Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Sur Wellness, Glasgow

Service Provider: Sur Wellness Limited

26 August 2026

NHS SCOTLAND

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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 Sur Wellness on Wednesday 26 August 2026. We spoke with a number of staff during the inspection. This was our first inspection to this service.

Based in Glasgow City Centre, Sur Wellness is an independent clinic providing non-surgical and minor surgical treatments.

The inspection team was made up of one senior inspector and two inspectors.

What we found and inspection grades awarded

For Sur Wellness, 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 service had a clear vision which was accessible to patients on its website. Staff meetings were in place and staff told us that leadership was approachable. Service aims, objectives and key performance indicators should be developed. The clinical governance policy must be reviewed to help make sure clear governance structures are in place.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was actively sought and used to continuously improve the service. Risks were identified and reviewed regularly. Clear procedures for managing complaints were in place. A duty of candour report must be published. Healthcare Improvement Scotland must be notified of certain events that occur in the service. All policies should be up to date and document policy review updates. Information in policies should reflect Scottish law and legislation. An audit programme should be developed. A quality improvement plan should be developed.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment and equipment was clean and well maintained. Appropriate infection control measures were in place. Patients reported high levels of satisfaction and told us they felt safe and cared for in the service. Processes and training were in place for staff delivering intense, pulsed light (IPL) and laser treatments. All background and safety checks for staff must be documented. Batch numbers of medicines used should be recorded in patient care records.	✓ Satisfactory

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:

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/ihc_inspection_guidance/inspection_methodology.aspx

Further information about the Quality Assurance Framework can also be found on our website at:
https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

What action we expect Sur Wellness Limited 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 five requirements and seven recommendations.

Direction	
Requirement	
1	The provider must review its clinical governance policy to ensure clear governance structures in place that promote quality and safety and reflect the service being delivered (see page 13). Timescale – by 1 October 2026 *Regulation 13(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendation	
a	The service should develop clear and measurable aims and objectives, along with key performance indicators to help measure its progress in achieving these (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	
2	The provider must provider must publish an annual duty of candour report (see page 19). Timescale – by 1 October 2026 *Regulation 5(2)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011*
3	The provider must notify Healthcare Improvement Scotland of certain matters as detailed in our notifications guidance (see page 19). Timescale – by 1 October 2026 *Regulation 5(1)(b)* *The Healthcare Improvement Scotland (Applications and Registration) Regulations 2011*
4	The provider must ensure that all staff working in the service are enrolled in the Disclosure Scotland Protecting Vulnerable Groups (PVG) scheme by the provider before they start working in the service (see page 19). Timescale – immediate *Regulation 8* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
b	The service should update its patient participation policy, setting out a structured way of engaging with its patients and demonstrating how it uses their feedback to drive improvement (see page 15). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8

Implementation and delivery (continued)	
Recommendations	
c	The service should add a document control sheet to each of its policies to demonstrate reviews have taken place. In addition, the service should ensure all policies are up to date with current guidance and Scottish legislation (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
d	The service should ensure that all staff undertake training in complaints and the principles of duty of candour (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
e	The service should develop a planned programme of audit (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
f	The service should develop a quality improvement plan (see page 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Results	
Requirements	
5	The provider must ensure that all staff working in the service, including those with practicing privileges, have appropriate, and documented, recruitment checks and immunisation status and health declaration in place before they start working in the service (see page 24). Timescale - immediate *Regulation 8(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Results (continued)	
Recommendations	
g	The service should ensure batch numbers and expiry dates of all medicines used are recorded on each individual patient care record (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11

An improvement action plan has been developed by the provider and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/find_a_provider_or_service.aspx

Sur Wellness Limited, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Sur Wellness 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 service had a clear vision which was accessible to patients on its website. Staff meetings were in place and staff told us that leadership was approachable.

Service aims, objectives and key performance indicators should be developed. The clinical governance policy must be reviewed to help make sure clear governance structures are in place.

Clear vision and purpose

The service had a detailed website which included an overarching vision and purpose to create a 'sanctuary' for its patients. The vision was to combine health and wellness, surgical and medical aesthetics in a 'personal, transformative' way.

We saw that the service had a business plan in place, which detailed future plans for the service and provider.

What needs to improve

While we were told the service had organisational values which were discussed with staff at interviews, we saw no written organisational values, service aims and objectives in place (recommendation a).

- No requirements.

Recommendation a

- The service should develop clear and measurable aims and objectives, along with key performance indicators to help measure its progress in achieving these.

Leadership and culture

The service was owned by a nurse practitioner who worked in the service. The provider had appointed a service manager, who was also the clinic and theatre manager. Also working in the service was:

- a patient co-ordinator
- a range of healthcare professionals working under practicing privileges (staff not employed directly by the provider but given permission to work in the service)
- a scrub nurse, and
- an assistant patient co-ordinator, who was also a receptionist.

We were told that each morning the service manager led a morning huddle (meeting) for all staff to prepare for the day ahead. In addition, the service manager, theatre manager and medical staff met on a weekly basis. We saw minutes of this meeting.

We also saw evidence of formal monthly staff meetings, with agendas and recorded minutes in place. This helped make sure that all staff understood how delivery of the service was continually monitored. Regular discussions were held about complaints and adverse events, including lessons learned at clinical and management level.

A clinical governance policy was in place which all staff had signed to say they had read. The policy detailed various governance processes, including clinical audit, clinical effectiveness and risk.

Staff told us that the owner and service manager were always visible in the service and approachable. Staff were able to give us examples of things they had raised or felt able to raise with leaders in the service, for example if they had concerns about patient care. All staff we spoke with told us they felt listened to and their suggestions for changes or improvements to the service were considered.

What needs to improve

Although a clinical governance policy was in place. The policy had not been reviewed within its required review date at the time of our inspection. We saw that while the policy referred to the need for a clinical governance committee, this committee had not been implemented at the time of our inspection. The policy also referenced the Care Quality Commission (CQC) and Healthwatch, which are only applicable outside of Scotland. The policy did not make reference to Healthcare Improvement Scotland (requirement 1).

Requirement 1 – Timescale: by 1 October 2026

- The provider must review its clinical governance policy to ensure clear governance structures in place that promote quality and safety and reflect the service being delivered.

- No recommendations.

Key Focus Area: Implementation and delivery

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
How well does the service engage with its stakeholders and manage/improve its performance?		

Our findings

Patients were fully informed about treatment options and involved in all decisions about their care. Patient feedback was actively sought and used to continuously improve the service. Risks were identified and reviewed regularly. Clear procedures for managing complaints were in place.

A duty of candour report must be published. Healthcare Improvement Scotland must be notified of certain events that occur in the service. All policies should be up to date and document policy review updates. Information in policies should reflect Scottish law and legislation. An audit programme should be developed. A quality improvement plan should be developed.

Co-design, co-production *(patients, staff and stakeholder engagement)*
Patients could contact the service in a variety of ways, including:

- by telephone
- email
- online enquiries through the service's website or social media pages, and
- text messages.

The service's website contained information on treatments available, the booking system and treatment costs. It also detailed information on staff working in the service, including their qualifications.

The service was able to demonstrate how patient feedback would be gathered and used to continuously improve the service. The patient co-ordinator contacted all patients by telephone the day after their treatment (including surgery) and again 1 week later. Patients were then sent electronic correspondence after 30 days requesting feedback on their overall experience of using the service. The patient co-ordinator documented and recorded this information, which helped to encourage patients' participation and involvement in the service's future direction. We saw that patients left feedback about their

experience on the service's website. The service also gathered patient feedback informally, through verbal discussions and comments received on social media.

What needs to improve

We saw no process in place for letting patients know how their comments and suggestions had been used to improve the service. The service's participation policy should be updated to include this information (recommendation b).

We discussed with the service that its website should be reviewed to make sure it clearly explains where patients would receive consultations and treatments. For example, we found that in some instances, only surgical consultations were carried out at the clinic, while the surgery itself would take place at a different location. We will follow this up at future inspections.

- No requirements.

Recommendation b

- The service should update its patient participation policy, setting out a structured way of engaging with its patients and demonstrating how it uses their feedback to drive improvement.

Quality improvement

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

The service manager was aware of the notification process to Healthcare Improvement Scotland and the need to notify us of certain events that occur in the service. A clear system was in place to record and manage any accidents and incidents that may occur.

We saw policies in place to help make sure that patients had a safe experience in the service. Most of the service's policies were reviewed every 2 years or as required. Key policies included those for:

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

Maintenance contracts for fire safety equipment, laser and intense pulsed light (IPL) equipment and the fire detection system were up to date. Electrical and

fire safety checks were monitored regularly. The service had a clinical waste contract in place.

Infection prevention and control measures were in place to reduce the risk of infection. Equipment was cleaned between appointments, and the clinic was cleaned at the end of each day. Equipment, including personal protective equipment (such as disposable aprons and gloves) was single-use to prevent the risk of cross-infection, where appropriate.

Medicines were obtained from an appropriately registered supplier, and the service was registered to receive safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). A stock control system allowed the service to monitor medicines supplies. Temperature-sensitive medicines were stored in a locked medical refrigerator and medical devices, such as dermal fillers were stored in a lockable cupboard. Medical refrigerators were clean and in good working order, with temperatures monitored and recorded daily to make sure medicines were stored at the correct temperature and safe to use. We saw that this logbook was fully completed and up to date. The theatre manager was responsible for controlling access to medicines, including controlled drugs.

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

The theatre area had dedicated oxygen cylinders, an automated external defibrillator (AED) and a cardiac arrest trolley which theatre staff checked daily. Signatures and dates were attached to the equipment. The theatre was not operational at the time of our inspection, with operations planned to commence in October 2026.

The service's complaints policy was available in the service. The policy stated that patients could complain to Healthcare Improvement Scotland at any time and the policy included our contact details. Healthcare Improvement Scotland had not received any complaints about the service since its registration in June 2024.

The service had a duty of candour policy in place (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong). Staff fully understood their duty of candour responsibilities and the service had published duty of candour information on its website.

Staff we spoke with were aware of the service's safeguarding policy, had received training and knew the procedure for reporting concerns about patients at risk of harm or abuse.

On the day of treatment, patients had a face-to-face consultation and were asked to complete a consent form, which the patient and practitioner signed. Patients were emailed a variety of information before and after their treatment. Patients were given a cooling-off period of up to 1 year before agreeing to go ahead with treatment. Patients could telephone the service, where staff would triage and review their post-treatment queries during service hours. Queries would then be passed to the appropriate clinician for further review and advice. Out-of-hours enquiries would go directly to the service manager.

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

The service had a recruitment and induction policy in place for employees. In addition, some individuals working in the service under practicing privileges had individual written agreements in place.

Some of the staff, including those working in the service on practising privileges were subject to a variety of checks during the recruitment process, including checking they are not listed under the Protection of Vulnerable Groups (PVG) (Scotland) Act 2007. Staff files contained a checklist to help make sure that appropriate recruitment checks had been carried out.

All relevant healthcare staff participated in formal appraisal processes in line with their professional regulatory bodies, such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). This helped make sure that staff remained up to date and fit to practice, as well as providing confidence and assurance in their own performance. We were told that the service kept up to date with research and good practice through continued professional development and mutual support of professional colleagues. We were told that senior staff met regularly to share cases and learning outcomes from each

other. The service manager also met regularly with a range of other aesthetic services and professional colleagues. They also attended training, including research at conferences and national aesthetic events.

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

Staff with practicing privileges contracts provided the service with their annual appraisals from their NHS posts, including proof of continued learning. Appraisals we saw were comprehensively completed.

What needs to improve

All services are required to produce a duty of candour report every year. The service had not produced a yearly duty of candour report (requirement 2).

We saw that one of the provider's relevant individuals was no longer listed as a director of the provider on Companies House and that the provider address had changed. The service had not notified us as required to as part of the Healthcare Improvement Scotland notification guidance (requirement 3).

We saw no evidence that any staff had completed training in complaints or the principles of duty of candour (recommendation c).

Not all staff working in the service had been enrolled in the PVG scheme. We were told this was because two staff were still on probation and one staff member had provided a Disclosure and Barring Service (DBS) check (the English equivalent of a PVG check). All staff working in the service must be enrolled in the PVG scheme (requirement 4).

Some of the service's policies had not been reviewed for a considerable period of time. While some policies had clear review dates, there was no documented evidence to demonstrate that these reviews had been carried out or to identify if any amendments had been made. In addition, some policies referred to English legislation and organisations, such as the Care Quality Commission. (recommendation d).

The majority of staff working in the service had been working in the service for less than 1 year and therefore had not received an annual appraisal at the time of our inspection. We will follow this up at future inspections.

Requirement 2 – Timescale: by 1 October 2026

- The provider must provider must publish an annual duty of candour report.

Requirement 3 – Timescale: by 1 October 2026

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

Requirement 4 – Timescale: immediate

- The provider must ensure that all staff working in the service are enrolled in the Disclosure Scotland Protecting Vulnerable Groups (PVG) scheme by the provider before they start working in the service.

Recommendation c

- The service should add a document control sheet to each of its policies to demonstrate reviews have taken place. In addition, the service should ensure all policies are up to date with current guidance and Scottish legislation.

Recommendation d

- The service should ensure that all staff undertake training in complaints and the principles of duty of candour.

Planning for quality

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

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

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

We saw an arrangement in place to refer patients to another service in the event that the service was unable to operate, such as during a temporary closure.

The service completed monthly audits, such as those for:

- infection prevention and control
- medicines, and
- patient care records.

We saw that all results from audits were documented and actions taken if appropriate.

What needs to improve

We saw a range of audits had been carried out including clinic environment, infection prevention and control and medicines management. The clinical governance policy contained a template audit programme however there was no evidence this template was being used to determine when audits should be taking place (recommendation e).

While we saw a selection of 'plan, do, study, act' forms, these contained limited detail about planned improvements. The service did not have a formal quality improvement plan in place to help plan and monitor improvement activities (recommendation f).

- No requirements.

Recommendation e

- The service should develop a planned programme of audit.

Recommendation f

- The service should develop a quality improvement plan.

Key Focus Area: Results

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

Our findings

The environment and equipment was clean and well maintained. Appropriate infection control measures were in place. Patients reported high levels of satisfaction and told us they felt safe and cared for in the service. Processes and training were in place for staff delivering intense pulsed light (IPL) and laser treatments.

All background and safety checks for staff must be documented. Batch numbers of medicines used should be recorded in patient care records.

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 satisfactory self-evaluation.

We saw the service was clean and tidy, was of a high standard and well maintained. Daily cleaning schedules were fully completed and up to date. The service employed a cleaner to carry out daily cleaning. An external cleaning company was employed to carry out a 'deep clean' of the service every 3 months. The correct cleaning products were used in line with national guidance, such as chlorine-based cleaning products for sanitary fixtures and fittings. Equipment for most procedures was single-use to prevent the risk of cross-infection. Equipment re-used for operations was sent to an external sterilising unit. Personal protective equipment (such as disposable gloves and aprons) was readily available to staff. A clinical waste contract was in place. Clinical waste and used sharps equipment was disposed of appropriately.

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

- 'Beautiful place immaculate and nice private.'
- 'Facilities are immaculate and well catered for.'
- 'The environment is exceptionally hygienic & I have always felt in incredibly safe hands.'

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

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

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

- 'From the minute I walk in the door being greeted by front of house to having my treatment executed the full team are aware of who I am, what I am there for & the service is always executed with the highest level of professionalism.'
- 'Met by professional receptionist who was able to access appointments and confirm attendance.'
- 'Very well organised as always.'

IPL and laser skin treatments were provided to patients. The service had a registered laser protection advisor and local rules were in place to maintain patient and staff safety. All safety measures were in place when this treatment was carried out, including safety warning signs on the locked treatment room

door. We saw evidence that all staff who provided IPL and laser treatments completed up-to-date core of knowledge training. All safety checks on the laser equipment had been carried out and were documented. Details of patch testing and treatments for patients were documented in the patient care records we reviewed.

We reviewed seven staff files, including those for staff members working under practicing privileges agreements. Employed staff files we reviewed included documentation for that individual, such as:

- a contract with a detailed job specification or description
- CVs
- evidence of qualifications held, and
- notes from their interview.

All individuals working under practicing privileges had been enrolled in the PVG scheme. We saw that the service had a system in place to record PVG status, details of appropriate insurance held by the individual and their immunisation status.

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

What needs to improve

Not all individuals with practicing privileges had all the correct information in their files. For example:

- in two of these staff files, we saw Information Commissioner's Office (ICO) certificates in place for services other than Sur Wellness
- no references had been asked for, for any of the individuals, and
- one file contained an unsigned practicing privileges agreement.

In the files we reviewed of the employed staff, we saw:

- no copies of ID to verify the identity of any staff
- no employed staff had been enrolled in the Disclosure Scotland PVG scheme, and
- one member of staff had no immunisation record on file (requirement 5).

Batch numbers for all local anaesthetic used for patients were recorded on a separate sheet containing the patients and consultant's initials and date of treatments. However, this information could be misplaced or lost. Batch numbers for all medicines should be recorded in patient care records (recommendation g).

Requirement 5 – Timescale: immediate

- The provider must ensure that all staff working in the service, including those with practicing privileges, have appropriate, and documented, recruitment checks and immunisation status and health declaration in place before they start working in the service.

Recommendation g

- The service should ensure batch numbers and expiry dates of all medicines used are recorded on each individual patient care record.

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: https://www.healthcareimprovementscotland.org/scrutiny/the_quality_assurance_system.aspx

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

Telephone: 0131 623 4300

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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