learning and to help improve the quality of care provided. We saw examples of positive feedback also being shared with the relevant staff by email. An example of an improvement made following feedback from patients was that the online appointment booking system had been simplified.

The service also engaged with patients through a monthly newsletter where they were kept informed about improvements, new treatments or other changes in the service.

We also saw that the service held meetings with clients (companies who had contracts in place with the service to provide healthcare services to their employees). Clients were able to give feedback during these meetings. For example, a client had suggested that there were too many doctors working

under a practicing privileges arrangement and their employees were not having appointments with the same doctor each time. The service responded by reducing the number of doctors the client's employees saw to improve continuity of care and the patient experience.

A staff survey had recently been emailed to all staff. At the time of our inspection, the results had not yet been collated as more responses were expected. However, there were other formal ways in which staff could provide feedback on the service, including during weekly team meetings and staff annual appraisals. For example, we were told that, during their appraisal, a member of reception staff had suggested a way to improve transparency about the fees for patients. We saw that the suggestion was added to the service's quality improvement plan and actions implemented.

The service's main website provided clear information on the services provided, including information on the:

- costs
- team and the clinicians' qualifications and experience
- range of services and treatments offered, and
- risks, benefits and aftercare if applicable.

As the range of services and treatments had expanded, a second website had been developed. This was a dedicated website for the gender identity service and provided patients with easier access to the bespoke information they required. Gender identity patients also received a newsletter and link to a blog specific to the gender identity service.

Since the last inspection in 2022, improvements had been made to the benefits available for staff, including the addition of free bus travel and annual health screening. More training opportunities and certified courses were also now available.

- 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 was aware that, as a registered independent healthcare service, it had a duty to report certain matters to Healthcare Improvement Scotland, as detailed in our notifications guidance. Since registration with Healthcare Improvement Scotland in May 2018, the service had submitted appropriate notifications to keep us informed about changes and events in the service.

Appropriate policies, procedures and processes were in place to deliver safe, person-centred care and these were regularly reviewed. Staff could access all policies, non-clinical and clinical procedures on a shared internal intranet system. If a change was made to a policy, the version number was updated and it was documented if the change required the updated policy to be shared with all staff. If so, all staff were asked to sign that they had read and understood the updated policy.

A safeguarding policy described the actions staff should take in case of an adult or child protection concern.

The clinic environment helped maintain patients' privacy and dignity. Individual consulting and treatment rooms had 'engaged' signs on doors when in use and windows were adequately screened. Patients who completed our online survey said they had been treated with dignity and respect.

Medicines management policies and protocols helped to make sure medicines were managed safely and effectively. The service was registered with the Medicines and Healthcare products Regulatory Agency (MHRA) to receive safety information on medicines and medical devices. Medicines were stored in a locked fridge and the fridge temperature was monitored to make sure medicines were stored at the appropriate temperature. A stock audit for medicines and the emergency drugs kit helped to make sure all items had not passed their expiry and best-before dates.

Emergency medicines were easily accessible and medical emergencies information posters were displayed for staff to quickly refer to. Emergency equipment was available on both floors of the clinic and was calibrated (serviced) annually. All clinical staff had received life support training, including using the heart defibrillator equipment.

An infection prevention and control policy described the precautions in place to prevent patients and staff being harmed by avoidable infections. This included information on hand hygiene, and the management of sharps and clinical waste. Appropriate products were used to clean equipment and the environment, and cleaning schedules detailed the required cleaning tasks. A contract was in place for the safe disposal of sharps, such as needles and syringes, and other clinical waste.

A fire safety policy was in place and an annual fire risk assessment was carried out. Fire safety signage was displayed, and the fire exit routes were clearly signed and accessible. Fire safety equipment was safety checked every week, as well as annual checks by an external fire safety contractor. Fire evacuation drills were carried out. A safety certificate was in place for the fixed electrical wiring, and the portable electrical equipment had been tested.

A complaints policy detailed the process for how patients could make a complaint to Healthcare Improvement Scotland. Complaints information was displayed in the clinic and on the website for patients to view. We saw a comprehensive complaints management system. Each complaint received was logged with a detailed report, actions to be taken, if appropriate, and supporting documents.

A duty of candour policy was in place (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). A duty of candour statement and the service's yearly duty of candour report was available in the service and on the website.

The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights). Information management policies described how patient information would be securely managed. Following a suggestion by a staff member, information security had recently been improved in relation to tracking who accessed patient care records. The service kept a data breach log, which included details of an incident that had occurred, remedial action taken and communication with the Information Commissioner's Office. Staff received information management training at their induction.

A consent policy detailed how the service would ensure that informed consent was obtained from patients before any treatment took place. As well as consent for treatment, other consents were obtained, such as consent for digital images and sharing information with other healthcare professionals, if required.

All patients who responded to our online survey said they had been given enough time to reflect on the treatment options before giving consent. All patients told us they felt fully informed and included in decisions about their care and had confidence in the service. Comments included:

- 'Everything explained.'
- 'Doctor was very thorough and explained everything clearly.'
- '100% full confidence in YourGP.'

Patients had a face-to-face consultation with a clinical or medical staff member before their treatment. Discussions at the consultations included:

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

Standard operating protocols were in place for all processes and procedures, and these were reviewed annually by the clinical leads. These are step-by-step sets of instructions that guide healthcare professionals in performing routine and critical tasks safely, consistently and in line with medical standards. This ensures that every action supports quality care and patient safety.

Policies that detailed safe recruitment and staffing were in place, including for staff working under a practicing privileges arrangement. We noted that practicing privileges contracts were also in place. Staff had received an appropriate level of Disclosure Scotland background check to make sure they were safe to work in the service. Other checks included:

- indemnity insurance cover
- identification
- references (including one from current employer)
- immunisation status
- registration with professional body, and
- qualifications and training.

An induction process included mandatory training and covered topics such as the service's policies and procedures, fire safety and emergency procedures. Staff also had job-specific training plans in place. For example, all clinical staff received infection control training and life support training, including resuscitation and use of emergency equipment.

Employed staff had one-to-one meetings every 3 months and annual appraisals with their line manager. The medical staff working under a practicing privileges arrangement had an annual review by the clinical leads.

We noted development opportunities for staff. For example, a member of reception staff had recently received training to carry out healthcare assistant duties such as phlebotomy (taking blood) and patient observations.

The service kept up to date with industry developments and best practice through ongoing training and its membership of professional bodies, including:

- the British Association for Medical Aesthetic Complications
- the Independent Doctors Federation that provides access to online learning, educational events and conferences, and peer support
- Practice Index (support for GP practice managers, with weekly updates and a discussion forum), and
- World Professional Association for Transgender Health.

The service maintained supportive professional relationships with some NHS services as part of shared patient care arrangements. The service also received referrals from these NHS services to provide second-opinion patient assessments.

What needs to improve

While gender identity specialists worked in the service, other staff such as nursing staff and receptionists had not received basic gender identity training. This would help them to understand and practice cultural sensitivity towards trans and gender diverse patients. This could include training for dignity and respect purposes and the avoidance of misgendering (recommendation b).

- No requirements.

Recommendation b

- The service should ensure that relevant staff have received basic gender identity training.

Planning for quality

The provider had two clinics in Edinburgh and a comprehensive contingency plan was in place in case of events that may cause an emergency closure of one of the clinics or cancellation of appointments, such as power failure or sickness. This helped to make sure patients could continue their treatment plans in the other clinic. Appropriate insurances were in date, such as employer liability, medical malpractice, and public and products liability, and were displayed in the service.

A programme of audits helped to review the safe delivery and quality of the service. Audits included:

- environmental (including infection prevention and control precautions, health and safety)
- medicines management
- patient care records (of both employed and practicing privileges staff)
- fire safety, and
- laboratory reports.

Patient care records for patients accessing the gender identity service were audited against the service's specific treatment pathway document for transgender and gender diverse patients.

Audit findings were documented, and an action plan completed, if required. We saw evidence of findings then being discussed in the minutes of staff meetings. For example, following an audit of patient care records, staff were reminded that the completion of patients' emergency contact information was mandatory.

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. The service's quality improvement plan was regularly reviewed and included detailed improvement activities, such as:

- improving the checking process for results/process from labs (highlighted following an abnormal result), and
- developing a training plan for healthcare assistants (highlighted during an exit interview).

Risk assessments were carried out for any risks associated with the service, such as health and safety risks. A risk register was used to record the risks and this was updated when required.

- No requirements.
- No recommendations.

Key Focus Area: Results

Domain 6: Relationships	Domain 7: Quality control
How well has the service demonstrated that it provides safe, person-centred care?	

Our findings

Patients had confidence in the staff and the service. The clinic environment and equipment were clean and well maintained. Patient care records were well completed. Recruitment processes and ongoing checks of staff helped to make sure they remained safe to work in the service.

Good medicines governance must be followed when using unlicensed medicines for treatment, including obtaining informed consent from patients.

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

The clinic was modern, clean and well organised. All patients who responded to our online survey said they were satisfied with the facilities and equipment in the environment they were treated in.

Staff cleaned the treatment rooms and equipment between patient appointments, and a full clean of the treatment rooms was carried out by a cleaning contractor at the end of the day. Cleaning schedules were signed off when cleaning tasks had been completed.

We saw a weekly stock check took place to ensure all single-use medical equipment remained in date.

Medical devices such as heart monitors, blood pressure equipment, thermometers and medicine fridges all appeared clean and in good condition. We saw evidence of annual servicing and calibration of all equipment. There was specific documentation of checks staff carried out on the emergency equipment such as the oxygen cylinder, nebulizer (a small machine that turns liquid medicine into a fine mist so patients can breathe this into their lungs more easily) and heart defibrillator.

Effective measures were in place to reduce the risk of infection and cross-contamination. For example, the service had a good supply of personal protective equipment (such as disposable aprons and gloves), and alcohol-based hand gel and hand hygiene posters were displayed. The correct product was used for cleaning sanitary fittings, including clinical hand wash basins, and a stronger dilution was used for the management of blood contamination.

We saw that sharps disposal units were labelled correctly and not overfilled, and that the disposal hold for all clinical waste was secure.

The four patient care records we reviewed had been well completed with detailed information, including documentation of:

- consultation
- medical history
- patient's GP and emergency contact details
- treatment plan
- consent
- medicine dosage, batch numbers and expiry dates
- procedure, and
- the provision of aftercare information.

We reviewed two employed staff files and three practicing privileges staff files. All included evidence of relevant initial identify and background checks, as well as ongoing checks such as ensuring clinical staff were still included on the relevant professional register. This ensured safe remained safe to work in the service. We also saw evidence of appropriate training, and that staff had completed an induction process when starting work in the service and had documented annual appraisals.

Patients told us in our online survey that they had confidence in the service and staff. Comments included:

- 'In depth professionalism and informative throughout.'
- 'Efficient reception and informed GP.'

What needs to improve

We saw that the service used bacteriostatic saline to reconstitute the vials of botulinum toxin. This is when a liquid solution is used to turn a dry substance into a specific concentration of solution. The bacteriostatic saline used is an unlicensed product and the use of this instead of normal saline for reconstitution means that the botulinum toxin is being used outwith its Summary of Product Characteristics and is therefore termed as unlicensed use. We were told this provided better pain relief for patients. However, there was no evidence in the patient care records that the use of unlicensed bacteriostatic saline and the unlicensed use of botulinum toxin had been discussed with patients or that informed consent had been sought before treatment was administered (requirement 1).

Requirement 1 – Timescale: immediate

- The provider must ensure that when unlicensed medicines are used that appropriate medicine governance arrangements are in place, including a documented rationale for use and informed patient consent.

- No recommendations.

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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