Supporting better quality health and social care for everyone in Scotland

Quality Assurance and Regulation Plan 2026-27

March 2026

NHS
SCOTLAND

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Introduction

Healthcare Improvement Scotland’s Quality Assurance and Regulation Directorate aims to make a real difference to the people of Scotland by providing confidence in the quality and safety of care provided by the NHS and independent healthcare providers, focusing on issues that we know matter most to people using services, their families and carers. We do this through independent targeted assurance work, which encourages improvement in the quality of health and social care.

Further information about our statutory powers can be found in the Operating Framework: Healthcare Improvement Scotland and Scottish Government.

Our quality assurance and regulation activity is split into three functional categories: inspection, regulation, and review (including responsive inspections or reviews). We undertake these activities in a planned and proactive manner to provide public assurance on safety and quality of care and highlight areas of good practice and opportunities for learning to support ongoing improvements across the whole of Scotland.

Our plans for each programme, which include details of our planned activities for inspection, regulation and review from April 2026 to March 2027 are outlined below. This plan is part of the HIS Integrated Delivery Plan which describes how Healthcare Improvement Scotland will meet our two aims of delivering quality (ensuring care is safe, effective and evidence-based and person-centred and equitable) and enabling reform (including informed decision-making, underpinning change and supporting specific changes). The HIS Integrated Delivery Plan also outlines how our work relates to the following portfolio themes:

- Frailty
- Mental Health
- Perinatal
- Children & Young People
- Planned & Acute Care
- Primary & Community Care
- Urgent & Unscheduled Care
- Underpinning Change.

For those of our programmes that align to one or more of the portfolio themes, we will work collaboratively, using a quality management approach, with the other programmes across HIS in the portfolio. This annual Quality Assurance and Regulation Plan is continually reviewed and may be subject to further change in response to emergent external scrutiny priorities and changing resource considerations.

An indication of the planned number of inspections and other key assurance activities are detailed below where available, however the number of planned inspections may change during the year.

There are several reasons for this, including the complexity of inspections, follow-up activity that may be required in response to inspection findings, and new requests for external quality assurance in response to emergent concerns which may require the rapid redeployment of resource and reprioritisation of existing work programmes.

Inspection

NHS Inspections

Our NHS Inspections focus on Acute Hospital, Adult Mental Health inpatient units, and Acute maternity inspections.

Our current programme of inspection of NHS Hospitals is the 'Safe Delivery of Care'. The Safe Delivery of Care inspection methodology is designed to support NHS boards in complying with national standards, improving patient outcomes, and identifying areas for improvement. It aims to provide robust and proportionate public assurance that is reflective of, and responsive to, current system pressures and is focused on helping services identify and reduce risks within the current operating environment, whilst minimising the impact of inspection on staff delivering frontline care.

Acute

Over the course of 2026-27, we will complete the current phase of our acute hospital inspection programme by undertaking a series of shorter, unannounced *Safe Delivery of Care* follow-up inspections across all previously inspected areas, with a focus on the NHS Boards progress against their published improvement action plans.

During this period, we will develop a comprehensive, co-produced evaluation framework to ensure our inspection approach continues to reflect wider system learning and adapts in response to emerging insights, needs and national priorities.

Additionally, during 2026-27, our Acute Hospital Inspection Programme will form part of a wider, Quality Management System approach to improving the quality and safety of Urgent and Unscheduled care across NHS Scotland. HIS's portfolio-based approach provides a structured way to bring together HIS's assurance, improvement, evidence and engagement activity in this high-risk area, while maintaining a consistent Quality Management System (QMS) approach to how this work is delivered.

Mental Health

For 2026–27, we will adopt a refreshed approach to supporting mental health services by positioning Mental Health work as a cohesive, organisation-wide portfolio. This portfolio will bring

together intelligence, insights and operational expertise from across the organisation, enabling a whole-system approach to improving mental health outcomes through the Quality Management System for Mental Health.

The portfolio will encompass the following areas:

- Scottish Patient Safety Programme – Mental Health
- Mental Health Renewal
- Mental Health Responsive Support
- Mental Health Assurance

As part of this portfolio, QARD will continue to support the safety and wellbeing of people in NHS adult mental health in-patient services through unannounced inspections. These inspections will assess the safety and quality of care, identifying areas for improvement and highlighting good practice. The insights gained through this work will inform and shape the planning and delivery of wider organisational improvement activity.

Maternity

Healthcare Improvement Scotland has aligned and strengthened its existing programmes of work to create a coordinated, evidence-informed and collaborative Perinatal Quality Management System (QMS). This approach will enable our national improvement, assurance, evidence, standards, and engagement activities to systematically gather, analyse, and use that intelligence to inform HIS support to NHS boards and respond to future recommendations from the Scottish Government Maternity Taskforce.

Phase 1 of the *Safe Delivery of Maternity Care* inspection programme began in January 2025. This first phase adopts a staged approach, with an initial focus on 18 acute maternity services, including obstetric-led and consultant-led hospital maternity units in the first 2 years.

Planning for Phase 2 will begin during 2026, with the intention of expanding our inspection scope to reflect the broader perinatal care pathway.

Programme	Programme Aim	Scrutiny body/ bodies involved	Inspection activity
NHS Acute Hospital inspections	To provide assurance of the safe delivery of care in NHS hospitals through targeted inspection activity that is reflective of and responsive to the	Healthcare Improvement Scotland	Our inspections will continue to be risk-based and proportionate. We will continue to undertake unannounced inspections including follow up

Programme	Programme Aim	Scrutiny body/ bodies involved	Inspection activity
	evolving context of service delivery.		inspections to assess the safe delivery of care and NHS Boards' progress against previous requirements and improvement action plans. It is intended 10 hospital inspections will be carried out within NHS board areas between April 2026 and March 2027. Inspection reports and associated improvement action plans will be published on our website. Locations of inspections are not available as these are unannounced.
NHS Acute Adult Mental Health Inspections	To contribute to the safety and wellbeing of patients and service users within mental health services through targeted inspection activity that is reflective of and responsive to the evolving context of service delivery.	Healthcare Improvement Scotland	There are up to 10 inspections planned for 2026-27. A report will be published for each inspection.
NHS Acute Maternity Inspections	To provide assurance of the safe delivery of acute maternity services in NHS hospitals through targeted inspection activity that is reflective of and responsive to the evolving context of service delivery.	Healthcare Improvement Scotland	There are 10 inspections planned for 2026-27. A report will be published for each inspection.

Multiagency Inspections

Our statutory strategic multiagency inspection programmes have to date focused on three areas - joint inspection of adult support and protection, joint inspection of adult services and joint inspection of services for children and young people. These joint inspections are delivered under section 115 of the Public Services Reform (Scotland) Act 2010, together with regulations made under the 2010 Act. We also play a crucial role in providing quality assurance of the healthcare provided to people within the justice system through our inspections of prisons and police custody suites.

The joint strategic inspections of services for adults, and for children and young people, will continue with the same respective methodologies as during 2025-26. In 2026-27 joint inspections of adult services will focus on adults with learning disabilities from early 2026. Joint inspection of services for children and young people changed its focus from children and young people at risk of harm to children and young people subject to compulsory supervision orders living at home with their parents, from summer 2025.

The National Public Protection Leadership Group (NPPLG) was established to drive continuous improvement of public protection arrangements across Scotland. Priority two in the NPPLG workplan is 'enhancing our culture of learning through independent scrutiny and inspection'. A multiagency Public Protection Scrutiny Working Group (PPSWG) has been established to support delivery of priority two, but with cognisance of any other cross-cutting priorities. The PPSWG planned to commence initial multiagency scrutiny work focused on violence against women and girls focusing on domestic violence during 2026-27. This work is currently on hold as scrutiny partners have realigned resources to address the Ministerial ask for a national review related to group-based child sexual abuse and exploitation from early 2026 to summer 2027 (see below). This work will be reinstated with the agreement of Scottish Ministers at the conclusion of the national review.

New commission: National Review of Group-based Child Sexual Abuse and Exploitation

In December 2025, Scottish Ministers formally requested a national review into group-based child sexual abuse and exploitation and group-based child criminal exploitation. The national review will be led by the Care Inspectorate and His Majesty's Inspectorate of Constabulary in Scotland (HMICS) working with Healthcare Improvement Scotland and His Majesty's Inspectorate of Education (HMIE).

Scottish Government wish to be assured about accountability and assurance mechanisms for Chief Officer Groups (COGs) in Scotland. This will be related to their understanding, response, and improvement in tackling the threats that organised networks represent to the safeguarding of children and young people from child exploitation. The review will gather evidence which will

support Scottish Government Ministers' considerations of whether there should be a future public inquiry into group-based child sexual abuse and exploitation.

The work is now underway and will take a phased approach. It is anticipated that the review will take 18 months to complete.

On 25th February 2026, the Scottish Government announced its intention to establish an independent Public Inquiry into group-based child sexual abuse. The Inquiry will focus on the prevalence of group-based Child Sexual Abuse and Exploitation now and in the recent past and will draw on evidence from the above ongoing independent National Review being led by the four Inspectorates.

Programme	**Programme Aim**	**Scrutiny body/ bodies involved**	**Inspection activity**
Joint inspection of adult services (integration and outcomes)	Healthcare Improvement Scotland has a statutory responsibility to undertake joint inspections of services for adults with the Care Inspectorate.	Healthcare Improvement Scotland and Care Inspectorate	The intention is to complete one progress review and up to two joint inspections of health and social care partnerships during 2026-27. These joint inspections will focus on the effectiveness of partnership working in creating seamless services that deliver good health and wellbeing outcomes for people and their unpaid carers, through the lens of different service user groups.
Joint inspection of services for children and young people	The inspection programme takes account of the experiences and outcomes of children and young people in need of care and protection by looking at the services provided for	Care Inspectorate (lead agency), Healthcare Improvement Scotland, His Majesty's Inspectorate of Constabulary in Scotland, and His	There are three inspections focusing on children subject to compulsory supervision orders living at home with their parents planned in 2026-27. In addition, supported improvement work with one partnership is anticipated.

Programme	Programme Aim	Scrutiny body/ bodies involved	Inspection activity
	them by community planning partnerships in each of Scotland’s 32 local authorities.	Majesty’s Inspectorate of Education Scotland.	
Joint inspection of prisoner healthcare	Healthcare Improvement Scotland works with His Majesty’s Inspectorate of Prisons for Scotland (HMIPS) to provide expertise to the inspection of healthcare in prisons in Scotland.	His Majesty's Inspectorate of Prisons for Scotland (lead agency) and Healthcare Improvement Scotland	There are four inspections planned for 2026-27, A report will be published for each inspection. Follow-up activity (eg inspections) will also take place where required.
Joint inspection of police custody centres	Healthcare Improvement Scotland works with His Majesty’s Inspectorate of Constabulary in Scotland (HMICS) to provide expertise to the inspection of healthcare in police custody centres in Scotland.	His Majesty’s Inspectorate of Constabulary in Scotland (lead agency) and Healthcare Improvement Scotland	There are two inspections planned for 2026-27. A report will be published for each inspection. Follow-up activity (eg inspections) will also take place where required. A national thematic review of young people in custody is planned, a report will be published of the findings.
Multiagency scrutiny of public protection	As part of the directive from the National Public Protection Leadership Group (NPPLG) Healthcare Improvement Scotland has worked with a range of relevant scrutiny partners to develop an approach for multiagency scrutiny of public protection. The plan is to establish a multiagency scrutiny	Care Inspectorate (lead agency), Healthcare Improvement Scotland, His Majesty’s Inspectorate of Constabulary in Scotland, and His Majesty’s Inspectorate of Education in Scotland	Commencement of joint inspection activity is currently on hold as scrutiny partners have realigned resources to address the Ministerial ask for a national review related to group-based child sexual abuse and exploitation.

Programme	Programme Aim	Scrutiny body/ bodies involved	Inspection activity
	programme in due course.		
National review of group-based child sexual abuse and exploitation	The programme aim is to develop and deliver a national review of responses to group-based child sexual abuse and exploitation (CSAE), working with the Care Inspectorate, HMICS and HMIE.	Care Inspectorate and His Majesty's Inspectorate of Constabulary in Scotland (lead agencies), His Majesty's Inspectorate of Education in Scotland and Healthcare Improvement Scotland	A national evaluation exercise of all local authority areas to baseline awareness and understanding of strengths and challenges will be undertaken. Targeted risk-based scrutiny and assurance activity will follow (this will likely continue into 2027-28).

Regulation

Our regulation programmes focus on delivery of all elements of our regulatory responsibilities for both independent healthcare (IHC) and Ionising Radiation (Medical Exposure) Regulations (IRMER). This includes proactive inspections, responding to notifications of incidents and enforcement activity for both programmes of work, and registration of IHC services and investigations of complaints about these registered services.

The regulation of IHC and the enforcement of IR(ME)R in Scotland are distinct statutory functions of HIS. As we engage with private organisations as well as NHS Boards, there are formal frameworks set out in IR(ME)R and the NHS Scotland 1978 Act and associated regulations. These frameworks impose duties on HIS NHS Boards and the providers of IHC services in relation to registration, inspection and complaints as well as mechanisms for the enforcement of improvement. These are distinct and separate functions from the wider and more general role HIS has in relation to the quality assurance of services provided by NHS Scotland.

As well as delivering these programmes we are working through a period of review for both IHC and IR(ME)R, this is to consider our future regulatory model and identify any improvements. Currently both are part of the external review of our regulatory activity. In relation to our IR(ME)R

inspection activity our commissioning arrangements are under review for future developments to adopt a new graded approach to the inspection of all facilities where ionising radiation is used for medical exposures this is in line with the recommendations of the Integrated Regulatory Review Service (IRRS) mission.

The Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill was being considered by the Scottish Parliament at the time of writing this plan. The Bill contains provisions to extend the regulatory powers of HIS in respect of independent healthcare services. Once the Bill is passed, it is anticipated that planning and preparatory work in relation to its implementation will require to be undertaken in discussion with the Scottish Government during 2026-27.

Programme	Programme Aim	Scrutiny body/ bodies involved	Inspection activity
Ionising Radiation (Medical Exposure) Regulations (IRMER)	Through inspections and the notifications process, the aim of this work is to provide public assurance of the safe use of ionising radiation for medical exposure.	Healthcare Improvement Scotland	An inspection plan is in place to carry out at least 10 inspections per annum. Routine inspections are announced. Work is ongoing with Scottish Government to review the commission to address the Integrated Regulatory Review Service mission recommendation to adopt a facilities based graded approach to inspection. In addition, we will respond to all notifications (approximately 130 per year).
Independent Healthcare (IHC)	Healthcare Improvement Scotland is the regulator of registered independent healthcare services in Scotland. Our regulatory functions include: • registering IHC services • proactive inspections of registered services	Healthcare Improvement Scotland	The planned number of inspections of IHC services for 2026-27 is currently set at 129. However, there is a priority to review the current service risk assessment (SRA) framework, as identified for investment and digital review in Q4 2025-26. Once implemented proposals for the 2026-27 workplan will be to undertake a review of the service risk assessment (SRA) for all services in line with the revised

Programme	Programme Aim	Scrutiny body/ bodies involved	Inspection activity
	• investigating complaints about registered IHC services • responding to notifications from IHC registered services • taking enforcement action of registered IHC services where necessary, and • continued development work to support the regulation of IHC.		SRA framework and subsequently seek to undertake 90% of inspections due per quarter by the service's due date ensuring a transition to a more intelligence led model of inspections rather than a fixed value number of inspections per annum. Where the system requires flexibility to unanticipated demands, we may lower our control limit to 60%, this is in acknowledgement that inspection is the only truly flexible element of IHC workload. The number of planned inspections is subject to change throughout the year for a range of reasons including, but not limited to: • high priority reactive activity that requires resource to be diverted from planned inspections • cancelled registration of a service • follow-up inspections in response to initial inspection findings.

Review (including ad hoc reviews)

Our bespoke review programmes contribute to two key themes:

1. Working collaboratively to review and respond to concerns about the quality and safety of services:

- Responding to Concerns, and
- Sharing Health and Care Intelligence Network

2. Reviewing and learning from adverse events, children and young people's deaths, and death certification:

- Learning from adverse events
- National Hub for reviewing and learning from the deaths of children and young people, and
- Death Certification Review Service

In addition to the above review programmes, responsive reviews may be commissioned by Scottish Government or instigated by Healthcare Improvement Scotland to address an identified need.

Working collaboratively to review and respond to concerns about the quality and safety of services

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
Responding to Concerns	Healthcare Improvement Scotland has a duty to respond to patient safety/quality of care concerns raised about NHS services by NHS Scotland employees or referred to us by another organisation. All concerns made to us are subject to a level of assessment to ensure an appropriate response.	Healthcare Improvement Scotland	Ongoing process of assessment and investigation of concerns raised, and communication with those raising concerns. Revised RTC methodology created and will be published following feedback and sign off process. Joint guidance developed and will be published in partnership with Independent National

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
			Whistleblowing Officer (INWO).
Sharing Health and Care Intelligence Network	The Sharing Health and Care Intelligence Network (SHCIN) is a mechanism that enables seven national organisations with a scrutiny, improvement, or training role at system/service level in Scotland, and nine professional regulators, to share, consider, and respond to intelligence and emerging issues that may indicate risks about health and social care systems across Scotland.	• Audit Scotland • Care Inspectorate • General Chiropractic Council • General Dental Council • General Medical Council • General Optical Council • General Osteopathic Council • General Pharmaceutical Council • Healthcare Improvement Scotland • Health & Care Professions Council • Mental Welfare Commission for Scotland • NHS Education for Scotland • Nursing and Midwifery Council • Public Health Scotland • Scottish Public Services Ombudsman • Scottish Social Services Council	The SHCIN focuses on prioritisation of emerging issues in the health and care system which supports a more agile and responsive approach, taking early action on new risks as individual network members or as a collaborative across the SHCIN. The group will meet on a quarterly basis during 2026-27, with the option to convene a review panel meeting should an emerging concern arise out with scheduled meetings.
NHS Greater Glasgow & Clyde Emergency Department progress review	HIS is committed to assessing progress by NHS Greater Glasgow & Clyde in implementing an improvement plan to address the 30 recommendations for in the NHS Greater Glasgow &	Healthcare Improvement Scotland	By Summer 2026, HIS will issue a formal request to NHS GGC for a position statement supported by relevant evidence and data on its progress. A Progress Review Panel will provide specialist knowledge and

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
	Clyde Emergency Department review report published in March 2025.		expertise in assessing progress made to date. The Panel will undertake a rigorous assessment of the submission, and following this process, the panel will consolidate its findings and conclusions into a Progress Review report which will be published on the HIS website during November/December 2026.

Reviewing and learning from adverse events, children and young people's deaths, and death certification

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
Learning from adverse events	Support a consistent national approach to identification, review, reporting and learning from adverse events based upon national and international good practice.	Healthcare Improvement Scotland	Data on commissioning of Significant Adverse Event Reviews is still being reported to HIS, however, there is variation in the way that data is recorded at a local level, so it is not comparable at a national level across boards. Following a letter from the Cabinet Secretary to NHS board Chief Executives in September 2025 around improving the quality and timeliness of significant adverse event reviews, HIS will report to Scottish Government monthly quantitative data and

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
			quarterly qualitative data regarding board adherence to the National Framework. This reporting structure will be developed in collaboration with NHS boards during 2026-27 and this will include publication of data. A revised notification system will be tested during 2026 which will include the occurrence of significant adverse events. This will allow the identification of patient safety themes and trends alongside improved analysis. The Adverse Events national learning system will be further developed through the development of learning dashboards following analysis of NHS boards submission of learning summaries.
National Hub for reviewing and learning from the deaths of children and young people	Healthcare Improvement Scotland, in collaboration with the Care Inspectorate, co-host the National Hub for Reviewing and Learning from the Deaths of Children and Young People and aim to ensure the death of every child and young person is reviewed to an agreed minimum standard.	Healthcare Improvement Scotland and Care Inspectorate	Publication of the annual Data release report for 2024-25 is planned for May 2026. The National Hub will also provide data from its portal on numbers of child death, and themes from child death reviews, to NHS Boards and Local Authorities in May and November 2026.

Programme	Programme Aim	Scrutiny body/ bodies involved	Key activity
Death Certification Review Service	The Death Certification Review Service (DCRS) provides independent scrutiny of deaths in Scotland not reported to the Procurator Fiscal with the aim of improving: • the quality and accuracy of Medical Certificates of Cause of Death (MCCDs) • public health information about causes of death in Scotland • clinical governance issues identified during the death certification review process The service is also responsible for authorising repatriation to Scotland of persons who have died abroad.	Healthcare Improvement Scotland	DCRS will: • Review approximately 12% of Medical Certificates of Cause of Death (MCCD). • Provide advice around death certification via the DCRS enquiry line. • Review all applications for repatriation to Scotland and where appropriate approve disposal. • Implement eMCCD into secondary care.

Responsive Reviews

There are no responsive reviews planned for 2026-27. This Quality Assurance and Regulation Plan will be updated if a need for a responsive review is identified.

Standards and Indicators

Healthcare Improvement Scotland is the national standards development agency for Healthcare in Scotland. The role of the Standards and Indicators team, which is transitioning to the Quality Assurance and Regulation Directorate for 2026-27, is to work with stakeholders to develop national standards and indicators which are based on current evidence and best practice. The standards aim to ensure national consistency in the multidisciplinary delivery and coordination of

high-quality healthcare. The standards also aim to support current and future service provision and national improvements. The current priorities workplan for the 2026-27 year are the development of standards for Domestic Homicide and Suicide reviews, Urgent and Unscheduled care (Emergency Departments) and Food, Fluid and Nutrition.

Programmes will be kept under regular review for any impacts on our ability to deliver planned work with the resources available to HIS and our partner agencies.

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