Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Laurabelle Aesthetics, Dundee

Service Provider: Laurabelle Aesthetics Ltd

10 June 2025

NHS SCOTLAND

Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email his.contactpublicinvolvement@nhs.scot

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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 Laurabelle Aesthetics on Tuesday 10 June 2025. We spoke with the service manager who is also the owner of the service during the inspection. We received feedback from 14 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 Dundee, Laurabelle Aesthetics is an independent clinic providing non-surgical treatments.

The inspection team was made up of one inspector.

What we found and inspection grades awarded

For Laurabelle Aesthetics, 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 practitioner is a registered nurse and an independent nurse prescriber. The service had clear aims and objectives, which were available for patients to view. A 3-year vision strategy plan had been developed. A system should be in place to help measure the service's progress in meetings its aims and objectives. Regular, formal staff meetings should include staff feedback.	✓ 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. Clear processes and procedures were in place for managing complaints. Patient feedback was actively sought and used to continually improve the service. Appropriate safety assurance processes included a risk management system. A formal audit programme should be implemented. A quality improvement plan should be developed. A practicing privileges policy should be developed.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean and well equipped and maintained. Good infection control measures were in place. Patients reported good levels of satisfaction and told us they felt safe in the service. Information documented in the patients' care records was clear and precise. Prescription-only medication must be discarded if patients cancel or do not attend for appointments and stock control should include checking expiry dates. All patient care records should be accessible to the service manager.	✓ 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 Laurabelle Aesthetics Ltd 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 10 recommendations.

Direction	
Requirements	
	None
Recommendations	
a	The service should ensure a system is in place to make sure the aims and objectives identified in its strategy plan are being met (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 develop a more regular programme of formal staff meetings. These should be documented and include any actions taken and those responsible for the actions. Minutes of meetings should be shared with all members of staff to ensure issues discussed and decisions made are communicated to anyone unable to attend a meeting (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

Implementation and delivery	
Requirement	
1	The provider must ensure that appropriate recruitment checks are carried out on all staff before they start working in the service and on an ongoing basis (see page 18). Timescale – immediate *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
c	The service should adhere to its participation policy to direct the way it engages with its patients and 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
d	The service should develop and implement a system to determine review dates for its policies and procedures with documented evidence of when reviews are undertaken and what changes or updates were subsequently made (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
e	The service should develop and implement a practicing privileges policy which demonstrates the safe delivery of care with individual responsibility and accountability clearly identified (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
f	The service should have an induction programme for all new staff, including those working under practicing privileges (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery (continued)	
g	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 20). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
h	The service should make sure audits accurately assess areas of concern and action plans are put in place with the nominated person responsible for dealing with issues identified through the audit process (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
i	The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (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	
2	The provider must demonstrate good medicines governance for the prescribing and administration of medicines and implement a more effective stock control and monitoring system to ensure that expiry dates for prescriptions remain in-date or are removed from stock (see page 23). Timescale – immediate *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Results (continued)	
Recommendation	
j	The service should ensure that practitioners record information in one patient care record system, so that the service manager and owner has access to all patient care records (see page 23). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

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

Laurabelle Aesthetics Ltd, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Laurabelle Aesthetics 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 practitioner is a registered nurse and an independent nurse prescriber. The service had clear aims and objectives, which were available for patients to view. A 3-year vision strategy plan had been developed. A system should be in place to help measure the service's progress in meetings its aims and objectives. Regular, formal staff meetings should include staff feedback.

Clear vision and purpose

The service's aims, objectives and mission statement were available for patients to read on its website. This included the service's vision of delivering high quality person-centred care with a focus on patient safety and wellbeing. The service also aimed to provide the highest standard of treatment while supporting patients' agreed outcomes.

The service's values were also readily available for patients to view. The values were:

- accountability
- compassion
- empowerment
- excellence
- integrity, and
- professionalism.

The service's vision and strategy plan stated its short-, medium- and long-term goals with three main priorities:

- year 1 – foundation and growth
- year 2 – expansion and collaboration, and
- year 2 – leadership and innovation.

The service also identified three immediate priority areas as key performance indicators, which were:

- evaluating the effectiveness of treatments and patient satisfaction
- evolving the vision to strengthen the service identity with a focus on patient-centred medical aesthetics, and
- optimising the patient's journey through embedding consistent high standards.

The service had five registered nurses working under practicing privileges, which is where staff are not employed directly by the provider but given permission to work in the service.

The service manager told us the service's goal was to continue to offer an easily accessible service for the local community with flexible appointments.

What needs to improve

The service had a vision with identified aims, objectives, and timeframes. However, it did not have a process in place to help measure its progress in meeting the aims and objectives (recommendation a).

- No requirements.

Recommendation a

- The service should ensure a system is in place to make sure the aims and objectives identified in its strategy plan are being met.

Leadership and culture

The owner (practitioner) was also the service manager and an experienced registered nurse and independent nurse prescriber, registered with the Nursing and Midwifery Council (NMC). The service had adequate staff numbers who were suitably qualified to carry out the aesthetic treatments offered to patients. The five registered nurses working in the service under a practicing privilege contract were also all registered with the NMC.

The service's leadership structure involved the staff all reporting back to the service manager. The service manager met with staff individually and as a group to give updates on service changes to the clinic and patient feedback.

Staff were encouraged informally to participate and contribute to the day-to-day running of the service. While at the time of our inspection, team meetings were held infrequently, we were told team meetings would be held every 3

months in future. We saw evidence of the March 2025 team meeting, including the meeting's agenda and recorded minutes. The minutes of the meeting included discussions about staff training, audit results and patient feedback.

We were told that the service had recently asked staff to give feedback about the service and had added these anonymous contents to its social media pages.

The service's governance approach included:

- a complaints-handling process
- a risk register and risk assessments
- gathering and evaluating feedback informally, and
- reporting of adverse events.

What needs to improve

Staff had attended one formal meeting in 2025. We were told the service had identified that team meetings should be scheduled with designated dates and the agenda should include points for staff feedback and suggestions. The service also planned to carry out a yearly staff survey to collect and review staff feedback. However, no process was in place for staff to formally make suggestions, voice their opinions or ideas for improvement at the time of our inspection (recommendation b).

It would benefit the service to formally address areas of improvement and add these to a quality improvement plan. We will follow this up at a future inspections.

- No requirements.

Recommendation b

- The service should develop a more regular programme of formal staff meetings. These should be documented and include any actions taken and those responsible for the actions. Minutes of meetings should be shared with all members of staff to ensure issues discussed and decisions made are communicated to anyone unable to attend a meeting.

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. Clear processes and procedures were in place for managing complaints. Patient feedback was actively sought and used to continually improve the service. Appropriate safety assurance processes included a risk management system.

A formal audit programme should be implemented. A quality improvement plan should be developed. A practicing privileges policy should be developed.

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

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

A number of patients were returning patients who had used the service for some time. Most new patients had been recommended to the service from existing patients or word of mouth, including social media reviews. All consultations were appointment-only.

The service's website included information on treatments available, a booking system and treatment costs, as well as detailed information about staff and the treatments each staff member could deliver. Patients also had the ability to pay for treatments online through the website.

The service actively sought feedback from patients about their overall experience using a variety of methods, in line with its patient participation policy. For example, feedback was collected formally and informally. This included verbal feedback, bespoke patient questionnaires emailed to patients 1 hour after treatments and through online apps. This helped to encourage patients to participate in improvements in the service.

We were told the service reviewed feedback regularly and information gathered was used to inform service improvement activities. The service had introduced the ability for online payments after a systems failure and patient feedback.

The service also produced a seasonal 3-monthly newsletter for patients to advise of any changes and updates that it made. This newsletter was sent out to patients electronically.

What needs to improve

We discussed with the service the importance of having a structured approach to patient feedback. This should include:

- analysing the recorded feedback results
- implementing changes to drive improvement, and
- measuring the impact of improvements (recommendation c).

- No requirements.

Recommendation c

- The service should adhere to its participation policy to direct the way it engages with its patients and 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. During our inspection, we saw that the service had not had any incidents or accidents that should have been notified to Healthcare Improvement Scotland. A clear system was in place to record and manage accidents and incidents.

The service had policies and procedures in place to support the safe delivery of person-centred care. These included those for:

- complaints
- duty of candour
- emergency arrangements policy
- information management, and
- medication.

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

Maintenance contracts for fire safety equipment, the boiler and fire detection systems were up to date. Electrical and fire safety checks were monitored regularly. The service had a clinical waste contract in place.

Information about how to make a complaint was clearly displayed in the waiting area and included details on how to contact Healthcare Improvement Scotland. The service had not received any complaints since it registered with Healthcare Improvement Scotland in October 2022.

Duty of candour is where healthcare organisations have a professional responsibility to be honest with patients when something goes wrong. The practitioner fully understood their duty of candour responsibilities and the service's duty of candour report was displayed on its website. We noted that the service had no incidents for the 12 months before our inspection.

The service had a safeguarding (public protection) policy in place. The practitioner had completed safeguarding training and knew the procedure for reporting concerns about patients at risk of harm or abuse.

Patients received information electronically before their treatment. On the day of treatment, patients received a face-to-face consultation where they completed a consent form electronically, which the patient and practitioner signed. An appropriate cooling-off period was included to allow patients time to consider the treatment options. A comprehensive assessment included a full medical history, as well as current medications. The service provided aftercare information, which included the service's contact details where appropriate. We saw examples of aftercare instructions, such as for aesthetic procedures and

treatments. If patients experienced an adverse event following treatment, they could contact clinical staff over the telephone or the social media app outside of clinic times. Emergency appointments were offered, if required.

Staff completed an informal induction period and were allocated mandatory training to complete, this included safeguarding of adults and children and duty of candour. The service manager was responsible for making sure that staff completed mandatory training.

Patient care records were stored on an electronic and 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 kept up to date with changes in the aesthetics industry, legislation and best practice guidance in a variety of ways. The service manager is a member of the British Association of Medical Aesthetic Nurses (BAMAN) and also of the Aesthetics Complications Expert Group (ACE). The manager was also part of a local aesthetics study group for peer support. This group met twice a year and produced minutes of the meetings, which the practitioner was responsible for.

The practitioner engaged in regular continuing professional development and had completed their revalidation. This is managed through the Nursing and Midwifery Council (NMC) registration and revalidation process, as well as yearly appraisals. 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 NMC every 3 years. They also kept up to date with appropriate training, such as for:

- adult support and protection
- equality and diversity, and
- infection control.

We saw evidence of the practitioner's personal and professional development displayed in the service.

What needs to improve

The service had completed various checks, including appropriate background checks on all staff working in the service. However, we noted not all staff had two references, a record of their immunisation status or a current appraisal

from their substantive NHS post, or equivalent appraisal. We saw no evidence of a formal process carried out for ongoing checks (requirement 1).

While policies were in place to support the safe delivery of person-centred care, these were out of date and no formal process was in place to review the policies (recommendation d).

The service had five members of staff working in the service under a practicing privileges contract. All staff had a practicing privileges contract in place agreeing to conform and work in the services policies and procedures. However, we saw no evidence that the service had a practicing privileges policy in place (recommendation e).

Staff working under practicing privileges had contracts detailing training, requirements and performance management. However, we saw no evidence that these staff members had completed a formal induction programme (recommendation f).

Requirement 1 – Timescale: immediate

- The provider must ensure that appropriate recruitment checks are carried out on all staff before they start working in the service and on an ongoing basis.

Recommendation d

- The service should develop and implement a system to determine review dates for its policies and procedures with documented evidence of when reviews are undertaken and what changes or updates were subsequently made.

Recommendation e

- The service should develop and implement a practicing privileges policy which demonstrates the safe delivery of care with individual responsibility and accountability clearly identified.

Recommendation f

- The service should have an induction programme for all new staff, including those working under practicing privileges.

Planning for quality

The service's clinical governance process included a risk register, which was reviewed regularly. Appropriate risk assessments were in place to effectively manage risk in the service, including those for:

- data protection
- environmental assessments, including slips, trips and falls
- fire
- infection prevention and control, and
- medicine management.

Risk assessments were easy to follow and we saw that most risks had been reviewed and that action plans were in place for risks reviewed.

We saw evidence that the service carried out some audits regularly. These included audits of infection prevention and control, medicine management and health and safety.

The service had a contingency plan in place to make sure patients could access aesthetic treatments from peers and aesthetic colleagues should the service cease to operate.

What needs to improve

While the service carried out some audits, it did not have a formal audit programme in place to determine when audits would take place. The audits carried out could also be developed to include policy review and patient feedback (recommendation g).

The service had completed several audits on stock control. However, we saw items of stock which were out of date, such as syringes and needles (recommendation h).

The service did not have a formal quality improvement plan in place. A formal quality improvement plan would help the service to structure and record its improvement processes. This could include outcomes identified from:

- accidents and incidents
- audits
- complaints
- education and training events, and
- patient feedback (recommendation i).

- No requirements.

Recommendation g

- 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 h

- The service should make sure audits accurately assess areas of concern and action plans are put in place with the nominated person responsible for dealing with issues identified through the audit process.

Recommendation i

- The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement.

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 and maintained. Good infection control measures were in place. Patients reported good levels of satisfaction and told us they felt safe in the service. Information documented in the patients' care records was clear and precise.

Prescription-only medication must be discarded if patients cancel or do not attend for appointments and stock control should include checking expiry dates. All patient care records should be accessible to the service manager.

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, of a high standard and well maintained. Cleaning schedules were in place, fully completed and up to date. All equipment for procedures was single-use to prevent the risk of cross-infection. Personal protective equipment was readily available to staff and in plentiful supply. A clinical waste contract was in place. Clinical waste and used sharps equipment was disposed of appropriately. We saw a good supply of alcohol-based hand rub and appropriate personal protective equipment was available. The correct cleaning products were used in line with national guidance, such as chlorine-based cleaning products for sanitary fixtures and fittings.

The medical fridge was clean and in good working order. A temperature recording logbook was used to record fridge temperatures every day. This made sure medicines were stored at the correct temperature. The logbook was fully completed and up to date. We saw a safe system in place for the procurement and prescribing of medicines.

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:

- ‘The clinic was spotless, I saw the practitioner open new packets and needles while setting up for treatment, she washed her hands and wore appropriate PPE I had no concerns.’
- ‘I was very pleased to see local infection control guidelines were adhered to and the use of PPE worn and disposed of appropriately. The consultation and treatment room is entirely private.’
- ‘The clinic is very welcoming, cosy, friendly, 1st class clinic, I always look forward to my treatments with the practitioner.’

We reviewed five electronic patient care records. All entries were legible, signed and dated. Each patient care record showed a clear pathway from assessment to treatments provided. Patient consent to treatment was noted on all records reviewed, and the practitioner had signed and dated their entries. Medicine batch numbers and expiry dates were also noted. The cost of treatments was detailed so patients knew exactly what they were paying. Advice on specific aftercare was given with each treatment and evidenced in all patient care records we reviewed. Patient information included a full medical history, with details of any:

- existing health conditions
- medications, and
- previous 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:

- ‘I know the practitioner is a trained nurse, also the way she explained the treatment and answered my questions gave me reassurance she had the right knowledge and skills.’
- ‘I know that the practitioner is also a trained nurse, I always feel very safe in the clinic knowing that the standards of practice & cleanliness is adhered to.’

The practicing privileges staff files we reviewed contained information on mandatory training, most of the background checks including Protecting Vulnerable Groups (PVG) and expectations of staff working in the service.

We saw evidence of good standards of medicines management in line with the service's medicine management policy. This included completed records of medicines prescribed and used for treatments in the service.

We saw the service used bacteriostatic saline to reconstitute vials of botulinum toxin (when a liquid solution is used to turn a dry substance into a fluid for injection). Bacteriostatic saline is an unlicensed product and the use of this rather than normal saline for reconstitution means that botulinum toxin was used outside of its Summary of Product Characteristics. This means it is deemed as unlicensed use. The service discussed this process with patients during their consultations and included information about it in their consent forms, advising that the drug was used as an off-license medicine.

What needs to improve

We saw an unopened box of botulinum toxin in the medical refrigerator, which was in-date. However, this medication was prescribed for a patient who had cancelled their appointment and the prescription still fixed to the drug was out of date (requirement 2).

The service manager and owner of the service was not able to access patient care records of the staff working in the service under a practicing privilege contract. While we did see evidence of a selected few notes they could access, this was not consistent. The service manager only had access to areas where they had completed the initial face-to-face consultation in order to prescribe the patients' prescription-only medications (recommendation j).

Requirement 2 – Timescale: immediate

- The provider must demonstrate good medicines governance for the prescribing and administration of medicines and implement a more effective stock control and monitoring system to ensure that expiry dates for prescriptions remain in-date or are removed from stock.

Recommendation j

- The service should ensure that practitioners record information in one patient care record system, so that the service manager and owner has access to all patient care records.

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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