Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

Announced Inspection Report: Independent Healthcare

Service: Forte Aesthetics, Dundee

Service Provider: Catherine Myles

11 February 2026

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

First published April 2026

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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 Forte Aesthetics on Wednesday 11 February 2026. We spoke with the manager during the inspection. We received feedback from five 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, Forte 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 Forte 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 service's aims and objectives should be shared with patients and staff. Governance of practicing privileges staff must be implemented. Key performance indicators that include monitoring the safe care and treatment of patients should be developed.	Unsatisfactory
Implementation and delivery	*How well does the service engage with its stakeholders and manage/improve its performance?*
Policies were in place for the safety, care and treatment of patients and staff. Improved governance processes would help to ensure oversight of safe medicines management. A proactive approach must be taken for the assessment and management of risk, including expanding the range of risk assessments undertaken and developing a risk register. Regular audits, gathering and analysing patient feedback, and a mandatory staff training programme would help to ensure the safe delivery and quality of the service. A duty of candour report must be produced and published.	Unsatisfactory
Results	*How well has the service demonstrated that it provides safe, person-centred care?*
The environment and equipment was clean and well maintained, with appropriate infection prevention and control practices in place. Patients spoke positively about their experience of the service. Formal recruitment, induction and appraisal processes would help to ensure staff are safe to work in the service. Access to all patient care records would enable the manager to comply with regulations and monitor patient care.	Unsatisfactory

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 Catherine Myles 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 eight requirements and nine recommendations.

Direction	
Requirement	
1	The provider must further develop its practicing privileges policy and have practicing privileges contracts that describe the governance procedures in place to ensure safe delivery of care with individual responsibility and accountability clearly identified and agreed (see page 12). Timescale – immediate *Regulation 12(d)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendations	
a	The service should share its aims and objectives with patients and staff (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

Direction (continued)	
Recommendations	
b	The service should develop key performance indicators to include monitoring the safe care and treatment of patients (see page 11). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.19

Implementation and delivery	
Requirements	
2	The provider must further develop its medicines management policy and implement measures to ensure safe medicines management, including ensuring that: a) systems are in place to ensure emergency equipment and medication is always available, and b) medicines, medical supplies and emergency drugs and equipment can be checked and audited (see page 16). Timescale – immediate *Regulation 3(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
3	The provider must produce and publish an annual duty of candour report (see page 16). Timescale – by 11 May 2026 *Regulation 5(2)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011*
4	The provider must develop effective systems that demonstrate the proactive management of risks to patients and staff (see page 18). Timescale – by 11 May 2026 *Regulation 13(2)(a)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Implementation and delivery (continued)	
Recommendations	
c	The service should implement a structured approach to gathering and analysing patient feedback, which all staff use, to demonstrate the impact of improvements made. Patients should be informed of the changes made as a result of their feedback (see page 14). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.8
d	The service should develop a list of mandatory training for staff to complete. This should include clinical training to ensure patient safety, as well as training on governance procedures (see page 16). Health and Social Care Standards: My support, my life. I have confidence in the people who support and care for me. Statement 3.14
e	The service should make its complaints process easily available to patients (see page 16). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.20
f	The service should ensure that practicing privileges staff are registered with the Information Commissioner's Office (see page 16). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.11
g	The service should develop a programme of audits to cover key aspects of care and treatment, such as patient care records, the clinic environment and equipment, staff files and medicines management. Audits should be documented and improvement action plans implemented (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
h	The service should develop and document a formal business contingency plan that sets out the arrangements for continuity of care for patients, in the event of the service closing for any reason (see page 18). Health and Social Care Standards: My support, my life. I have confidence in the organisation providing my care and support. Statement 4.14

Results	
Requirements	
5	The provider must implement effective systems that demonstrate that staff working in the service, including staff working under practicing privileges, are safely recruited, including that all staff are enrolled in the Protecting Vulnerable Groups (PVG) scheme by the service, and that key ongoing checks then continue to be carried out regularly (see page 21). Timescale – immediate *Regulation 8(1)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
6	The provider must develop a formal role-specific induction package for all staff to evidence that they have the appropriate support and knowledge required for their role (see page 21). Timescale – by 11 May 2026 *Regulation 12(a)(d)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
7	The provider must introduce regular one-to-ones and annual appraisals to allow all staff the opportunity to discuss progress in their role or any concerns (see page 21). Timescale – by 11 May 2026 *Regulation 12(c)(i)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

Results (continued)	
Requirements	
8	The provider must ensure that the manager has access to all patient care records at all times: a) so that all relevant documentation is available to view by an authorised person when requested, including Healthcare Improvement Scotland inspectors during an inspection b) in case of an emergency, and c) for auditing purposes (see page 21). Timescale – immediate *Regulation 5(2)(a)* *The Healthcare Improvement Scotland (Inspections) Regulations 2011* *Regulation 4(3)(b)* *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*
Recommendation	
i	The service should complete and submit a self-evaluation as and when requested by Healthcare Improvement Scotland (see page 21). 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

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

We would like to thank all staff at Forte 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 service's aims and objectives should be shared with patients and staff. Governance of practicing privileges staff must be implemented. Key performance indicators that include monitoring the safe care and treatment of patients should be developed.

Clear vision and purpose

The service had developed aims and objectives that included providing quality and safe non-surgical aesthetic treatments based on evidence-based practice and ensuring patients can make informed choices about the treatments they receive.

A business plan detailed the strategy for the next year to continue to improve and develop the service.

What needs to improve

The service's aims and objectives were not visible in the service and there was no evidence that they had been shared with patients and staff. This would help to inform them of the service's purpose and goals (recommendation a).

While 'key performance indicators' were listed as a future improvement in the service's business plan, none had yet been identified. Key performance indicators should be developed to include monitoring the safe care and treatment of patients, such as adverse events and compliance with clinical audits (recommendation b).

- No requirements.

Recommendation a

- The service should share its aims and objectives with patients and staff.

Recommendation b

- The service should develop key performance indicators to include monitoring the safe care and treatment of patients.

Leadership and culture

The manager/owner was present in the service every day and provided visible leadership. A number of staff, who were registered nurses, worked in the service under a practicing privileges agreement (staff not employed directly by the provider but given permission to work in the service). The majority of these nurses were nurse prescribers and we were told that a nurse prescriber was always present in the service while patients attended for treatments.

All staff involved in clinical procedures were registered with the Nursing and Midwifery Council.

We saw evidence of good communication with staff, including team meetings held every 3 months. Meeting minutes were shared on an online messaging app with the full team. This helped to ensure that those who could not attend were updated.

A whistleblowing policy was in place that detailed the process for supporting and encouraging staff to raise concerns about suspected wrongdoing in the service.

What needs to improve

Although a practicing privileges policy was in place, there was no evidence that staff working under a practicing privileges arrangement were subject to management and oversight to ensure their compliance with the service's policies and procedures. Staff working under practicing privileges managed and retained their own patient care records. The manager did not have access to these records, and was unaware of what the patient consultation and assessment process was, as well as patient aftercare arrangements. This means that they were unable to ensure the treatments provided were safe and that the patient care records were being fully completed (requirement 1).

Requirement 1 – Timescale: immediate

- The provider must further develop its practicing privileges policy and have practicing privileges contracts that describe the governance procedures in place to ensure safe delivery of care with individual responsibility and accountability clearly identified and agreed.

- No recommendations.

Key Focus Area: Implementation and delivery

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

Our findings

Policies were in place for the safety, care and treatment of patients and staff.

Improved governance processes would help to ensure oversight of safe medicines management. A proactive approach must be taken for the assessment and management of risk, including expanding the range of risk assessments undertaken and developing a risk register. Regular audits, gathering and analysing patient feedback, and a mandatory staff training programme would help to ensure the safe delivery and quality of the service. A duty of candour report must be produced and published.

Co-design, co-production *(patients, staff and stakeholder engagement)*
The service did not have a website or social media accounts at the time of the inspection. Information about the services and treatments provided was available on each practitioner's own social media account.

The service's participation policy detailed methods used to obtain patient feedback and how this would be used to inform service delivery and improvement. A patient feedback survey had been developed.

Staff had opportunities to provide feedback on the service and make suggestions for improvement during team meetings and informally to the manager.

What needs to improve

We saw no evidence that the service was following its participation policy. For example, feedback received in any format such as verbal, email or text message was not being collated or analysed. Patients had also not yet been asked to complete the feedback survey. Although we saw evidence that some staff requested feedback from their own patients using their own feedback methods, this was also not being shared with, or collated by, the service (recommendation c).

- No requirements.

Recommendation c

- The service should implement a structured approach to gathering and analysing patient feedback, which all staff use, to demonstrate the impact of improvements made. Patients should be informed of the changes made as a result of their feedback.

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 that, as a registered independent healthcare service, it had a duty to report certain matters to Healthcare Improvement Scotland, as detailed in our notifications guidance.

A log book was available in the staff room for staff to document and report any accidents and incidents that may occur in the service. We were told none had taken place to date.

The service had a number of policies and procedures for the safety, care and treatment of patients and staff. We noted that these had recently been updated.

The service's complaints policy made clear that patients could make a complaint to Healthcare Improvement Scotland at any time. The service told us no complaints had been received since registering with Healthcare Improvement Scotland in July 2023, and we had not received any complaints about the service.

A safeguarding (public protection) policy detailed a clear protocol for staff to respond to any adult protection concerns. Other policies that protected patients were also in place such as a privacy and dignity, and equality and diversity.
A consent policy detailed how consent would be obtained from patients.

A duty of candour policy was in place (where healthcare organisations have a professional responsibility to be honest with people when something goes wrong).

An infection prevention and control policy detailed the precautions that would be taken to reduce the risks of infection, such as hand hygiene and the use of personal protective equipment (such as disposable aprons, gloves and face masks).

A health and safety policy described how the service would meet its responsibilities to ensure the health, safety and welfare of its employees, patients and the public.

A yearly fire risk assessment was carried out. Fire safety signage was displayed, and fire safety equipment was regularly checked. The fixed electrical wiring, portable electrical appliances and gas boiler had received appropriate safety checks.

Medicines were stored in locked cupboards and a locked fridge. The fridge temperature was monitored to make sure medicines were stored at the appropriate temperature.

We were told that patient care records were stored securely on individual electronic tablet devices used by the practitioners. 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.

All patients who responded to our online survey told us they had received adequate information about their procedure and felt involved in the decisions about their care. They also confirmed they were given time to consider all the information provided before having a procedure. Comments included:

- 'I was involved and provided with lots of information at every step.'
- 'No pressure and lots of time to consider options and treatment plans.'

What needs to improve

We were told that each nurse had their own lockable cupboard that contained their emergency medicines. We could not be assured what emergency medicines and equipment were available as the cupboards were locked at the time of our inspection. Due to this lack of accessibility, there was no evidence that appropriate safety checks on any emergency equipment and medicines were carried out by the manager. We also noted that the service did not hold stock medicines as the nurses brought their own supplies of medicines and medical supplies with them. There was no evidence that safety checks on the medicines used in the service were carried out (requirement 2).

Services are required to produce and publish a yearly duty of candour report, even where the duty of candour has not been invoked. The report should contain information about staff training on duty of candour. An annual duty of candour report had not been produced or published (requirement 3).

We were told that the service had not had any instances requiring the need to implement duty of candour principles. However, the service could not be assured of this as we saw no evidence that staff had completed duty of candour training. We also saw no evidence of other types of clinical governance training such as:

- complaints management
- obtaining informed consent, and
- safeguarding (recommendation d).

The complaints policy was not displayed in the clinic and, therefore, was not accessible to patients (recommendation e).

As practicing privileges staff removed their individual electronic tablet devices containing their patient care records when not working in the service, they would need to be individually registered with the Information Commissioner's Office, as well as the service (recommendation f).

Requirement 2 – Timescale: immediate

- The provider must further develop its medicines management policy and implement measures to ensure safe medicines management, including ensuring that:
  a) systems are in place to ensure emergency equipment and medication is always available, and
  b) medicines, medical supplies and emergency drugs and equipment can be checked and audited.

Requirement 3 – Timescale: by 11 May 2026

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

Recommendation d

- The service should develop a list of mandatory training for staff to complete. This should include clinical training to ensure patient safety, as well as training on governance procedures.

Recommendation e

- The service should make its complaints process easily available to patients.

Recommendation f

- The service should ensure that practicing privileges staff are registered with the Information Commissioner's Office.

Planning for quality

Appropriate public liability and medical malpractice insurance was in place.

Risk assessments had been carried out for fire and water safety, and identified remedial actions completed.

What needs to improve

While some risk assessments had taken place, there was no evidence to demonstrate that general risks within the service had been assessed such as business, clinical, and other health and safety risks. All risks to patients and staff must be effectively managed. There was also no overarching risk register in place to monitor key risks on an ongoing basis (requirement 4).

Audits are useful for ensuring compliance, patient care and safety, and general improvement of the service. There was no evidence of an audit programme detailing the type and frequency of audits to be carried out. This would help the service improve how its audit activity was planned. For example, no audits were taking place to ensure:

- patient care records were being fully completed and consultations documented
- staff files could evidence all recruitment and ongoing checks
- the environment and equipment complied with infection prevention and control, and health and safety legislation, and
- safe medicines management (including that medicines were stored, prescribed, administered and disposed of appropriately) (recommendation g).

No contingency plan was in place in case of emergencies, so that patients could continue their treatment plans (recommendation h).

Quality improvement is a structured approach to evaluating performance, identifying areas for improvement and taking corrective actions. Some plans for improvement were listed in the service's business plan such as more continued professional development opportunities for staff. However, there was no dedicated quality improvement plan. This would help to structure and record service improvement processes and outcomes, and would also allow the service to measure the impact of any changes and demonstrate a continuous cycle of improvement. We will follow this up at future inspections.

Requirement 4 – Timescale: by 11 May 2026

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

Recommendation g

- The service should develop a programme of audits to cover key aspects of care and treatment, such as patient care records, the clinic environment and equipment, staff files and medicines management. Audits should be documented and improvement action plans implemented.

Recommendation h

- The service should develop and document a formal business contingency plan that sets out the arrangements for continuity of care for patients, in the event of the service closing for any reason.

Key Focus Area: Results

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

Our findings

The environment and equipment was clean and well maintained, with appropriate infection prevention and control practices in place. Patients spoke positively about their experience of the service.

Formal recruitment, induction and appraisal processes would help to ensure staff are safe to work in the service. Access to all patient care records would enable the manager to comply with regulations and monitor patient care.

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.

The clinic environment appeared modern, clean and well-equipped. Equipment was in good condition. Cleaning of the treatment rooms and equipment was carried out between patient appointments, as well as a full clean of the clinic every day. All patients who responded to our online survey said they were satisfied with the facilities and equipment in the environment they were treated in. Comments included:

- 'Always a welcoming and safe environment.'
- 'Clean, pleasant, uncluttered and organised in advance.'

Measures were in place to reduce the risk of infection and cross-contamination. For example, the service had a good supply of personal protective equipment and alcohol-based hand gel. A cleaning schedule was completed and up to date, and appropriate cleaning products were used for general cleaning and for any blood contamination. A waste contract was in place to make sure that clinical waste, including sharps, was well managed and disposed of appropriately.

All patients who responded to our online survey felt they were treated with dignity and respect. They also confirmed that they had confidence in the staff:

- '… have complete faith in [practitioner].'
- 'Always professional and organised.'

The manager had evidence of emails they had received from the practicing privileges staff with some recruitment information such as insurance policies, aesthetic training certificates and their professional registration status.

What needs to improve

Staff files were not kept. Only checklists for each staff member were available, which indicated that appropriate background and identity checks had been carried out before they began working in the service. However, there was insufficient evidence to support this. We saw no evidence that could demonstrate that all required checks had been carried out to make sure staff had been safely recruited. For example, we did not see:

- occupational health status
- proof of identity, and
- references.

We also found that the service had not enrolled its employees in the Protecting Vulnerable Groups (PVG) scheme. At recruitment, the service requested the employees provide evidence of their own Disclosure Scotland check. This means that the service would not be directly notified of any PVG updates to ensure staff remain safe to work in the service. The PVG scheme, managed by Disclosure Scotland, helps to ensure people who are unsuitable to work with children and protected adults cannot do regulated work with these vulnerable groups (requirement 5).

There was no evidence of a formal induction for new staff to make sure that they had the appropriate support and direction to work to the service's policies and procedures (requirement 6).

There was also no evidence of one-to-one meetings between the manager and individual staff members or formal appraisals taking place to make sure staff's performance was documented and evaluated (requirement 7).

As there were no practitioners present during the inspection, we were unable to access any patient care records. The manager was also unable to access patient care records when staff were not present in the service. This means that, in an emergency situation, or for auditing purposes, they would not have access to the information they require (requirement 8).

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. Although requested, the service did not submit a self-evaluation before the inspection (recommendation i).

Requirement 5 – Timescale: immediate

- The provider must implement effective systems that demonstrate that staff working in the service, including staff working under practicing privileges, are safely recruited, including that all staff are enrolled in the Protecting Vulnerable Groups (PVG) scheme by the service, and that key ongoing checks then continue to be carried out regularly.

Requirement 6 – Timescale: by 11 May 2026

- The provider must develop a formal role-specific induction package for all staff to evidence that they have the appropriate support and knowledge required for their role.

Requirement 7 – Timescale: by 11 May 2026

- The provider must introduce regular one-to-ones and annual appraisals to allow all staff the opportunity to discuss progress in their role or any concerns.

Requirement 8 – Timescale: immediate

- The provider must ensure that the manager has access to all patient care records at all times:
  a) so that all relevant documentation is available to view by an authorised person when requested, including Healthcare Improvement Scotland inspectors during an inspection
  b) in case of an emergency, and
  c) for auditing purposes.

Recommendation i

- The service should complete and submit a self-evaluation as and when requested by Healthcare Improvement Scotland.

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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