Dr Khawaja Masood Munir

Deansgate Surgery

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated it as inadequate because:

- The service did not have effective governance systems in place.
- Some staff had not had training in key skills including safeguarding.
- The service did not control infection risk well.
- The service did not fully assess risks to patients and record how these would be acted on.
- The service did not manage safety incidents well and learn lessons from them.
- The service did not manage medicines well.
- Managers did not have clear processes to monitor the safety and effectiveness of the service and make sure staff were competent.
- The service did not have some of the local policies, procedures and audits expected to support governance, ensure compliance with legislation and to support staff to do their roles safely.
- The service did not manage patient consent well.

However:

- Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness and respected their privacy and dignity.
- People could access the service when they needed it and did not have to wait too long for treatment.

Following this inspection, due to the concerns we found, we told the registered manager they were failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served two warning notices under Section 29 of the Health and Social Care Act 2008. The warning notices related to Regulation 12(1) Safe care and treatment and Regulation 17(1) Good governance.

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate	

Summary of findings

Contents

Summary of this inspection

Background to Deansgate Surgery

Deansgate Surgery is operated by Dr Khawaja Masood Munir. The service is based in Manchester city centre and provides hair transplant cosmetic surgery and platelet-rich plasma hair restoration therapy for private fee-paying adults. The clinic is based on the 4th floor of Speakers House, on Deansgate, with the entrance having a platform lift the initial steps to the lobby where lift access takes any disabled patient to the clinic which is all on the same level. The clinic is shared with another organisation who specialise in non-invasive and non-surgical hair treatments. Car parking facilities are available via numerous car parks and on-street parking next to the clinic.

The clinic facilities are spread over six clinical rooms, a shared reception, a patient waiting area, a staff room, an office, two consultation rooms and a kitchen. The service had plans in place to lease additional office and storage space in the building. Toilets are in a corridor adjacent to the service.

The location has not been inspected before.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 31 May 2022. The team that inspected the service comprised of two CQC Inspectors.

During the visit we interviewed eight staff members who were based at the service including the two surgeons one of whom was also the registered manager, five technicians and a patient liaison officer.

We spoke with two service users. We reviewed four sets of service users' medical records. You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure the safe and proper management of medicines. (Regulation 12(1))
- The service must ensure that processes to assess, monitor and improve the quality and safety of the service they provide are effective. (Regulation 17(1)
- The service must ensure that appropriate policies, systems and processes are in place to govern the service, support staff to do their roles safely and manage the risks to patients (Regulation 17(1)).
- The service must ensure that there is a system that staff, and managers use to identify, report, investigate and learn from incidents so that improvements to the service can be made and the risk to patients is reduced (Regulation 17(1)).

Summary of this inspection

- The service must ensure that robust recruitment processes are in place and ensuring that all staff undergo an up to date disclosure and barring service check and that they are qualified and competent to perform their role (Regulation 17(1)).
- The service must ensure that risks to the health, safety and or welfare of people who use the services in relation to the prevention, detection and control the spread of infections must be assessed and appropriately mitigated (Regulation 17(2)).
- The service must ensure that robust procedures are in place to record all decisions taken in relation to care and treatment and make reference to discussion with people who use the service and record their consent (Regulation 17(3)).

Action the service SHOULD take to improve:

- The service should ensure they make reasonable adjustments to enable service users to receive their care and treatment.
- The service should ensure that all psychological assessments are recorded in the patient medical record.

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Good	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Good	Requires Improvement	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Surgery safe?

Inadequate

Mandatory training

The service did not provide mandatory training in key skills to all staff.

The service had a training policy that listed the mandatory training required for all staff, the policy was not dated and had no version history. The policy was not available for us to view during our inspection. It was provided by the registered manager after our visit and had a created date of 05 June 2022. Some staff had received training in key areas such as basic life support and infection control, however there was no evidence staff had received training in child safeguarding, sepsis, health and safety and security, equality and diversity and fire safety. The provider had a training matrix to monitor staff compliance with mandatory training and not all staff employed were listed. Managers could not be sure that all staff had completed the training required to perform their roles safely and reduce the risks to patients.

Safeguarding

Staff did not always complete training about how to recognise abuse or understand how to report abuse and protect patients.

The service had a local safeguarding policy dated 11 January 2020 but not all staff we spoke with were aware of it and did not know how to access it. The policy did not describe the required level of safeguarding training for staff. The policy stated that training in safeguarding procedures was included in staff local induction, but safeguarding was not included on the induction PowerPoint that was shared with us. The policy did not list the types of abuse that staff should be aware of such as female genital mutilation (FGM), modern slavery and forced marriage. The safeguarding policy listed out of context references to dentists and child reactions to dental examinations.

The training matrix the provider used to monitor staff compliance with mandatory training showed that staff had only completed level one safeguarding training. No staff had completed child safeguarding training. Staff were able to verbally describe that they would telephone the local authority or inform their manager if they had identified a safeguarding concern, however not all staff knew the relevant local authority or how to make a referral. Managers could not be sure that all staff had completed the knowledge required to recognise and report abuse.

Inadequate

Surgery

Cleanliness, infection control and hygiene

The service did not always control infection risk well.

The service had a local infection control and decontamination policy but not all staff we spoke with were aware of it and did not know how to access it. The policy was not available for us to view during our inspection. It was provided by the registered manager after our visit and had a created date of 03 June 2022. However, this policy did not make any reference to COVID-19 precautions and the guidance was not in line with the most up to date best practice guidelines. The service had a separate policy which outlined COVID-19 requirements. The policy listed out of context references to primary care dental practices and references Department of Health Technical Memorandum 01-05 which is for decontamination in primary care dental practices.

Staff followed some infection control principles including the use of personal protective equipment (PPE) and hand hygiene.

The clinical waste bins we observed were foot pedal operated however these were very full of clinical waste touching the lid. There were no hand soap or paper towel dispensers in the rooms we observed clinical procedures being carried out in.

Staff used a desktop steriliser to decontaminate some of the instruments used during procedures however, these are not compliant with the Department of Health Technical Memorandum 01-01: management of surgical instruments (medical devices). The guidance recommends that desktop sterilisers should only be used as a last resort. If used, there 'should be measures in place to audit each use of the steriliser and identify which cycles are for the steriliser's routine validation and which are for surgical decontamination'. This audit should ensure that the steriliser was only used for instrument decontamination in exceptional circumstances. The service did not have the records described; this increased the risk to patients from infection.

The services infection control and decontamination policy also stated that 'at a minimum, practices should audit their decontamination processes every six months, with an appropriate review dependent on audit outcomes. It is important that the audits are made available to regulatory bodies for inspection when required. Audit documents should be stored for at least two years. They should not be removed from the premises or destroyed.' 'A record of the temperature and pressure achieved at the daily test, to ensure this is satisfactory before the autoclave is used for sterilizing instruments. These outcomes should be recorded in the logbook together with the date and signature of the operator.' Therefore, the service was not compliant with its own policy.

The service did not have a dedicated cleaner or cleaning contract in place. There was no evidence of a planned deep clean. Staff contributed to cleaning; however, we did not see that the service provided any guidance on clinical cleaning for staff or kept any record of clinical cleaning training. We did not see any evidence of cleaning schedules being used outside of the clinical rooms and there was limited cleaning equipment available. The mops used for cleaning clinical areas were visibly dirty and the service had no spare mop heads. Cleaning equipment was stored unsecured in a kitchen area and COSHH items were not stored in a secure locker. We observed a large area of mould on a wall in one clinical room. We pointed this out to staff who informed us that this had been reported to building maintenance. We did not see that any risk assessment or action had taken place to assess, mitigate or remove the risk of mould to patients.

However, the service was able to provide evidence of hand hygiene audits for 2021 and 2022.

Environment and equipment

Inadequate

Surgery

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The service had an equipment safety policy and procedure dated 11 January 2020. The policy listed out of context reference to dental instruments and dental environment. The policy only included information relating to decontamination and the services defibrillator and did not include information about other medical equipment such as blood pressure monitors.

The service did not provide evidence that sterilisation equipment was validated by an Authorised Engineer of Decontamination. The service did not provide any evidence that all staff using equipment were appropriately trained and competent.

The registered manager told us that all staff received training in the use of specialist equipment. However, they were not able to provide us with evidence of this training. The registered manager told us that staff performed equipment checks as part of the daily use of equipment. However, they were not able to provide us with evidence that these checks were taking place. The registered manager told us that faulty machines would be replaced, however, there was a risk that incorrect readings would not be identified unless they were outside of normal parameters.

The service also had a building maintenance contract but not all staff knew how to report issues. Staff told us that they always experienced a quick response when they reported building faults but we observed a large area of damp and mould on a wall in a clinical area that staff told us had been reported several months ago in one of the clinical rooms.

Portable appliance testing (PAT) was completed in November 2021. The service had a contract to ensure that clinical waste was disposed of safely, but this did not include pharmaceutical waste. Staff disposed of clinical waste in appropriate bins and waste was stored securely whilst awaiting collection by the contractor.

The service had a defibrillator and oxygen for use in the event of an emergency. We saw that staff checked this equipment regularly. The service had enough suitable equipment to help them to safely provide training to patients. The service had fire extinguishers which were regularly checked by an external provider. However, the service had no evacuation equipment at the top of the stairs.

The building was secure and could be accessed by ringing a doorbell. There was lift access available to the clinic. There was also an internal CCTV which recorded 24 hours per day seven days per week without recording sound. However, not all visitors to the service were informed of the CCTV recording system and there were no signs in the clinic informing them of its use. There was no evidence that the service had registered the use of the CCTV to the Information Commissioner's Office (ICO).

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks.

The service identified patient risks through a medical screening completed for each patient by the third-party referrer. A health questionnaire form was completed on the day of surgery and included past medical history, surgical history, mental health condition and allergies.

Staff discussed mental health and wellbeing with patients and were mindful about making sure that patients did not have unrealistic expectations for the procedures. Staff verbally described that they would get consent from patients to contact their GP if they believed a patient was suffering from mental health or emotional issues.

Inadequate

Surgery

Staff completed basic clinical observations on patients pre and post op.

The services inclusion/exclusion policy stated that 'There is no set/fixed criteria to exclude patients for treatments.' However, we were told on the day of inspection that people with mobility issues would not be accepted for surgery due to their inability or difficulty getting on the couch and staying in one position for long periods.

The service had a sepsis policy, but it did not include a created or review date. The policy was not available for us to view during our inspection. It was provided by the registered manager after our visit and had a created date of 04 June 2022 following our visit. The policy states 'it is important staff have training and an understanding of Sepsis.' However, sepsis or managing a deteriorating patient training was not included in the staff training policy requirements. Staff did not receive training in sepsis. This meant there were risks staff may not recognise signs of a life-threatening medical emergency.

Staffing

The service did not always have enough staff with the right qualifications.

The service employed a small team of staff made up of two hair transplant surgeons, a registered manager and a team of technicians. The registered manager was also one of the hair transplant surgeons. Staff arranged procedures in line with patient needs and preferences as well as staff availability.

At the time of our inspection, there was no mandatory accredited training requirement for hair transplant surgery in the UK. However, a General Medical Council (GMC) licensed doctor must have performed the surgical steps of the procedures. The doctors who performed hair transplant procedures at the clinic were GMC registered. In line with the Cosmetic Practice Standards Authority (CPSA) hair transplant standards practitioners have the option to be added to the GMC specialist register. The doctors were not on the specialist register and the manager did not provide evidence that they could be assured that they had up to date knowledge and training to perform their roles well.

The registered manager and other staff based at the clinic had been in post for different lengths of time. Managers did provide induction records for all staff employed at the service and some staff had not completed training in key areas. Staff were able to verbally describe the skills and experience they felt relevant to their role.

Staff told us that they did not lone work at the service.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always up-to-date, However, records were stored securely and easily available to all staff providing care.

We reviewed four sets of patient records during our inspection and found that consent was not always recorded as a two-stage process. The service did not keep adequate records of the medicines provided to patients on discharge. There were no psychological assessments recorded in the patient medical records.

Records were held electronically, and password protected. Some paper forms were subsequently scanned onto the patient medical records.

Medicines

Inadequate

Surgery

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

The service did not store medicines safely. We saw that medicines were not stored in their original packaging and were stored in loose strips in medicines cupboards. Patients were not given their medicines with information leaflets or written directions on how to take their medicines. This was a risk as patients might take their medicines incorrectly which could lead to harm.

At the time of our inspection we saw that no cupboards were lockable and there was a risk that medicines could be accessed by patients and visitors to the service when not monitored by staff.

At the time of our inspection we saw no evidence that discharge medicines were being prescribed for individual patients. We saw that technicians used a standard template to supply medicines for patients without any record of clinical oversight. There was a risk that patients could be provided with medications to which they have a contraindication.

At the time of our inspection we saw no evidence that adequate records of the medicines provided to patients on discharge were being recorded. We saw that technicians ticked the name of medicines and did not record quantity and doses of the medicines issued. There was a risk that should a problem arise regarding medicines after discharge the service would be unable to identify what medicines were supplied.

We did not see any evidence of a process to monitor stock levels or medicine expiry dates and there was a risk that missing medicines may not be identified or that patients may be issued with out of date medication.

The service did not have processes in place to monitor the ambient temperature of room environments where medicines were stored including maximum and minimum temperature ranges and therefore could not be assured that the medicines were stored in line with manufacturers guidance.

Incidents

The service did not manage patient safety incidents well.

The service did not have a clear system to identify and report incidents. The services incident reporting policy provided to us had a created date of 03 June 2022 following our inspection. Staff told us they were unaware of an incident policy and had not received any training in incident reporting.

The registered manager provided us with three incident report forms dated January 2022, March 2022 and April 2022. These forms had a created date of 03 June 2022 following our inspection as were the clinical meeting notes were the registered manager told us the incidents were discussed.

None of the three incident forms provided by the service contained service user details or a date of incident therefore the service did not have effective systems in place to look back at incidents and link the incident to patient records.

The services duty of candour policy and procedure included a blank accident and incident log and investigation record which was different to the form included in the services incident reporting policy.

Inadequate

Surgery

Are Surgery effective?

Inadequate

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

During our inspection we were unable to review any of the services policies. When we asked to review policies during our inspection, the registered manager told us that no policies were available in the clinic in paper or electronic form as these were stored on their personal laptop. When we spoke with staff, they were unable to tell us or show us how they would access any policies. We found that some of the policies sent to us as part of the data request process had a created date which was after the date of our inspection.

We reviewed a sample of policies following our inspection and found that not all the service policies were comprehensive and in line with up to date best practice guidelines.

At the time of our inspection the service did not have an audit programme in place to monitor service quality against its own policies or national guidelines. Following our inspection the registered manager provided us with an audit schedule and policy document which had a created date of 05 June 2022 following our visit and stated 'some of the topics to be reviewed' included 'handwashing audit' and 'post-operative infections and management for folliculitis'. The registered manager was unable to tell us how they were assured that the service was being delivered in line with best practice.

Nutrition and hydration

Staff gave patients enough drinks to meet their needs.

Patients told us that staff asked them before their procedure what they would like to drink, staff would then go to get this for them. Patients felt well informed about the day of their procedure and what they should or shouldn't eat or drink beforehand.

Pain relief

Staff did not always assess and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff told us that they regularly asked patients if they were in pain during their procedure and that doctors would provide pain relief if it was safe to do so. Patients received information to take home that told them what they should do if they felt pain after their procedure. However, during our inspection, we did not observe staff discuss pain relief with any patient and pain scores were not recorded in the patients' medical records.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment.

Inadequate

Surgery

The service did not provide any evidence that they were performing regular audits of the care being delivered by staff to ensure that this care was safe and in accordance with best practice.

The service did not have a clear process for collecting, collating, acting on and learning from patient outcomes. The service did not have any data around effectiveness or infection rate or how often patients had experienced any complications during or after their procedure and did not participate in any national audits. The service did not currently submit data on the Private Healthcare Information Network (PHIN).

However, the two patients we spoke with said they were happy with the treatment they had received.

Competent staff

The service did not always make sure staff were competent for their roles.

There is currently no mandatory accredited training requirement for hair transplant surgery in the UK. However, a General Medical Council (GMC) licensed doctor must perform the surgical steps of the procedure. The doctors who performed hair transplant procedures at the clinic were GMC registered. The Cosmetic Practice Standards Authority (CPSA) recommend that doctors who perform hair transplant procedures complete specialist training and apply to be added to the GMC specialist register. The doctors were not on the specialist register.

On the day of our inspection we asked to see records of employment checks for staff in line with schedule three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager was unable to provide these and they informed us that the information was in the process of being uploaded to a new IT platform. Following our inspection some records were provided by the registered manager. However, we did not see evidence that checks of professional registration were performed regularly and the registered manager did not have a policy that out lined how often this should be completed. The manager also did not provide evidence that photographic identification, curriculum vitae (CV), qualification certifications, health declarations and references were obtained at the time of recruitment.

Staff were encouraged to attend team meetings. However, staff told us that they had not seen minutes from the meetings and did not know how or where to access them.

However, staff told us that they had an annual appraisal with a named individual and that they felt the process was inclusive. Annual appraisal dates were recorded on the staff training matrix however, this did not include all staff.

Multidisciplinary working

Doctors and technicians worked together as a team to benefit patients. They supported each other to provide good care.

All patients who attended the service were referred by external providers. The registered manager told us that the service worked closely with the external providers and staff reported good communication and effective working relationships with the referring providers. Staff told us that they had a good working relationship with their colleagues and that they supported each other well.

Patients told us that they felt well supported by staff.

Seven-day services

Inadequate

Surgery

Patients could contact the service seven days a week for advice and support after their surgery.

The service operated on a seven-day service based on demand. The service offered a structured programme of follow up appointments at regular intervals up to 18 months after procedures. Staff also made regular contact with patients in the days immediately after their procedure and patients were able to contact staff out of hours on an on-call mobile number for advice.

Health promotion

Staff gave patients practical support and advice.

The service provided patients with good post-operative care information to help promote hair growth and get the most out of their procedure. Patients told us they were happy with the information they received before and after procedures. However, health promotion advice was not recorded in the patient records we reviewed and there was no health promotion literature displayed within the clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. However, they did not always follow national guidance and ensured that patients gave consent in a two-stage process.

Following our inspection, the registered manager provided us with a consent and cooling off policy document that had a created date of 05 June 2022. Consent, capacity and cooling off are not listed on the staff info sheet or in the services staff training policy. It was not clear from this policy when the patient should be provided with information and when consent should be obtained. The policy referred to a two-stage process as recommended by the Royal College of Surgeons, but it was not clear how Deansgate Surgery met this and what part the referrers played in this process.

We reviewed four sets of patient records during our inspection and found that consent was not always obtained in a two-stage process.

Patients completed a medical questionnaire before their first consultation, this asked them to confirm if they were undergoing treatment or suffering from any mental health conditions. Staff were able to explain that they would discuss these questions with patients and seek consent to contact their GP to check if they were suitable for treatment. The doctors had training in assessing the psychological needs of the patients however, psychological assessments were not recorded in patients' medical records.

Staff understood the importance of checking patients' understanding of their treatment and ensuring that patients did not have any unrealistic expectations of the outcomes. Patients told us that they felt well informed about what to expect on the day and after their procedure.

Are Surgery caring?

Good

Compassionate care

Inadequate

Surgery

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us that staff treated them well and with kindness. Staff were able to give examples of times they had adapted treatment in line with the cultural needs of patients. Staff understood the need to keep patient information private and secure.

We observed that patients had the opportunity to ask questions during the training and that staff supported patients to understand the training that was being delivered. The service did not have a policy on the use of chaperones and staff did not receive chaperone training. Staff told us that patients were entitled to bring someone with them to the clinic if required.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients told us that staff regularly phoned them to check how they were after a procedure. Staff understood the importance of managing patient's expectations about procedures and the timescales for seeing results. Staff were able to describe the social and emotional impact of hair loss on patients and how to manage this sensitively.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their treatment and what to expect before and after their procedure. Patients told us that staff involved their families in their care if they wanted them to. Patients were asked after each procedure to provide feedback, but this was not formalised.

Are Surgery responsive?

Requires Improvement

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people.

Patients did not have to be local to access the service if they were willing to travel to appointments. Staff arranged appointments in line with patient needs and preferences as well as staff availability. Patients told us that they had found it

easy to reschedule appointments and talk to staff when they needed to. Patients booked follow up appointments on the day of their procedure and staff understood the importance of contacting patients if they missed their appointments. However, the did not attend (DNA) policy the registered manager provided us with following our inspection which had a created date of 03 June 2022.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

The service worked with a wide variety of patients and staff said that there were no adult groups or protected characteristics that they would not consider for treatment. However, staff had not completed equality and diversity training.

The services equality and diversity policy referred to the relevant legislation such as the Equality Act. Protected characteristics were listed in the policy.

Wheelchair users could access the building and patients could reach the service by lift or stairs however the service had no evacuation equipment at the top of the stairs for wheelchair users. There was no onsite parking for service users.

The service said it would fund translation services for patients who needed them, although no contract was in place with translation services and not all staff knew how to access them.

Access and flow

People could access the service when they needed it and received the right care.

People could access the service when they needed it. Staff arranged procedures in line with patient needs and preferences as well as staff availability and the service did not have a long waiting list. The manager told us that they would rearrange appointments straight away if the doctors or other staff were sick and they would apologise to patients.

Managers worked to keep the number of cancelled procedures to a minimum. In the previous 12 months there had been a small number of cancelled appointments due to non-clinical issues.

Learning from complaints and concerns

The service did not have a clear process for receiving, recording, investigating and responding to complaints.

Following our inspection, we requested a copy of the services complaints log. This document was dated from June 2021, but the document properties showed that it had a created date of 3 June 2022, after our inspection. The complaints listed on the log were not dated and the timeline of investigation and response was not included.

Following our inspection, the registered manager provided us with minutes of a clinical meeting dated 17 March 2022 where complaints were listed as a standing agenda item. However, the document had a created date of on 3 June 2022 following our inspection.

Inadequate

Surgery

During our inspection we did not see any information available on display in the clinic about how to make a complaint. The services complaint suggestions and compliments policy stated that complaints training was included in the staff induction. However, this was not included in the induction presentation that the registered manager shared with us and complaints training was not listed on the services staff training matrix. Staff were not aware of a complaints policy.

The complaint policy contained information about services which were not relevant to Deansgate Surgery, for example, The Parliamentary and Health Service Ombudsman (PHSO) who considers unresolved NHS complaints.

Are Surgery well-led?

Inadequate

Leadership

Leaders did not have an effective plan to manage priorities and issues that the service faced.

During our inspection, the registered manager did not demonstrate that they had the skills and abilities to manage the service safely. For example, they did not demonstrate that they understood the purpose and importance of clinical audit, they did not demonstrate that they knew how to safely store medicines and they did not demonstrate they understood the requirement to undertake employment checks in line with Schedule 3 of the Health and Social Care Act 2008. Staff told us that leaders were visible within the service. The registered manager was also one of the surgeons. Staff reported that they felt well supported and that they had opportunities to develop their skills and knowledge.

Vision and Strategy

The service did not have a formal strategy to turn what they wanted to achieve in to action.

During our inspection staff told us they were unaware of a vision and strategy document for the service and were not aware of plans to expand the service provision. The registered manager stated that there are plans to expand the service and utilise additional space in the current premises.

Following our inspection, the registered manager provided us with a vision and strategy document which had a created date of 5 June 2022. The vision and strategy document contained four points and there was no evidence that the provider had engaged with staff and service users in its development.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff felt the organisation had a culture of openness and honesty and was open to ideas for improvement. Staff that we spoke with felt supported and valued by managers and the organisation. Staff spoke highly of the diversity of staff within the service.

Inadequate

Surgery

The service had a whistleblowing policy. Not all staff that we spoke with understood duty of candour and their responsibility to be open and honest with service users. The providers duty of candour policy dated 11 January 2020 referred to another cosmetic surgery provider.

Governance

Leaders did not operate effective governance processes. Some staff were unclear about their roles and accountabilities.

The service did not have the expected processes to govern the service or some of the documented local policies and procedures that are expected in a health and social care setting to support governance and ensure compliance with legislation and guide staff to perform their roles safely. Policies were not available to staff and most policies and other documents provided to us following our inspection had a created date which was after the date of our inspection.

The service did not have a robust system or processes for auditing service and patient outcomes to improve the quality and safety of the service. For example, the service did not have a process to measure how many patients developed an infection after their treatment. This is an expected element of clinical governance and the lack of audit processes posed a potential risk to poor quality of care for patients.

The service did not have records available to the commission regarding the persons employed to carry on the regulated activity meeting all parts of the regulations. For example, we did not see comprehensive recruitment documentation or that the manager had oversight.

The registered manager provided us with GMC registration information for the two registered doctors working at Deansgate Surgery. One of these documents was dated 2018 and did not provide evidence of how the service was assured that the professional registrations of staff were up to date.

The service did not have Disclosure and Barring Service (DBS) certificates for seven members of staff to ensure that vulnerable patients were not at risk.

The service provided us with two service level agreements (SLA) with providers who referred into the service. Both SLAs were identical. One was written in September 2021 and the other in April 2020. The SLA with the provider with whom they used the clinical rooms did not contain any information about responsibilities in relation to the clinic environment, for example cleaning and clinical waste. Consent and cooling off was not covered in the SLA. Inclusion and exclusion criteria were also not identified on the SLA.

The service did not have processes in place to identify and minimise the impact of risks to people who used the service.

The service did not ensure all staff were trained in key skills and ensure that staff were competent in the use of specialist equipment.

Some staff we spoke with were unsure about their roles and accountabilities.

Management of risk, issues and performance

The service did not use systems to manage risk, issues or performance effectively.

Inadequate

Surgery

The service did not have processes in place to identify and minimise the impact of risks to people who use the service. The service risk register that the provider shared with us in March 2021 contained only two risks; medicines management and COVID-19. When we requested an updated copy of the services risk register following our inspection, they provided a risk register policy which contained a blank risk register. The risk policy had a created date of 5 June 2022 following our visit.

The registered manager was unable to provide a copy of the building fire risk assessment during our inspection. Following our inspection, we requested a copy of the fire risk assessment for the service. The registered manager provided us with a Deansgate Fire Safety policy dated 11 January 2020.

The registered manager was unable to provide us with any building risk assessments.

However, the service had registered to receive patient safety alerts from the Central Alerting System (CAS). CAS alerts contain important public health messages and other safety critical information and guidance to health and social care providers.

Information Management

The service did not collect and analyse data to understand performance or make decisions and improvements.

During our inspection, the registered manager and staff told us that they did not have access to all the required information to perform their role. For example, staff personnel files, staff induction and training records and local policies.

The service had an information governance policy and procedure dated 11 January 2020. The policy stated that 'All staff will be trained to meet the Practices standards in respect of: Records management, Staff confidentiality code of conduct, Access control, Information handling, Use of mobile computing devises, Information incidents and staff guidance and training.

However, none of these topics were listed on the induction PowerPoint or staff training matrix that the registered manager provided us with therefore we could not be assured staff had received this training.

The service did not carry out audits to ensure compliance with policies and procedures or best practice guidance. The service did not have a set process for collecting information about patient outcomes and experiences to improve the service. The service did not have a full suite of policies and procedures to govern the delivery of the service and ensure compliance with legislation and best practice guidance.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service did not have a formal process for engaging with patients to obtain feedback, however patients told us that staff contacted them regularly to see how they were and keep them up to date about their treatment plans. The service had a public website that contained information about the service.

Inadequate

Surgery

The service did not run staff surveys or hold staff forums, but staff told us they felt they could openly discuss issues with the management.

Learning, continuous improvement and innovation

The service did not have clear plans for learning, continuous improvement or innovation.

There was limited understanding of quality improvement methods from staff and the skills to use them however, the registered manager was able to discuss plans to trial new surgical blades. The service planned to measure better healing outcomes for patients through audit of infections healing times and rates. The service was not involved in any research projects.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure the safe and proper management of medicines. (Regulation 12(2)(g))

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance processes to ensure they were able to assess, monitor and improve the quality and safety of the service (Regulation 17(1)).