Healthcare Improvement Scotland

Action Plan

Service Name:	The Secret
Service number:	02472
Service Provider:	Aestheti-kaly Ltd
Address:	705 Govan Road, Glasgow, G51 2YJ
Date Inspection Concluded:	07 April 2026

Requirements and Recommendations	Action Planned	Timescale	Responsible Person
Requirement 1: The provider must ensure that all relevant staff undertake duty of candour training (see page 16). Timescale – immediate *Regulation 5(2)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*	Provider Response: We acknowledge this requirement. Duty of Candour training is currently being arranged for all relevant staff and will be formally scheduled within the next week. All staff will complete the training within one month of the assessment date, ensuring full compliance with Regulation 5(2) of the 2011 Regulations. Actions Underway: • Training provider identified and dates being finalised • All relevant staff will be allocated to the confirmed session • Completion deadline set for one month from the assessment date • Training Matrix updated to reflect “scheduled – pending confirmation”	1 Month – Due on 22nd June 2026	Dr Kaly Jaff

	Evidence to be Provided: • Training booking confirmation (to follow once date is finalised) • Training Completion certificates for each staff member Requested Amendment: We request that the action plan is updated to reflect that Duty of Candour training is in the process of being scheduled and will be completed within the agreed timescale.		
Requirement 2: The provider must follow its own recruitment policy and complete appropriate checks on all staff before they start working in the service and on an ongoing basis (see page 17). Timescale – immediate *Regulation 8(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*	**Provider Response:** We acknowledge these findings as recorded on the day of inspection. All required pre-employment and ongoing recruitment checks had been completed at the time of inspection; however, some documents were not immediately accessible due to the way files were stored across digital and paper systems. This included PVG documentation, interview notes, reference requests, and application forms/CVs. The service operates a head-hunting recruitment model, which does not involve public job advertising. This approach is fully permitted within national safe-recruitment guidance, provided that all statutory checks are completed — which they were. The issue identified related to document accessibility rather than the completion of checks. **Actions Underway:**		

	• Recruitment files reorganised so all documents are stored in a single, centralised location • Recruitment checklist updated to explicitly list all required documents and verification points • Governance file created to evidence PVG, references, right-to-work, qualifications, and interview documentation • Quarterly recruitment audits introduced to ensure all documentation is consistently accessible and up to date • Headhunting recruitment process documented clearly within the recruitment policy to reflect how checks are completed when roles are not publicly advertised **Evidence to be Provided:** • Updated recruitment checklist • Consolidated recruitment-compliance file • Quarterly recruitment audit template • Confirmation of completed checks for all staff (already reviewed during inspection) **Requested Amendment:** We request that the action plan is updated to reflect that all recruitment checks had been completed at the time of inspection, and that the actions taken relate to improving document accessibility and clarity around our head-hunting		

	recruitment model, rather than addressing gaps in safe-recruitment practice.		
Requirement 3: The provider must complete and submit an annual return when requested by Healthcare Improvement Scotland (see page 21). Timescale – immediate *Regulation 5(1)(c)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*	**Provider Response:** We acknowledge this requirement. While the annual return was submitted on the morning of inspection, the service has consistently completed and submitted annual returns annually when requested by Healthcare Improvement Scotland. This was an isolated administrative delay and does not reflect a pattern of non-compliance. **Actions Underway:** • Annual return submission process reviewed to strengthen internal tracking • Governance calendar updated to include an explicit annual-return reminder and verification point • Monthly governance meetings will now include a statutory-returns check • Administrative lead assigned responsibility for monitoring and confirming submission deadlines **Evidence to be Provided:** • Updated governance calendar showing statutory-return checkpoints • Governance meeting minutes reflecting new monitoring processes	Ongoing/Next Annual Return Submission.	

	• Confirmation of annual return submission (already completed) **Requested Amendment:** We request that the action plan is updated to reflect that annual returns are routinely submitted each year as required, and that the late submission on this occasion has been addressed through strengthened governance processes.		
Requirement 4: The provider must ensure that the safe recruitment of staff is completed in line with policy and national guidance, including Protecting Vulnerable Groups (PVG) and basic disclosure background checks before staff commence working in the service. A process must be in place to obtain a PVG review update for all staff at regular intervals. This will ensure that staff remain safe to work in the service (see page 21). Timescale – immediate *Regulation 8(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*	**Provider Response:** We acknowledge this requirement. All staff held valid PVG or Disclosure certification at the time of inspection; however, for two staff members the PVG was not yet linked to the service. Organisation-linked PVG applications will be completed by the end of July to ensure the service receives ongoing notifications in line with safe-recruitment standards. **Actions Underway:** • Organisation-linked PVG applications for the two identified staff will be submitted by the end of July • Recruitment checklist updated to include mandatory PVG linking at onboarding • Annual PVG re-verification log updated to reflect organisational linking requirements	1 Month – 10th July 2026	

	• Governance file consolidated to clearly evidence PVG verification and re-checks **Evidence to be Provided:** • Confirmation of PVG linking applications (to be provided once submitted) • Updated recruitment checklist and annual re-verification log • PVG certificates for all staff (already reviewed during inspection) **Requested Amendment:** We request that the action plan is updated to reflect that all staff held valid PVG / Disclosure certification at the time of inspection, and that organisational linking will be fully completed by the end of July.		

Requirements and Recommendations	Action Planned	Timescale	Responsible Person

Recommendation a: The service should ensure that information about its vision is available to patients (see page 11). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19	**Provider Response:** We acknowledge this recommendation. On the day of inspection, information about the service's vision was not yet publicly available. This has now been addressed. The service's vision statement has been added to our website in a clear and accessible location to ensure full alignment with Health and Social Care Standard 4.19. **Actions Completed:** • Vision statement published on the service website • Website navigation updated to ensure the vision is easy for patients to locate • Governance file updated to include a copy of the published vision statement • Patient information materials reviewed to ensure consistent messaging **Evidence Provided:** • Website link: https://drkalyjaff.co.uk **Requested Amendment:** We request that the action plan is updated to reflect that the service's vision is now publicly available to patients and that this recommendation has been fully addressed following the inspection.		

Recommendation b: The service should identify overall key performance indicators and a process for monitoring and measuring these to help it achieve its vision and aim (see page 11). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19	**Provider Response:** We acknowledge these findings as recorded on the day of inspection. While the service had a full audit framework in place, overall key performance indicators (KPIs) had not yet been formalised into a single documented process. This has now been addressed. The service has identified its KPIs and established a clear process for monitoring and measuring these to support achievement of the service's vision and aim, in line with Health and Social Care Standard 4.19. **Actions Completed:** • KPI framework developed and formalised into a single governance document • Monthly, quarterly, and annual KPI review cycles established and documented • KPI outcomes incorporated into monthly governance meetings and annual service review		

	• KPI dashboard added to the governance file to evidence ongoing monitoring **Evidence Provided:** • KPI framework document • KPI monitoring schedule (monthly, quarterly, annual) • Governance meeting minutes reflecting KPI review • KPI dashboard template **Requested Amendment:** We request that the action plan is updated to reflect that KPIs and a structured monitoring process have now been fully formalised following the inspection.		
Recommendation c: The service should introduce a formal process to obtain and review staff feedback (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	**Provider Response:** We acknowledge these findings as recorded on the day of inspection. Staff meetings, 1:1 discussions, and annual appraisals were already in place to gather staff feedback; however, we recognise that opportunities for anonymous feedback and formal surveys had not yet been explored. This has now been considered. The service has strengthened its staff-feedback process and will review whether anonymous mechanisms would add value within our clinic setting.		

	Actions Completed: • Staff-feedback procedure formalised and added to the governance framework • Monthly staff-feedback review added as a standing agenda item at staff meetings • Annual appraisal documentation updated to include structured staff-feedback prompts • Staff-feedback log created to record themes, actions, and follow-up • Exploration initiated into whether anonymous feedback or survey tools (including options within the new online system) would be beneficial for our team **Clarification:** • Staff already had regular opportunities to provide feedback through 1:1s, appraisals, and team meetings • The service values open communication and will assess whether anonymous options would enhance staff engagement • Any future adoption of anonymous tools will be based on staff preference and operational suitability **Evidence Provided:** • Staff-feedback procedure • Updated appraisal documentation		

	• Staff-feedback log • Governance meeting minutes reflecting staff-feedback review **Requested Amendment:** We request that the action plan is updated to reflect that a formal staff-feedback process has now been established and that the service is exploring the potential value of anonymous feedback mechanisms following the inspection.		
Recommendation d: The service should monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated (see page 14). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8	**Provider Response:** We acknowledge these findings as recorded on the day of inspection. Patient feedback was already being encouraged, collected, and acted upon; however, we recognise that a formalised process for monitoring and evaluating whether the actions taken had achieved the intended improvements was not yet in place. This has now been addressed to ensure full alignment with Health and Social Care Standard 4.8. **Actions Completed:** • A formal monitoring and evaluation procedure has been developed and added to the governance framework		

	• The patient-feedback log has been updated to include: – feedback theme – action taken – evaluation of impact – evidence of improvement • Monthly governance meetings now include a standing agenda item to review the effectiveness of actions taken in response to patient feedback • A quarterly review cycle has been introduced to assess trends, outcomes, and whether further improvement is required • Complaints and feedback processes have been aligned to ensure consistent documentation, follow-up, and evaluation **Clarification:** • Patient feedback and complaints were already being reviewed and acted upon prior to inspection • The evaluation stage has now been formalised into a clear, documented process • This strengthens the existing governance structure and supports continuous quality improvement **Evidence Provided:** • Updated patient-feedback log • Monitoring and evaluation procedure • Governance meeting minutes reflecting review of improvement outcomes • Quarterly review template		

	Requested Amendment: We request that the action plan is updated to reflect that a formal process for monitoring and evaluating improvements arising from patient feedback has now been fully established following the inspection.		
Recommendation e: The service should further develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvements (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19	**Provider Response:** We acknowledge these findings as recorded on the day of inspection. The service had a range of quality improvement activities in place, including audits, governance reviews, patient-feedback actions, and risk processes; however, these were not yet brought together into a single, formal quality improvement plan (QIP). This has now been addressed. A consolidated QIP has been developed to strengthen oversight, ensure improvement activity is coordinated, and align actions with identified risks and priorities, in line with Health and Social Care Standard 4.19. **Actions Completed:** •A formal Quality Improvement Plan has been developed and added to the governance framework • All improvement activity — including audits, patient feedback, complaints, and risk processes — is now consolidated within the QIP • Monthly governance meetings updated to include a standing agenda item for reviewing QIP progress • Quarterly service-wide review introduced to evaluate improvement trends and measure impact		

	• Annual improvement summary created to evidence outcomes and inform future priorities **Clarification:** • Quality improvement activity was already taking place prior to inspection • The QIP now brings these activities together into one coordinated, transparent framework • This strengthens oversight, supports prioritisation, and enhances the existing quality assurance processes **Evidence Provided:** • Quality Improvement Plan • Audit schedule and completed audit examples • Governance meeting minutes reflecting QIP review • Quarterly and annual improvement review templates **Requested Amendment:** We request that the action plan is updated to reflect that a formal, consolidated quality improvement plan has now been fully developed and implemented following the inspection.		

Name	Dr Kaly Jaff
Designation	Owner/CEO
Signature	Date

		22/05/2026

In signing this form, you are confirming that you have the authority to complete it on behalf of the service provider.

Guidance on completing the action plan.

- **Action Planned**: This must be a relevant to the requirement or recommendation. It must be measurable and focussed with a well-defined description of how the requirement/recommendation will be (or has been) met. Including the tasks and steps required.
- **Timescales** for some requirements can be immediate. If you identify a requirement/recommendation timescale that you feel needs to be extended, include the reason why.
- **Person Responsible**: Please do not name individuals or an easily identifiable person. Use Job Titles.
- Please do not name individuals in the document.
- If you have any questions about your inspection, the requirements/recommendations or how to complete this action plan, please contact the lead inspector for your inspection.