Signature Medical Limited

Signature Clinic - Manchester

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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location improved. We rated it as requires improvement because:

- Whilst the service recorded incidents, there was not a robust system for reporting and monitoring incidents. However, leaders told us they were implementing a new system imminently which would enable them to have better oversight of incidents.
- At the time of this inspection, the service still did not have robust systems for gathering patient feedback to help shape services.
- The service conducted staff surveys but there was no evidence of collating and analysing feedback in order to make improvements.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. During the previous inspection the safeguarding lead did not have the appropriate level of safeguarding, however there were now 2 safeguarding leads with Level 3 training.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service had made improvements since the last inspection including introducing an infection prevention and control lead and regular audits. They were no longer undertaking any procedures requiring general anaesthetic which reduced risks including that posed by the location of the theatres on the first floor.
- At the time of the previous inspection, we found that leaders did not fully monitor the effectiveness of the service and there were insufficient governance processes in place. There was now a new leadership team, and a clear governance process was in the process of being embedded in the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	Our rating of this service improved. We rated it as requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Signature Clinic - Manchester

Signature Clinic Manchester is operated by Signature Medical Limited. The service offers a range of cosmetic surgery treatments for adults over 18 years old, on a private fee-paying basis. The main types of procedures offered are blepharoplasty and gynaecomastia.

The main service provided by this clinic is cosmetic surgery, the provider is registered for the regulated activities Surgery and Treatment of Disease, Disorder, or Injury. The registered manager at the location is also the registered manager for 2 other locations of Signature Medical Limited.

The cosmetic surgery services are provided from the clinic location in Rochdale, which has a reception and waiting room area on the ground floor, with 2 theatres and recovery areas for service users, on the first floor. The premises also has bathroom and toilet facilities, storage areas and a staff room. The clinical areas are not accessible for disabled people.

The service was last inspected on 18 July 2023 and a Warning Notice was issued. This inspection was a focussed follow up to the concerns identified on the Warning Notice.

How we carried out this inspection

We carried out an inspection of the service on 3 January 2024. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The inspection was carried out by 2 CQC hospital inspectors.

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 that there is a robust process in place for incident reporting, including logging any mitigating actions and shared learning. Regulation 12(1)(2)(b)
- The service must ensure systems are in place to gather staff feedback. Regulation 17(1)(2)(e)
- The service must ensure the risk register is fit for purpose including dates indicating when risks were added and when mitigating actions were taken or are due by. Regulation 17(1)(2)(a)

Action the service SHOULD take to improve:

- The service should consider a more reliable system of gathering patient feedback in order to hear patient views and shape services.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Good	Not inspected	Insufficient evidence to rate	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Not inspected	Insufficient evidence to rate	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

Safe	Requires Improvement
Effective	Good
Responsive	Insufficient evidence to rate
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

During the previous inspection it was noted that staff did not all have the appropriate level of training for providing care relating to the use of general anaesthetic, however the service was no longer providing treatments that required general anaesthetic.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

During the previous inspection we found that the safeguarding lead did not have up to date training. There were now two safeguarding leads with Level 3 safeguarding training – the Director of Clinical Services and the Head of Governance. In addition, the Assistant Director of Clinical Services was due to undertake Level 3 Safeguarding training.

We saw there was information available for staff on who to contact in the event of a safeguarding concern, including posters in the staff room.

Requires Improvement

Surgery

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained. During the previous inspection cubicle curtains did not have dates on to monitor their use, however the curtains now were dated and were within date.

Staff used records to identify how well the service prevented infections. It was noted in the previous inspection that the service did not always routinely complete swabs for Methicillin Resistant Staphylococcus Aureus (MRSA) for patients having local anaesthetic procedures. Leaders told us their policy now included that any patients who were health care workers would be swabbed for MRSA in line with National Institute for Health and Care Excellence (NICE)guidance.

Staff followed infection control principles including the use of personal protective equipment.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff worked effectively to prevent, identify and treat surgical site infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

During the previous inspection we found that the design of the environment did not follow national guidance for procedures carried out under general anaesthetic. However, the service was no longer performing procedures under general anaesthetic. One of the risks highlighted was that the theatres were on the first floor and there were no lifts. The service had an evacuation chair for use in emergencies and staff were trained to use it. They did not operate on patients with mobility issues, and this was part of the pre-assessment criteria.

Since the previous inspection the clinic had installed a new system for ventilation. They had mobile air filters in each of two theatre rooms which generated 25 air changes per hour in each theatre.

At the time of the previous inspection the service was using a reuseable earth plate for diathermy. This had resulted in patient safety incidents in which patients had been injured by cautery burns from diathermy equipment whilst they were under anaesthetic. They now used single use adhesive plates. The theatre manager had undertaken a training session with staff and staff completed competency assessments on the use of these. The training was also part of induction for new staff. There had been no incidents of cautery burns since this change. There were diathermy safety posters in theatres and a new standard operating procedure.

During the previous inspection we observed 2 trolleys in the theatre recovery area, one of which was visibly rusty, and the second had surgical drapes placed over. When these were removed, the trolley had sticky surgical tape marks in partly adhered to the trolley, indicating it was not clean. We found these had been replaced with new ones and were part of the monthly walk around checklist.

During the previous inspection it was noted that service users also did not have access to call bells following their procedures. There were now call bells in place in both theatres and toilet areas.

Requires Improvement

Surgery

The design of the environment followed national guidance. However, we noted that one worksurface side had exposed wood at the time of inspection. In the days following the inspection the service provided evidence that this had been rectified.

Staff carried out daily safety checks of specialist equipment. During the previous inspection we found that staff check-lists for equipment checks, including for the emergency trolley, were inaccurately recorded. Records were generally of a poor standard and often illegible. We found that the service had improved and saw evidence of completed daily checklists which included the emergency trolley, and fridge and room temperatures.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. During the previous inspection we found that 1 of the external clinical waste bins had a faulty lock. This was still an issue on this inspection, however, leaders told us this risk was mitigated as it was not in use and additional collections were in place for the one bin that was in use.

During the previous inspection we saw the Control of Substances Hazardous to Health (COSHH) cupboard remained open with the keys in the lock and were potentially accessible to members of the public. We found that these substances were now stored securely and there were COSHH safety posters on display.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. The service made sure patients knew who to contact to discuss complications or concerns.

During the previous inspection we found that staff did not routinely use a nationally recognised tool to identify deteriorating patients and did not always escalate them appropriately. The service now had a patient monitoring policy which included the use of the National Early Warning Score tool (NEWS2). There was also a deterioration and transfer out policy which detailed clinical indications for transfer out and preparations for transfer. The service was looking into incorporating the American Society of Anaesthetists tool for grading comorbidities and risk.

It was noted at the previous inspection that the service did not ensure that the World Health Organisation's (WHO) 5 steps to safer surgery checklist was followed completed by staff in a timely way. During this inspection we observed staff completing the checklist.

At the time of the previous inspection, risk of venous thromboembolism (VTE) was identified only for patients who were undergoing general anaesthetic procedures. Managers told us that all patients undergoing surgery were now risk assessed for VTE.

Staff completed risk assessments for each patient. We saw the patient selection criteria which included various conditions such as anticoagulant therapies, asthma, cancer, cardiac history, and diabetes.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Requires Improvement

Surgery

The service had enough nursing and support staff to keep patients safe. During the previous inspection we found that health care assistants were performing tasks they were not qualified for. Leaders told us there were now clearly defined roles for nurses and health care assistants. The service now employed a full-time registered nurse who undertook the duties that were only suitable for qualified nurses such as scrub duties for surgery. When this nurse was unavailable, they used regular agency staff.

The health care assistant role was now called a "Circulator" and tasks included escorting patients to and from reception, observations, and performing additional tasks in theatre.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

At the previous inspection it was found that records were not always clear, comprehensive, or up to date. There were no care plans or pain scores recorded. Leaders told us they had changed their medical notes and implemented a Local Anaesthetic Care Pathway and that pain scores were now recorded. During this inspection we reviewed 5 patient records and found they included care plans, pain scores, and consent.

Records were stored securely. The service used a combination of paper and electronic records.

Leaders told us the group had implemented records audits across the 3 clinics. We viewed a records audit for December 2023 and saw that the scoring criteria included legibility, discussion of patient expectations and risks of complications. There was then an action plan based on the results.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

During the previous inspection we found that medicines were not always administered by staff who had completed appropriate training, qualification and who were competent to do this. Aftercare packs including antibiotics and paracetamol were being given by unqualified staff. However, leaders told us that these were now only administered by the qualified nurse or operating department practitioner on shift.

At the previous inspection it was noted that controlled drugs were not always stored securely. However, the service informed us that controlled drugs were no longer stored on site as they were not required since the service had ceased all general anaesthetic procedures.

Incidents

The service did not always manage patient safety incidents well. However, when incidents were reported, managers investigated incidents and shared lessons learned with the whole team and the wider service.

During the last inspection it was noted that the service did not have effective systems for recording and investigating incidents occurring in the service, or processes for sharing any learning identified. We found that they still did not have a robust system for logging and monitoring incidents. Leaders told us that the process to report incidents was for staff to write down the details and tell the clinic manger. However, leaders told us they were due to implement a new electronic system for incident reporting.

Requires Improvement

Surgery

We reviewed Clinical Governance meeting minutes and saw evidence of shared learning from incidents that had occurred in another clinic within the group, and that this had been shared on a staff training session. The registered manager informed us following the inspection that where incidents and learning were identified, tasks were assigned to staff with target dates.

Is the service effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

During the previous inspection we saw that policies did not always reference best practice and national guidance. The service did not demonstrate in its policies how it ensured that cosmetic surgery was managed in accordance with professional and expert guidance for example as published by the Royal College of Surgeons. Leaders informed us they were in the process of updating all their policies and procedures and that these included reference to national guidance. For example, we viewed the 'Eight Steps of Safer Surgery" policy, and this referenced the World Health Organisation (WHO) Safer Surgery Saves Lives initiative including the WHO safer surgery checklist.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

At the time of the previous inspection, the service did not participate in any relevant national clinical audits. The registered manager informed us at that time that they were aware of the Royal College of Surgeons' recommendations, also the Competition and Marketing Authority's future requirement, for Patient Reported Outcome Measures (PROMS) or 'QPROMS' data collection to be collected. This was anticipated to be introduced from July 2024.

Leaders told us the service was now measured outcomes including infection rates, return to theatre, and readmissions. These were reported in the clinical governance and compliance meeting. We reviewed the minutes for October and November 2023 and saw that this data was compared across the other locations in the group.

The service had an audit schedule which included a quarterly health and safety floor walk, hand hygiene, infection prevention and control (IPC), and medicines management.

Competent staff

The service made sure staff were competent for their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. During the previous inspection we found that healthcare assistants worked unsupervised in areas of practice which they were not qualified or trained for. However, this had now improved, and healthcare assistants were only undertaking tasks suitable to their role. Leaders told us there was always a registered nurse or operating department practitioner on shift to undertake tasks that should only be done by someone who was clinically trained, such as scrub duties. There were clearly defined roles to differentiate the healthcare assistants and nursing staff.

Requires Improvement

Surgery

During the previous inspection we found that none of the consultants in the service participated in the Royal College of Surgeons' (RCS) Cosmetic Surgery certification scheme. Although this was not mandatory for consultants practising in independent health, the scheme would support the service in demonstrating how it was meeting the RCS's Professional Standards for Cosmetic Surgery 2016. This was still the case at the time of this inspection.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

During the previous inspection we saw that staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. Patients' consent was documented on the day of the procedure only and there was no record of any prior consent seen in the notes. Leaders told us the service now sends patients a consent form by email detailing the risks of the procedure after the initial consultation, to ensure that they have information pertaining to the risks well in advance of the procedure. They said most consent forms were signed on the day due to the preoperative assessment being via video call.

The pre-operative assessment included a discussion of the different treatment options, including the option of not having a procedure. There was a 14-day cooling off period where patients could cancel their procedure with no penalties.

Is the service responsive?

Insufficient evidence to rate

There was insufficient evidence to rate responsive as this was a focussed follow-up inspection.

Learning from complaints and concerns

The service had a process to investigate concerns and complaints. However, it was not always easy for people to give feedback and raise concerns about care received.

During the last inspection we did not see any information about how to raise a concern displayed in patient areas and this was still the case on this inspection. However, managers told us that patients received a follow up call which was an opportunity for them to raise concerns. Previously there was also no information on how to raise a concern or make a complaint on the website, however there was now a "Complaints Policy and Procedure" page on the company website detailing the complaints process.

Both prior to and following the previous inspection we heard from service users who had experienced a poor response in seeking follow up to their concerns, and who also felt inhibited from raising any further complaint due to a strongly worded response received from the provider. We did not find evidence that this had improved. Following our inspection, the Registered Manager informed us that the service now had a dedicated complaints manager who is a GMC registered doctor, and had experience in complaints handling. Responses were monitored and shared with the Medical Director and the Registered Manager told us the service had not received any further negative comments on complaints since this process was included.

Requires Improvement

Surgery

During the last inspection we found that the service did not signpost service users to other routes for resolution of their complaint and was not a member of the Independent Services Complaint Advisory Services, or the Independent Doctors Federation with regards to complaints management. Leaders told us they were in discussions with a health and care adjudication service to get a third-party complaints resolution process established. This would be the third stage in the complaints process. Following the inspection the provider told us they were now signed up to a third-party complaints adjudicator and details of this had been shared with staff in February 2024. The service also now had a patient liaison officer who would try to resolve issues in the first instance.

We saw meeting minutes showing that the clinical governance and compliance committee discussed complaints. The minutes also stated that staff were encouraged to record any expression of dissatisfaction, and that these should be viewed as complaints and therefore investigated, and actions taken as required.

Is the service well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had changed its leadership structure since the last inspection. There was a newly employed Assistant Director of Clinical Services who started working for the clinic in November 2023. They had recently applied to become the Registered Manager and the application was in progress at the time of inspection. The leadership team also included the Director of Clinical Services, Head of Governance and a Theatre manager who worked across the group clinics, as well as the current Registered Manager who was the Medical Director and Chair of Clinical Governance. In our previous inspection we found that leaders did not have a clear focus on good safety practice in the service. We found that this had improved significantly, and leaders demonstrated a strong focus on safety. The service also had a pharmacist and a lead infection prevention and control (IPC) nurse.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided some opportunities for career development.

Staff we spoke with were positive about working for the service. During the last inspection we found there was limited opportunity for career progression. A member of staff we spoke with on this inspection told us they were being supported to do an operating department practitioner apprenticeship, and another member of staff had been promoted to clinic manager.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Requires Improvement

Surgery

At the previous inspection we found there were unclear, and ineffective systems and processes in place for assessing, monitoring, and improving the quality and safety of the services provided. Communications between different parts of the service and individual responsibilities at senior levels were not always clear; there was a lack of formal recording in meeting minutes, with an apparent reliance on the registered manager's knowledge of the service in day-to-day practice. The governance framework was newly implemented and not yet embedded in the service and there was a lack of whole service development in building robust systems for oversight and governance in the service. We found significant improvement at this inspection. The provider had undertaken a full review of its processes and made changes to the clinical governance system to ensure monitoring of quality and safety. Leaders told us there was now a clear clinical governance system and defined roles in the leadership team, including a head of governance.

Following our previous inspection, the service brought in a new governance team and structure. The team included the Director of Clinical Service, Assistant Director of Clinical Services, Head of Governance, IPC nurse, theatre manager and pharmacist. They had been working to improve the compliance of the service, bringing together their areas of clinical expertise.

There was a monthly clinical governance and compliance meeting which reported to the board. We reviewed the minutes from the meetings in October and November 2023 and saw that there were standard agenda items including audits, complaints, risk register, patient safety alerts, and updates to policies and procedures.

The governance team also met weekly to review any challenges or areas that need to be escalated or shared across the group. Leaders told us this worked well and meant they had strong communication and could deal efficiently with any issues arising.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, however, there was limited evidence on oversight of risk.

The clinic had a risk register which included storage facilities, stock levels, clinical waste management, and the stairs being the only way to get up and down from the first floor where the theatres were located. The risk register included impact, probability and priority ratings, and mitigating actions. However, there were no dates to show when a risk was added or when an action was taken. This meant the risk register was limited in its effectiveness for management and oversight of risk.

Engagement

There were no formal processes in place for engagement with patients and staff.

The service did not have robust systems for gathering patient feedback to help shape services. Leaders told us they relied on patient feedback from an external website, which did not specify which of the group's clinics the feedback was about. At the time of inspection, the page for Signature stated "We've found out that this company has been pressuring people to remove or edit their negative reviews". Following the inspection, the Registered Manager told us they also monitored Google reviews. However, this feedback was not collated and analysed to monitor themes and help shape services. They also informed us they were implementing a standardised patient feedback form in February 2024 which included scoring.

The service conducted staff surveys but there was no evidence of collating and analysing feedback in order to make improvements.

Requires Improvement

Surgery

Learning, continuous improvement and innovation

The leadership team demonstrated a strong focus on improving services.

During the previous inspection we found that leaders did not use any standardised improvement methods in the service and there was a lack of focus on quality improvement and innovation. At this inspection we viewed the services improvement plan which was detailed and included monitoring the progress of improvements. Areas covered in the action plan included a review of mandatory training, medical equipment training, IPC audits, standardisation of infographics, such as safety posters, and a governance display board including lessons learned and top risks.

This section is primarily information for the provider

Requirement notices

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that there is a robust process in place for incident reporting, including logging any mitigating actions and shared learning. Regulation 12(1)(2)(b)

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure systems are in place to gather staff feedback. Regulation 17(1)(2)(e) The service must ensure the risk register is fit for purpose including dates indicating when risks were added and when mitigating actions were taken or are due by. Regulation 17(1)(2)(a)