Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: FrownDocs, Stirling

Service Provider: FrownDocs Ltd

30 September 2025

NHS SCOTLAND

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Contents

1 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 26 October 2020

Recommendation

The service should ensure that all policies and procedures are regularly reviewed and updated to make sure all information is correct.

Action taken

A staff member had been appointed to help monitor and manage quality improvement in the service. This included reviewing policies and procedures which now had dates identified for review. Staff were made aware of any changes to documents through staff meetings and communication updates.

Recommendation

The service should ensure all documentation is completed for each patient treatment.

Action taken

A new electronic system for documenting all information about patients' appointments and treatments had been implemented. These records were audited on a regular basis to ensure no information was missing. The service also now used an artificial intelligence (AI) app which listened to and then transcribed patient/practitioner discussions. These were then stored in the patients' notes. This was done with the consent of patients and met general data protection regulations.

Recommendation

The service should ensure the correct waste disposal bins are used for the disposal of all medications.

Action taken

A clinical waste contract was now in place. This ensured all clinical waste was disposed of in the appropriate clinical waste containers and these were regularly uplifted from the service.

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 FrownDocs on Tuesday 30 September 2025. We spoke with two members of staff during the inspection. We received feedback from 11 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Stirling, FrownDocs is an independent clinic providing non-surgical and minor surgical treatments.

The inspection team was made up of one inspector.

What we found and inspection grades awarded

For FrownDocs, the following grades have been applied.

Direction	*How clear is the service's vision and purpose and how supportive is its leadership and culture?*
Summary findings	**Grade awarded**
A well-defined leadership structure and governance framework helped deliver safe, evidence-based, person-centred care. Senior management was visible, and staff said they felt valued, respected and well supported. Clear and measurable aims and objectives were in place and available in the service. Evidence of the positive impacts and good outcomes from the aims and objectives was shared at team meetings and in a patient newsletter. A strategic plan and quality assurance framework included identified measures to make sure the service was meeting its aims and objectives.	✓✓ Good
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was actively sought and used to continually improve the service. Appropriate safety assurance processes included a comprehensive audit programme. All appropriate risks were identified and reviewed regularly. Clear procedures for managing complaints were in place. The quality improvement plan helped the service to implement and take forward improvements. Healthcare Improvement Scotland must be notified of certain events that occur in the service. A patient participation policy should be developed.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment and equipment were clean and well maintained. Appropriate infection control measures were in place. Patients reported high levels of satisfaction and told us they felt safe and cared for in the service. Patient care records were comprehensively completed. There was a good standard of medicines management. Appropriate policies, processes and training was in place for staff delivering intense pulsed light (IPL) and laser treatments, including additional oversight of treatment by a senior practitioner.	✓✓ Good

Although all staff had appropriate background and safety checks documented, a formal process must be in place for ensuring relevant annual professional registration checks are carried out.	

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 FrownDocs 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 two requirements and one recommendation.

Implementation and delivery	
Requirement	
1	The provider must notify Healthcare Improvement Scotland of certain matters as detailed in our notifications guidance (see page 17). Timescale – immediate *Regulation 5(1)(b)* *The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011*

Implementation and delivery (continued)
Recommendation
a The service should develop and implement a patient participation policy that sets out a structured way of engaging with its patients and demonstrating how it uses their feedback to drive improvement (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8

Results
Requirement
2 The provider must implement a formal process to ensure all relevant annual professional registration checks on the clinical staff working in the service are carried out (see page 22). Timescale – by 30 December 2025 *Regulation 12(a)* *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

FrownDocs 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 FrownDocs 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

A well-defined leadership structure and governance framework helped deliver safe, evidence-based, person-centred care. Senior management was visible, and staff said they felt valued, respected and well supported. Clear and measurable aims and objectives were in place and available in the service. Evidence of the positive impacts and good outcomes from the aims and objectives was shared at team meetings and in a patient newsletter. A strategic plan and quality assurance framework included identified measures to make sure the service was meeting its aims and objectives.

Clear vision and purpose

The service's vision to provide person-centred aesthetic treatments 'prioritising clinical excellence, safety and exceptional patient care' had been created with the input of the full team and was embedded throughout all aspects of the service. The service's values included safety, respect, learning, trusted professionalism and patient satisfaction. Both the service's vision and values were clearly displayed on a wall-mounted patient information TV screen in the reception area for patients to view.

The service's aims and objectives were displayed in the service to demonstrate its short, medium and longer terms plans. These included:

- increasing the number of staff who worked under a practicing privileges contract (staff not employed directly by the provider but given permission to work in the service)
- increasing the number of minor surgical treatments provided, and
- growing the medical side of the business.

The service's quality strategy was embedded throughout the service's key strategic documents. This included the service's annual strategic plan, the quality improvement plan and a quality assurance framework. The provider assessed its governance processes in line with this quality assurance framework.

The service had employed an individual staff member to help monitor and manage quality improvement in the service.

Key performance indicators had been identified to help measure and evaluate how well the service was performing. These included:

- refining, embedding and communicating the service's strategic vision through an upgraded website
- strengthening quality assurance through proactive performance reviews, and
- expanding engagement channels for patients.

Various systems and processes were in place to monitor performance against the key performance indicators, for example reviewing audits on a regular basis, and reviewing data, including staff development, patient feedback and engagement, to help improve the service. The management team also continually reviewed how the service was delivered, including treatments offered and requested by patients and staff. Staff and patient feedback and views also helped the service to plan and deliver accessible care. A training needs analysis was carried out to ensure the service was able to take a proactive approach to anticipating workforce requirements, helping to minimise any disruptions to the service to safeguard the delivery of patient care.

The strategic plan was reviewed every 6 months, using staff and patient feedback to assess its progress. This information was discussed and documented at the monthly team meetings.

We saw evidence that the service had identified priorities for the coming year in its quality strategy. These included ways to enhance its strategy around key performance areas.

The service's quality improvement plan helped to formalise and direct the way the service drives and measures improvement. This plan was also used to measure how the service was performing against its key performance indicators.

The service issued a regular newsletter to all patients. This included information on the service's aims and objectives, and how the service was performing against the key performance indicators. A 'journal' section on the service's website also shared similar information with patients and stakeholders.

- No requirements.
- No recommendations.

Leadership and culture

The service's lead practitioner was registered with the General Medical Council (GMC) and the Royal College of General Practitioners. The management team was formed of the service's lead practitioner, the lead practitioner from another service in the provider group and the service manager. The lead practitioner and the other members of medical staff formed the service's significant adverse events team.

Staff in the service included healthcare professionals with permanent contracts or appointed under practicing privileges, and also non-healthcare professionals. All staff were encouraged to participate and contribute to the day-to-day running of the service. As part of the governance structure, team meetings were held every month, as well as regular 'catch ups' for staff. The meetings were available for staff to join online if they could not attend in person. Minutes of team meetings we saw included identified areas of responsibility for staff to take forward any actions, as well as discussions about:

- audit results
- current treatments
- staff wellbeing
- patient and staff feedback reviews, and
- staff training and development opportunities.

Team meeting minutes also showed that staff could make suggestions and voice ideas for improvements to the service. For example, additional training sessions were arranged for staff who were unsure or uncertain of laser treatments. The service closed for a half day to facilitate this training session.

Staff we spoke with told us they felt valued and listened to by the management team. They also felt there was an 'open door' policy, and they could approach the management team at any time with any concerns or issues they may have identified. The service's whistleblowing policy described how staff could raise a concern about patient safety and/or practice. The service held various staff team building events throughout the year to enhance working relationships in the service and to give staff a voice to assist in shaping the service. An annual event had recently been introduced where staff and their families could request a 'health MOT' free of charge.

- 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

Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was actively sought and used to continually improve the service. Appropriate safety assurance processes included a comprehensive audit programme. All appropriate risks were identified and reviewed regularly. Clear procedures for managing complaints were in place. The quality improvement plan helped the service to implement and take forward improvements.

Healthcare Improvement Scotland must be notified of certain events that occur in the service. A patient participation policy should be developed.

Co-design, co-production *(patients, staff and stakeholder engagement)*
Patients could contact the service in a variety of ways, including by telephone, email, text messages and online enquiries either through the service's website or social media pages.

The service's website contained information on treatments available, the booking system and treatment costs, as well as detailed information on staff working in the service, including their qualifications. Patients could also access information about treatment through posters and leaflets displayed and available in the service's reception area. Monthly newsletters were also emailed to patients to advise of updates on the service, for example additional times for appointments and treatments, or new treatments being offered or trialled, treatment prices, improvements made to the service as a result of patient feedback, and staff changes, including staff joining the service.

The service was able to demonstrate how patient feedback would be gathered and used to continually improve the service. All patients were sent an electronic feedback survey after their treatments and were actively encouraged to provide feedback. Informal feedback was also gathered verbally and through social media. We saw that patients also left feedback about their experience on the service's website.

We saw that the service collated and regularly reviewed all feedback received, with information used to inform the service's improvement activities and the quality improvement plan. Any changes in the service that led to improvements, for example introducing longer appointment times for patients, and helping to reduce unexpected time delays, were monitored and evaluated through the service's audit programme.

A noticeboard in the staffroom was used to provide key information for staff. For example, updated information on the service's policies and procedures, training opportunities, audit programme and key staff events like birthday and staff recognitions rewards. Information could also be accessed on the service's internal online system.

What needs to improve

We saw the service actively sought and formally reviewed feedback from patients and fed back how this had improved the service. We discussed with the service that the development of a patient participation policy would assist in formalising a structured process for gathering, recording and using patient feedback to improve the service (recommendation a).

- No requirements.

Recommendation a

- The service should develop and implement a patient participation policy that sets out a structured way of engaging with its patients and demonstrating how it uses their feedback to drive improvement.

Quality improvement

We saw that the service clearly displayed its Healthcare Improvement Scotland registration certificate and was providing care in line with its agreed conditions of registration.

A clear system was in place to record and manage accidents, incidents and adverse events. Any accidents or incidents that occur were reported to the service's significant adverse events team. These are then reviewed and any actions to be taken and lessons learned are shared with staff.

The service was proactive in developing and implementing policies to help make sure that patients had a safe experience in the service. Policies were reviewed every year as part of the audit process by a dedicated member of staff, or as required, to make sure they remained relevant to the service and in line with national guidance. Key policies included those for:

- emergency arrangements and safety
- infection prevention and control
- medication management, and
- safeguarding (public protection) of adults.

Maintenance contracts for fire safety equipment, oxygen therapy and the fire detection system were up to date. Electrical and fire safety checks were monitored regularly.

Medicines were obtained from an appropriately registered supplier, and the service was registered to receive safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). A stock control system enabled the service to monitor medicines supplies. Temperature-sensitive medicines were stored in a locked medical refrigerator and medical devices, such as dermal fillers, were stored in a lockable cupboard. The medical refrigerator was clean and in good working order, with the temperature monitored and recorded every day to make sure medicines were stored at the correct temperature and safe to use. We saw that this logbook was fully completed and up to date. The lead practitioner was responsible for controlling access to medicines. For example, clinical staff had to obtain the keys to the medical refrigerator to access medicines required for patients' treatments.

Arrangements were in place to deal with medical and aesthetic emergencies. This included up-to-date training for staff. Emergency medicines were available for patients who may experience aesthetic complications following treatment. We saw regular checks carried out and documented for all emergency equipment in the service.

The service's complaints policy was available in the service. This stated that patients could complain to Healthcare Improvement Scotland at any time and the policy included our contact details. At the time of our inspection, we noted that no complaints had been received by Healthcare Improvement Scotland or the service since the service was registered with us in April 2018. We saw evidence that staff members had received training in complaints handling, grievances and customer service.

The service had a duty of candour policy (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). Staff fully understood their duty of candour responsibilities and the service had published a yearly duty of candour report on its website. Staff were also aware of the service's safeguarding (public protection) policy, had received training and knew the procedure for reporting concerns about patients at risk of harm or abuse.

On the day of treatment, patients had a face-to-face consultation where they completed a consent form, which was signed by both the patient and practitioner. Patients could also request a video consultation appointment. Patients were emailed a variety of aftercare information before and after their treatment. Patients were able to have a cooling-off period before they agreed to go forward with treatment. Patients were able to telephone the service where their post-treatment queries would be reviewed by the service manager during service hours and passed to the appropriate clinician for further review and advice. Out-of-hours enquiries would go directly to the lead clinician.

Patient care records were stored electronically, and the system was password-protected. This protected confidential patient information in line with the service's information management policy. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) and we saw that it worked in line with data protection regulations.

Staff members were recruited in line with the service's recruitment and staffing policy. The service also had a practicing privileges policy. Both policies included a description of the expectations on all staff working in the service, including staff working under practicing privileges. The recruitment process was completed by the service in line with national recruitment guidance from the Scottish Government.

All staff members were subject to the numerous checks required during the recruitment process, including them not being listed under the Protection of Vulnerable Groups (Scotland) Act 2007. Staff files contained a checklist to help make sure that appropriate recruitment checks were carried out. The service had a continuous learning culture. Staff had a personal development plan which they agreed with both the service manager and the lead practitioner. Staff were encouraged to identify further training or development which they felt would benefit them in their current roles and with potential promotional opportunities.

The service had accessed training for staff through the local authority's business gateway programme which provides access to free business support services. This included leadership modules for the service manager.

All relevant healthcare staff participated in formal appraisal processes, in line with their professional regulatory bodies, such as the GMC. This helped to ensure that staff remain up to date and fit to practice. This helped to provide confidence and assurance in their own performance. We were told that the service kept up to date with research and good practice through continued professional development and mutual support of professional colleagues. For example, all medical staff met regularly to share cases and learning outcomes from each other. The lead practitioner also met regularly with a range of other aesthetic services and professional colleagues. They also attended training, including research, at conferences and national aesthetic events.

The service informally reviewed other similar sized services, such as reviewing their Healthcare Improvement Scotland inspection reports or websites, and used this information to review and make improvements to its own service. This information was shared and discussed at team meetings.

Staff completed an induction period and were allocated mandatory training to complete. This included safeguarding of adults and duty of candour training. The service manager and lead practitioner were responsible for making sure that staff completed mandatory training. Staff files we reviewed included evidence of completed mandatory training.

Staff supervision sessions were carried out regularly and recorded in staff files. This involves staff reflecting on their practice and identifying any learning needs. All staff had an annual appraisal carried out, and this information was available in the staff files. Staff with practicing privileges contracts provided the service with their annual appraisals from their NHS posts, including proof of continued learning. Appraisals we saw had been comprehensively completed. Staff we spoke with told us their appraisals helped them feel valued and encouraged their career goals.

What needs to improve

The service told us it was aware of the notifications process and had previously submitted appropriate notifications to Healthcare Improvement Scotland, as required. However, we noted that the service had two incidents or accidents that had been investigated by the service's significant adverse events team. These incidents should also have been reported to Healthcare Improvement Scotland (requirement 1).

Although information about how to make a complaint was available for patients on the website, the service could also consider adding a specific link to its complaints policy. We will follow this up at a future inspection.

Requirement 1 – Timescale: immediate

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

- No recommendations.

Planning for quality

Appropriate risk assessments were in place to effectively manage risk in the service, including those for:

- contingency planning
- waste management
- data protection
- health and safety
- environmental assessments, including slips, trips and falls
- fire, and
- infection prevention and control.

The risk assessments were included in a risk register, which was reviewed regularly. We found that the risk assessments were easy to follow. We saw that all risks had been reviewed and that action plans were in place detailing what action had been taken to reduce any identified risks.

In the event that the service was unable to operate, such as a temporary closure of the service, we saw an arrangement was in place that patients would be referred to another service. This business continuity information was included as part of the service's quality strategy.

The service completed monthly audits, such as those for:

- complaints
- infection prevention and control
- medicines
- patient care records
- patient and staff feedback, and
- safe management of equipment.

We saw that all results from audits were documented, and actions taken if appropriate. Audit results were also reflected in the service's quality improvement plan, which was regularly reviewed and updated.

Information in the quality improvement plan also included:

- how the service planned to anticipate workforce requirements
- mitigating service or care disruption and safeguarding delivery of the service
- service redesign, and
- clinical and operational services.

The quality improvement plan also detailed improvements made to the service as a result of patient feedback. For example, adding additional time to patients consultations with practitioners to ensure patients felt they had enough time, and patients waiting times not exceeding their appointment times.

We saw that information generated from the clinical staff meetings and significant adverse events team meetings was reviewed by the management team and then disseminated and shared with staff. This helped to ensure that all staff understood how delivery of the service was continually monitored. Regular discussions took place about complaints and adverse events, including lessons learned at both clinical and management level.

- No requirements.
- No recommendations.

Key Focus Area: Results

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

Our findings

The environment and equipment were clean and well maintained. Appropriate infection control measures were in place. Patients reported high levels of satisfaction and told us they felt safe and cared for in the service. Patient care records were comprehensively completed. There was a good standard of medicines management. Appropriate policies, processes and training was in place for staff delivering intense pulsed light (IPL) and laser treatments, including additional oversight of treatment by a senior practitioner.

Although all staff had appropriate background and safety checks documented, a formal process must be in place for ensuring relevant annual professional registration checks are carried out.

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 comprehensive self-evaluation.

We saw the service was clean and tidy, was of a high standard and well maintained. Cleaning schedules were fully completed and up to date. The correct cleaning products were used in line with national guidance, such as chlorine-based cleaning products for sanitary fixtures and fittings. All equipment for procedures was single use to prevent the risk of cross-infection. Personal protective equipment (such as disposable gloves and aprons) was readily available to staff. A clinical waste contract was in place, and clinical waste and used sharps equipment was disposed of appropriately.

Patients who responded to our online survey told us they felt safe and were reassured by the cleaning that took place to reduce the risk of infection in the service. All patients stated the clinic was clean and tidy. Some comments we received from patients included:

- 'Lovely clinic with spacious, clean and stylish rooms.'
- 'The facilities are amazing! So relaxing, homely but yet professional.'
- 'Highly satisfied with the facilities and environment.'

We saw evidence of good standards of medicines management, including a safe system for the procurement and prescribing of medicines, in line with the service's medication management policy. This included completed records of stock checks and medicines prescribed and used for treatments in the service.

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 outside of its 'Summary of Product Characteristics' and is unlicensed. We were told this provided better pain relief for patients. We saw 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 and that informed consent had been sought, agreed by the patient and we saw this documented in the patient care record. This information was included in individual risk assessments that were completed for every patient where bacteriostatic saline was used.

The five patient care records we reviewed showed that patients received a face-to-face consultation about their expectations before treatments were offered. A comprehensive assessment included past medical history, as well as risks, benefits and side effects of treatments. Patient care records were legible, accurate and up to date. Details of patients' next of kin, GP and emergency contact were documented, as well as consent to share information with other healthcare professionals, as needed. Practitioners had signed and dated their entries. Medicine batch numbers and expiry dates were also noted.

Patients who responded to our online survey told us they were extremely satisfied with the care and treatment they received from the service. Some comments we received included:

- ‘From start to finish the service was professional and well organised, even now waiting on results is so well organised.’
- ‘I don’t feel rushed at all and felt well looked after. Even had someone to hold my hand which calmed me and made me feel in safe hands.’
- ‘From the front desk to the clinical staff everyone was friendly and helpful.’

Intense pulsed light therapy (IPL) and laser skin treatments were provided to patients. The service had a registered laser protection advisor and local rules were in place to ensure patient and staff safety. All safety measures were in place when this treatment was being carried out, including safety warning signs on the locked treatment room door. We saw evidence of up-to-date core of knowledge training completed by all staff who provided IPL and laser treatments. All safety checks on the laser equipment had been carried out and were documented. Details of patch testing and treatments for patients were documented in the patient care records we reviewed. We also saw additional input into patients’ laser treatment plans from senior practitioners documented in the patient care records if this had been requested by staff.

We reviewed three staff files, including for those staff members with practicing privileges. We saw that all appropriate pre-employment checks had been carried out. This included information on staff identity, qualifications, fitness to practice, Protecting Vulnerable Groups (PVG) checks, training including continuous professional and personal development, appraisal and supervision sessions. We also saw evidence in staff files and training records of completed mandatory training.

From our own observations of staff interactions, we saw a compassionate and co-ordinated approach to patient care and treatment delivery, with effective oversight from a supportive management team.

What needs to improve

The service discussed professional registration and revalidation with clinical staff during their supervision sessions and annual appraisals. However, no formal process was in place to assure the service that staff members’ professional registration status remained up to date (requirement 2).

Requirement 2 – Timescale: by 30 December 2025

- The provider must implement a formal process to ensure all relevant annual professional registration checks on the clinical staff working in the service are carried out.

- 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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