

Announced Inspection Report: Independent Healthcare

Service: Revive MS Support, Glasgow

Service Provider: Revive MS Support

24–25 August 2026

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First published October 2026

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1 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 Revive MS Support on Monday 24 and Tuesday 25 August 2026. We spoke with a number of staff and clients during the inspection. We received feedback from 76 clients through an online survey we had asked the service to issue to its clients for us before the inspection. This was our first inspection to this service.

Based in Glasgow, Revive MS Support is an independent clinic providing nursing assessment and support for people living with multiple sclerosis.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Revive MS Support, the following grades have been applied.

Direction	<i>How clear is the service's vision and purpose and how supportive is its leadership and culture?</i>
Summary findings	Grade awarded
A clear 3-year strategic framework was available on the service's website and included information on the service's vision, mission and values. The main objectives of the service covered aspects including support, collaboration, sustainability and effectiveness. There was a clear process of governance within the service and with its board of trustees. Staff spoke positively of the leadership and culture of the service with the senior management team easily available to staff. Measurable key performance indicators would help to demonstrate ongoing review of how the service was developing and improving.	✓✓ Good
Implementation and delivery	<i>How well does the service engage with its stakeholders and manage/improve its performance?</i>
Information about the service was clearly available on the website and in patient information leaflets. Results from client and staff feedback surveys were discussed at staff training days. A full range of policies and procedures were available to help deliver safe patient care. The proactive management of risks and an operational plan supported the service to continually improve. A more formal process for reviewing clients' health before each hyperbaric oxygen therapy session should be introduced. An audit programme should be developed.	✓✓ Good
Results	<i>How well has the service demonstrated that it provides safe, person-centred care?</i>
The service was clean, well maintained and free from clutter. This was clearly a busy service with clients telling us how important the service was to them. Patient care records were appropriately completed and included requesting consent to share information with external healthcare professionals and clients' next of kin. A documented cleaning schedule must be in place to ensure the correct cleaning processes are being followed.	✓✓ Good

Appropriate Control of Substances Hazardous to Health (COSHH) signage must be in place where hazardous products are stored. Staff and volunteer recruitment files showed some gaps with ensuring safe recruitment.	
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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 Revive MS Support 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 six recommendations.

Direction
Requirements
None
Recommendation
a The service should develop measurable key performance indicators to help monitor how well the service is being delivered (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

Implementation and delivery
Requirements
None
Recommendations
b The service should ensure clients are informed of any changes made to the service as a result of their feedback (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
c The service should develop a documented check-in process to show that a review has been completed every time a client attends for hyperbaric oxygen therapy (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
d The service should develop a programme of regular audits to cover key aspects of care and treatment. Audits must be documented and improvement action plans implemented (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery (continued)	
Recommendations	
e	The service should develop and document a formal business contingency plan that sets out the arrangements for the continuity of care for clients, in the event of the service closing for any reason (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.14

Results	
Requirements	
1	The provider must develop a cleaning schedule which includes details on cleaning products, processes and records of completion of cleaning (see page 22). Timescale – immediate <i>Regulation 3(d)(i)</i> <i>The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011</i>
2	The provider must ensure that appropriate Control of Substances Hazardous to Health (COSHH) signage is displayed in areas where hazardous substances are stored (see page 22). Timescale – immediate <i>Regulation 3(a)</i> <i>The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011</i>
Recommendation	
f	The service should obtain two references for new members of staff, in line with safe recruitment practices, and ensure that a signed volunteer agreement is in place between volunteers and the provider (see page 22). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

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](#)

Revive MS Support, the provider, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at Revive MS Support 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
<i>How clear is the service's vision and purpose and how supportive is its leadership and culture?</i>	

Our findings

A clear 3-year strategic framework was available on the service's website and included information on the service's vision, mission and values. The main objectives of the service covered aspects including support, collaboration, sustainability and effectiveness. There was a clear process of governance within the service and with its board of trustees. Staff spoke positively of the leadership and culture of the service with the senior management team easily available to staff.

Measurable key performance indicators would help to demonstrate ongoing review of how the service was developing and improving.

Clear vision and purpose

The service is a registered charity providing free nursing assessment and support for anyone over the age of 18 years with a diagnosis of, and living with, multiple sclerosis (MS) in Scotland. This is a lifelong condition that affects the brain and spinal cord, interrupting how messages travel through the body. Referrals to the service can be made by healthcare professionals, or individuals can self-refer.

The service had published a clear 3-year strategic framework on its website for 2023-2026. This highlighted its vision, mission and values. The vision was to ensure that everyone affected by MS was supported, valued and empowered, with its mission to ensure that everyone experienced a caring and inclusive community, and the values of the service included support, friendship and honesty. We were told that an updated strategic framework was being progressed.

Four main strategic objectives had been identified of:

- support
- collaboration
- sustainability, and
- effectiveness.

Examples of goals for the service to achieve, aligned to the objectives, included to:

- meet the needs of people with MS by further developing person-centred, accessible and evidence-based support services
- empower people with MS to express their views, wishes and choices while ensuring that they remain involved in all decisions that affect their lives, and
- develop improved partnerships with NHS, healthcare professionals and MS specialists to improve signposting to the service and to other sources of support.

Planned actions for the service to take forward were included within the strategic framework to ensure the goals could be achieved. We saw that progress against meeting the goals were a fixed agenda item on the board of trustee's meetings held every 3 months. All items on the service's operational/improvement plan were aligned to the goals.

What needs to improve

We saw that statistical information about aspects of the service was considered at board meetings, for example client numbers and the growth and expansion of the service. However, there was no evidence of measurable key performance indicators that would demonstrate ongoing development and improvement of the service (recommendation a).

- No requirements.

Recommendation a

- The service should develop measurable key performance indicators to help monitor how well the service is being delivered.

Leadership and culture

A wide variety of staff worked in the clinic to help the service provide an extensive range of support for its clients. This included:

- MS specialist nurse and physiotherapy teams
- speech and language therapy
- counselling therapy
- welfare and benefits
- fatigue management
- podiatry

- hyperbaric oxygen therapy (a complementary treatment where the client breathes in concentrated oxygen in a pressurised chamber with the aim of improving symptoms of MS)
- continence nurse service
- support for family and friends, and
- community café.

Most staff were employed by the service, but some non-clinical staff worked as contractors. A number of volunteers helped to contribute to the delivery of care, such as counselling and assisting clients in the gym.

The service's senior management team consisted of the chief executive officer, clinical lead, finance and facilities manager, and head of fundraising. A clear governance process was in place, including a variety of operational and clinical meetings. These included:

- clinical governance meetings
- senior management team meetings, and
- regular board meetings.

The board met every 3 months, where the services offered were discussed, as well as financial matters, operational updates and client numbers. Every 3 months, the service closed for a staff training day where staff were updated on aspects of the service and were involved in educational sessions. External experts were often invited to speak with staff. Topics covered areas such as benefits insight, and equality and diversity.

The manager told us they had an open-door policy where staff had the opportunity to speak with the senior management team on a regular basis. Staff we spoke with told us they felt confident in their job role, felt supported and that the manager was always visible and available to speak with. They told us that they felt confident in escalating concerns and were aware of how to do so.

Staff we spoke with told us.

- 'I love it, I think it's a great service, I really feel we deliver person centred care.'
- 'I love, love working here and feel supported to do so.'

■ 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
<i>How well does the service engage with its stakeholders and manage/improve its performance?</i>		

Our findings

Information about the service was clearly available on the website and in patient information leaflets. Results from client and staff feedback surveys were discussed at staff training days. A full range of policies and procedures were available to help deliver safe patient care. The proactive management of risks and an operational plan supported the service to continually improve.

A more formal process for reviewing clients' health before each hyperbaric oxygen therapy session should be introduced. An audit programme should be developed.

Co-design, co-production (patients, staff and stakeholder engagement)

Information on how to submit a self-referral to access the clinic and information on all of the activities available, for example classes and groups taking place in the service, was available on the service's website. This information was also available in leaflets at reception.

The service met with its stakeholder, NHS Greater Glasgow and Clyde, every 6 months. The NHS board provided a non-clinical contract with the service, covering services such as:

- advocacy
- exercises classes with physiotherapy support, and
- welfare and benefits support.

The service's participation policy highlighted the importance of obtaining client involvement and feedback. A monthly client newsletter was emailed to all those registered on the website. This covered updates about the service, including new activities on offer. Once a year, a link was included in the newsletter asking clients to complete a survey about their experiences of using the service. Results were then made available on the website. Clients could also provide verbal feedback at any time.

A monthly staff newsletter had recently been produced to keep staff informed of developments in the service. A staff survey had also recently been issued. The results of both the staff and client surveys were shared with staff during the training days, and improvement actions were developed as a result.

Information was regularly made available to staff on a shared electronic digital hub where each staff member had access to their own team platform. This included information such as clients attending that day, and any service updates. Staff were reminded to check the hub regularly. We were told that, as a result of information on the hub, online team meetings may be set up for staff to discuss certain issues further.

We were told that new groups had been developed as a result of client feedback. This included a young adults group and a newly diagnosed group allowing people to feel supported by the service and by each other. Clients who completed our online survey told us:

- ‘Staff always provide you with relevant and up to date information allowing informed choices to be made. There is never any pressure to come to quick decisions but always as an individual to make the right decisions.’
- ‘The treatment I received... was the best I have ever had. Everything was explained patiently, kindly and with compassion and understanding.’
- ‘In every interaction I was treated with dignity and respect. My views were truly heard...’
- ‘They treat you as a human being and are very aware that, for a person living with MS, sometimes just getting to the building can be a huge challenge.’
- ‘Staff have a very good understanding of MS and symptoms of the illness and how this impacts differently on each person.’

What needs to improve

Although results of the client surveys were available on the website, there was no information about the outcomes of feedback or any subsequent actions taken to improve the service (recommendation b).

- No requirements.

Recommendation b

- The service should ensure clients are informed of any changes made to the service as a result of their feedback.

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 senior management team had a clear knowledge of when to notify Healthcare Improvement Scotland of any changes or events, in line with our notifications guidance.

The service had a wide range of policies available. These could be accessed in paper format at reception and on the staff internal intranet system. Policies included:

- consent
- safeguarding (public protection)
- cardiopulmonary resuscitation (an emergency treatment given when a patient's heart stops, or they stop breathing), and
- health and safety.

The service's infection prevention and control policy referenced national guidance and referred to the relevant standard infection control precautions. This included information on hand hygiene and clinical waste.

Medicines were not prescribed, administered or stored in the service. The service's medicine management policy referred to clients who may require to self-medicate while visiting the clinic. The policy covered aspects such as ensuring the medication was stored safely with the client's possessions, and if the client was unable to self-medicate then the client's carer was required to attend to support this.

An electronic process was in place to report any accidents and incidents that took place. These were then investigated by the senior management team, which included reviewing the contributing factors and any controls in place. Outcomes of the investigation were fed back to staff directly.

The service's complaints policy included a timeline to manage complaints and Healthcare Improvement Scotland's contact details and making clear that clients could contact Healthcare Improvement Scotland at any time. This policy was available on the website. We reviewed two recent complaints and saw these had been managed in line with the service's complaints process. Outcomes had been fed back to the complainant and to staff highlighting the lessons learned.

Duty of candour is where the organisation has a professional responsibility to be open and honest with patients when something goes wrong. The service had a duty of candour policy in place, and a duty of candour report was available on the website. We were told that staff updates were planned about duty of candour at their 3-monthly training days.

Patient care records were stored electronically on a password protected secure system. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential information was safely managed.

Before attending the service for the first time, clients were sent an electronic form to complete. This included details of their emergency contact and GP contact details, past medical history, regular medications and any allergies. Clients who first attended the service had a detailed assessment carried out by the nurse specialist. As part of this consultation, a number of validated assessment tools were completed covering a range of symptoms that the client may be experiencing. This included assessing:

- mobility
- fatigue severity
- swallowing
- bladder or bowel function
- cognition, and
- pain.

Clients were given the opportunity at their first visit to discuss advanced care planning for their future health and personal care.

Clients had the opportunity to access a hyperbaric oxygen (HBO) chamber in the service. Standard operating procedures and policies were in place for this treatment. We spoke with the members of staff responsible for ensuring which clients the treatment was appropriate for and then for keeping them safe. Clients were made aware that there was only limited evidence that this treatment could positively impact on MS symptoms. Before embarking on a series of sessions, an assessment was carried out which included contacting the client's GP to ensure that they did not have any conditions that may be contraindicated by using this service, for example asthma. Contraindications are when a specific condition or factor (such as age, body mass index or another illness) makes a particular treatment, medication or procedure inadvisable as it could cause harm or possible complications for the patient.

A staff recruitment process was in place, and an external human resource (HR) company was contracted by the service to ensure staff were recruited safely. Appropriate background checks were obtained for staff, including:

- qualifications
- professional registration checks
- Disclosure Scotland Protecting Vulnerable Groups (PVG) scheme status, and
- identity checks.

An induction policy was in place to support new staff members joining the service. This included 3-monthly and 6-monthly reviews. An induction checklist was completed which covered general aspects of the service, HR information, and health and safety training. This was signed off by the employee and their line manager once completed.

A learning and development policy covered staff induction, training and appraisal. Staff members had access to online training and education modules in order to complete training relating to their job role. These included:

- moving and handling
- basic life support
- adult support and protection
- equality and diversity
- fire safety
- violence and aggression, and
- falls, frailty and prevention.

The service provided opportunities for continuous professional development. Staff were supported to access external training opportunities, for example attending relevant conferences and workshops.

Information on completion of staff training was recorded, with a traffic light system used to identify when training required to be updated. We saw a high compliance rate of training completed. A yearly appraisal process was in place and included individual professional development plans for staff members with objectives identified. This was then reviewed every 6 months with the individual's manager.

A record of professional registrations was in place, such as staff registered with the Nursing and Midwifery Council, and we were told this was reviewed every month.

A number of volunteers provided support in the service, for example working in the café, and providing appropriate support as part of the counselling and physiotherapy teams. A volunteer recruitment and induction policy was in place with appropriate Disclosure Scotland checks completed as part of their recruitment. Volunteers had the opportunity to carry out training specific to their role, for example food hygiene training.

What needs to improve

We were told that there was a verbal 'check-in' on the day that clients were attending for hyperbaric oxygen therapy. This was to ensure there were no new issues that may mean they were not suitable for treatment that day. However, there was no documented evidence of this check-in for each individual (recommendation c).

- No requirements.

Recommendation c

- The service should develop a documented check-in process to show that a review has been completed every time a client attends for hyperbaric oxygen therapy.

Planning for quality

The service had an active risk register. Each team completed their own relevant risk assessments, and was responsible for ensuring these were kept up to date. For example, this included risk assessments for the gym classes and for the hyperbaric oxygen therapy. A number of strategic non-clinical risk assessments were also in place, for example cyber security, information technology and aspects of fundraising. The risk assessments included the processes in place to reduce the risk and actions required. The risk register, which included risks from all teams, could be accessed by all staff on the shared electronic digital hub.

An up-to-date fire risk assessment was in place and a servicing contract with an external fire safety company that involved regular servicing of the fire alarm system and fire equipment. A number of external companies were contracted to provide servicing of other areas such as the closed circuit television system, the elevator, and regular gas and electrical servicing, including portable appliance testing (PAT) of electrical equipment. We saw a 6 monthly servicing contract in place for the hyperbaric oxygen therapy equipment.

We noted that the risk assessments were discussed at the regular board and clinical governance meetings. The outcomes of these were fed back to staff at the 3-monthly staff training days.

The service's operational plan acted as a quality improvement plan and was aligned to the strategic objectives. The plan included the introduction of new services, for example the young adults group and cognitive behavioural therapy (a type of talking therapy about how thoughts, feelings and actions are connected). Each item on the operational plan was risk assessed and a risk rating system was used. The plan included information on who was responsible, timescales and the results.

What needs to improve

Some audits were completed, for example a yearly review of patient care records and a regular but informal walkround of the service to look for any structural or maintenance issues with the building. However, there was no formal audit programme in place. This would help to ensure a more structured approach to auditing, including detailing what audits should be carried out and when. This could include:

- a regular review of patient information and consent, and
- infection prevention and control practice (recommendation d).

We spoke with the service about the need for a business contingency plan. This would help to ensure a plan was in place for clients should the service require to close unexpectedly (recommendation e).

- No requirements.

Recommendation d

- The service should develop a programme of regular audits to cover key aspects of care and treatment. Audits must be documented and improvement action plans implemented.

Recommendation e

- The service should develop and document a formal business contingency plan that sets out the arrangements for the continuity of care for clients, in the event of the service closing for any reason.

Key Focus Area: Results

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

Our findings

The service was clean, well maintained and free from clutter. This was clearly a busy service with clients telling us how important the service was to them. Patient care records were appropriately completed and included requesting consent to share information with external healthcare professionals and clients' next of kin.

A documented cleaning schedule must be in place to ensure the correct cleaning processes are being followed. Appropriate Control of Substances Hazardous to Health (COSHH) signage must be in place where hazardous products are stored. Staff and volunteer recruitment files showed some gaps with ensuring safe recruitment.

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 environment was clean, well maintained and free from clutter. A cleaner was employed by the service and attended Monday–Friday after the service had closed. We were told that staff cleaned equipment appropriately in between each client appointment. All cleaning products were stored securely in a locked cupboard. Information posters were displayed about how to use these products and how to avoid cross-contamination. Personal protective equipment was available, including disposable gloves and aprons. We saw that clinical waste was disposed of appropriately.

We reviewed five patient care records and saw that appropriate client information was documented. This included recording clients' GP and next of kin details and documenting consent to share information with them, where appropriate. A thorough assessment process was in place and conversations were documented about the client's expectations of treatments available. A number of clinical pathways were in place to help staff determine the most

appropriate treatment for the individual client. This included pathways to follow should there be a change in a client's condition, helping staff to determine the next course of action. We also saw detailed regular entries completed by other members of the multidisciplinary team, for example the physiotherapy and advocacy teams.

During the inspection, we saw that this was a busy service. As well as attending for appointments, clients and carers stayed to socialise and use the café services. We were told that carers also had access to a carer support group. We were told that, due to the high demand of the service, waiting lists were in place for some treatments, for example the hyperbaric oxygen therapy. We were told this was being reviewed at senior management and board meetings.

Clients who completed our online survey told us:

- 'There is care in everything they do.'
- 'I come along each week... and enjoy the company of other carers and monthly to the carers support group. Everything... is wonderful, all the support on offer and care given.'
- 'The staff are all friendly and speak to you as a person and an equal, very much caring about you.'
- '... has been a lifeline for me, particularly when I was first diagnosed. The staff there are so lovely, caring, welcoming and kind.'
- '... my ability to manage my symptoms has vastly improved since working with... staff.'

What needs to improve

While we saw a cleaning checklist was used in each toilet, there was no evidence of a cleaning schedule for any area of the clinic. For example, there was no information available on:

- what products were to be used for which aspects of cleaning, for example the type of products to be used for sanitary fittings
- how often the mop heads were to be changed or cleaned, and
- how often a deep clean of the entire clinic was to be carried out (requirement 1).

There was no signage displayed on the door of the cleaning cupboard to alert staff that Control of Substances Hazardous to Health (COSHH) cleaning materials and products were being stored there (requirement 2).

As part of the recruitment process, potential new staff members were asked to provide two referees. However, some of the staff files we reviewed showed that this information was missing. When reviewing the recruitment checks for volunteers, we saw that reference information had been documented but had not been followed up. We also noted that there was no formal volunteer agreement in place between the service and each volunteer. We were told that volunteers were often clients of the service and, therefore, this information was not routinely checked (recommendation f).

Requirement 1 – Timescale: immediate

- The provider must develop a cleaning schedule which includes details on cleaning products, processes and records of completion of cleaning.

Requirement 2 – Timescale: immediate

- The provider must ensure that appropriate Control of Substances Hazardous to Health (COSHH) signage is displayed in areas where hazardous substances are stored.

Recommendation f

- The service should obtain two references for new members of staff, in line with safe recruitment practices, and ensure that a signed volunteer agreement is in place between volunteers and the provider.

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.ihtregulation@nhs.scot

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We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
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