Signature Medical Limited

Birmingham

Inspection report

6 George Road
Edgbaston
Birmingham
B15 1NP
Tel: 07547300360
www.signatureclinic.co.uk

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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 caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We have not previously inspected this location. We rated it as requires improvement because:

- There service did not consistently manage cleanliness, hygiene, and maintenance and the provider was slow to act on risks. While staff reported safety incidents, a lessons learned process was in its infancy and there was no well-defined track record of improvements.
- Clinical care was based on national guidance but there was limited monitoring of effectiveness, and the audit programme was not designed to drive efficacy and quality. Managers did not have assurance of consistent evidence-based care.
- Staff were trained in key skills but did not have good access to continuing professional development or specialist training.
- Governance systems were undergoing significant overhaul and improvement to address shortfalls in quality and clinical oversight and risk management. The provider had identified and was acting on key risks and changes were not yet embedded. The improvement programme aimed to address gaps in leadership, performance monitoring, and clinical quality assurance.
- Engagement between the provider and local clinic staff and patients was inconsistent. While this was an area of focus for improvement, there was not a well-defined programme to address key issues.

However:

- The service had enough staff to care for patients. Staff understood how to protect patients from abuse. They carried out good pre-operative risk assessments, kept good care records, and managed medicines well.
- Staff provided good care and treatment and managed pain relief well.
- Staff treated patients with compassion and kindness and respected their privacy and dignity. They supported patients to make decisions about care and patient feedback was generally good.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	We rated this service as requires improvement. Please see the main summary.

Summary of findings

Contents

Summary of this inspection

Background to Birmingham

The Birmingham clinic is operated by Signature Medical Limited and provides non-invasive cosmetic surgery on a private basis to adults over the age of 18. The service registered with CQC in June 2021 and has not previously been inspected.

Care and treatment are delivered from a modified residential property over 2 floors. Facilities include a waiting and reception area, 2 operating theatres, a recovery room, and a consultation room.

The service has a registered manager in post and is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder, or injury

How we carried out this inspection

We carried out unannounced inspections on 18 October 2023 and 13 November 2023 using our comprehensive methodology. Our inspection team included a CQC lead inspector, 2 nurse specialists, and an off-site operations manager.

During our inspection we spoke with staff and patients, observed care being delivered, and reviewed clinical records. After our inspection the provider sent us documents such as audits and governance records that contributed to our judgement.

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 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 SHOULD take to improve:

- The service should ensure infection prevention and control systems provide assurance of safety and meet national best practice standards. Regulation 12.
- The service should ensure staff manage the risks of domestic electrical equipment. Regulation 15.
- The service should consider how to better manage clinical waste disposal when both theatres are in use. Regulation 15.
- The service should ensure air purifiers in surgical theatres are fit for purpose in the areas installed. Regulation 15.
- The service should ensure the new complaints manager improves the breadth and depth of learning from complaints. Regulation 16.

Summary of this inspection

- The service should ensure the independent adjudication process is clearer and more readily accessible. Regulation 16.
- The service should ensure delays and disruption to clinics are consistently managed and communicated to patients. Regulation 17.
- The service should ensure improvements to clinical governance, quality assurance, and risk management continue to be developed and are fully embedded in the service. Regulation 17.
- The service should ensure that use of CCTV in the clinic meets national information management standards. Regulation 17.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Surgery

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

Is the service safe?

Requires Improvement

We have not previously inspected or rated this service. We rated safe 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, which was comprehensive and met the needs of patients. Staff completed up to 29 modules depending on their role and responsibilities. Some modules were common to all staff, such as infection control, manual handling, and conflict management.

Clinical staff completed training in sepsis management, sharps awareness, medical gases, anaphylaxis, and managing a deteriorating patient.

At the time of our inspection all staff were up to date with training and the provider scheduled updates in advance to ensure there were no lapses.

Staff described training as rewarding and useful for their role.

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. All staff undertook adult and children safeguarding level 3 training. The service did not provide care to people under the age of 18 and staff maintained child safeguarding awareness as good practice in recognition that a child may accompany an adult who was undergoing treatment.

The clinical governance specialist was the safeguarding lead and trained to level 3. Staff knew how to contact them for guidance and support.

Staff had contact details for the local authority safeguarding team and the provider's policy provided guidance in making a referral.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act, and had completed training in doing so.

A member of staff trained to chaperone was available at all times patients were present. Staff offered patients a chaperone at the pre-assessment stage of care and again on the day of surgery.

The provider had implemented new safeguarding training targeted to cosmetic surgery settings. Staff said this was a significant improvement on standard training and as a result they were able to readily identify and report concerns.

Staff acted quickly to protect patients at risk from harm when they presented with safeguarding needs or vulnerabilities. For example, a patient had used the post-operative text message service to disclose their intent to self-harm. The receptionist had escalated the situation and obtained help for the patient. Staff also worked together to secure help for the child of a patient who had left them unaccompanied in a nearby hotel for an extended period of time. After these incidents staff met to discuss their response and identify learning.

Cleanliness, infection control and hygiene

The service did not consistently control infection risk.

Clinical areas were clean and had suitable furnishings which were clean. However, non-clinical areas were not always thoroughly cleaned.

We found evidence of dust and dirt in the reception area, hallway and stairwell, and a toilet used by patients during the second day of our inspection. Cleaning checklists indicated all areas were cleaned regularly but our findings indicated there was a lack of assurance of cleaning standards.

An infection prevention and control (IPC) nurse worked at provider level across each clinic. They carried out a bi-monthly audit of clinic standards and practices, including hand hygiene. The clinic scored an average 76% compliance in the previous 12 months, which was lower than the provider's 95% target. The audit flagged hand hygiene and environmental management as 2 areas in need of significant improvement. The IPC nurse had introduced a programme of refresher training, leadership support, and spot-checks to address this.

Staff followed infection control principles including the use of personal protective equipment (PPE) and the aseptic non-touch technique (ANTT). During our inspection staff demonstrated consistently good practice in both processes.

The provider displayed a hand wash technique poster above each sink, which demonstrated the various stages of good hand hygiene practice through a series of pictures. However, the posters were out of date and did not show updates to NHS and World Health Organisation (WHO) guidance. We spoke with the clinic manager about this who said they would update the information. This reflected part of wider work by the provider to improve standards and consistency.

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

Staff worked effectively to prevent surgical site infections. The service reported no surgical site infections in the previous 12 months.

Requires Improvement

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well.

The design of the environment was compliant with the Department of Health and Social Care (DHSC) health building notice (HBN) 00/10 in relation to flooring in the healthcare environment and HBN 07/01 in relation to the clinical environment. However, gaps in maintenance meant the clinic was not continuously compliant. For example, both theatres had damaged floors and walls. This included evidence of holes in the walls and exposed floor plugs at the threshold to the theatre. The damage meant surfaces were not fully sealed and risked the build-up of bacteria. This presented a risk of contamination and surgical site infections.

Staff had recognised the risk but had not taken rapid action to mitigate it. After our inspection the provider closed they theatre with the most pressing risk from service whilst repairs were underway. The service then scheduled repairs in the second theatre.

Staff said they flushed taps regularly to avoid the risk of Legionella build-up. They demonstrated good knowledge of this but did not keep records, which meant the provider did not have assurance of safe practice. Senior staff had recently formed a new clinical governance and compliance committee (CGCC), which had recognised the need for documenting water temperatures.

Medical consumables were mostly stored on racks above floor level. However, several cardboard boxes containing supplies were stored on the floor. This was not complaint with HBM 00/09 in relation to infection control in the built environment.

Hallways between clinical areas were carpeted, which presented a risk of contamination since they cannot be cleaned as easily as non-porous surfaces.

The use of PPE and steaming processes reduced the risk of infection, but the provider did not have a deep clean or steam cleaning schedule for carpets.

Each theatre was fitted with an air purifier preset to manage air exchange. Whilst this was good practice and helped reduce the risk of infection, the unit in theatre 1 was too small to effectively exchange the air in the room. We spoke with the registered manager about this at the time of the inspection who said they would address it.

The deputy manager documented weekly fire safety checks including the fire alarm and emergency lighting system. Records showed they took corrective action where they found a defect or problem. The service had 2 fire marshals and there was always 1 available whenever patients were booked into the clinic.

Staff carried out checks of specialist equipment before beginning a surgical list. The provider had a planned preventative maintenance schedule in place for clinical equipment. This meant equipment was always calibrated and safe for use. The deputy clinic manager had contact details for on-call maintenance staff in the event of a failure.

Staff disposed of clinical waste in line with DHSC HTM 07/01 in relation to the safe management and disposal of healthcare waste. This included a 1-way streaming system to remove clinical waste from the building and into a secure storage bin. However, if the upper floor theatre was in use, staff had to use a carpeted area to reach the clinical waste bin outside. This presented a risk of contamination if hazardous material, such as bodily fluid, leaked onto the carpet.

Requires Improvement

Surgery

Staff managed sharps in line with national requirements, including secured and labelled sharps bins.

Staff sent removed tissue samples to a laboratory for histology after required procedures. The handling and management of samples was in line with national legislation.

The clinic had sterilisation equipment on site and a trained member of staff led this process. They documented cycle numbers and sterilisation dates for all reusable surgical equipment. Staff used sterile gauze to dry reusable surgical instruments and followed good practice to pack equipment ready for use. This was compliant with DHSC HTM 01/01 for the sterilisation of surgical instruments.

The service maintained sterilisation and decontamination equipment, including autoclave machines and an ultrasound bath, in line with manufacturer guidance. Staff carried out and documented regular calibration and maintenance checks and kept a log of validation checks carried out on each of day surgery.

Electrical equipment had up to date safety testing although staff did not always follow good health and safety practices. For example, theatre 1 had a trailing electrical extension cord that was not surge-protected. Surge protection reduces the risk of a fire in the event of a power surge.

The clinic was located in a repurposed residential building over 2 floors, with steep, narrow staircases connecting all floors. An evacuation chair was available on the 1st floor and staff had completed training to use it.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Emergency equipment was located on site and included an automatic external defibrillator (AED), oxygen cylinders with a range of masks, and an anaphylaxis kit. Equipment was appropriate for the size of the clinic and types of treatment offered.

In the event a patient deteriorated, staff were trained to stabilise them whilst awaiting a 999 ambulance. Resuscitation information was printed from the Resuscitation Council UK and was up to date at the time of the inspection.

The provider had a protocol for the emergency transfer of deteriorating patients. This included documentation staff were required to complete whilst awaiting an ambulance and the records they would supply to paramedics.

Staff completed risk assessments for each patient before surgery. These included risks relating to medical conditions such as diabetes or HIV as well as risk management for sepsis and venous thromboembolism. Staff used compression bandages and stockings during procedures to reduce the risk of deep vein thrombosis and pulmonary embolism in line with national guidance.

Staff used the WHO surgical safety checklist to manage procedures safely. During our inspection staff demonstrated attention to detail and a good standard of communication during each procedure. For example, they followed WHO best practice of establishing clear roles and responsibilities. They team counted swabs before and after surgery to reduce the risk of a retained object.

Requires Improvement

Surgery

During each procedure staff used a dry wipe board to note the time of each stage of the procedure as well as medicines used and any other actions of note. Following each procedure, staff took a photograph of the board before clearing it for the next patient. This provided a back-up to the WHO safety process and was good practice.

Staff were trained in life support to a level commensurate with their role. Non-clinical staff, healthcare assistants (HCAs), and nurses and were trained in basic life support. Operating department practitioners (ODPs) and surgeons were trained in immediate life support.

Surgeons acted on concerns about mental health and capacity at the pre-assessment stage of care. They arranged for psychosocial assessments or a risk assessment where patients could not fully understand their procedure or where the surgeon felt the requested surgery was clinically inadvisable.

Medical staff carried out a pre-surgical assessment of each patient. This included a review of their medical history and current medicines. Patients needed to have a body mass index (BMI) lower than 30 for surgery to be safe. Where patients with a BMI higher than this asked for surgery, staff declined to proceed, signposted them to weight loss services, and advised them to return once their BMI was within the safe range for surgery.

The provider monitored clinical reasons for surgeons who declined to proceed with a requested procedure. In the previous 12 months, surgeons declined 6 treatments based on each patient's current medical condition and requested more information from their treating doctor. This included cardiology conditions and patients who were immunosuppressed.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave agency and locum staff an induction.

The service had enough nursing and support staff to keep patients safe. The deputy manager planned staffing based on scheduled appointments and procedures. All care was pre-planned, which meant the service was able to accurately calculate required staffing in advance.

The deputy manager was based permanently at this site along with a team of 6 healthcare assistants (HCAs), 2 operating department practitioners (ODPs), a receptionist. The nursing team were permanently employed and attached to the provider's Rochdale service. They worked shifts at the Birmingham clinic with prior arrangement during planned surgery.

Medical staff worked across regional patches in the provider's network and worked under a practising privilege agreement. The provider required a disclosure and barring service check, evidence of medical indemnity insurance, and registration with the General Medical Council before a surgeon was able to provide care and treatment.

The provider had an agreement with an agency for additional operating department practitioners (ODP). ODPs worked for an agency and the provider usually secured the same staff for procedures to promote consistency.

Employed ODPs were registered with the Health and Care Professions Council and the provider required agency staff to have the same level of qualification and registration.

Requires Improvement

Surgery

All staff, including agency staff, completed an induction before they could work in the clinic. We observed an induction on the first day of inspection. Whilst this followed the provider's guidance and included the most critical areas of work, it lacked detail and substance. After our inspection the provider told us inductions took place over a few days and were more detailed than we observed.

A typical team included a surgeon, a scrub nurse, an ODP, and a health care assistant. This was appropriate for the type of care provided.

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.

Patient notes were comprehensive, and all staff could access them easily. Staff documented demographic and medical history along with pre- and post-operative photography. Where a surgeon had requested a risk assessment to manage a pre-existing medical condition, this was clearly documented.

When patients transferred to a new team, there were no delays in staff accessing their records. Clinical records were accessible only by the operating surgeon and could be shared with colleagues in the provider's network when needed, for example, if a patient attended a different clinic for follow-up.

Records were stored securely. Staff used paper records during treatment and then scanned those into the provider's electronic system. The system had controlled access and 24/7 IT support in the event of an issue.

A senior nurse audited a sample of clinical records each month. Where they found areas for improvement, they provided guidance to staff and followed up with a re-audit shortly afterwards. Whilst audits demonstrated good standards of practice, it was not evident that improvements were fully embedded. For example, a theme of non-compliance was delayed and inaccuracies in uploading pre-operative photographs to the patient record system and unsigned paperwork. Audits did not always indicate guidance from the provider was effective in improving standards.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The surgeon issued a prescription and the ODP checked this before issuing the medicines as part of a 2-step safety process.

Staff stored and managed all medicines and prescribing documents safely. For example, medicines were stored in locked cupboards or fridges with restricted access. They documented temperature checks of medicine storage areas, including fridges, regularly. While there had been no instances of temperatures exceeding safe thresholds, staff knew how to contact the supplying pharmacy for advice in the event of an issue.

A pharmacist worked at provider level across the clinic network. They carried out a quarterly medicines management audit of practices such as storage, stock control, and administration. The most recent audit took place in October 2023. They found broad compliance with expected standards, with some areas for improvement. These did not relate to patient safety and instead encouraged good housekeeping and organisation.

Requires Improvement

Surgery

Incidents

The provider was in the process of improving how staff managed patient safety incidents. Staff recognised and reported incidents and near misses but there had been a lack of investigation and shared learning, which had been addressed. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the service's policy. The provider had a basic reporting system that involved staff emailing a member of the senior team with details of any incident. The deputy clinic manager logged each incident on a local tracker.

In the previous 12 months staff reported 10 incidents. None of the incidents resulted in patient harm and in each case, staff documented their immediate actions.

Incidents included clinic delays, patients becoming unwell before surgery, and issues that temporarily interrupted the service, such as a flood. Whilst reporting by staff was good, there was a lack of follow-up by the provider. For example, 4 incidents related to issues that involved the provider's head office but there was no documented learning or outcome.

Staff we spoke with understood the duty of candour and the provider's policy and threshold that would trigger a disclosure. The deputy clinic manager was responsible for the duty of candour at clinic level.

Staff met to discuss investigations and consider improvements to patient care. For example, the service introduced an in-depth pre-operative consultation process. This reflected learning from an incident in which a patient's medical condition changed between the pre-operative consultation and the day of surgery. The patient did not disclose this to staff and the provider's process did not require staff to ask about changes to condition. The new process addressed these issues.

The provider had recently introduced a new electronic incident reporting system that would enable staff to access information from all clinics in their network. This would streamline identifying themes and concerns and enable staff to learn from incidents and investigations more readily at other clinics. The clinic was in a transitional phase while the new system was fully implemented, and staff used both systems during this time.

As part of the new incident reporting system, the CGCC had introduced a lessons learned process shared amongst all clinics. It addressed the previous gaps in follow-up after an incident and used a clear structure to present staff with the causes of an incident, the outcomes of the investigation, and learning applied to practice and policies.

Is the service effective?

Good

We have not previously inspected or rated this service. We rated it as good.

Evidence-based care and treatment

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

Requires Improvement

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The providerbased training, policies, and procedures on best practice standards from organisations relevant to the care offered, such as the Royal College of Surgeons, the World Health Organization (WHO), the Resuscitation Council UK, and the National Institute for Health and Care Excellence.

The clinical governance and compliance committee (CGCC) had implemented a new online system that enabled staff to access policies digitally. This replaced the previous system of printed policies and improved access and the provider's ability to update items quickly.

The CGCC monitored updates to national guidance to inform the provider's policies and practices. A team of subject matter experts reviewed emerging treatments and research findings to inform the services and treatments offered. This provided assurance patients received treatment in line with the latest best practice.

The team used a rolling programme of 9 audits to benchmark standards of care against other clinics in the provider's network. This reflected good practice but there was limited evidence the provider used data to build evidence-based practice and to monitor or improve care.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff performed surgery under local anaesthetic, which meant fasting was not always necessary prior to treatment. Where a procedure required patients to fast beforehand, staff assessed this individually. The surgeon checked each patient's adherence to their fasting instructions prior to beginning treatment.

Staff provided patients with drinks and snacks during post-operative recovery.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Surgery was performed under local anaesthetic and surgeons titrated the dose as needed during procedures if the patient experienced increasing discomfort.

Staff discussed the possibility of discomfort during the consent process and prior to treatment. During procedures they reassured patients about what they were feeling and how it could best be managed.

Staff knew how to recognise non-verbal signs of pain and monitored this throughout procedures. For example, during our inspection the surgeon noticed patients' facial expressions and offered them more analgesia or a break if they were uncomfortable. Staff prescribed, administered, and recorded analgesia in line with national standards.

Surgeons provided each patient with printed information about managing their recovery after the procedure. This included guidance on the use of non-prescription pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

Requires Improvement

Surgery

Outcomes for patients were positive and consistently met their expectations. Surgeons explored patient's desired outcomes at the pre-operative assessment stage of care to ensure their goals were realistic and to manage expectations. Staff used medical photography to track treatment goals. They took photographs of the operation site before treatment began, after each treatment, and when treatment finished.

Staff provided detailed post-operative care instructions to each patient. This included printed information and mouthwash to address distaste that could be experienced after some procedures.

The provider had a centralised clinical aftercare team who contacted each patient within 24 hours of surgery. This process checked recovery and enabled patients to ask questions or raise concerns. The team followed this with a further telephone call to the patient 1 week after surgery. Where patients had concerns or where dissatisfied, the aftercare team arranged a face-to-face meeting with the operating surgeon.

There were no unplanned returns to theatre in the previous 12 months and no unplanned transfers to other services.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers supported staff to develop through 3-monthly supervisions and annual, constructive appraisals of their work.

The CGCC was in the process of reviewing staff training to identify opportunities for more specialist development beyond the provider's mandatory training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The clinic team met monthly, and minutes indicated awareness of the key challenges and pressures.

Staff met each morning for a 'huddle' to plan the day ahead and review the patient list. This ensured they were prepared for unexpected events and complications.

Staff worked under varying contracts and with different lengths of experience in this clinic. The provider's induction programme aimed to standardise practices and ensure everyone work to the same level of competency regardless of their experience. For example, during our inspection we observed a good standard of practice by a scrub nurse who had joined the service 8 weeks previously.

The service had introduced competencies in the national safety standards for invasive procedures (NatSSIPs 2) to complete a new process for swab count. The swab count was part of a standard safety checklist and following the NatSSIPs 2 requirement provided assurance of effective practice.

Staff completed practical simulation training for emergencies. This included a cardiac arrest simulation and the head of theatres provided learning points afterwards.

Staff met colleagues from the provider's clinic network for group training and meetings periodically. This helped to standardise practice and competencies and meant staff had the opportunity to learn from each other's experiences.

Requires Improvement

Surgery

Multidisciplinary working

Multidisciplinary processes and opportunities were limited and in the process of development.

Staff arranged multidisciplinary (MDT) meetings as needed to review care for patients with comorbidities or with a heightened risk of complication.

Where a patient presented with an existing health condition, including mental health, staff liaised with GP's or the treating consultant to discuss the appropriateness of cosmetic surgery.

The CGCC had implemented an MDT meeting schedule that meant surgeons and clinical colleagues would meet quarterly to review unusual cases and identify learning from the care of patients with complex needs. This was a new initiative as part of a range of governance and efficacy improvements.

Seven-day services

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

The clinic opened in line with patient demand. Staff opened the clinic on the day after surgical lists to facilitate a post-operative check-up, which was compulsory for each patient.

The provider's aftercare team was available by telephone 7 days a week from 8am to 11pm. Outside of these hours, patients knew to contact local NHS services for urgent support. The aftercare team was staffed by non-clinical advisors who connected patients with their operating surgeon in the event of a clinical concern.

A senior nurse and the group infection prevention and control nurse provided duty cover for this clinic. If a patient wished to be seen by a clinician and their operating surgeon was unavailable at short notice, a nurse would provide an in-person appointment.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, staff provided guidance on weight loss and fitness where patients presented with a body mass index over the maximum safe threshold for surgery.

Staff provided smoking and drinking cessation advice on an individual basis where this would help a patient's recovery and outcomes.

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 with a cooling off period of at least 14 days between stages.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with best practice. Surgeons ensured patients understood the risks and benefits of treatment before agreeing to a procedure. This included a discussion of the patient's expectations to make sure it was likely the procedure would meet their needs.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Requires Improvement

Surgery

Staff followed the standard national 14 day cooling off period between initial consent and a surgical procedure taking place. They obtained consent again on the day of surgery after reminding patients of the possible risks, side effects, and recovery period.

Staff completed training in the Mental Capacity Act (2005). As all care was elective, they did not make best interest decisions on behalf of patients. Where a patient did not understand treatment options or could not consent, the surgeon stopped the treatment process and sought psychologist advice.

Staff asked patients for consent to use medical photography as part of the outcome tracking process. The provider had a clear policy that detailed the use of photography, including for marketing. Patients could opt-out of photographs for marketing purpose and have this used solely to measure their own treatment.

Is the service caring?

Good

We have not previously inspected or rated this service. We rated it as good.

Compassionate care

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. They took time to interact with patients and those close to them in a respectful and considerate way. We observed this during our inspection. For example, staff were patient and kind when speaking with patients. They made them feel welcome and at home in the clinic.

Patients said staff treated them well and with kindness. In recent feedback patients noted they were “delighted” and “really happy” with the results of treatment and felt they had been well looked after. For example, 1 patient said, “As soon as I walked into the clinic I was welcomed and made to feel at ease. All the staff were professional and friendly.”

Staff understood patients could often be nervous when they presented for surgical treatment. They supported them with compassionate care to relax. Patient feedback reflected this, and a recent patient noted, “Thank you for your lovely bedside manner, your patience and kindness.”

Staff followed the provider’s policy to keep patient care and treatment confidential. They used private spaces for discussions that included confidential information and followed good practice when handling paperwork or leaving a computer unattended.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff gave patients emotional support and advice when they needed it. They recognised the personal nature of choosing cosmetic surgery and spent time with each patient to make sure they were making a decision that was right for them. For example, they supported patients who wished to bring a loved one with them to discuss treatment options and those who wanted more than 1 consultation to ask questions and discuss treatment planning.

Requires Improvement

Surgery

Staff understood the emotional and social impact that a person's treatment had on their wellbeing and tailored care and communication to meet their needs. Patients commented positively on this in feedback. A recent patient said, "I felt embarrassed about [the intimate nature] of my procedure but the team put me at ease and even made me laugh."

During our inspection staff worked with a young, nervous patient before surgery to make sure they still wanted to go ahead and to review their other options.

In feedback, patients commented on how staff made them feel at ease and helped them relax during procedures. A recent patient said, "[Staff] made me feel very special throughout the whole procedure, the surgical team were very caring." Another patient said, "I was nervous about my procedure but the whole team were friendly and put me at ease."

Understanding and involvement of patients and those close to them

Staff supported patients to make decisions about their care and treatment.

Staff made sure patients understood their care and treatment before agreeing to surgery.

During our inspection surgical teams worked well together to help patients relax. They used conversation and good humour as diversional therapy to distract patients from discomfort and provided them with a stress ball to assist. Staff adapted their reassurance approach to the specific patient, such as by providing more in-depth discussion and commentary for a patient who had not previously undergone surgery.

Patients could give feedback on the service and their treatment and staff supported them to do this. They provided patients with a questionnaire and provided alternative options such as e-mail and telephone. Patients gave positive feedback about the service and said the team kept them informed about their procedure. They also commented on the service provided by the aftercare team and said they appreciated being involved in the recovery process.

Is the service responsive?

Requires Improvement

We have not previously inspected or rated this service. We rated it as requires improvement.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

The clinic was accessible by patients with mobility needs, including those who used a wheelchair. The whole treatment cycle could be delivered from the ground floor and the service had an accessible toilet.

The service had arrangements in place for language interpretation. Staff arranged in-person or telephone interpreters on request or where clinicians found a patient could not fully understand treatment information given in English. The provider offered on-demand printing of information guides and care documentation, such as consent forms, in other languages and could provide these in Braille.

Requires Improvement

Surgery

The service provided care and treatment to patients who could make their own decisions about surgery and who could provide consent. Where surgeons found mental health needs, they referred patients for a psychological assessment, or contacted their mental health doctor, before proceeding with care.

Staff worked with patients to provide a flexible service. They offered appointment times to suit patients' working hours and enabled patients to access aftercare at other clinics in the network if that was more convenient.

Access and flow

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

The service opened and operated on demand to meet patients' needs. Appointments were agreed in advance and surgical procedures met patient requests and surgeon availability. This meant there were no waiting lists and instead staff and patients worked together to arrange times.

While there was no waiting list, incident reports reflected significant delays on some clinic days caused by poor planning or avoidable events. It was not evident staff kept patients informed of delays or that the provider maintained a good awareness of access issues on a day-to-day basis.

The service had not cancelled any appointments in the previous 12 months for non-clinical reasons. Where a surgeon was unwell or unexpectedly unavailable, the provider offered alternative dates or a change of clinic.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them, but learning was not always in depth. The service had a system for referring unresolved complaints for independent review although this was not readily accessible.

The provider had a complaints policy that established timeframes for responding to and resolving complaints. While the policy clearly laid out what patients could expect, it did not provide details of how to escalate a complaint if it was unresolved, such as to an independent arbitration service. Instead, it instructed patients to ask the clinic manager for more details.

Staff displayed details of how to complain in the clinic waiting room, although this was not available on the website. This meant the provider did not have assurance patients knew how to complain.

The clinic manager was able to resolve minor issues and concerns at a local level, but the provider did not enable them to resolve issues relating to delays. This was reflected in incident reports in which patients were unhappy about delays, but the clinic manager could not resolve the issue without input from head office.

In the previous 12 months the service reported 15 formal complaints. The registered manager investigated each complaint to identify themes. Dissatisfaction with clinical standards and outcomes, surgeon attitude, delays on the day of surgery, and the aftercare service were the key themes of complaints. In each case the service responded to the patient with corrective action, such as an extra surgical review or extended aftercare.

The provider documented learning from each complaint, but this did not always match the extent of the issue or lead to improved practice. For example, the nature of complaints suggested patients did not fully understand the recovery period or the immediate side effects of care. In addition, the provider did not act on negative feedback about delays to clinics.

Requires Improvement

Surgery

A new complaints manager had recently been appointed and was working to improve how the provider acted on and learned from complaints.

Is the service well-led?

Requires Improvement

We have not previously inspected or rated this service. We rated it as requires improvement.

Leadership

Leaders had variable skills and abilities although a significant restructure had improved the management and understanding of priorities and issues the service faced.

The registered manager was the business owner and medical director and worked across the clinic network. Together with the chief executive officer, chief medical officer, operations director, financial director, and the head of legal, they formed the senior leadership team (SLT).

The clinic manager led the day-to-day operation of the service. Other leadership roles were centralised across the provider's network.

The SLT had introduced a new buddy system that paired a member of the clinical governance and compliance committee (CGCC) with the clinic manager. This formed part of a new clinical governance system aimed at improving standards of practice.

Staff spoke highly of leadership and 1 individual described the registered managed as "visible, supportive and makes sure we have everything we need for the clinic." However, the range of gaps in assurance we found during the inspection indicated gaps in leadership, particularly in relation to the provider's competent oversight of this clinic.

Vision and Strategy

The service had a vision for what it wanted to achieve although there was limited strategic oversight. Staff had limited knowledge of the vision or corporate values.

The provider's vision and mission were focused on providing friendly, straightforward cosmetic surgery that was value for money. The senior team facilitated work within core values that aimed to promote a positive experience for patients that was minimally intrusive and achieved their goals.

Staff did not have a good knowledge of the vision, mission, and core values although knew how to find them on request. The CGCC recognised this as an area for improvement and had begun to embed the values in new areas of work such as the monthly newsletter and leadership support.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear although there was limited evidence this extended to patients.

Requires Improvement

Surgery

There was a lack of assurance of a good relationship between the provider and clinic staff. Incident reports included references to staff being concerned about working late following delays, patients becoming upset because of a lack of support for delays, and the provider's scheduling department arranging back-to-back surgeries that did not allow staff to take breaks.

While there was no documented evidence that the provider understood the local pressures under which staff worked, the newly formed CGCC had identified several areas for improvement and were in the process of implementing new strategies. For example, they implemented a new Freedom to Speak Up Guardian role and a champion, both of whom were available at short notice to staff. The team had implemented regular communication with staff and provided opportunities to meet and discuss their work, both formally and informally.

Incident reports reflected a lack of support for patients locally when things went wrong. For example, when a clinic was running late and a patient wanted to reschedule their appointment, staff noted their response was to tell the patient they would be issued a financial penalty. Patient feedback was mostly positive and so such instances were in the minority. However, they reflected a need for improved culture on the provider's behalf.

Governance

Leaders operated improving governance processes that reflected previous gaps.

The group theatre manager, director of clinical services, the lead pharmacist, the infection prevention, and control (IPC) lead, and the clinical governance specialist formed the CGCC with oversight from the medical director and medical advisory committee (MAC). They met monthly and worked nationally at provider level and were responsible for clinical governance across the clinic network.

Governance systems were functioning to the extent the provider had basic oversight of the clinic's work and its key risks. Audits, recruitment standards, and evidence-based policies kept people safe but gaps in clinical governance meant the provider did not have consistent assurance of quality and clinical outcomes.

The CGCC was newly formed and was in the process of overhauling the provider's governance systems and structure. They had introduced a monthly newsletter that shared information such as incidents and learning from across the provider's network. Staff spoke positively of the new system and said they felt better connected to colleagues in other clinics.

Minutes from the first 2 meetings indicated a positive move towards change, with a good understanding of the challenges and gaps in compliance. The committee had established new governance assurance systems, such as regular whole-clinic inspections using regulatory frameworks and a significantly improved approach to areas such as infection control and staff training. The provider had engaged the services of a consultant microbiologist to support the IPC nurse in establishing consistent improvements in the clinic and across the provider's network.

Management of risk, issues, and performance

Staff escalated relevant risks and issues but there was limited evidence of action from the provider. The provider had limited plans to cope with unexpected events.

During our inspection we found pest catchers (rodent bait boxes) situated around the clinic and exterior walls. We asked the clinic manager about the devices. They said they were unaware of any risk and said the provider had installed them as good practice. However, during the first day of our inspection we observed rats present in the car park and exterior

walkway connected to the building. Rodents can pass dangerous diseases to people through their urine and faeces and their presence in a clinical environment is of concern. We asked the provider for more information on this. The IPC lead prepared a risk assessment and management plan that was appropriate for the risk and would protect people from harm. However, it was not clear why there was limited knowledge of this at a local level.

The IPC lead carried out audits and spot checks at the clinic as part of provider-level management of risk and performance. While there were areas for improvement in practice and monitoring, the CGCC had acted with immediate changes, including the closure of theatres for refurbishment and repair.

The safety, quality, and risk committee worked across the provider's clinics and monitored incidents and audit outcomes to maintain an overview of standards of care. The team was working closely with the CGCC to implement improvements. These were credible and evidence-based and addressed the key concerns found in the clinic.

The provider had an agreement in place with a local CQC-registered private ambulance service to provide emergency department transfers. Staff used this in the event a patient deteriorated, and the NHS 999 service could not provide a timely response. This reflected good practice as a result of the provider's understanding of regional pressures on the NHS.

Incident reports indicated areas of inconsistent oversight from the provider. For example, staff reported instances of delayed clinics due to the provider booking consecutive patients with insufficient time between them. Staff reported an incident of a patient becoming aggressive and filming them because they were dissatisfied with a procedure and without immediate help from the provider's head office. In another incident, clinics were delayed because the provider scheduled a patient with a latex allergy in the middle of a clinic, instead of at the beginning of the list. While the new CGCC had a strategy to improve risk management and staff support, incident reports did not reflect an existing understanding of performance.

The provider had implemented a series of fire safety improvements following a risk assessment that found multiple areas of failure and risk. Staff had addressed the highest areas of risk, and a further specialist assessment was needed to confirm a reduction.

The senior team used a risk log to identify, manage, and track risks to the service. At the time of our inspection there were 6 active risks. Each risk had a named accountable member of the SLT, a record of current action, and risk mitigation.

Information Management

Information systems were integrated and secure.

All staff completed information management and data security training. They demonstrated good knowledge of secure processes during our inspection.

The provider controlled access to digital patient records and limited this to clinic managers and the operating surgeon. An external contractor provided IT and cybersecurity support and staff had 24/7 access in the event of a systems failure.

CCTV was in use in the clinic and the service was not compliant with the Data Protection Act. For example, there were no notices or signs in situ to explain the purpose and use of CCTV and staff did not know who was responsible for CCTV or how or when they accessed recordings.

Engagement

Leaders were improving how they engaged with staff. The provider had variable engagement with patients.

Requires Improvement

Surgery

While feedback from patients was generally positive, it was not evident the provider engaged well during challenges. For example, staff noted in an incident report that the provider would penalise a patient financially for rescheduling an appointment despite this being caused by significant delays in the clinic. Reports indicated clinic staff did not have the authority or support to make decisions to support patients and instead had to defer to the provider's head office at a later time. The provider told us this was due to the use of a centralised booking system that meant clinic managers did not have access to surgeon availability.

Recent patient comments included, "I would highly recommend [the provider] and I'd visit again!" and, "I can't fault anything, the surgeon was fantastic, and everyone made me feel so relaxed."

The provider carried out an annual staff survey. The most recent results indicated staff rated the SLT highly and were happy with working conditions, with a need for some action to reduce stress during busy periods. Staff noted they felt supported and pleased with the standard of care they provided to patients. The CGCC was building on the positive aspect of this relationship by better incorporating clinic staff in clinical governance and risk management processes.