Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Bo-Fox, Kirkcaldy

Service Provider: Laura Reekie

18 July 2025

NHS SCOTLAND

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1 Progress since our last inspection

What the provider had done to meet the requirements we made at our last inspection on 22 October 2020

Requirement

The service provider must develop and implement a practicing privileges policy for staff working in the service. This should set out the appropriate pre-employment safety checks in place and clearly identify individual responsibilities and accountabilities.

Action taken

A practicing privileges policy set out the appropriate pre-employment safety checks in place, identifying individual responsibilities and accountabilities. **This requirement is met.**

What the service had done to meet the recommendations we made at our last inspection on 22 October 2020

Recommendation

The service should ensure that all control measures that are in place for the management of COVID-19 are reflected in the services risk assessment and the infection prevention and control policy.

Action taken

Risk assessments were in place and reflected any infection control measures in the service.

Recommendation

The service should ensure that all re-useable cleaning equipment is decontaminated in line with the guidance for the management of linen in the Health Protection Scotland national infection prevention and control manual. This will reduce the risk of cross-infection.

Action taken

All equipment was single-use and disposed of and or discarded after use. No items in the service required decontamination.

Recommendation

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

Action taken

The service carries out a variety of audits. However, it did not have a formal progamme or schedule audits in place. This recommendation is reported in Domain 5: Planning for Quality (see recommendation d on page 20).

Recommendation

The service should ensure that the COVID-19 screening questionnaire is revised in line with current guidance.

Action taken

The service was able to demonstrate COVID-19 screening questionnaires were reviewed in line with current guidance and completed for every patient receiving treatment in the service.

Recommendation

The service should ensure that the consent to treatment form is revised to include information about COVID-19 risks and precautions.

Action taken

Previous patient care records showed that this information was included in patient consent forms for all patients receiving treatment at that time.

Recommendation

The service should ensure that patients are screened for COVID-19 the day before and on the day of their appointment. This will minimise the risk of cross-infection.

Action taken

The service was able to demonstrate that patients had been screened for COVID-19 at that time.

Recommendation g

The service provider should provide service users with written information about Covid-19 risks and precautions following their appointment.

Action taken

The service was able to demonstrate all patients received written information about COVID-19 risks and precautions following their appointments.

2 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 Bo-Fox on Friday 18 July 2025. We spoke with the service manager who is the sole practitioner for the service during the inspection. We received feedback from 20 patients through an online survey we had asked the service to issue to its patients for us before the inspection.

Based in Kirkcaldy, Bo-Fox is an independent clinic providing non-surgical treatments.

The inspection team was made up of two inspectors (one inspector was shadowing).

What we found and inspection grades awarded

For Bo-Fox, 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. Clear aims and objectives were available for patients to view. A short-, medium- and longer-term plan also included how the service would make sure it met its aims and objectives. Regular, formal staff meetings should take place and include staff feedback.	✓✓ Good
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 decisions about their care. Clear processes and procedures were in place for managing complaints. A quality improvement plan was in place. Patient feedback was actively sought and used to continually improve the service. Appropriate safety assurance processes include a risk management system and external audits. Improvements made after feedback should be shared with patients. An audit plan should be implemented.	✓✓ Good
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment was clean, tidy and well equipped. Patients reported good levels of satisfaction and told us they felt safe in the service. Good medicines governance must be followed when using unlicensed medicines for treatment, including obtaining informed consent from patients for the use of unlicensed medicines. All staff working in the service must have all appropriate background and safety checks documented. Information about patients' GP, next of kin or emergency contacts should be documented 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: 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 Laura Reekie 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 five recommendations.

Direction	
Requirements	
	None
Recommendation	
a	The service should introduce formal staff meetings. These should be documented and include staff feedback, any actions taken and those responsible for the actions. Minutes of meetings should be shared with all members of staff (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

None

Recommendations

b The service should develop a process to communicate to patients how patient feedback is used to improve the service (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

c 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

d The service should introduce a formal audit programme to make clear when audits will be carried out (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

1 The provider must implement effective systems that demonstrate that staff working in the service, including staff working under practicing privileges, are safely recruited and that key ongoing checks then continue to be carried out regularly (see page 23).

Timescale – by 18 October2025

Regulation 8(1)
The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011

Results (continued)	
Requirements	
2	The provider must ensure that when unlicensed medicines are used, appropriate medicine governance arrangements are in place, including documented rationale for use and informed patient consent (see page 23). Timescale – by 18 September 2025 *Regulation 3(d)(iv)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
e	The service should ensure patients' GP, next of kin or emergency contact details are documented appropriately in patient care records. If the patient refuses to provide the information, this should be documented (see page 24). Health and Social Care Standards: My support, my life. I am fully informed about what information is shared with others about me. Statement 2.14

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

Laura Reekie, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Bo-Fox for their assistance during the inspection.

3 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. Clear aims and objectives were available for patients to view. A short-, medium- and longer-term plan also included how the service would make sure it met its aims and objectives. Regular, formal staff meetings should take place and include staff feedback.

Clear vision and purpose

The service's aims, objectives and purpose were kept in a patient information folder available for patients to read in the clinic. This also included the service's vision of creating a space where every patient felt safe and valued with a focus on personal goals and wellbeing.

The service's purpose of offering high quality care also included its values, which were also readily available for patients to view. These included:

- clinical excellence
- continuous improvement
- empowerment
- inclusion
- person-centred, and
- transparency and trust.

The service reviewed this information yearly, using patient feedback and audit information to assess its progress.

A quality improvement plan was also used to measure how the service was performing against key performance indicators. Non-clinical indicators included patient retention rate and a growing patient base. Clinical indicators, such as patient satisfaction and patient outcomes were also recorded. This information was acted on to improve the service.

The service also identified three immediate priority areas, which were:

- implementation of digital system
- performance management, and
- stakeholder engagement.

An independent nurse prescriber worked in the service under a practicing privileges agreement (where staff are not employed directly by the provider but given permission to work in the service).

The practitioner told us the service's goal was to benchmark its annual performance review against the aims and objectives and key performance indicators. It also planned to benchmark its performance against other clinics to keep the clinic's services in line with evolving patients' expectations and industry standards.

- No requirements.
- No recommendations.

Leadership and culture

The owner (practitioner) was also the service manager and an experienced registered nurse, 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 independent nurse prescriber was also registered with the NMC.

The service operated under a leadership structure where all staff reported directly to the service manager. The manager held informal meetings with staff to share updates on service changes, clinic developments, patient feedback, and training opportunities. Staff were also encouraged, in an informal manner, to participate and contribute to the daily running of the service.
The service's governance approach included:

- a complaints handling process
- a risk register and risk assessments
- audit reviews
- gathering and evaluating patient feedback
- reporting of adverse events, and
- reviewing findings from previous Healthcare Improvement Scotland inspections.

What needs to improve

We were told staff had informal meetings and discussions, covering:

- audit results
- patients feedback
- staff suggestions, and
- training.

However, we saw no recorded evidence of these meetings, staff making suggestions or staff sharing feedback with the service manager (recommendation a).

- No requirements.

Recommendation a

- The service should develop a 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.

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 decisions about their care. Clear processes and procedures were in place for managing complaints. A quality improvement plan was in place. Patient feedback was actively sought and used to continually improve the service. Appropriate safety assurance processes include a risk management system and external audits. Improvements made after feedback should be shared with patients. An audit plan should be implemented.

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 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 after treatments and through online apps. This helped to encourage patients to participate in service development.

We saw service reviewed feedback regularly and information gathered was used to inform service improvement activities. The service had moved to new premises as a direct result of patient feedback indicating patients would prefer to have treatments in a premises designed specifically for aesthetic treatments.

Any changes in the service that led to improvements were monitored and evaluated through the audit programme and quality improvement plan. The provider used any feedback received to inform and assure service quality.

What needs to improve

While the service made improvements after receiving patient feedback, it was not clear how it shared these outcomes with patients (recommendation b).

- No requirements.

Recommendation b

- The service should develop a process to communicate to patients how patient feedback is used to improve the service.

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 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 accident and incidents.

The service was proactive in developing and implementing policies to help make sure that patients had a safe experience in the service. Policies were reviewed every 2 years or as required, to make sure they remained relevant to the service and in line with national guidance. Key policies included those for:

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

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 April 2018.

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 in hard copy in a locked cupboard and some were kept on the service's new electronic system, which it planned to fully integrate in future. The practitioner and the independent nurse prescriber were the only staff with possession of the cupboard key to access patient care records. The electronic system was password-protected. 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 was a member of the Aesthetics Complications Expert Group (ACE) and part of a local peer group who shared ideas and advice. Members of this peer group also carried out external audits of the service.

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

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 c).

- No requirements.

Recommendation c

- 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. 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 audits regularly. These included:

- complaints
- infection prevention and control
- medicines
- patient care records
- patient and staff feedback, and
- safe management of equipment.

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.

We saw that all results from audits were documented, as well as actions taken if appropriate. Audit results were also reflected in the quality improvement plan. The quality improvement plan was regularly reviewed and updated.

What needs to improve

While the service carried out regular audits, it did not have a formal audit programme and schedule in place. This would help the service improve how it planned its audit activity (recommendation d).

- No requirements.

Recommendation d

- The service should introduce a formal audit programme to make clear when audits will be carried out.

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, tidy and well equipped. Patients reported good levels of satisfaction and told us they felt safe in the service. Good medicines governance must be followed when using unlicensed medicines for treatment, including obtaining informed consent from patients for the use of unlicensed medicines. All staff working in the service must have all appropriate background and safety checks documented. Information about patients' GP, next of kin or emergency contacts should be documented 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 comprehensive 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:

- ‘Very clean and very professional.’
- ‘The treatment room is clean, well it and really comfortable.’
- ‘Clean, organised, safe disposals of sharps and clinical waste.’

We reviewed five patient care records. All entries were legible, signed and dated. Each patient care record showed a clear pathway from assessment to treatments provided. Patients’ consent to treatment was noted on all patient care records we reviewed and we saw that the practitioner had signed and dated their entries. Medicine batch numbers and expiry dates were also noted. 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:

- ‘The practitioner is a qualified and knowledgeable nurse and I felt very confident in her practice.’
- ‘The practitioner is very well educated and confident in treatments and procedures.’
- ‘The practitioner explained all the process and her certificates are well displayed.’

The practicing privileges staff file we reviewed contained a signed contract that the member of staff and the service manager had signed. We saw some evidence of information about:

- expectations of staff working in the service
- mandatory training
- professional registration checks, and
- Protecting Vulnerable Groups (PVG) checks.

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.

What needs to improve

The service had completed some checks, including appropriate PVG checks on staff working in the service. However, we noted that no checks had been carried out to make sure staff granted practicing privileges had:

- a record of immunisation status
- indemnity insurance
- proof of identity in place, or
- two references (requirement 1).

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 meant that botulinum toxin was used outside of its Summary of Product Characteristics. This means it is deemed as unlicensed use. However, we saw no evidence to suggest the service discussed this process with patients during their consultations or included information about it in their consent forms, advising that the drug was used as an off-license medicine (requirement 2).

Of the five patient care records we reviewed, we saw no evidence of the patients' GP, next of kin or emergency contact details documented. Patient care records also did not contain evidence of patients consenting or being asked to share relevant information with their GP or other healthcare professionals in an emergency. If the patient refuses to agree, this information should also be documented (recommendation e).

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

Requirement 2 – Timescale: by 18 September 2025

- The provider must ensure that when unlicensed medicines are used, appropriate medicine governance arrangements are in place, including documented rationale for use and informed patient consent.

Recommendation e

- The service should ensure patients' GP, next of kin or emergency contact details are documented appropriately in patient care records. If the patient refuses to provide the information, this should be documented.

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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