Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Clinic M, Inverness

Service Provider: Clinic M Limited

24 September 2026

NHS SCOTLAND

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Contents

1 A summary of our inspection 4

2 What we found during our inspection 11

Appendix 1 – About our inspections 25

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 Clinic M on Thursday 24 September 2026. We spoke with a number of staff during the inspection. We received feedback from two patients through an online survey we had asked the service to issue to its patients for us before the inspection. This was our first inspection to this service.

Based in Dochgarroch in Inverness, Clinic M is an independent clinic providing non-surgical and minor surgical treatments.

The inspection team was made up of two inspectors.

What we found and inspection grades awarded

For Clinic M, 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's vision and purpose was accessible to patients and the public. Strategic priorities were in place. Leadership was visible and approachable. Evidence of the ongoing review of the key performance indicators should be developed. Staff told us they enjoyed working for the clinic. Staff meetings allowed staff to contribute to the development of the service.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
A participation policy was in place. The service gathered feedback and actively implemented improvements as a result. Information about treatments offered was available on the service's website. Complaints information was accessible. A range of policies were in place. A duty of candour report must be published. All risks must be proactively identified and managed. A structured audit programme should be in place.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and well equipped. Clinical handwash basins were cleaned in line with national guidance. Patients reported good levels of satisfaction and told us they felt safe in the service. Medications and consumables were in-date and checked regularly. Patient care records were comprehensive. An annual return must be completed and submitted to Healthcare Improvement Scotland. The service should always document consent from patients for sharing of information with their emergency contact in an emergency.	✓ 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:

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 Clinic M 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 three requirements and 10 recommendations.

Direction	
Requirements	
	None
Recommendations	
a	The service should develop and implement a process for reviewing, monitoring and measuring how the service is performing against its strategic priorities (see page 12). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
b	The service should share the outcome of meetings and action points with all members of staff (see page 13). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
c	The service should introduce a formal process to obtain and review staff 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 4.19

Implementation and delivery	
Requirements	
1	The provider must publish an annual duty of candour report (see page 19). Timescale – immediate *Regulation 5(2)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
2	The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff (see page 20). Timescale – immediate *Regulation 13(2)(a)* The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011
Recommendations	
d	The service should monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated (see page 16). 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 further develop its emergency arrangements policy to reflect how it will care for patients in the event of all common medical emergencies, including vascular occlusion and local anaesthetic toxicity (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
f	The service should implement a system to record and monitor all staff training. (see page 19). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14

Implementation and delivery	
Recommendations (continued)	
g	The service should further develop its audit programme to include a schedule of when the audits will take place. Audits should also include infection control (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	
Requirement	
3	The provider must complete and submit an annual return as requested by Healthcare Improvement Scotland (see page 23). Timescale – immediate *Regulation 5(1)(c)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
h	The service should record patients' consent to share information with their next of kin or emergency contact in the event of an emergency in the 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 4.19
i	The service should record on a checklist when the resuscitation trolley has been checked (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
j	The service should securely destroy original Disclosure Scotland PVG records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff (see page 24). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.24

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

Clinic M 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 Clinic M 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's vision and purpose was accessible to patients and the public. Strategic priorities were in place. Leadership was visible and approachable. Evidence of the ongoing review of the key performance indicators should be developed. Staff told us they enjoyed working for the clinic. Staff meetings allowed staff to contribute to the development of the service.

Clear vision and purpose

The goal of the service was 'to provide patients with a comprehensive health care plan that involves all available treatments options,' including 'advanced innovative treatments' only available privately. It provided evidence-based treatments.

The vision of the service was to 'provide high-quality, compassionate and personalised healthcare that promotes wellbeing.' Its vision also stated that the care provided would prevent 'avoidable deterioration' and support people to maintain independence in their lives.

The service stated its values as:

- Clinical integrity: care should be clinically justified, evidence-informed and within the competence of the service.
- Compassion and respect: patients should feel listened to, valued and treated with dignity.
- Continuous improvement: the service used feedback, audit, incident review and outcome monitoring to improve services.
- Openness and honesty: the service explained benefits, risks, limitations, alternatives, likely outcomes and costs.
- Person-centred care: the service placed the individual, their circumstances and priorities at the centre of care.
- Prevention and wellbeing: the service promoted strength, mobility, balance, nutrition and healthy ageing.

The service's business plan demonstrated how it would achieve its vision and purpose. The business plan's strategic priorities included making sure that appropriately qualified staff were recruited and retained and that patients received a high-quality service.

What needs to improve

It was unclear how the provider reviewed the performance of the service against its strategic priorities (recommendation a).

- No requirements.

Recommendation a

- The service should develop and implement a process for reviewing, monitoring and measuring how the service is performing against its strategic priorities.

Leadership and culture

The clinic manager was responsible for the day-to-day running of the service, working with clinical and non-clinical staff. Healthcare staff in the clinic worked under practicing privileges agreements (where staff are not formally employed by the service but have an agreement in place to do so). Staff included:

- a radiographer
- administrative staff
- consultant medical doctors, and
- nurses.

All clinical staff working in the service were registered with an appropriate professional body, such as the:

- General Dental Council (GDC)
- General Medical Council (GMC)
- Health and Care Professions Council (HCPC), and
- Nursing and Midwifery Council (NMC).

The service had a recruitment policy in place, which set out how staff would be recruited, along with the recruitment checks that would be carried out for all staff. We were shown a staff handbook that was given to non-clinical members of staff. The service also had clinical and clinical assistant onboarding packs. The service's practicing privileges policy also detailed how practicing privileges were granted to healthcare care professionals in the service.

All staff attended regular one-to-one meetings with their line manager. We saw that all staff who had been with the service for over a year had received a documented annual appraisal.

We saw evidence of a range of governance meetings, such as written agendas and minutes. The meeting minutes also included an action tracker. Governance meetings included those for:

- clinical governance
- estates management
- magnetic resonance imaging (MRI), and
- staff meetings.

We saw evidence of regular reviews carried out when a new treatment was implemented. For example, the introduction of a gynaecological service and an ultrasound scanning service.

We were also told that the clinic manager had daily communications with staff.

Staff we spoke with told us they felt supported in their role and that leadership was accessible and actively involved in the day-to-day running of the service. This allowed for clear communication, early identification of any issues and timely support for staff.

We were told that staff had contributed to improvements in the service, including the following:

- Implementing a daily register, which recorded when blood samples had been posted.
- Introducing an out-of-hour arrangement flowchart to aid reception staff.
- Introducing 'what three words' to the resuscitation trolley, so that emergency services would know where to attend if requested. 'What three words' is a system that divides the entire surface of the Earth into a grid of 3-metre by 3-metre squares and gives every single square a unique address made of three random words.

What needs to improve

While we saw minutes, agendas and action plans for different meetings, it was unclear how the outcomes from these were fed back to staff (recommendation b).

Feedback could be given verbally and was encouraged in the service. However, no formal process was in place to gather staff feedback (recommendation c).

- No requirements.

Recommendation b

- The service should share the outcome of meetings and action points with all members of staff.

Recommendation c

- The service should introduce a formal process to obtain and review staff feedback.

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

A participation policy was in place. The service gathered feedback and actively implemented improvements as a result. Information about treatments offered was available on the service's website. Complaints information was accessible. A range of policies were in place.

A duty of candour report must be published. All risks must be proactively identified and managed. A structured audit programme should be in place.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service provided information, including about the clinic, the treatments available and costs through its website, as well as its social media account. Patients could use a messaging app, social media or the website to contact the service with enquiries.

Patients could provide feedback about their experience of the service verbally, through a messaging app or the service's social media account. The service also sent out an automated email after treatment asking patients to leave a review.

We were told that new patients had used the service after recommendations from friends. All consultations were appointment-only.

Improvements in the service made as a result of patient suggestions included:

- displaying a wifi code for patients
- introducing MRI head scans, and
- re-designing the patient waiting area away from the reception desk.

What needs to improve

While the service made improvements, it did not have a process in place to measure the impact of improvements made and share that with patients (recommendation d).

- No requirements.

Recommendation d

- The service should monitor and evaluate improvements made as a result of patient feedback, to determine whether actions taken have led to the improvement anticipated.

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.

Policies and procedures were in place to support the delivery of person-centred care. These included those for:

- complaints
- duty of candour (where healthcare organisations have a statutory responsibility to be honest with patients when something goes wrong)
- emergency arrangements
- infection prevention and control
- information management
- medication, and
- minor surgery.

An infection prevention and control policy was in place. The service had good awareness of infection prevention and control practices, including hand hygiene and clinical waste management. We saw that cleaning checklists were accurately completed. Equipment used, including personal protective equipment (for example, aprons and gloves) and the majority of minor surgical equipment was single-use to prevent the risk of cross-infection.

Re-usable equipment, such as stethoscopes were de-contaminated using appropriate detergent wipes. We saw a standard operating procedure in place for an autoclave, along with evidence of regular testing before its use.

We saw that clinical hand wash basins were cleaned in line with national guidance.

The service manager was aware of the notification process and what the service should notify Healthcare Improvement Scotland of. Appropriate notifications had been submitted to Healthcare Improvement Scotland. A clear system was in place to record and manage accidents and incidents.

The complaints procedure was displayed in the clinic and on the service's website. This advised patients that they could contact Healthcare Improvement Scotland at any point during the complaint process and included Healthcare Improvement Scotland's contact details.

The electronic patient care records we reviewed included consent for treatment, to take photographs and to share information with other healthcare professionals.

Arrangements were in place to deal with medical emergencies, including:

- a resuscitation trolley
- anaphylaxis emergency kits
- first aid supplies, and
- up-to-date training in anaphylaxis.

We saw that flowcharts were kept on the resuscitation trolley and in the clinical treatment rooms. These detailed how medical emergencies would be dealt with, such as:

- anaphylaxis
- cardiac arrest
- local anaesthetic toxicity, and
- vascular occlusion.

The service had a current electrical safety certificate in place.

We saw systems and processes in place for the MRI scanner, including daily quality assurance checks. Staff we spoke with showed us evidence that before carrying out a MRI scan, they would:

- carry out safety checks
- check that the correct patient was attending for the MRI scan, and
- verify the scanning request.

We were told that a face-to-face consultation and assessment was carried out to assess patients' suitability for treatment. The initial consultation included discussions about:

- benefits and risk of treatment
- desired outcomes of the patient
- expectations
- information about aftercare, and
- treatment costs.

Patient care records contained patient information, including:

- a detailed consultation and assessment process
- contact details
- discussion about the consent process, and
- past medical history.

We saw that aftercare for minor surgical procedures, anti-wrinkle injections and dermal fillers was sent electronically to patients after treatment. This included information about who patients could contact if they had any questions or queries about the treatment they had received.

Appropriate arrangements were in place to maintain the privacy and dignity of patients. All consultations were appointment-only. The service had a separate waiting area for patients located away from the reception desk. We were told that the waiting area had been moved to better aid patients' privacy when they were checking in at reception.

Patient information was stored securely on a password-protected device. This helped to protect 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 the service followed the appropriate data protection regulations.

We saw that service had fire extinguishers in place, including an MRI-safe fire extinguisher. These had been serviced yearly.

We saw that healthcare professions had engaged in regular continuing professional development and revalidation. This is managed through their registration and revalidation process. Revalidation is where clinical staff are required to gather evidence of their competency, training and feedback from patients and peers for their professional body, such as the GMC or NMC every 3 years. Those who are registered with the GDC comply with their registration

requirement by completing and keeping a log of their continuous professional development.

What needs to improve

While the service had a duty of candour policy in place, we saw no evidence that it had published a yearly duty of candour report (requirement 1).

Policies had been regularly reviewed and updated. The service had flowcharts setting out how medical emergencies would be dealt with. However, the service's emergency arrangements policy did not set out how it would deal with these emergencies (recommendation e).

The service had a training and education policy, as well as a training plan in place for the nursing team and clinical support staff. Some staff could show us evidence of training and education. However, this was not consistent. We did not see a consistent approach to recording staff training, such as complaints, duty of candour or moving and handling training. The service should implement a system to record and monitor all staff training (recommendation f).

Requirement 1 – Timescale: immediate

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

Recommendation e

- The service should further develop its emergency arrangements policy to reflect how it will care for patients in the event of all common medical emergencies, including vascular occlusion and local anaesthetic toxicity.

Recommendation f

- The service should implement a system to record and monitor all staff training.

Planning for quality

We saw that the service had a service improvement document in place. The service also had a business continuity plan. This detailed a contingency arrangement that would give patients an option to continue their treatment plans with an alternative practitioner, in case of emergencies (such as sickness, flood or power failure). Appropriate insurances were in date, such as public and employer liability insurance.

The service had developed a risk register and had some risk assessments in place, including those for fire and slips, trips and falls.

An asset register was in place, which detailed equipment that the service held and the dates that equipment servicing was due.

The service had carried out audits on:

- blood test and histology results tracking
- complaints
- consent
- hand washing, and
- medication.

What needs to improve

We saw some risk assessments in place including those for fire, laser safety, legionella, MRI scanning and slips, trips and falls. However, the service did not have other patient safety risk assessments in place, such as those for:

- data protection
- electrical safety
- infection control
- medications, and
- waste management.

We saw some safety data sheets for chemicals used, such as chlorine tablets or cleaning chemicals. However, control of substances hazardous to health (COSHH) risk assessments had not been carried out. While the service had a health and safety document which detailed risk, it had not been reviewed and updated at the time of our inspection (requirement 2).

We saw evidence that the service carried out some audits. However, the service did not have a documented audit schedule in place that set out the frequency of audits (recommendation g).

Requirement 2 – Timescale: immediate

- The provider must provider must develop effective systems that demonstrate the proactive management of risks to patients and staff.

Recommendation g

- The service should further develop its audit programme to include a schedule of when the audits will take place. Audits should also include infection control.

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 was clean and well equipped. Clinical handwash basins were cleaned in line with national guidance. Patients reported good levels of satisfaction and told us they felt safe in the service. Medications and consumables were in-date and checked regularly. Patient care records were comprehensive.

An annual return must be completed and submitted to Healthcare Improvement Scotland. The service should always document consent from patients for sharing of information with their emergency contact in an emergency.

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 clinic was clean, tidy and well maintained. We saw good compliance with infection prevention and control procedures. Appropriate cleaning wipes were used and the clinical handwash sink was cleaned in line with national guidance, such as chlorine-based cleaning products for sanitary fixtures and fittings. Cleaning checklists were in place and had been completed when rooms had been cleaned including between patients. We saw a good supply of antibacterial soap and disposable paper hand towels to maintain good hand hygiene.

Personal protective equipment was readily available and in plentiful supply. Clinical waste was disposed of appropriately. Single-use mops were used to clean the flooring.

Patients who responded to our online survey told us they felt safe and that the cleaning measures in place to reduce the risk of infection in the service were reassuring.

All patients stated the clinic was clean and tidy. Some comments we received from patients included:

- ‘Receptionists are super helpful, clinic is spotless and everything is there in place.’
- ‘Very clean, modern and airy. Great ease to park too.’

Medications and single-use items were in-date (such as gloves, syringes, needles and dressing packs).

A medication fridge was in place, which was clean and in working order. The service kept a temperature recording logbook, where fridge temperature was recorded when temperature sensitive medication was stored. We saw that this was fully completed and up to date.

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

- ‘Options are always given and explained but final decision is always mine to make.’
- ‘The practitioner made sure I understood all her comments. Nothing was rushed and my concerns were answered with care. They took the photos and notes and were very helpful and kind.’
- ‘Treatment plans are discussed and going forward things I may want to try in the future. I always feel they have my best interests at heart.’
- Nothing was rushed. Over an hour with the practitioner... I had time to consider my options and was not rushed into doing anything

We reviewed five patient care records, four from patients receiving aesthetic treatments and one who received a minor surgical procedure. We saw that all were comprehensively completed, with appropriate consent documentation in place. We saw that for the patient receiving a minor surgical procedure, discussions about consent and what this meant was detailed in the patient care record. The patient also signed the consent form on the day of treatment.

The patient care records we reviewed included a consent form that the patient and practitioner signed on the day of treatment. Details of the treatments administered, including the dose of anti-wrinkle injections, dermal filler or local anaesthetic administered were recorded along with the medicine batch

numbers and expiry dates. Each patient care record showed a clear pathway from assessment to treatments provided. Specific aftercare advice was given with each treatment. We saw that arrangements were in place to make sure the service could support patients in the event of a medical emergency. Each practitioner had signed and dated their entries in the patient care records.

We reviewed five files of staff the service directly employed and two members of staff working under a practicing privileges arrangement. The majority of staff files included evidence of appropriate initial and ongoing checks to help make sure staff were safe to work in the service. Staff had completed an induction process when starting in the service, as well as ongoing occupational health training where appropriate. We saw evidence of documented yearly appraisals where staff had been in post for more than 12 months.

What needs to improve

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. While requested, the service had not submitted an annual return for the last 2 years (requirement 3).

The service did not record patients' consent to share information with their next of kin in the event of an emergency in the patient care record (recommendation h).

While we were told that the resuscitation trolley was regularly checked, the service did not record when these checks were completed (recommendation i).

The service kept Disclosure Scotland PVG certificates in staff files, rather than securely destroying the original Disclosure Scotland PVG records in line with current legislation (recommendation j).

The provider had not carried out the Disclosure Scotland PVG checks that the certificates documented. However, we were told and saw evidence that the provider had recently registered as an authorised signatory with Disclosure Scotland and had requested Disclosure Scotland PVG certificates for all members of staff. We will follow this up at future inspections.

Requirement 3 – Timescale: immediate

- The provider must complete and submit an annual return as requested by Healthcare Improvement Scotland.

Recommendation h

- The service should record patients' consent to share information with their next of kin or emergency contact in the event of an emergency in the patient care record.

Recommendation i

- The service should record on a checklist when the resuscitation trolley has been checked.

Recommendation j

- The service should securely destroy original Disclosure Scotland PVG records in line with current legislation and implement a system to record PVG scheme identification numbers for all staff.

Appendix 1 – About our inspections

Our quality assurance system and the quality assurance framework allow us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this system to check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. Inspections may be announced or unannounced.

We follow a number of stages to inspect independent healthcare services.

Before inspections

Independent healthcare services submit an annual return and self-evaluation to us.

We review this information and produce a service risk assessment to determine the risk level of the service. This helps us to decide the focus and frequency of inspection.



Before

During inspections

We use inspection tools to help us assess the service.

Inspections will be a mix of physical inspection and discussions with staff, people experiencing care and, where appropriate, carers and families.

We give feedback to the service at the end of the inspection.



During

After inspections

We publish reports for services and people experiencing care, carers and families based on what we find during inspections. Independent healthcare services use our reports to make improvements and find out what other services are doing well. Our reports are available on our website at: **www.healthcareimprovementscotland.org**

We require independent healthcare services to develop and then update an improvement action plan to address the requirements and recommendations we make.

We check progress against the improvement action plan.



After

More information about our approach can be found on our website: [The quality assurance system and framework – Healthcare Improvement Scotland]

Complaints

If you would like to raise a concern or complaint about an independent healthcare service, you can complain directly to us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Email: his.ihcregulation@nhs.scot

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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