THMG Maidenhead

Inspection report

55 St. Lukes Road
Maidenhead
SL6 7DN
Tel: 033008384292

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at THMG Maidenhead on 16 November 2022. The service was registered with the Care Quality Commission (CQC) in June 2020. We carried out this first rated inspection as part of our regulatory functions. The inspection was undertaken to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

THMG Maidenhead is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (regulated activities) Regulations 2014.

THMG Maidenhead is registered with CQC to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Surgical procedures

At the time of our inspection, 2 clinic managers were the joint CQC registered managers. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- The service had safety systems and processes in place to keep people safe. There were systems to identify, monitor and manage risks and to learn from incidents, this included reviews from delayed wound healing and any post-operative infections.

- There were regular reviews of the effectiveness of treatments, services, and procedures to ensure care and treatment was delivered in line with evidence-based guidelines.

- Staff treated patients with compassion, respect and kindness and involved them in decisions about their care.

Overall summary

- Feedback from patients was consistently positive and highlighted a strong person-centred culture. For example, since July 2022, there had been 24 responses to the in-house survey with all 24 (100%) receiving positive 5-star reviews (5 stars is the maximum score).

- Information was shared to patients via newsletters, social media and blogs via the website. Recent blog updates which related to regulated activities included the promotion of breast cancer awareness during breast cancer awareness month.

- There was a clear strategy and vision for the service. The leadership and governance arrangements promoted good quality care.

- There was a focus on continuous improvement and improving safety within the sector. For example, the provider worked closely with the Joint Council for Cosmetic Practitioners (JCCP) and contributed to the co-design of new standards.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

The inspection was led by a Care Quality Commission (CQC) Inspector, they were joined by a second Inspector and had access to advice from a specialist advisor.

Background to THMG Maidenhead

THMG Maidenhead (known as 'the location') is operated by LCHMG Limited, (known as 'the provider') who provide services for 7 locations across England. In November 2019, The Harley Medical Group was acquired by Sk:n Clinics (who, in turn, are operated by Lasercare Clinics (Harrogate) Limited).

THMG Maidenhead registered with the Care Quality Commission (CQC) on 24 June 2020 and is registered to treat patients aged 18 and over.

The clinic is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

THMG Maidenhead provides consultations for cosmetic surgery for adults only. It does not provide services for children. Surgical procedures are carried out at hospitals throughout England, with most cases from the Maidenhead clinic seen at hospitals in London.

The clinic offers consultations and pre- and post-operative assessments and care. Furthermore, blood tests and other screening tests are carried out at the clinic if relevant to a patient's pre-operative or post-operative care.

Regulated activities are provided from:

- THMG Maidenhead, 55 St Lukes Road, Maidenhead, Berkshire SL6 7DN

The service website is:

- www.harleymedical.co.uk/our-clinics/maidenhead

THMG Maidenhead shares a location with Sk:n Maidenhead Clinic (which is operated by the same provider) and whilst some facilities are shared, there are some rooms used exclusively by this service.

THMG Maidenhead is open every weekday with a range of opening hours. The service is open between 10am and 6pm every Monday, between 10am and 8pm every Tuesday, between 9am and 6pm every Wednesday, between 11am and 7pm every Thursday between 9am and 5pm every Friday. Appointments are also available every Saturday between 9am and 5pm. This service does not offer an out of hours service. Patients who need medical assistance out of corporate operating hours can access out of hours support via the contact centre, this is detailed in patient literature supplied by the service.

Consultations, care and assessments are provided by a consultant who works at the clinic under practising privileges. A clinic manager, a nurse, patient advisor and a team of reception, administration and coordinator staff undertake the day-to-day management and running of the service. Staff are supported by the provider's regional and national management and governance teams.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently. This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

We carried out this inspection on 16 November 2022. Before visiting the location, we looked at a range of information that we hold about the service. Before and during our visit, we interviewed staff, reviewed documents and clinical records, and made observations relating to the service and the location it was delivered from.

Due to the current pandemic, we were unable to obtain comments from patients via our normal process where we ask the provider to place comment cards in the service location. However, we were shown examples of patient feedback which the provider monitored on an ongoing basis. We did not speak to patients on the day of the site visit.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

We rated safe as Good because:

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse.

- The service had policies and systems to safeguard children and vulnerable adults from abuse. Policies were readily available with details of relevant local authority safeguarding teams. For example, we saw the policy included contact details and information for the Royal Borough of Windsor and Maidenhead's Safeguarding team. The policy also contained regional and national safeguarding information for the wider organisation (The Harley Medical Group/ THMG, referred to as the provider). All staff have received relevant safeguarding training in line with the role they carry out.

- THMG Maidenhead did not offer regulated activities (consultations and treatments) to patients under 18 years of age. Clear guidance was provided to patients that children should not attend unless chaperoned by another adult in addition to the patient. Staff asked patients for photo identification to confirm patients were 18 years of age or over.

- The provider carried out all required staff checks at the time of recruitment. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). All staff who acted as chaperones were trained for the role and had undergone a DBS check.

- We reviewed processes for the monitoring of staff immunisations. Records provided contained evidence of Hepatitis B status and other immunisation records were available. We noted that in response to inspection findings of other locations within the provider brand, the organisation had developed a new policy on immunisations. The provider was also reviewing their approach to ensure staff immunisations were undertaken and monitored on an ongoing basis in partnership with occupational health.

- The clinic manager was the infection control lead, supported by the provider's medical standards team.

- There were effective systems to manage infection prevention and control within the service. Cleaning and monitoring schedules were in place and all cleaning was carried out by staff employed within the service. Auditing of infection control was last undertaken in November 2022; the compliance percentage score was 98%. Any areas requiring attention had been clearly highlighted for action and progress was routinely monitored.

- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in clinical rooms, the clinic had a contract with a company for the disposal of clinical waste and consignment notes were retained for 3 years.

- There were sufficient stocks of personal protective equipment, including aprons and gloves. The service performed minor surgical procedures for which they used single-use, disposable items to minimise the risk of cross infections.

- There was a documented generic risk assessment in place to manage risk within the premises that was reviewed on a monthly basis. We saw the assessment included a description of the risk, who was affected, the impact of the risk and the likelihood of the risk happening.

Good

Are services safe?

- The most recent legionella (a bacterium which can contaminate water systems in buildings) risk assessment was completed in May 2022.

- The provider had carried out fire safety risk assessments, the most recent assessment was completed in March 2022. There was appropriate fire-safety equipment located within the service such as fire extinguishers and emergency lighting which had been regularly serviced (July 2022) and maintained.

- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical wiring and portable appliances had undergone testing in August 2022.

Risks to patients

There were systems in place to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff required to meet patient needs. Clinical staff working on a sessional basis were scheduled according to patient demand.
- There were planned induction processes in place and a plan of required training for staff to complete as part of their induction process. The service was supported by the provider's central human resources team to coordinate inductions.

- The organisation's national contact centre was open from 9am until 8pm Monday to Saturday to offer help and support to patients. Outside of these hours' patients were advised to seek emergency assistance.

- Although the service did not see acutely unwell patients, staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff had completed a range of training to manage medical emergencies. There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. There was a risk assessment in place for emergency drugs to inform the rationale for any recommended drugs not being held at the clinic.

- There was a defibrillator and oxygen available on the premises which were subject to regular checks.

- There were appropriate professional indemnity arrangements in place for clinical staff.

- The provider had in place public and employer's liability insurance policies.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Clinical records were stored on a secure, password-protected, electronic system. Hand-written, active clinical records were stored securely in locked cabinets within a secure room. After a successful trial at other locations, the provider had migrated to a fully electronic clinical record system.

- The service had systems for sharing information with staff and other agencies when necessary, for example the patient's NHS GP, to enable them to deliver safe care and treatment.

Good

Are services safe?

- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

- As part of the pre- and post-operative assessments, there was an established process for sending blood (pre-assessment) and wound swab samples (post-operative) for histology (analysis) and receiving results for review. All items sent for histology were logged and tracked when dispatched. Results were accessed via the service's computer system and reviewed by a clinician. Patients were contacted if there was a cause for concern and appropriate referrals to other services were made when needed. If there were no concerns, patients were still contacted and sent a copy of the test result.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including emergency medicines and equipment minimised risks.

- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

- Although the use of prescription stationery was minimal, there was a safe system for managing prescriptions. The numbers of the prescriptions were logged when issued to a clinician and when used for a patient. The clinic kept a copy of each prescription in the patient file, for reference if required, and there was a cloud-based solution being used where prescriptions were sent securely to the patient once authorised by a prescribing clinician.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues and to support the management of health and safety within the premises.

- The provider had developed monitoring processes which provided a clear, accurate and current picture to local and national leaders which led to safety improvements. A Medical Standards and Clinical Governance Committee ensured local and group oversight, and prompt intervention when required.

Lessons learned and improvements made

The service had systems to ensure they learned when things went wrong.

The service had not reported any serious incidents relevant to the regulated activities we inspected. We were therefore unable to test whether the system was applied as intended. However, we saw:

- There were systems for recording and acting on significant events. The provider used an internal 'Patient Safety Incident' (PSI) system to ensure standardised reporting and management of events and incidents. Staff understood their duty to raise concerns and report incidents and near misses via the PSI system. Staff told us the local and national leaders supported them to complete PSIs whenever required.

Good

Are services safe?

- Every quarter, the clinic manager audited post-operative assessments, with a view to identify any trends or additional learning from post-operative infections including delayed wound healing. We saw between May 2022 and July 2022, there had been zero infections recorded and between August 2022 and October 2022, there had been 1 case identified. On review, this case was the delayed healing of a wound which led to an infection as a result of a patient not following the strict aftercare advice.

- There were appropriate systems for reviewing and investigating when things went wrong. The service learned, shared lessons across the organisation and took action to improve safety in the service.

- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.

- The service had systems in place for reporting and investigating notifiable safety incidents. Safety alert information and other organisational messaging such as medical team updates were cascaded to staff within local services via update bulletins issued by central teams and reinforced by local managers. The service acted on and learned from external safety events as well as patient and medicine safety alerts.

- We also found the provider used feedback and findings from previous Care Quality Commission inspections at other locations within the organisation to make improvements. For example, improvements in the management of staff immunisation records and improvements regarding the management of medical emergencies.

Good

Are services effective?

We rated effective as Good because:

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice.

- All staff employed by the service had high levels of skills, knowledge and experience to deliver the care and treatment offered by the service.

- The provider had embedded systems and processes to ensure all clinicians and practitioners kept up to date with current evidence-based practice. We saw clinicians assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance. These included the National Institute for Health and Care Excellence (NICE) and General Medical Council (GMC) best practice guidelines.

- The service used a clinical notes booklet to record all patient information, including their medical history, patient expectation of treatment outcomes and clinical notes. The notes booklet showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way. We reviewed clinical records relating to 8 patients who had received treatment within the service. We found the records were clear and contained detail for the treatment provided.

- The service ensured they provided information to support patient's understanding of their treatment, this included various stages of pre and post treatment advice and support. Staff within the service, including a dedicated patient advisor, provided face to face appointments, telephone calls and videos calls to set expectations before any treatment. Patients were also able to access post-treatment support via follow-up appointments at different time intervals and on the telephone.

- Patients saw a nurse for a pre-op consultation which included a check on their medical history, plus psychological assessments to see if they were suitable for surgery. This assessment used a nationally recognised psychological screening and audit tool, known as a RoFCAR. The RoFCAR is a tool designed to help aesthetic providers identify patients who may be at risk for a poor post-operative result. It is designed to be used in addition to an in-depth consultation. The RoFCAR is also designed to facilitate audit in line with professional guidelines and to provide a clearer understanding of post-procedural psychosocial gains.

- Following the pre-op consultation, the patient would then return to see the consultant who would further explain the procedure, obtain consent to the procedure and ensure the patient was aware of any risks that may be involved in the procedure.

- Following the procedure, the patient would return for a post-operative assessment, which included suture removal, dressing changes, etc.

- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was able to demonstrate quality improvement activity.

Good

Are services effective?

- The service used information about care and treatment to assess the need to make improvements. There was an audit manager and audit lead for the provider, who oversaw the auditing process, improvement action planning and completion of actions.

- A Medical Standards and Clinical Governance Committee provided a central structure under which patient treatment outcomes were monitored.

- Staff employed on a sessional basis were subject to review of their performance within the service and monitoring of their clinical decision making and patient treatment outcomes.

- The provider had produced an audit schedule to ensure ongoing monitoring and auditing of the service at specific intervals and to provide assurance to leaders that systems were operating as intended. The auditing was implemented by regional and national support roles who worked closely with local managers to identify risks and implement improvements. For example, regional audit staff worked with local managers to undertake quarterly auditing of all aspects of service delivery, including for example, a review of health and safety and premises safety, medicines management and infection, prevention and control. The two most recent audits were completed in July 2022 with a score of 94% and November 2022 with a score of 95%. We saw the areas (record keeping) in need of review had been highlighted within the report and clear action plans had been produced and shared with staff.

- We saw the auditing processes included staff interviews to confirm their level of knowledge and understanding. Service locations received a score and rating which reflected the level of risk identified by the audit – the lower the score, the higher the risk. Action points arising from the audit had been identified and systems were in place to ensure these were monitored and acted upon.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The provider understood the learning needs of staff and provided protected time and training to meet them.

- There were planned induction processes in place and a plan of mandatory training for staff to complete as part of the induction process.

- There was an effective induction system for new staff tailored to their role. This was monitored to ensure all staff completed training, were observed during their induction period and signed off as competent. Information was available on what activities staff could undertake so that patients were booked in appropriately for their appointments.

- The clinic had up to date records of skills, qualifications and training which meant that staff could demonstrate their knowledge, for example if they worked in other THMG clinics.

- Clinical staff employed on a sessional basis provided evidence of their professional external appraisal summary to the provider and participated in weekly meetings.

Coordinating patient care and information sharing

Staff worked with other organisations when necessary, to deliver effective care and treatment.

Good

Are services effective?

- Patients received coordinated and person-centred care. All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. Staff referred to, and communicated effectively with, other services when appropriate. This included the patient's own GP when procedures had been planned or if additional, alternate medical needs were indicated.

- Before providing any procedure, the service ensured they had adequate knowledge of the patient's health, any relevant tests they may have had, and their medicines history.

- The use of a digital communication system allowed patient information to be shared appropriately (this included when patients moved to other THMG services or external services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.
- We reviewed the consent policy and variety of consent forms for the different procedures provided. Our review of clinical records confirmed the consent process had been followed and discussions between the practitioner and patient had taken place.

Supporting patients to live healthier lives

Staff supported patients to manage their own health and maximise their independence.

- Patients were provided with information about procedures, including the benefits, risks and potential side effects of treatments.
- Where patients presented with concerns or complications post-treatment, staff had access to additional clinicians including registered nurses from across the organisation as well as a group medical standards team for advice, triage and support.
- If patients' needs could not be met by the service, staff would redirect them to the most appropriate service for their needs.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making. Staff had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS are a set of safeguards designed to protect people's liberty that are part of the Mental Capacity Act.

- Consent was obtained for the use and retention of photographs that were used before and after treatments. This included specific consent for the use of photographs for marketing purposes.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received from 3 different on-line feedback resources. This included a rating, review collection system based on patient's willingness to recommend the service.
- The provider had partnered with different online review websites to collect, collate and publish reviews from patients and to help use the feedback to continually improve the services provided.
- Feedback from patients was positive about the way staff treated people. Our current inspection methodology no longer uses comment cards; however, we did see other patient feedback provided by the provider. This showed that patients were consistently positive about the welcome, compassion and kindness they received from staff. Other comments highlighted the team showed ultimate care at all stages of the procedures.
- Staff understood patients' personal, cultural, social and religious needs. Staff we spoke with displayed an understanding and non-judgmental attitude to all patients. Staff had completed training in equality and diversity, and those that spoke with us confirmed they placed a high importance on making all patients feel comfortable and at ease with their treatments.
- The service gave patients timely support and information in relation to their care and treatment.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing. During the first contact with a patient, the provider's national contact centre gathered information to ensure all the patients' needs could be met.
- Information about procedures and pricing was available to patients on the service's website and within the clinic. Patients were provided with individual care plans including price quotations for their treatment following their first consultation.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Consultations and treatments took place behind closed doors and conversations could not be overheard. Staff told us they would knock on treatment room doors and wait before entering, to maintain patients' privacy and dignity.

Good

Are services caring?

- Staff knew that if patients wanted to discuss sensitive issues, they could offer them a private room to discuss their needs.We also saw appointment times were planned to ensure the likelihood of a busy reception area was reduced.

- Chaperones were available should a patient choose to have one. The provider's chaperone policy was on display in the waiting area. All staff who provided chaperoning services had undergone required employment checks and received training to carry out the role.

- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. All patient records and information kept as hard copies were stored in locked cabinets within a locked room. Staff working in the reception area operated a clear desk policy and hard copy documents were promptly locked away.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs. All stages of care were elective and provided according to patient need.

- Patients had a choice of time and day when booking their appointment. THMG Maidenhead was open every weekday with a range of opening hours. The service was open between 10am and 6pm every Monday, between 10am and 8pm every Tuesday, between 9am and 6pm every Wednesday, between 11am and 7pm every Thursday between 9am and 5pm every Friday. Appointment were also available every Saturday between 9am and 5pm.

- Pricing for different treatments was discussed with the patients. As treatments were personalised to each client, indicative pricing was displayed on the clinic's website. They were discussed in advance of any treatment programme.
- The facilities and premises were appropriate for the treatments provided. The clinic was housed over two floors of a converted residential building, with regulated activities provided on both floors. The service was able to treat those with mobility restrictions who were unable to use stairs via a treatment room on the ground floor. If required, appointments could be made at a sister clinic at THMG Watford (approximately 27 miles away).

- We reviewed publicly available information regarding patient experiences at the service. The service encouraged patients to use online channels to review and rate their experience. We were told this feedback was used to respond to patient needs. At the time of our inspection (November 2022) one of the national review websites rated the provider as 'Excellent' with 9 reviews and an overall score of 4.3 stars (5 stars is the maximum score). Another website reviewed and rated the Maidenhead clinic. At the time of our inspection, the clinic had received 21 reviews with an overall score of 4.7 stars (5 stars is the maximum score).

- The provider also provided us with the results of their in-house feedback survey, this was known as 'Reputation'. Between July 2022 and October 2022, there had been 24 reviews via the in-house survey. Of the 24 reviews, all 24 (100%) were positive 5-star reviews (5 stars is the maximum score).

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.

- Patients were able to register their interest in booking an appointment via the provider's website and this was followed up by the national contact centre to arrange a free non-obligation consultation. The contact centre would then confirm the preferred method of consultation, whether this was in person or virtual.

- The provider had a central contact centre which operated from 8am to 8pm Monday to Friday, from 9am to 5.30pm on Saturdays, and 9am to 4.30pm on Sundays, so that patients could book appointments and make enquiries outside the clinic's normal opening times. The provider also offered medical on-call support.

Good

Are services responsive to people's needs?

- Waiting times, delays and cancellations were minimal and managed appropriately.

Listening and learning from concerns and complaints

The service responded to complaints and feedback appropriately.

- Feedback, including comments of concern or complaints, was encouraged. The service had created a 'How did we do?' notice which they attached to appointment cards that advised patients to contact the clinic manager directly if there were areas where the service did not meet expectations.
- The service had a complaints policy in place and information about how to make a complaint or raise concerns was available for patients to read in the reception area and on the provider's website.

- The clinic manager was the lead for complaints, with support from the regional head of operations.

- Records indicated that the clinic had received 5 complaints within the previous 12 months which pertained to regulatory activities. We looked at 2 of the complaints and found these were satisfactorily handled and dealt with in a timely way. Lessons were learnt from concerns and complaints and action was taken to improve the quality of care. This included an annual complaints summary report which included an analysis of trends and timelines.

- The service clearly informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. The service's written complaints policy included up to date information to support patients should their complaint remain unresolved. For example, there was reference within the policy to the Independent Sector Complaints Adjudication Service (ICAS) from whom additional advice and support may be sought.

- The provider informed us that the management of complaints had been impacted by the COVID-19 pandemic, clinic closures and changes in staff and management. The provider had identified the shortfalls and in response had established a new complaints department in September 2021. The new complaints department was working with clinic managers to provide guidance, resource and future training in complaints management.

Good

Are services well-led?

We rated well-led as Good because:

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services and the cosmetic surgery sector. Staff were open and transparent regarding local, regional and national factors that had impacted upon the operation of the clinic.

- The clinic manager worked alongside other clinic managers from different services within the provider and was supported in their role by the regional head of operations, the regional audit lead and other regional and national teams.

- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The provider supported potential leaders by offering a clinic manager programme for career development.

- The size and scope of the organisation provided leadership resilience to individual clinics. For example, a Care Quality Commission (CQC) registered manager from a different clinic within the group had applied and added the location THMG Maidenhead to their existing registration on an interim basis, pending the return to work of the substantive clinic manager who was also the registered manager.

- Leaders at all levels within the service were visible and approachable. They worked closely with staff to make sure they prioritised compassionate and inclusive leadership. For example, on the day of our site visit, the local team was supported by the regional head of operations and the audit manager.

- Leaders understood the challenges and had developed strategies focused upon key areas including clinical governance, risk management and the use of technology.

- There was a local, regional and national staffing structure in place across the organisation and staff were aware of their individual roles and responsibilities. The provider had individual members of staff and teams to undertake lead roles in key areas.

Vision and strategy

The service had a clear vision and credible strategy to deliver quality care and promote good outcomes for patients.

- The provider had set out clear brand values which were to be accessible, approachable, expert and responsible. The organisation's vision was 'founded on care', which was key to its ethos, ensuring commitment to the highest standards in delivering medical procedures and aftercare.

- THMG Maidenhead, although registered under its own CQC registration, shares its policies and values with the values of the wider company (provider). These values included the promotion of positive patient experiences.

Good

Are services well-led?

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy. The clinical strategy was to embed a culture of excellence, utilise clinical and technical innovations, improve risk management, and improve clinical governance.

Culture

There were systems and processes to support a culture of quality sustainable care.

- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The provider informed us that there had been no serious incidents in the past 12 months relating to the regulated activities carried out by the service.
- The provider wasaware of and had systems in place to ensure compliance with the requirements of the duty of candour.
- Staff felt respected, supported and valued. The clinic manager had just returned from an extended period of leave, they highlighted the support from the provider and different members of staff during their absence and during their return.
- There was a culture of promoting positive relationships and prompt and effective communications between staff and different national teams. In addition, from the feedback we reviewed there was an ethos of on-going positive relationships between patients, THMG staff and staff from other services within the group.
- There was an emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity and staff were supported to complete equality and diversity training.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out and understood. For example, the medical standards committee issued update bulletins on topics such as policy changes, audits and governance. Managers participated in regular conference calls, which covered risks, updates and sometimes involved guest speakers. The clinic manager had regular update meetings to highlight any changes and to discuss patients' specific needs.
- There were regional and national structures implemented by the provider, for example, clinical governance and central medical committees. These ensured appropriate levels of oversight and support to local teams, to ensure consistent and effective governance arrangements.
- The provider was registered with the Information Commissioner's Office and had appointed a Data Protection Officer.

Good

Are services well-led?

- Staff understood their individual roles and responsibilities. They signed to show that they had received, and read, updated policies. They also signed to show they had read and understood relevant Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider used performance information, which was reported and monitored, and management and staff were held to account.

- Leaders had established appropriate policies, procedures and activities to ensure safety and assure themselves that they were operating as intended. Leaders understood the need to submit data or notifications to external organisations when required.

- There was a system for cascading information within the organisation.

- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Correspondence sent from the service was emailed through an encryption service to ensure confidentiality.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There were mainly effective governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks including risks to patient safety.

- Leaders had oversight of safety alerts, incidents and complaints. There was a system for recording and acting upon significant events alongside other incidents which met the threshold for review, including post-operative infections.

- Clinical audit had a positive impact on quality of care. There was clear evidence of action to change services to improve quality. Internal quality audits were integral and embedded within the service, the most recent quality audit had been completed in November 2022 to assess quality of care against the CQC key lines of enquiry and found no areas of concern for follow up.

- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their work.

Appropriate and accurate information

The service maintained appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. The service used feedback from patients combined with performance information to drive improvement.

- The provider carried out all required staff checks at the time of recruitment, and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation.

Good

Are services well-led?

- Confidential electronic information was stored securely on computers and digital cloud-based platforms. Staff demonstrated a good understanding of information governance processes.

- The provider ensured document management processes were followed, which included version control, author and review dates.

Engagement with patients, the public, staff and external partners

- The service encouraged and heard views and concerns from the public, patients, staff and external partners.

- Patients were asked to provide feedback following their treatment at the service. Feedback, including comments of concern or complaints was encouraged.

- The service was transparent, collaborative and open with stakeholders about performance.

- Information was shared to patients via newsletters, social media and blogs via the website. Recent blog updates which related to regulated activities included the promotion of breast cancer awareness (during breast cancer awareness month) and included a guide to breast self-examination and breast cancer symptoms.

- Staff felt confident in providing feedback to managers. The provider had identified a Freedom to Speak Up guardian to provide additional support to staff.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous improvement and improving safety within the sector. For example, the provider worked closely with the Joint Council for Cosmetic Practitioners (JCCP) and contributed to the co-design of new standards. The JCCP is an organisation working closely with the government and national bodies seeking greater regulation of cosmetic and non-surgical aesthetic treatments in the UK.

- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

- There were systems to support improvement and innovation, including a focus on the use of digital technology to drive improvement and share information across the organisation. This included, after a successful pilot, the clinic had moved to a new communication tool as part of their digital strategy.