Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Veincentre (Edinburgh), Edinburgh

Service Provider: Veincentre Ltd

7 October 2025

NHS SCOTLAND

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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 Veincentre (Edinburgh) on 7 October 2025. We spoke with the registered manager and medical director during the inspection. We received feedback from 21 patients through an online survey we had asked the service to issue to its patients for us before the inspection. This was our first inspection to this service.

Based in Edinburgh, Veincentre is an independent clinic providing non-surgical treatments.

The inspection team was made up of one inspector.

What we found and inspection grades awarded

For Veincentre (Edinburgh), 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 clinic had a well-defined and measurable vision and purpose, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and purpose. Key performance indicators were regularly monitored and reported. Clear benchmarking was in place and continuously monitored. A clear governance structure was in place.	✓✓✓ Exceptional
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
The provider benchmarked its services against each other to support continuous improvement. Patient and staff feedback was actively encouraged through a variety of methods and used to improve the service. A comprehensive audit programme, policies and procedures set out the way the service was delivered and supported staff to deliver safe and person-centred care. A culture of learning was evident. Clinical and non-clinical risk assessments were in place. A quality improvement plan and staff training programme helped to improve how the service was delivered. A duty of candour report was published every year.	✓✓✓ Exceptional
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The care environment and patient equipment appeared clean. Equipment was fit for purpose and regularly maintained. Comprehensive employment checks were carried out for all staff. Patient care records were detailed with appropriate consents gained. Patients were very satisfied with their care and treatment and said they would recommend the service to family and friends.	✓✓✓ Exceptional

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 Veincentre 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 no requirements and no recommendations.

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

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

We would like to thank all staff at Veincentre (Edinburgh) for their assistance during the inspection.

2 What we found during our inspection

Key Focus Area: Direction

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

Our findings

The clinic had a well-defined and measurable vision and purpose, with a clear strategy and defined key performance indicators to achieve it. Key principles and values had been identified in line with the vision and purpose. Key performance indicators were regularly monitored and reported. A clear governance structure was in place.

Clear vision and purpose

The service is part of the provider's organisation, Veincentre Ltd. A mission statement was available on the websites of the provider and the service, as well as in patient information packs and in the clinic. The provider's mission statement was to have patients 'walk out happy'. This had been developed after the media and communications team had carried out a survey on a sample of potential patients to the service.

The organisation had six core values:

- effectiveness
- efficiency
- honesty
- respect
- safety, and
- value for money.

Staff had contributed to developing the provider's core values during a staff engagement event with the senior management team. The values were revisited at team meetings and staff appraisals to encourage and support staff engagement in the wider development of the service.

Based on its core values, the provider measured the service's performance through key performance indicators (KPIs). These included:

- complications
- consultant feedback
- performance
- profit generated
- repeat treatments required
- staff and patient feedback, and
- treatment times.

KPIs were measured and regularly discussed at senior management meetings, clinical governance and quality compliance meetings. Staff were kept updated on results through:

- local clinic meetings
- one-to-one meetings and annual appraisals with their line manager, and
- 'town hall meetings' that the chief executive officer held.

Accomplishments were shared with patients through the service's website and social media accounts.

The senior management team and executive board reviewed staff and patient feedback, audit results and performance yearly. This informed the provider's mission statement and KPIs for the following year.

The service had a 12-month strategy in place, which outlined the site-specific plans for a 12-month period. The document included actions for the forthcoming year, such as emerging priorities and planned improvements.

We saw evidence that these were shared with staff and were displayed on large posters in the clinic's staff room.

- No requirements.
- No recommendations.

Leadership and culture

The clinic had a highly skilled staffing resource, which included a mix of clinical and non-clinical staff. For example:

- a consultant interventional radiologist
- a consultant vascular surgeon
- clinical administrators
- nurse practitioners, and
- the service manager.

The service manager (who was also the provider's regional quality compliance lead) was responsible for the day-to-day planning, management of the service and led all meetings for staff. Minutes from meetings showed a set agenda was in place, that all staff could speak up at meetings and staff were consistently asked for feedback. The service held debrief meetings at the start of every clinic.

The provider managed the service through:

- an overarching corporate board
- an executive team
- clinic managers, and
- regional nurses.

The provider had an effective leadership structure and governance framework with well-defined roles, responsibilities and support arrangements in place. A chief executive officer was responsible for the overall management and strategic direction of all of the provider's services. The chief executive officer was accountable to the provider's corporate board and the medial director was the lead for its medical advisory committee. This team led learning and development for all healthcare staff in the organisation.

Senior leaders and representatives from the management team were members of a variety of committees set up to monitor and manage all aspects of clinical, operational and financial performance. The key focus for each committee was linked to the provider's strategic plan and KPIs. For example, the medical director chaired the provider's clinical governance committee, which met every 2 months in line with the provider's clinical governance policy. The focus of this committee was to review patient safety, clinical outcomes and quality of care. Minutes were comprehensive and standard agenda items included:

- clinical audit results
- complaints
- health and safety
- improvement actions
- patient feedback analysis, and
- risk management.

The service manager was responsible for implementing the principles of the clinical governance policy to support the consistent delivery of high-quality care for the service's patients.

Senior management attended weekly regional meetings discussing all of the provider's services in the region. We saw clear lines of escalation from the service to these wider organisational meetings. Information from these meetings was shared with staff to keep them informed and up to date with any organisational changes.

A variety of staff meetings and ways of sharing information helped to support effective communication with staff. Each service held a monthly meeting, with minutes from these meetings then emailed to staff. Items discussed at these meetings included patient and staff safety, operational issues and new training opportunities for staff.

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

- in-house webinars
- intranet information
- newsletters
- open forums
- specific focus groups, and
- staff engagement posters to display in the service advertising events, awards and 'What's happening in the next 12 months' posters to keep staff informed.

From feedback we received, it was clear that staff were motivated and committed to deliver high standards of patient care. Staff told us they felt involved in developing and improving the service and were encouraged to freely share their views and opinions. We saw that staff feedback had influenced a recent patient safety initiative to develop alert cards for patients using blood-

thinning medicines to carry. We were told that senior leaders were approachable and supportive.

We were also told that staff were supported to develop in the service. Staff we spoke with at different levels told us how the organisation had supported their learning and development. This had allowed the staff to progress in their career and develop the business. For example, we saw that the organisation had advertised for a 'freedom-to-speak-up champion' for each region. Staff were encouraged to nominate themselves for this role and we saw that a 'menopause champion' was already in place. The service told us that these champions completed further training and development, with the aim of being able to share their knowledge with other staff. Staff who performed these extra roles were also rewarded with financial incentives.

- 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

The provider benchmarked its services against each other to support continuous improvement. Patient and staff feedback was actively encouraged through a variety of methods and used to improve the service. A comprehensive audit programme, policies and procedures set out the way the service was delivered and supported staff to deliver safe and person-centred care. A culture of learning was evident. Clinical and non-clinical risk assessments were in place. A quality improvement plan and staff training programme helped to improve how the service was delivered. A duty of candour report was published every year.

Co-design, co-production *(patients, staff and stakeholder engagement)*
A detailed patient information pack included information on the service and the provider, as well as information about:

- available treatments
- recovery and aftercare
- the risks involved with treatments, and
- what to expect.

The pack also included the service's contact details, instructions for an emergency situation (including a tear-off page for medical practitioners) and frequently asked questions. The information pack was sent electronically to patients when they booked their appointment and a hard copy was offered to patients in the service.

The service's website and social media was regularly updated to help make sure that patients had the most up-to-date information on the treatments offered.

Patient feedback was actively sought about their experience and this was used to improve the way the service was delivered. Patients were regularly encouraged to complete a 'how was our service' questionnaire during the course of their treatment. We saw that responses to this were very positive.

The service responded to online reviews patients had left and the patient advisory team collected and analysed all patient feedback. The senior management team met monthly to discuss patient feedback and positive feedback was shared with staff through newsletters. The patient advisory team and media team analysed all feedback, acting on any constructive feedback promptly. This was used to help inform the service's quality improvement plan.

Improvements made to the service were shared with patients, mostly through the service's social media accounts. Patients had communicated to the service they would like to see treatments for other types of veins. The provider had acted on this and was working on a patient pathway to introduce treatment for thread veins across its services.

A yearly staff feedback survey had a response rate of around 90%. Staff were also encouraged to give feedback at their 3-monthly one-to-one meetings with their managers, as well as during their annual appraisal.

As a result of staff feedback, the provider had decided to replace courier deliveries of stock to its clinics in the UK with a dedicated in-house stock delivery team. Staff reported some delivery delays, some incorrect orders and that they often had to work extra hours to put stock away at the end of the day. The dedicated stock team was then given responsibility of managing all aspects of stock including:

- checking expiry dates
- completing stock checks
- rotating stock.

Staff had given feedback that the improvements made had been very positive and freed up more time for clinical staff in the clinics.

The Times newspaper awarded the provider 'Best small company to work for' in 2024 after conducting a staff engagement survey with staff. The provider was completing this survey again for 2025 for another media outlet.

Staff told us that the organisation was a great company to work for. Comments included:

- 'I genuinely think that Veincentre is a fantastic set up and a great place to work. It is very well-organised, well-run and offers patients a very good service.'
- 'I would certainly recommend working at Veincentre to colleagues.'

The service recognised and offered benefits to its staff for their commitment to the service. This included:

- a cycle-to-work and season ticket scheme
- a day off on the staff member's birthday
- access to mental, physical and financial wellbeing support services
- instant access to digital online GP services
- paid sickness absence, annual leave and maternity leave, and
- staff-nominated reward schemes.

- 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 of the notification process to Healthcare Improvement Scotland. During our inspection, we saw that the service had not experienced any incidents or accidents that should have been notified to Healthcare Improvement Scotland in the previous 12 months. A clear system was in place to record and manage accidents and incidents.

Policies and procedures set out the way the service was delivered, supporting staff to deliver safe, compassionate, person-centred care. A process was in place for writing all policies, including submission to appropriate corporate groups and approving them through the medical advisory committee. Policies and procedures were updated regularly or in response to changes in legislation, national guidance and best practice. To support effective version control and accessibility, policies were kept electronically and all staff had access. Staff received information and training on new initiatives and policy updates. Key policies included those for:

- clinical governance
- complaints management
- dealing with emergencies
- infection, prevention and control, and
- medicine management.

The service's complaints policy advised that patients could complain or provide feedback to their patient advisory team at any time. The complaints procedure was published on the service's website and the service had received no complaints in the 12 months before our inspection.

Infection prevention and control policies and procedures were in line with Health Protection Scotland's *National Infection Prevention and Control Manual*. Procedures were in place to help prevent and control infection. Cleaning schedules were in place for all clinical areas. An infection control lead nurse participated in staff training and was also available to staff for advice.

The service had a medicines management policy in place and had standard operating procedures (SOPs) for dispensing medicines. Medicines were stored in locked cupboards and fridges. The fridge temperature was monitored to make sure medicines were stored at the appropriate temperature.

Emergency medicines were kept in an emergency station in the service. This was well equipped and contained enough medicines and equipment to deal with any foreseeable medical emergency connected to the types of treatments provided. The station also held operating procedures for emergencies. Daily checks on the equipment, oxygen and medicines were documented in a logbook. The defibrillator and oxygen were serviced yearly.

The service had a duty of candour policy (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). The service's most recent duty of candour report was published on its website. We noted that the service had not experienced any incidents that required it to follow the duty of candour process. All staff had completed duty of candour training.

A fire risk assessment was carried out every year. Fire safety signage was displayed and fire safety equipment was checked regularly and logged. Emergency lighting was in place throughout the service. A gas safety certificate and electrical safety certificate were in place for the service's fixed electrical wiring. A log was kept of all portable electrical appliances for safety testing.

We could see that servicing records were available for other equipment, including:

- CCTV and intruder alarm
- defibrillator
- laser equipment
- nurse call system

Staff in the service completed daily, weekly and monthly compliance checks on:

- fire safety equipment
- medical equipment
- non-medical equipment
- the environment and
- water temperature.

All checks were signed and logged on the appropriate compliance sheets.

A laser protection advisor visited the service regularly to make sure laser safety rules and guidance were followed in line with local policy. We saw that a recent visit from the advisor confirmed the service was fully compliant.

Patients booked their appointments using the service's online booking system, the customer service phone line or the 'contact me' form. Patients were then sent a health questionnaire, accessibility form and a patient information welcome pack. Patient consultations were always carried out face-to-face with the healthcare professional. A comprehensive assessment took place, which included an ultrasound scan to help advise on treatment. A range of treatments were discussed, including alternative treatment and the option to have no treatment at all. The risk and benefits of treatments were discussed and a detailed treatment costing card was given to the patients. On the day of treatment, patients reviewed a consent to treatment form which the patient and healthcare professional then both signed. Patients were offered follow-up appointments after all treatments.

All patients were given comprehensive aftercare support and follow-up, including out-of-hours contact details in the event they required it. Documentation was provided for the patient to share with their GP. An information sheet was also available to the patient to give to other healthcare professionals outside of the service, if required in an emergency.

All patient information was stored securely on password-protected devices and every practitioner had their own device. This helped to protect confidential patient information in line with the service's information management policy. At the end of the day, all devices were locked away in a lockable safe. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) and we saw that it followed the appropriate data protection regulations. A policy was in place for the safe management of information.

The service had recruitment and practising privileges policies in place. Practising privileges contracts were also in place for those staff not employed directly by the provider but given permission to work in the service.

The service's recruitment policies described how staff would be appointed. Appropriate pre-employment checks were carried out for employed staff and healthcare professionals appointed under practising privileges.

All staff appointments were subject to obtaining satisfactory references, fitness-to-practice checks and an up-to date Disclosure Scotland background check or Protecting Vulnerable Groups (PVG) membership update before they started working in the service.

The organisation delivered a detailed induction to all new members of staff. All staff had to complete mandatory training before starting work in the service, which also included competency-based training. Depending on staff role, shadowing and mentorship was also put in place before staff members were signed off as competent for their role. The organisation's induction process was reviewed regularly to make sure it remained fit for purpose.

We received feedback from staff that told us that they felt well supported in the service and the training and development in the service was continuous. The provider encouraged peer reflection and groups were set up in the organisation for this. One staff member we spoke with was already an experienced consultant in the field when they started working in the service. They had then completed induction and mandatory training, been given mentoring, supervision and had the provider's medical director shadow their first procedure with a patient in the service. They told us 'I have felt very supported ever since.'

The organisation encouraged continuing professional development and offered a variety of training opportunities through face-to-face courses and electronic learning, as well as in-house webinars. Senior management monitored training and development throughout the year to make sure all healthcare professionals in the service were fit to practice.

The organisation regularly set up a virtual multidisciplinary team meeting for the healthcare professionals to attend. This was set up with an external haematology consultant to discuss complicated cases or any adverse events. A database was set up, which logged all cases discussed as a reference point for healthcare professionals in the future.

A clear process allowed the senior management team to check that clinical staff's professional registration status and indemnity insurance for practising

privileges staff remained up to date. Regular staff reviews were carried out and supported through a formal yearly appraisal process.

- No requirements.
- No recommendations

Planning for quality

We saw robust systems were in place to proactively assess and manage risk to staff and patients to make sure that care and treatment was delivered in a safe environment. This included:

- audits
- reporting systems
- risk assessments detailing actions taken to mitigate or reduce risk
- risk register, and
- staff meetings.

A wide range of clinical and non-clinical risk assessments and a comprehensive risk register were in place. We saw this was regularly reviewed and discussed in local, regional and divisional clinical governance meetings. Risk assessments included:

- adverse treatment outcome
- consultant capacity
- laser safety
- medication errors
- needlestick Injuries, and
- patient allergy and special needs.

This helped to make sure that care and treatment was delivered in a safe environment, through identifying and taking action to reduce any risks to patients and staff.

Accidents and incidents were recorded and managed through an electronic incident management system. Each one was reviewed and reported through the clinical governance framework. Learning was fed back to staff through:

- appraisals
- e-mails
- one-to-one meetings, and
- team meetings.

A detailed contingency plan was in place for major incidents that would affect the running of the service and impact patient care. Arrangements were documented for staff to follow in case of events, such as a fire or loss of the water, electrical or gas supplies.

A comprehensive programme of clinical and non-clinical audits helped to deliver consistent, safe care for patients and identify areas of improvement. Audits carried out every month included those for:

- emergency equipment
- health and safety
- infection prevention and control
- medicines, and
- patient care records.

Every year, a member of staff (external to the service) would carry out larger audits in:

- adverse outcomes affecting patients after treatment
- health and safety
- infection, prevention and control, and
- medicine management.

Audits were recorded on the electronic reporting management system, where staff could provide updates on any actions taken. The service's registered manager provided oversight of all audits carried out in the service. The senior management team also reviewed these audits, which helped make sure that audits were completed appropriately and that required actions were completed. We saw outcomes from audits were discussed at local and regional clinical governance meetings. This data was used to benchmark the service

against other services in the organisation. Best practice was often shared between services for quality improvement.

The medical advisory committee carried out a national clinical audit of all of the provider's services. Patient care records of 48 consultants were audited, which totalled 250 sets of patient care records audited nationally. The aim of the audit was to make sure all VTE (venous thromboembolism) protocols and risk assessments for patients were complied with. The audit findings were categorised into a colour-coding system, which determined the level of compliance from the consultant and the level of feedback required. All feedback consultants received was in real-time and consultants were given the individual patient record for self-reflection. The results of this audit was positive, with only a small number of consultants requiring feedback with an action to re-audit them in 3–6 months.

The service completed an 'accessibility audit' in line with the completion of accessibility forms that patients had completed. Patients completed these before their first visit to the clinic to help the service make the patient's visit as comfortable as possible. Results of this audit were analysed and it was decided that the service should install a 'loop system' to assist patients with hearing difficulties. At the time of our inspection, the loop system had been installed.

Another service improvement made from the accessibility audit was introducing the use of a translation service for patients where English was not their first of preferred language. The service had signed up to a telephone translation service, which could be easily accessed if patients required it during appointments.

The provider had an overarching quality improvement plan. Part of the organisation's corporate improvement plan detailed the following:

- commencement of quality committee
- development of micro-sclerotherapy (treatment of thread veins by use of injectant) in clinics
- further progression of thermocoagulation training (treatment of spider veins by use of heat) for nurse practitioners, and
- opening more clinics nationally.

The service's local improvement plan evidenced local quality improvement initiatives, including the:

- installation of a controlled buzzer system
- installation of loop system
- introduction of translation services
- media team to organise videography of the exact location of clinic, local parking and directions to the clinic, which would be published on the service's website for patients to watch, and
- upgrading of the interior decor in the clinic waiting room.

The organisation is ISO 9001/14001 accredited. A quality management strategy had been introduced, outlining all the requirements of ISO and Healthcare Improvement Scotland. The new quality committee regularly reviewed the processes.

- 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 care environment and patient equipment appeared clean. Equipment was fit for purpose and regularly maintained. Comprehensive employment checks were carried out for all staff. Patient care records were detailed with appropriate consents gained. Patients were very satisfied with their care and treatment and said they would recommend the service to family and friends.

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.

The clinic environment was clean and well maintained. Cleaning schedules were in place for all clinical areas. Practitioners cleaned equipment between appointments and cleaned the clinic at the end of the day. All cleaning equipment was stored in a separate domestic cupboard. All cleaning equipment was colour-coded and disposable mop heads were used daily. We saw evidence of completed, up-to-date cleaning schedules.

Personal protective equipment (such as disposable aprons and gloves) was readily available. All equipment used was single-use to prevent the risk of cross-infection. Antibacterial hand wash and disposable paper hand towels were used to maintain good hand hygiene. A contract was in place for the disposal of sharps and other clinical waste.

Patients who responded to our online survey also told us they felt the service was kept extremely clean and tidy:

- ‘Clinic welcoming warm and clean.’
- ‘The Edinburgh facility felt very private and also very soothing.’
- ‘Very clean and professional set up, no issues.’

The service's medicine fridge was clean and in good working order. We noted a temperature-recording log was fully completed and up to date. This was used to record fridge temperatures every day to make sure medicines were stored at the correct temperature. We saw evidence of yearly calibration of the medicine fridge.

We reviewed three files including for staff granted practising privileges. We saw that appropriate background and health clearance checks had been carried out before they started working in the service. We saw evidence of yearly professional registration checks for clinical staff and up-to-date indemnity insurance checks for staff who were granted practising privileges. A signed contract or practising privileges agreement was available in the files we reviewed. Staff files also provided information about training, including mandatory training. We also evidence of one-to-one meetings carried out every 3 months and a completed yearly appraisal.

The five patient care records we reviewed showed that patients received a face-to-face consultation and were fully informed about any possible treatments. Patient care records were legible, accurate and up to date. The practitioner had signed and dated their entries. Dosage, batch numbers and expiry dates of medicines used were also documented. The patient care records also included information on:

- consent to treatment and sharing information
- discussion about costs
- emergency contact
- GP details
- medical history
- medications, and
- treatment plans and aftercare.

Patients who completed our online survey said the service was professional and well organised. They said they would recommend the service to others. Comments included:

- 'All details about the procedure were explained fully and comprehensively.'
- 'The vein centre explained everything really well. I can't recommend them enough.'
- 'Friendly and professional.'
- 'Was very impressed with the services provided, and the staff were first rate.'

- No requirements
- 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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