Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service Name: Atelier Clinic, Kilmarnock

Service Provider: Willow Tree Aesthetics Limited

23 September 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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www.healthcareimprovementscotland.scot

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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 Atelier Clinic on Tuesday 23 September 2025. We spoke with the manager (practitioner) and one staff member during the inspection. We received feedback from six 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 Kilmarnock, Atelier Clinic 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 Atelier Clinic 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 was to provide patient-centred care in a safe and inclusive environment. Staff were clear about their roles and responsibilities and described the manager (practitioner) leadership as fair, visible and approachable. The service's vision statement should be shared with patients. Key performance indicators should be identified and used to measure the service's performance. Staff meetings should be introduced and a record kept and shared with staff.	✓ Satisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Patients received sufficient information to make informed choices and consent. Policies and procedures set out the way the service would deliver safe care. This also included clear systems and processes to monitor and manage complaints and risk. Processes were in place to make sure medicines were handled safely and securely. An audit programme supported the continuous improvement of the service. Staff appraisals must be carried out for all staff members. Botulinum toxin should be administered according to the manufacturer's guidance. Risk assessments and a risk register would help to manage and reduce risks in the service. A quality improvement plan should be developed and implemented.	✓ Satisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care*
The clinic environment and equipment was clean and well maintained, with good infection control measures in place. Detailed records of patients' care and treatment were kept, with a clear patient pathway from assessment to aftercare documented. Safe recruitment processes were in place. Patients were positive about their experience. Safe recruitment and ongoing processes helped make sure staff remained safe to work in the service.	✓ 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 Willow Tree Aesthetics 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
Recommendations	
a	The service should ensure that information about the service's vision is available to patients (see page 10). 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 and implement a process for measuring, recording and reviewing key performance indicators (see page 11). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19
c	The service should formalise staff meetings, record a summary of discussions in meetings and any actions arising from staff meetings including those responsible for the actions. Minutes should be shared with all staff (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

Implementation and delivery	
Requirements	
1	The provider must ensure all staff receive regular performance reviews and appraisals to make sure that their job performance is documented and evaluated (see page 17). Timescale – immediate *Regulation 12(c)(i)* *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. This must include: *(a) a comprehensive risk register, and* *(b) appropriate risk assessments to protect patients and staff (see page 18).* Timescale – by 23 January 2026 *Regulation 13(2)(a)* The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011
Recommendations	
d	The service should ensure botulinum toxin is used in line with the manufacturer's and best practice guidance and update its medicines management policy to accurately reflect the processes in place (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
e	The service should develop and implement a quality improvement plan to formalise and direct the way it drives and measures improvement (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

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

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

We would like to thank all staff at Atelier Clinic 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 was to provide patient-centred care in a safe and inclusive environment. Staff were clear about their roles and responsibilities and described the manager (practitioner) leadership as fair, visible and approachable.

The service's vision statement should be shared with patients. Key performance indicators should be identified and used to measure the service's performance. Staff meetings should be introduced and a record kept and shared with staff.

Clear vision and purpose

The service had a vision to enhance natural beauty and wellbeing through high-quality, evidence-based aesthetic treatments delivered with clinical excellence, compassion and integrity. It aimed to provide patient-centred care and create a safe and inclusive environment that supports positive outcomes and long-term satisfaction for patients.

What needs to improve

While the service had a vision, this information was not readily available to patients in the service or on the service's website (recommendation a).

The service did not have a formal way to measure key performance indicators to provide reassurance that the service's vision was being met (recommendation b).

- No requirements.

Recommendation a

- The service should ensure that information about the service's vision is available to patients.

Recommendation b

- The service should develop and implement a process for measuring, recording and reviewing key performance indicators.

Leadership and culture

The service is owned and managed by the manager (practitioner), an independent nurse prescriber who was also an experienced aesthetics practitioner. Registered nurses worked under practising privileges (staff not employed directly by the provider but given permission to work in the service) and one of these was an independent nurse prescriber. All clinical staff were registered with their professional regulator, the Nursing and Midwifery Council (NMC).

The manager (practitioner) told us that they held informal catch ups with the staff and information was shared through an online messaging app. This included information on treatments, updates on new policies and procedures, current and ongoing priorities in the service and future training opportunities.

Policies were in place describing the procedure for staff to raise concerns, including a bullying and harassment policy.

The manager (practitioner) was accountable for the clinical governance processes to maintain patient safety. This included:

- an audit programme
- gathering and evaluating patient feedback, and
- reviewing clinical procedures and policies.

Staff we spoke with were clear about their roles and responsibilities and how to discuss any concerns or raise areas for improvement in the service. They told us they felt valued and respected in their role and spoke positively about the leadership and support provided. Staff told us they had been regularly kept up to date with any changes, such as updated policies and procedures. They also described the manager (practitioner) leadership as visible, approachable and supportive. Staff members were encouraged to attend conferences and training sessions to develop their skills.

What needs to improve

We were told that informal catch-ups occurred between the manager (practitioner) and staff. However, we saw no evidence of formal staff meetings taking place (recommendation c).

- No requirements.

Recommendation c

- The service should formalise staff meetings, record a summary of discussions in meetings and any actions arising from staff meetings including those responsible for the actions. Minutes should be shared with all staff.

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 received sufficient information to make informed choices and consent. Policies and procedures set out the way the service would deliver safe care. This also included clear systems and processes to monitor and manage complaints and risk. Processes were in place to make sure medicines were handled safely and securely. An audit programme supported the continuous improvement of the service.

Staff appraisals must be carried out for all staff members. Botulinum toxin should be administered according to the manufacturer's guidance. Risk assessments and a risk register would help to manage and reduce risks in the service. A quality improvement plan should be developed and implemented.

Co-design, co-production *(patients, staff and stakeholder engagement)*
Information about the treatments offered was available on the service's website and in patient information leaflets in the treatment room. Patients were also sent key information about their treatment including risks and benefits prior to their appointment through the service's online software system.

The service had a patient participation policy in place and actively encouraged patient feedback. We saw a variety of ways that patients could provide input into how the service continued to develop. Patients were encouraged to provide verbal feedback at any time during treatment and could provide feedback through the service's online software system. After a patient received treatment, the service also emailed a link asking them to leave a review on their experience of using the service. We saw evidence that feedback was consistently very positive.

- No requirements.
- No recommendations

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 manager (practitioner) recognised the importance of people's dignity and respect. All consultations were by appointment and only one patient was treated in the service at a time, maintaining confidentiality. Controlled access to the treatment room meant patients' privacy and dignity was not compromised.

All patients who responded to our online survey agreed they were treated with dignity and respect. Comments included:

- 'I was given opportunity to ask questions and felt listened to.'
- '…. listens to me and is always very respectful.'

The landlord was responsible for the servicing and maintenance of the building, this included electrical installation. The manager (practitioner) carried out portable appliance testing for electrical appliances and equipment to make sure of their safety for use. Appropriate fire safety equipment and signage was in place.

Patients completed the first part of their patient care record before their consultation, which included a medical history consultation form. Staff reviewed the completed forms before the patient's face-to-face consultation to assess their suitability for treatment.

All patients had a face-to-face consultation before a treatment plan was prepared or any treatment was administered. During their consultation appointment, discussions took place about the risks and benefits, costs and likely outcome of the desired treatment. Consent from patients was discussed and the patient and practitioner signed the consent form. Patients were given time to consider treatment options and ask questions before agreeing to treatment. This helped to make sure patients had realistic expectations of the proposed treatment.

As part of their treatment plan, patients were invited to attend a follow-up appointment. This allowed the service to make sure patients were happy with the results and provide any additional treatment or advice.

Written aftercare advice was provided before treatment and verbal aftercare advice at the time of treatment. This was documented in the patient care

record. Patients were also given the service's contact details in case of any complications.

All patients who responded to our online survey agreed they were involved in decisions about their care and treatment and given sufficient time to reflect on their treatment options before consenting to treatment. Comments included:

- 'Everything was fully explained beforehand and also after care.'
- 'I was given different options for treatments and given time to decide before making appointments for my chosen treatments.'

Patient care records were in paper and electronic format. Appropriate procedures were in place to make sure that information was held securely and to prevent unauthorised access. The service was registered with the Information Commissioner's Office (an independent authority for data protection and privacy rights) to make sure confidential patient information was safely stored.

Safe management processes were in place for ordering, storing and prescribing, as well as administering all medicines. All medicines were obtained from appropriately registered suppliers. Medicines were stored securely in a locked medical refrigerator. A system was in place to monitor the temperature of the fridge to make sure medicines were stored at the correct temperature. An effective stock control and rotation system allowed the service to regularly monitor the medicines supply.

A first aid kit and emergency medication were available along with emergency protocols to quickly deal with any medical emergencies, such as a complication or adverse reaction from treatment. The manager (practitioner) had been trained to deliver advanced life support in the event of a medical emergency.

The service kept a register of its policies and procedures. All were in-date, reviewed and updated regularly to reflect current legislation and best practice. We saw that some of the policies in place included those for:

- consent
- infection control, and
- medicines management.

The service's complaints policy included up-to-date contact details for Healthcare Improvement Scotland and made clear that patients could contact us at any time. Information on how to make a complaint was available in the

waiting area. The service had not received any complaints since it registered with Healthcare Improvement Scotland in September 2022.

The service had a duty of candour policy in place. This is where healthcare organisations have a professional responsibility to be honest with people when something goes wrong. The most recent report showed that no duty of candour incidents had occurred. A safeguarding (public protection) policy described the actions to take in case of an adult protection concern.

While the service had not had any incidents or accidents since registration, systems were in place to record any that may occur. The manager (practitioner) was aware of their responsibility to notify Healthcare Improvement Scotland of certain events in line with our notification guidance and relevant incidents under health and safety legislation.

The service's practising privileges policy highlighted the requirements for any staff working under practising privileges. We reviewed files for two staff members that had been granted practising privileges to work in the service. We found that safe recruitment policies and processes were in place for all staff, including relevant pre-employment checks before staff started working in the service, such as:

- Disclosure Scotland status
- insurance
- proof of ID
- qualifications, and
- references.

Staff files were well organised and contained signed contracts of employment and a record of training. We saw systems were also in place for the ongoing checks of clinical staff members' professional registration and revalidation with their professional regulatory body, the Nursing and Midwifery Council (NMC).

The manager (practitioner) and staff working under practising privileges worked in the NHS and engaged in regular continuing professional development through the NMC 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 NMC every 3 years.

The service was a member of a variety of industry specific and national organisations, including:

- the Aesthetic Complications Expert (ACE) Group
- the British Association of Cosmetic Nurses (BACN), and
- the Joint Council for Cosmetic Practitioners (JCCP).

These groups provide support if complications arise after a patient's treatment and provide learning opportunities, support and advice for its members.

The service subscribed to aesthetics journals and webinars and also attended regular conferences. This helped the service keep up to date with:

- best practice
- changes in legislation
- current product knowledge, and
- techniques.

What needs to improve

The manager (practitioner) spoke regularly with the staff. However, staff did not receive an annual appraisal. Regular review of staff performance must take place (requirement 1).

Requirement 1 – Timescale: immediate

- The provider must ensure all staff receive regular performance reviews and appraisals to make sure that their job performance is documented and evaluated.

- No recommendations.

Planning for quality

If the clinic became unavailable for use for any reason, we were told that patients would be notified and referred to a suitable alternative local service.

Quality assurance systems were in place, including carrying out regular audits to monitor the quality and safety of the care and treatments provided to patients. We saw evidence that patient care records were audited every month. This helped to make sure records were being fully and accurately completed. The audit reviewed areas such as consultation, medical history and patient consent. Additional audits included medicine management and daily cleaning schedules and. Where areas for improvement had been identified, planned actions and

timescales for completion were documented. All audit results we saw showed high compliance.

What needs to improve

While a fire risk assessment was in place, we saw no evidence of other risk assessments to protect patients and staff or a risk register. The development of a risk register would help to record details of all risks in one place and their potential impact. A risk register would also help to make sure risks were regularly reviewed and updated with appropriate processes in place to help manage any risks identified (requirement 2).

The service used botulinum toxin vials for single patient use that were then kept for up to 2 weeks for the patient's follow-up appointment. This is not in line with the manufacturer's or best practice guidance (recommendation d).

The service did not have a quality improvement plan in place. This would help to structure and record service improvement processes and outcomes. It would also allow the service to measure the impact of change and demonstrate a culture of continuous improvement (recommendation e).

Requirement 2 – Timescale: by 23 January 2026

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

  (a) a comprehensive risk register, and
  (b) appropriate risk assessments to protect patients and staff.

Recommendation d

- The service should ensure botulinum toxin is used in line with the manufacturer's and best practice guidance and update its medicines management policy to accurately reflect the processes in place.

Recommendation e

- 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 clinic environment and equipment was clean and well maintained, with good infection control measures in place. Detailed records of patients' care and treatment were kept, with a clear patient pathway from assessment to aftercare documented. Safe recruitment processes were in place. Patients were positive about their experience. Safe recruitment and ongoing processes helped make sure staff remained safe to work in the service.

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.

The clinic environment and equipment was clean, well maintained and in a good state of repair. Daily cleaning schedules were fully completed and up to date. The correct cleaning products were used in line with national guidance, for example chlorine-based cleaning products for sanitary fixtures and fittings.

The service's infection prevention and control policies and procedures were in line with national infection prevention and control guidance. This included an up-to-date clinical waste management contract and clear procedures for the safe disposal of medical sharps (such as syringes and needles), clinical waste and single-use patient equipment (used to prevent the risk of cross-infection). We saw a good supply of alcohol-based hand rub and appropriate personal protective equipment (such as disposable gloves and aprons) were available. Posters in the treatment room provided guidance on the correct hand washing procedure.

All patients who responded to our online survey were satisfied with the facilities and equipment in the service. Comments included:

- ‘Everything was clean.’
- ‘Very clean, tidy and professional clinic.’

We reviewed five electronic patient care records and saw evidence of comprehensive record keeping. All entries were legible, signed and dated. Each patient care record showed a clear pathway from assessment to treatments provided. Patient information included a full medical history, with details of any health conditions, medications, previous treatments and any areas which would highlight any risks associated with the treatment such as pregnancy or any previous allergic reactions. Patients’ GP and next of kin details, consent to share information with their GP and other relevant staff in the event of an emergency and having their photograph taken were all documented. Records were kept of each treatment session, diagrams and photographs of the treated area helping to inform the overall plan of care. Dosage and medicine batch numbers were also recorded for each treatment. This would allow tracking if any issues arose with the medications used.

Feedback from our online survey was very positive about the experience patients had at the service. Comments included:

- ‘… could answer all of my queries without any hesitation.’
- ‘Good appointment booking system and a professional and friendly approach.’
- ‘I received good information on my chosen treatments and felt like a thorough consultation before I decided to go ahead with my treatments. I felt at ease and was given good advice on after care plus follow-up contact.’

We saw the service used bacteriostatic saline to reconstitute the vials of botulinum toxin vials, this is when a liquid solution is used to turn a dry substance into a specific concentration of solution. The bacteriostatic saline used is an unlicensed product and the use of this instead of normal saline for reconstitution means that the botulinum toxin is being used outside of its Summary of Product Characteristics and is unlicensed. We were told this provided better pain relief for patients. We saw evidence in the patient care record that the use of unlicensed bacteriostatic saline and the unlicensed use of botulinum toxin had been discussed with patients and that informed consent had been sought and signed by the patient.

- No requirements.

- No recommendations.

Appendix 1 – About our inspections

Our quality of care approach and the quality assurance framework allows us to provide external assurance of the quality of healthcare provided in Scotland.

Our inspectors use this approach 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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