2025

delphi care solutions

# Signature Medical Limited:

# Signature Clinic London

## Mock Inspection

## Report and Improvement Plan

Site visit dates: 9, 10 (remote) & 12 December 2025

# Scope

Delphi Care Solutions were commissioned to complete an independent, evidence-based mock inspection of the Signature Medical Limited ('the provider') site: Signature Clinic London, 73 St Charles Square, London W10 6EJ ('the service').

Delphi completed the mock inspection on 9, 10 and 12 December 2025. During the mock inspection we identified good practice and some areas for improvement. Throughout the day, we shared feedback relating to these findings with managers.

This report provides comprehensive details of our findings and includes our recommendations. It is our opinion, if the Care Quality Commission (CQC) were to inspect on the days of our mock inspection, the rating for Signature Clinic London would be as follows:

| CQC KEY LINES OF ENQUIRY | | | | | |
|---|---|---|---|---|---|
| **Safe** 24/32 = 75% | **Effective** 18/24 = 75% | **Caring** 15/20 = 75% | **Responsive** 21/28= 75% | **Well-Led** 22/28 = 79% | **OVERALL** |
| **RATING: 3** Good | **RATING: 3** Good | **RATING: 3** Good | **RATING: 3** Good | **RATING: 3** Good | **RATING: 3** Good |

# Rating

CQC Quality Statements scoring system:
**4** = Evidence shows an exceptional standard.
**3** = Evidence shows a good standard.
**2** = Evidence shows some shortfalls.
**1** = Evidence shows significant shortfalls.

We use these thresholds to convert percentages to scores:

- over 87% = **4**
- 63% to 87% = **3**
- 39% to 62% = **2**
- 25% to 38% = **1**

# R/A/G Rating

The Red/Amber/Green (RAG) rating below provides a visual representation of the key areas to be focused on within the improvement plan. The following report details the findings of the mock inspection, utilising the Single Assessment Framework and Quality Statements currently used by the CQC.

| Complaints | Accidents and Incidents | Fire Safety | Safeguarding | Supervision |
|---|---|---|---|---|
| 🟢 | 🟢 | 🟢 | 🟢 | 🟢 |
| **Training** | **Staff Files** | **Staff Rotas** | **Medication** | **Audits and Governance** |
| 🟢 | 🟢 | 🟢 | 🟢 | 🟢 |
| **H&S Audits** | **Medication Audits** | **Infection Control** | **Environment** | **Care Planning** |
| 🟢 | 🟢 | 🟢 | 🟡 | 🟢 |
| **Specific Assessments** | **General Risk Assessment** | **Daily Notes** | **Quality Monitoring** | **MCA** |
| 🟢 | 🟢 | 🟢 | 🟢 | 🟢 |
| **Activities** | **Policy and Procedures** | **Whistleblowing** | **Culture** | **Person Centred Care** |
| 🟢 | 🟢 | 🟢 | 🟢 | 🟢 |

| SAFE: Score Range 1 – 4 per area (maximum Score 32) | | | | | | | | Total score |
|---|---|---|---|---|---|---|---|---|
| Learning Culture<br>3 | Safe Systems, Pathways and Transitions<br>3 | Safeguarding<br>3 | Involving People to Manage Risks<br>3 | Safe Environments<br>3 | Safe and Effective Staffing<br>3 | Infection Prevention and Control<br>3 | Medicines Optimisation<br>3 | **24/32**<br>**75%** |
| **EFFECTIVE: Score Range 1 – 4 per area (maximum Score 24)** | | | | | | | | |
| Assessing Need<br>3 | Delivering Evidence Based Care and Treatment<br>3 | How Staff Teams and Services Work Together<br>3 | Supporting People to Live Healthier Lives<br>3 | Monitoring and Improving Outcomes<br>3 | Consent to Care and Treatment<br>3 | | | **18/24**<br>**75%** |
| **CARING: Score Range 1 – 4 per area (maximum Score 20)** | | | | | | | | |
| Kindness Compassion and Dignity<br>3 | Treating People as Individuals<br>3 | Independence Choice and Control<br>3 | Responding to Peoples Immediate Needs<br>3 | Workforce Wellbeing and Enablement<br>3 | | | | **15/20**<br>**75%** |
| **RESPONSIVE: Score Range 1 – 4 per area (maximum Score 28)** | | | | | | | | |
| Person Centred Care<br>3 | Care Provision Integration and Continuity<br>3 | Providing Information<br>3 | Listening to and Involving People<br>3 | Equity in Access<br>3 | Equity in Experience and Outcomes<br>3 | Planning for the future<br>3 | | **21/28**<br>**75%** |
| **WELL-LED: Score Range 1 – 4 per area (maximum Score 28)** | | | | | | | | |
| Shared Direction and Culture<br>3 | Capable Compassionate and Inclusive Leaders<br>4 | Freedom to Speak Up<br>3 | Workforce Equality Diversity and Inclusion<br>3 | Governance Management and Sustainability<br>3 | Partnership and Communities<br>3 | Learning Improvement and Innovation<br>3 | Environmental Sustainability/ Sustainable Development<br>**N/A** | **22/28**<br>**79%** |

# Overview

We carried out an announced mock inspection at Signature Clinic London over three days. Two of these days were on-site, and one was remote. The service was most recently inspected by the Care Quality Commission (CQC) in June 2024 where it received an Inadequate rating overall, with an Inadequate rating for 'Effective', 'Responsive' and 'Well-Led'; a Requires Improvement rating for 'Safe'; and a Good rating for 'Caring'.

Signature Clinic London offers a range of cosmetic surgery treatments for adults aged 18 and older, on a private fee-paying basis. The service offers six core procedures, with the most commonly provided being blepharoplasty and gynaecomastia. The service only uses local anaesthetic and does not offer general anaesthetic.

The provider is registered for the regulated activities: Treatment of Disease, Disorder, or Injury, and Surgical Procedures.

The service refers to its service users as "patients," which is the term we have used in this report.

The service site has a reception and waiting area on the ground floor, with one theatre and recovery area for patients each on the ground and first floors. The site has bathroom and toilet facilities, dedicated storage areas, a medicines room, and a staff room.

# Safe

**Learning culture: Score 3**

We found that the service had a detailed, overarching approach to learning and continuous improvement, with a focus on patient safety and learning lessons which staff contributed to. This was directed and supported by a comprehensive governance approach to lessons learned which included sharing of information from all of the provider's sites.

Managers and staff were able to describe instances of how lessons learned were used to drive improvements. For example, following an accidental potential breach of confidential information during November 2025 the service revised its staff training and induction processes, and provided greater support for staff during busy periods.

The service used the Radar Healthcare electronic platform to support daily activities, analysis, quality assurance, audit, and compliance. We saw that the service had recorded 32 incidents in the last 12 months, all of which had been resolved at the time of our mock inspection.

Incident reporting consistently included consideration of who was affected; nature of the incident(s); impact; whether linked to any policies and/or procedures; any identified competency or training needs; root cause analysis, and any notification requirements (for example to CQC).

We saw that incidents were subject to suitable action planning and task allocation, for example to identify and embed necessary improvements. There was appropriate consideration of sharing findings and responding to those affected.

All staff were able to access the Radar Healthcare system to contribute to incident management and lessons learned processes. We saw that information, actions, and outcomes were properly shared with staff by email, during team meetings, as part of one-to-one and supervision sessions, and as part of training sessions. We saw that staff were able to ask questions and seek further information about incidents and findings to support their understanding and knowledge.

We saw specific examples of training having taken place in the last 12 months which included findings from incidents and lessons learned, for example General Data Protection Regulation (GDPR), governance, safeguarding, and incident reporting.

All policies we reviewed were appropriate in content, in date, and subject to suitable version control and sign-off processes. We saw where policies and procedures had been revised and updated in response to incidents and identified risks.

Senior managers working across the provider's sites were responsible for governance and oversight of lessons learned, including reporting themes, trends, and risks to Board level and ensuring staff at all sites received and understood the relevant information.

### Safe systems, pathways and transitions: Score 3

We saw that people received comprehensive, detailed information and consultations to help them decide if surgery was appropriate and safe for them. The service provided thorough information and explained this in detail at all stages of the patient journey.

We saw that staff monitored patients during their procedures to ensure safety and to manage any risks and properly documented this information. This information was subject to audit and quality assurance by managers to support consistency and best practice.

The service used an electronic system to manage consultations, appointments, and aftercare. Care records were paper-based and were electronically scanned when complete.

Managers and staff demonstrated that they understood the process for managing patients, and that if there was an emergency people would be transferred to hospital for treatment.

We saw that the service had comprehensive assessment criteria prior to carrying out procedures. This included discussion of surgery options, medical history, health, suitability, and consent. Detailed information was provided as part of the comprehensive, ongoing aftercare process.

The service had a formalised, risk-based approach which included consideration of medical history, plus procedure complexity and risk. Those judged ineligible or not suitable for surgery did not receive

it, and records showed this was explained clearly. We saw that the service engaged with the patient's GP if there were any questions or concerns about the suitability of procedures.

We saw that all staff, including non-clinical and reception staff, had received suitable basic life support training. However, for three staff this had expired five days before the first day of our mock inspection. The service manager told us this training was due to be scheduled to take place in December 2025 or January 2026. We recommend the service prioritises the delivery of this training to ensure that staff knowledge is current and up to date.

### Safeguarding: Score 3.

All managers and staff that we spoke with demonstrated a strong understanding of safeguarding and how to report concerns.

The provider had a safeguarding lead, who was the senior nurse who worked across all provider sites. The service manager was able to lead on safeguarding if the senior nurse was not available. All managers and staff that we spoke with demonstrated appropriate knowledge and understanding of safeguarding principles.

The service had dedicated, appropriate safeguarding policies and procedures, including clear and comprehensible flowcharts to support effective and timely action. These had last been reviewed and updated in July 2025.

The provider and service had dedicated quarterly safeguarding meetings, and the safeguarding lead produced quarterly safeguarding reports which included consideration of CQC key questions and relevant regulatory requirements. The safeguarding lead was in the process of compiling an annual safeguarding report for 2025 which would be shared with staff.

We saw that all staff (100%) had completed mandatory adult and children's safeguarding training, and this was all in date at the time of our mock inspection.

We saw that there was an appropriate governance and oversight process for safeguarding, including updating the Board of Directors. This included consideration and analysis of incidents to identify any trends and risks. We saw that safeguarding was also discussed during monthly clinical and operational meetings.

### Involving people to manage risks: Score 3.

We saw evidence that the service consistently worked with patients and prospective patients to manage risks and deliver safe care and treatment. Staff carried out comprehensive assessments of risks as part of the ongoing consultation and assessment process, as well as before, during and after procedures. This included the service's comprehensive aftercare processes.

We saw that staff proactively managed risk through continuous observations of and engagement with patients throughout their patient journey. This approach was supported by the named nurse who accompanied the patient throughout the process.

Managers and staff that we spoke with demonstrated that they understood how to identify and manage risks, and how to respond to mitigate these.

People were subject to comprehensive consultations prior to undergoing surgery, in order to identify key risks and to determine whether surgery was right for them. We saw that this was an ongoing, continuous process and included assessments up to and including the day of surgery.

Staff told us they used the recognised, standardised National Early Warning Score (NEWS) 2 throughout the process and worked to the relevant World Health Organisation (WHO) checklist. Care records we reviewed supported this. Managers carried out compliance audits as part of governance and oversight processes.

**Safe environments: Score 3.**

We found all areas of the site we saw to be well-maintained, free from clutter and suitable for providing safe care and treatment. The service had secure access for staff only, including coded door entry for certain areas.

The provider site's clinical areas included the ground floor, which was accessible by wheelchair users including by use of the service's wheelchair ramp.

We found the service to be free from potential risks, with well-maintained equipment, facilities, and technology. We reviewed documentation which showed us that managers and staff ensured the premises, equipment, facilities, and technology supported the proper delivery of safe care. This included all proper daily, weekly, monthly, and other checks which were supported by documented checklists and sign-off procedures.

We saw that the service had suitable processes for overseeing and managing areas including electrical and personal appliances, water and legionella, pest control, heating and lighting, building maintenance, medical equipment, furniture, and waste. There were records which provided evidence of suitable servicing and maintenance, and all of these which we reviewed were up to date. All required safety certificates were present and correct, current, and appropriately displayed and/or filed. Outside the service's premises was a steel stairway which had been inspected in 2025 by a suitable professional and was not due for a follow-up inspection until 2030.

The service had a comprehensive programme of audits relating to premises, maintenance, and equipment. These were overseen by a comprehensive audit oversight calendar, and the programme of audits was demonstrated as being up to date at the time of our mock inspection.

Within the service's documentation file relating to audits and checks were some examples which included the address of one or more of the provider's other sites. Managers told us this was because the work would have been commissioned by the provider, so may have included another address for administrative reasons. We recommend that, for clarity, the service includes the London site's address on all documentation relating to work at this site, and/or provides notes to make clear that this is the case.

We saw that the service had suitably identified an appropriate fire assembly point and had two designated fire marshals who had been suitably trained. We saw that fire exits were clearly signed and free from obstacles.

The service had a suitable business continuity plan to manage key incidents and risks that may affect the service's delivery of safe care, for example power outages.

We saw that the provider's evacuation chair (a specialised, portable device designed to safely move people with reduced mobility downstairs and across flat surfaces during emergencies) had not been recently serviced, and staff had not been trained in its use. This had been placed on the service's organisational risk register and additional guidance had been provided for staff. We recommend that the service ensures that the chair is properly serviced, with staff training completed, as soon as possible.

**Safe and effective staffing: Score 3.**

We spoke with the service manager and the provider's HR manager, who told us the service's staffing levels were the service manager's responsibility with support and oversight from provider senior managers. We found that the service had suitable processes and systems to ensure there were enough qualified, skilled, and experienced staff to deliver safe care.

The service used an electronic system to manage staff rotas and absences, overseen by the service manager. Rotas were completed well in advance and requests for absence were managed appropriately.

All managers and staff that we spoke with demonstrated a strong commitment to learning, safety, and raising concerns. Staff demonstrated they understood their responsibilities to raise concerns and report incidents and risks and told us they were fully supported by managers when they did so.

We reviewed five staff files and training records and found high levels of training and learning to support staff being equipped to deliver safe care. We saw that there was a 100% mandatory training completion rate for the service's staff at the time of our mock inspection. The service paid staff for any work-related training that was completed and provided access to the service site for remote training sessions if this was required or helpful for staff.

We found that recruitment practices and associated activities were robust. We saw there were effective checks to make sure staff were suitably qualified, competent, and experienced to carry out

their roles. Safe recruitment practices, for example employment history, seeking of references, and Disclosure and Barring Service (DBS) checks, were consistently used. Recruitment activity was subject to checklists and management oversight to ensure consistency.

We found supervision, appraisal, performance management, and staff team meetings processes to be consistent and effective, and these had been suitably documented. Staff were subject to checks of their competency, with appropriate actions (such as increased support and training) provided where needed. The service had formal performance management and competency processes, but service managers and HR manager told us they had not needed to use these up to the days of our mock inspection, as one-to-one meetings and appraisals had been sufficient to support effective performance management of staff.

We saw that turnover of staff was minimal, and the service only rarely needed to use agency staff to meet demand. The service did not use any volunteers at the time of our mock inspection.

Staff told us that staff wellbeing was properly considered, and we saw evidence to support this, for example in supervision records and meeting notes.

**Infection prevention and control: Score 3.**

The service site was visibly clean throughout on the days of our mock inspection. On-site cleaning was completed by staff who we saw had received appropriate training and guidance to properly fulfil this.

We observed a clinical procedure as part of our mock inspection. The patient was provided with a single-use, disposable theatre gown, hair net and ‘step in’ shoe covers. The theatre environment was visibly clean and tidy. The theatre table was covered with suitable protective disposable sheets.

The service had a range of infection prevention and control (IPC) policies and procedures which applied to all of the provider’s sites. This included documentation relating to cleaning processes and schedules, equipment, laundry, spillages, personal protective equipment (PPE), and waste.

The service manager was responsible for daily cleanliness checks of the site and documented results which were subject to audit and review by senior managers. Staff were provided with cleaning and IPC checklists at the start of their shifts and were responsible for completing and submitting these at the end of their shift to the service manager.

We saw that PPE was stored appropriately and was being used correctly whilst the inspection took place. Staff changing rooms and lockers were available on site. Staff uniforms were suitable, clean, tidy, and appropriate to role.

All cleaning equipment followed the national colour coding system and was appropriately stored. Cleaning products were in sufficient supply and accompanying data sheets were available for all staff.

In addition to daily cleaning, staff carried out additional deep cleaning every two weeks on days where there were no surgical procedures taking place. We saw that an external company had conducted deep clinical cleans throughout the site every six months.

The provider had an IPC lead who was a senior nurse and who worked across the provider's sites. We saw that they were leading on a range of IPC-related initiatives and projects (for example workwear, PPE, and wound swabbing procedures) at the time of our inspection. The IPC lead was due to complete additional, postgraduate training in IPC in 2026. Planned work included developing the IPC audit policy to include direct observation of clinical practice.

### Medicines optimisation: Score 3

The service stored medicines in a separate locked cold storage room. The London clinic site also stored medicines for the provider's other sites, and we saw that these were kept separately from the service's stocks with appropriate documentation, stock counting, and checking in and out processes.

We spoke with the provider's group pharmacist, who told us they worked alongside the service manager to complete two separate, full medicines audits per year. The pharmacist was appropriately involved in lessons learned and incident reporting processes and provided training and guidance for staff.

We saw that daily stock checks and temperature checks had been consistently completed and audited to ensure appropriate completion and compliance.

The provider did not currently stock-controlled drugs. There were storage facilities available to safely store controlled drugs if needed.

We saw that relevant medicines policies and procedures were suitable, with the management and oversight process clear. Policies were considered, reviewed, and signed off by the clinical governance panel. All doses of medicines were labelled and coded. There were processes in place to ensure that patients received medicines safely and all medicines administered were recorded on the medicines administration record. Medicines records were paper based and subsequently scanned on to the service's electronic database.

Suitable and qualified staff administered all medicines, and patients were properly prescribed medicines to take home following surgical treatments.

## Effective

### Assessing need: Score 3.

We saw that people were subject to comprehensive consultations at various stages prior to surgery. Patient feedback indicated that people felt their needs, preferences and requests had been properly

considered. This included choice of practitioner, and time, date, and location of the procedure(s). Assessment of need included comprehensive consideration of a person's medical history and their lifestyle.

We saw that people's needs were considered up to and including the day of procedure, and feedback indicated people felt they were kept well informed and up to date throughout the process. Comprehensive aftercare arrangements contributed to overarching, ongoing needs assessment.

Suitable, provider-wide policies and procedures were in place to support proper assessment of need.

People's communication needs were considered to support effective assessment, care and treatment, and aftercare.

### Delivering evidence-based care and treatment: Score 3.

We saw that the service planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards. We saw that people were given clear guidance in relation to pre-surgery, and aftercare and recovery, including nutrition and hydration advice.

Staff and managers that we spoke with had a good understanding of best practice standards for cosmetic surgery. They told us they followed surgical care pathways that were based on national guidelines, including National Institute for Health and Care Excellence (NICE) and General Medical Council (GMC) professional standards for cosmetic surgery. This approach was consistent with the provider's other sites.

Service processes were continually reviewed and updated in line with best practice as part of clinical governance and operational meetings. We saw that information was clearly, consistently, and regularly shared with staff as part of team meetings, information bulletins, and supervision/appraisal processes.

We saw that policies and procedures reflected current guidelines and were accessible to all staff. Staff could quickly access relevant information relating to patients' assessment, planning and delivery of care, treatment, and support.

### How staff teams and services work together: Score 3.

We saw that staff met regularly, including dedicated all staff monthly meetings. Managers across the provider's sites met twice daily to discuss any issues, concerns, and achievements.

We saw evidence that meetings supported improvements and best practice. There was a programme of dedicated provider group and training meetings including for example to discuss safeguarding, aftercare, infection control, and policies/procedures.

Patient feedback indicated they felt the service was well-coordinated and that staff worked well together to support their needs.

Managers and staff told us they prioritised working well together, and that staff supported each other to prioritise patient care. We saw that provider staff who worked across sites had good relationships with site staff and each other and provided suitable expertise and support.

### Supporting people to live healthier lives: Score 3.

We saw that patient wellbeing was considered holistically as part of planning. This included their health, lifestyle, and aspirations. We discussed examples with the service manager where prospective patients were advised against procedures due to their personal circumstances. We saw that the service prioritised patient well-being and recovery.

Patient feedback indicated that the service provided comprehensive support and guidance to promote health and wellbeing. We saw that the service provided guidance relating to alcohol use, smoking, and nutrition throughout the patient journey, including in the form of evidenced discussions and written information.

The provider's website included information and guidance relating to health and wellbeing.

### Monitoring and improving outcomes: Score 3.

The service used patient feedback forms and internet reviews to gain an understanding of its activity and outcomes. Evidence we reviewed (including feedback forms and internet reviews) indicated that a majority of patient feedback was positive.

The service and provider had a comprehensive approach to gathering, analysing, and communicating feedback to support improvements. This included analysis of trends and related action planning to support and drive improvement. We saw meeting agendas, minutes, and other documentation to evidence this.

The service was able to consider feedback and performance information in relation to surgeon, procedure type, and outcomes. Clinical and other staff appraisals included performance and outcomes information.

We saw evidence that suitable follow-up actions were completed in the event of any complications or adverse outcomes following surgery. This included medicines prescription and corrective procedures where necessary.

### Consent to care and treatment: Score 3.

We saw from the clinical procedure we observed that the service carried out suitable consent processes with the patient, including provision of detailed information, checking their understanding at repeated points, and providing a detailed consent form. This included staff explaining in detail the procedure and what it entailed, whilst repeatedly checking the patient's understanding.

The service had comprehensive processes for acquiring informed, written consent, which applied across all provider sites to promote consistency. This was supported by a detailed, provider-wide consent policy.

Patient feedback indicated that people were provided with detailed information relating to consent, alongside full information about their procedure including benefits and any risks. Information was provided during face to face and/or remote consultations, and as part of written guidance.

We saw from training records – and by speaking with managers and staff – that all staff had received suitable training in relation to obtaining consent. The service respected people's decisions if they wished to withdraw their consent or decline surgery. The service had a suitable accompanying consent policy and procedure which staff demonstrated they were aware of and could access.

The service provided a 14-day 'cooling off' period between providing initial consent to the day of surgery. Consent was discussed during the initial consultation, one or two days before the planned procedure, and again on the day of the procedure. This is in line with Royal College of Surgeons guidelines and best practice.

The service manager told us they had received no complaints, nor had any incidents, relating to any aspects of consent in the last 12 months.

## Caring

### Kindness, compassion, and dignity: Score 3.

During our visit we saw staff treating patients with kindness, compassion, respect, and dignity.

Staff and managers that we spoke with demonstrated a clear understanding of the principles of kindness, compassion and dignity, and were able to demonstrate how they prioritised these as part of care. We saw evidence of how patients' preferences, needs and concerns were addressed during different stages including the consultation process, clinical procedures we observed, and as part of aftercare.

We saw that information about patients was treated confidentially, and that staff respected and prioritised people's privacy, including by speaking with them discreetly.

The provider employed a patient experience manager who worked across the provider's sites. Their functions included direct engagement with individual patients who were considered as requiring or potentially benefiting from additional in-person support. We spoke with the patient experience manager who was able to give examples of how they had provided personalised, compassionate care.

The service provided complimentary car parking for patients which was helpful for the area of London where the site was located.

### Treating people as individuals: Score 3.

We saw that staff treated people as individuals and respected their distinct requirements and requests as part of the care provided.

We saw that people's needs were comprehensively considered as part of the consultation process. The service had a dedicated 'Patient Selection and Pre-Op Protocols' process which considered both medical history ('complex' or 'not complex') alongside the nature of surgery ('high risk' or 'low risk') and used this information to inform process.

We saw that the service prioritised patient experience and an empathic approach as part of people's journey. This included a specific focus on treating each person as an individual, including proper consideration of personal, cultural, and clinical needs. We saw evidence of a focus on continuity of care, including by allocating each patient a dedicated nurse to support them throughout the full process from consultation to aftercare. Managers told us that establishing a suitable rapport between patient and staff was a key focus. There was a chaperone process in place which patients could request at any time, and we saw that this was clearly communicated. These processes were supported and guided by the provider's patient experience manager.

Managers could describe examples of where people with additional needs and/or protected characteristics were properly supported, including those with hearing impairments, sight impairments, and language needs. The service was able to make reasonable adjustments including offering a range of appointment times and enabling people to be accompanied by a partner, relative or friend.

The service provided comprehensive post-procedure information to support people's recovery and aftercare, and we saw that this was tailored to the surgical procedure carried out and people's individual circumstances and needs.

We saw that all staff had completed equality, diversity, and human rights training.

### Independence, choice and control: Score 3.

We saw that the service prioritised empowering patients to make an informed choice, including by providing clear information to support them to make their own decisions. The service offered a range of face-to-face and remote appointments to support access to information and choice. We saw that

people were offered a choice of surgery dates and were able to select from a range of available surgeons.

The service offered a 'cooling off' period for if people changed their minds. Staff told us they respected people's wishes and properly supported them if they chose to decline treatment at any stage of the process.

Managers and staff told us the service prioritised people's independence whilst giving them enough information to make informed choices about their care and treatment.

### Responding to people's immediate needs: Score 3.

We observed a clinical procedure and saw that the patient was kept informed at all stages of the process, including where staff clearly responded to questions and provided advice and guidance in a reassuring, professional manner.

Staff told us how they monitored patients throughout all stages of their procedure, and how they responded quickly to any concerns identified. Immediate needs were considered within the context of a patient's own information and risk profile. People could be transferred to a hospital if required.

Patients were subject to enhanced observations following their procedure, and all staff were suitably trained to facilitate this.

We saw that patients were provided with comprehensive information relating to aftercare, including contact details in case they needed speak with staff.

### Workforce wellbeing and enablement: Score 3.

Managers and staff told us there was a positive, supportive culture at the service and that they and their colleagues were well-supported and worked well as a team. Throughout our visit we observed staff to be working collaboratively and in a mutually supportive way.

Staff were able to access dedicated support including access to occupational health and well-being services. We saw that staff had access to flexible working arrangements and adjusted work hours where this had been assessed and agreed. The service had an overtime policy which set out how staff cannot be made to work over 48 hours during a week with the aim of prioritising their wellbeing and health. Staff working longer hours were informed they must take suitable breaks. We saw evidence that staff were able to have suitable, regular breaks and access to appropriate rest areas.

We saw evidence that staff views were addressed as part of supervision sessions and appraisals, and as part of staff meetings.

We saw that the service was in the process of developing a range of initiatives to support staff wellbeing (including a recognition scheme, a staff council, enhanced employee assistance, and increased benefits), and that this was part of an action plan. The service had developed and implemented a quarterly 'Practitioners' Forum' across the wider provider organisation to facilitate discussion, support, and the development of practice. A staff benefits and wellbeing scheme was scheduled to be implemented during January 2026. This included financial benefits, counselling, leisure facilities, and enhanced support if required.

Managers told us of a small number of examples where staff had been subject to confrontational and abusive language and behaviour from patients who were dissatisfied with the service they had received. The patient experience manager had engaged with patients and staff to investigate these instances. We recommend that the provider considers formalising a set of behaviour standards and expectations for patients and prospective patients and establishes a policy and/or set of guidelines to be shared with staff, patients, and others. This would further support the service's evident positive commitment to workforce wellbeing.

# Responsive

**Person centred care: Score 3.**

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with patients, how to respond to any relevant changes in their needs.

We found from patient feedback that the service had taken their needs and preferences into account at all stages of their care. This included comprehensive consideration of factors and risk associated with mental health, including self-harm.

The service had a comprehensive consultation and assessment process which included detailed consideration of individual, person centred factors including medical history and current lifestyle. This information was used to inform individualised care plans which also included aftercare.

**Care provision, integration, and continuity: Score 3.**

We saw that staff had gathered suitable information about people as part of the consultation process to support effective care planning. Procedures were scheduled in advance so that staff, equipment and medicines were made available for use. Service schedules and procedures were considered as part of the twice-daily, service-wide meetings process.

We saw that the service's named nurse, consultation and aftercare processes supported the delivery of joined up care and continuity for patients. We saw that patients received personalised follow-up contact, which for most people took place at intervals of 24 hours, seven days, one month, and six months after the procedure. This could be modified according to individual need.

We saw that the service provided comprehensive, detailed information relating to aftercare for patients, including contact details for if they had any questions or concerns, or if they had experienced any complications or negative outcomes. The service offered follow-up appointments (in person or remote) and/or prescribed medicines depending on need.

We observed a clinical procedure where the surgeon provided bespoke advice to the patient including exercise and a recommended sleeping position. Staff also explained to the patient the follow up and support they would receive from the service and if they had any concerns they could contact the service for support at any time.

Managers and staff demonstrated a suitable awareness of delivering appropriate care for those with protected characteristics under the Equalities Act 2010.

**Providing information: Score 3.**

We saw that the service provided comprehensive information to patients in advance of any procedures they may have. Managers told us the key principle guiding the provision of information was to provide as much information as possible, tailored to the needs of the person receiving it.

We saw from patient feedback information that people were satisfied with and complimentary about the information they had received in terms of timeliness, quality, scope, and detail.

We saw that patients and prospective patients received detailed information about contracts and charges, and this information was subject to consumer rights good practice.

We saw that provision of information was seen as an ongoing process, with staff providing updates and further information throughout the patient journey. The service provided a range of hard-copy information leaflets and detailed material on its website, including for example, health promotion, hydration, smoking cessation, and wound care/infection control at home. The provider also used social media platforms effectively to share information and guidance relating to its services and related information.

We saw that staff had received training in data protection, confidentiality, and information security. Information about people we reviewed followed data protection legislation and other legal requirements and was handled in accordance with these requirements. The service had designated leads for information governance and Caldicott Guardian responsibilities.

The provider shared an example with us where there was an accidental potential breach of confidential information during November 2025 which we saw was handled appropriately, with suitable lessons learned applied.

**Listening to and involving people: Score 3.**

We found that the service had made significant improvements in its processes for listening to and involving people in the last 15 months.

The provider had recruited dedicated, experienced, and separate complaints and patient experience managers who we saw worked closely together across all sites to promote and support people sharing their feedback and/or raising complaints about their care.

We saw that the service had developed and implemented a comprehensive, structured, and documented approach to gathering and responding to feedback and complaints which applied across all of the provider's sites. This included for example a five working day acknowledgment timeframe and a 20-working day investigation and response timeframe, with associated monitoring and key performance indicators.

We saw that the complaints process was subject to three discrete stages (named stages 1, 2 and 3), with escalating levels of formality, independence, and seniority. We saw that all feedback and complaints were suitably logged, recorded, and shared by using the service's electronic integrated care platform.

Complaints, feedback, and associated actions were overseen and monitored, including trends analysis with information shared with staff and the provider's other sites to support continuous improvement and learning.

Managers were able to describe how complaints were divided between those relating to process, and those relating to surgical outcomes (i.e., people unhappy with the final results). We saw that the service was using this information to improve its information sharing process and expectations management with prospective patients.

Feedback we saw (including feedback forms and cards on site, plus review websites) was mostly positive, and there was evidence that this was improving. For example, the provider's aggregate feedback score on an internet review site had risen from 3.8 to 4.1 (out of five) in the last two months.

The service had a suitable complaints policy, and we found that staff had been properly trained in handling complaints. Where appropriate, complaints could be escalated to the Health and Social Care Complaints and Adjudication Partners (HSCAMP) adjudication service.

We saw that feedback and complaints had been discussed in staff and governance meetings as a standing item. Managers told us that complaints and feedback was used as part of lessons learned processes, and we saw examples of where this had taken place during the last 12 months.

Managers told us they planned to implement a forum of patients to support further improvements. Suitable patient candidates were being considered at the time of our mock inspection, and managers told us the service planned to have this in place by the end of January 2026.

The service (and wider provider organisation) was in the process of collating and analysing staff survey results from early 2025 at the time of our mock inspection. We recommend that the service continues to develop and embed a suitable staff survey process, which will enable comparison and analysis of results over time.

### Equity in access: Score 3.

Feedback we reviewed demonstrated that the service provided access to care, support, and treatment when it was needed. Feedback and care records indicated that people did not experience delays or other barriers to care.

We saw evidence that clear, honest information was provided in relation to treatment times. Care and treatment were sufficiently planned in advance to minimise the risk of delay. We saw that any cancellations were quickly rescheduled at a time and date that people were satisfied with.

The service properly monitored need and available resource to support efficient care delivery. At the time of our mock inspection, we saw that the service did not have a waiting list. Managers undertook ongoing analysis and monitoring of patient demand and resource to prevent disruptions or delay to procedures.

Twice-daily service and provider meetings were held to facilitate the effective planning, coordination, and delivery of care, which managers and staff told us minimised risk of unforeseen or predictable delays.

Where procedures had been cancelled, we saw that this was due to the patient's choice, or because the patient was assessed as being unfit or inappropriate for surgery.

### Equity in experience and outcomes: Score 3.

Feedback from patients indicated that outcomes promoted equality and removed barriers, including any potential discrimination. The provider site's clinical areas included the ground floor, which was accessible by wheelchair users including by use of the service's wheelchair ramp.

Managers and staff that we spoke with were able to describe how they treated people equally and without discrimination. We saw examples where people with protected characteristics were treated appropriately, with their wishes, preferences and needs met.

The service had a suitable equality and diversity policy which managers and staff we spoke with demonstrated they understood, including the implications for care and treatment provision. The service did not treat people who were unable to provide consent.

Managers were able to appropriately describe how the service could support people who may be at risk of experiencing inequality in experience or outcomes, including by providing personalised assessments, treatment, and aftercare in accordance with their needs.

**Planning for the future: Score 3.**

We saw that the service prioritised individualised, effective aftercare to support people's longer-term plans and aspirations. This included responding to and incorporating people's preferences and wishes.

Patient feedback we reviewed indicated that people were satisfied with their care plans, aftercare and outcomes. Discharge and aftercare arrangements were carefully considered and detailed, and we saw where plans had amended as a response to changing circumstances to support recovery.

We observed a clinical procedure and saw that there was suitable consideration of post operative procedures and aftercare.

# Well-led

**Shared direction and culture: Score 3.**

We found that the service and wider provider organisation had a clear vision, mission and accompanying values, and that managers and staff understood and consistently worked to these. The service and provider prioritised positive, life changing results; high quality care; minimal invasiveness; value for money; and accessibility for patients.

All managers and staff we spoke with were complimentary about the support and guidance they had received from managers and their colleagues, both at service and provider levels. There was a structured approach to line management, supervision and governance.

Provider and service priorities were considered as part of ongoing meetings, both at governance and operational levels. The provider had further developed and embedded a governance framework and committee structure over the last two months, which included information flowing up, down and across the organisational hierarchy. This included monthly provider governance meetings and then site-specific operational meetings for cascading information to staff.

Consistent objectives and associated performance indicators were included throughout the organisation, from senior leadership level to individual staff performance and conduct. The service and provider were working to an ongoing, overarching Quality and Service Improvement Plan, which was a live document which all staff could contribute to and update in real time.

Managers and staff demonstrated a commitment to dignity, respect, fairness, and person-centred care. We saw that managers consistently worked to promote these principles through for example staff meeting minutes, policies and procedures, and supervision records.

### Capable, compassionate, and inclusive leaders: Score 4.

We saw that managers demonstrated and modelled the principles of capability, compassion, and inclusivity.

We observed positive, respectful relationships and engagements between staff and managers at all levels during our visit, where different views were considered and valued. Staff and managers told us they felt respected by senior colleagues and were properly supported in their roles.

There were managers and staff with specialist, expert knowledge, and functions (for example complaints, patient engagement, infection control, health and safety and safeguarding) who worked across the service and other provider sites to support consistency and best practice. This process, including twice-daily provider-wide meetings, helped to promote engagement and collaboration, and reduced the risk of isolation for the service site and the staff working there.

Clinical work was managed and overseen by consulting doctors, the director of clinical governance, the associate director of clinical governance, the group pharmacist and the infection prevention and control senior nurse.

Managers and senior staff were able to demonstrate inclusivity and an understanding and appreciation of suitable care delivery and associated risks to this. This included by modelling inclusive principles such as involving and supporting staff at all levels throughout the organisation.

We saw examples of where conduct and performance had been addressed appropriately using supportive performance management processes. Managers were able to demonstrate a proactive approach to managing poor culture or poor performance, for example through detailed analysis of incidents and resultant discussions with staff around these. The service had access to a mediation process for staff if required.

Staff were encouraged in their development. We saw examples where staff, including the service manager at this site and other Signature sites, had been properly supported into more senior roles after joining the organisation in more junior positions.

### Freedom to speak up: Score 3.

We found that staff felt they were able to raise any concerns they had with senior colleagues, and that they would be listened to if they did so.

The service had a whistleblowing policy which was suitable and up to date. Staff we spoke with understood this, including how to contact the designated freedom to speak up guardian or one of the two freedoms to speak up champions if needed. These guardians worked across the provider's sites. Information relating to freedom to speak up and whistleblowing was highly visible throughout the service site.

Managers told us they had a 'open door policy' and we saw evidence of this throughout our mock inspection. We observed managers and senior staff to be highly visible and frequently engaged with colleagues and patients.

We saw examples of where meetings and one-to-one sessions had taken place where staff were encouraged to provide their views. We also saw evidence of where staff views had been documented and acted on, including as part of incident and risk review processes.

### Workforce equality, diversity, and inclusion: Score 3.

We saw evidence of a strong, supportive, inclusive culture at the service and provider, where staff at all levels were treated equally and respectfully.

Staff recruitment processes demonstrated adherence to equal opportunities principles. and reasonable adjustments could be made where required.

We saw evidence of staff survey processes which included proper consideration of equality, diversity, and inclusion. A staff survey had been conducted within the last 12 months which included due consideration of staff wellbeing and any discrimination, and managers were in the process of collating and analysing the results prior to carrying out a follow-up survey in early 2026.

Staff we spoke with demonstrated suitable awareness of equality, diversity, and inclusion principles, and told us they were treated fairly. We reviewed staff files and saw evidence that the service had understood and considered relevant factors including protected characteristics and reasonable adjustments as part of recruitment and supervision arrangements. The service manager and HR manager confirmed this.

### Governance, management, and sustainability: Score 3.

We found evidence of detailed, comprehensive governance arrangements at the service.

The service had an overarching Quality Service and Improvement Plan which we reviewed and found to be up to date. This included consideration of operational, clinical and support areas, and detailed where actions had been identified, implemented, completed, and reviewed as part of ongoing continuous improvement.

We saw specific areas in the work plan which had been and continued to be comprehensively reviewed, including for example patient satisfaction and IPC. Findings had been integrated into actions and training. All managers could access this information and were encouraged and were expected to contribute to the process.

The service had a governance calendar which provided oversight of the ongoing programme of audits, for example health and safety and infection prevention and control. The service also had associated risk management registers and plans to support improvements, including a dedicated risk register with appropriate assessment, scoring and escalation processes.

The provider had formal governance working group arrangements with a proper term of reference, structure, membership, quorum, and documented ways of working. This was suitably integrated with other meetings and groups at more senior and junior levels. We saw evidence of how information flowed into and out of these meetings.

We saw that twice-daily, service-wide meetings were used to consider governance across the provider organisation. Staff at all levels were properly engaged with performance and risk management and monitoring processes.

The provider had implemented a governance newsletter in the last 18 months for all staff working across all sites, which included consideration of areas such as policy and procedure, documentation, using the service's electronic databases, continuous improvement, risk management, incidents and lessons learned, patient feedback, and continuous improvement. Key provider leads were highlighted in this document, for example relating to health and safety, safeguarding, and IPC.

Managers and staff demonstrated a clear understanding of their responsibilities and were knowledgeable about how to comply with notification requirements and legal regulations.

Managers and staff demonstrated openness and honesty with patients if things went wrong with their care and provided them with a suitable apology. Complaints and feedback were continually reviewed and used as an opportunity to drive improvements throughout the service as part of the provider's overarching approach to patient satisfaction and associated improvement.

**Partnership and communities: Score 3.**

The service solely provided privately funded cosmetic surgery procedures for adults. There were no commissioning arrangements with other services, for example the NHS.

We saw that service managers and staff had ongoing, productive working relationships with the provider's other locations. This included twice-daily calls to share information, discuss concerns, issues, and risks, and to share best practice.

The service engaged proactively with patients and others through its website and social media channels.

### Learning, improvement, and innovation: Score 3.

We saw that the service had effective learning and improvement processes. This included ongoing monitoring and audits of clinical practice, reviews of compliance against standards and requirements, comprehensive reviews of incidents, and feedback and complaints.

This was supported by formal, documented incident and risk management processes and the overarching governance framework.

We saw that findings were shared across the service's staff team, and staff told us there was a positive culture of learning and improvement. Learning points were used as part of staff training and development.

We saw from meeting notes and staff supervision sessions that the service identified and used information as opportunities to address concerns and support improvement. Managers and staff that we spoke with demonstrated a willingness to learn and improve and could cite examples of where this had taken place.

We saw that the provider had further developed and implemented improvements across its sites since we carried out a mock inspection of one of the other sites in November 2025.

### Environmental sustainability / sustainable development: Score N/A

In line with current CQC methodology, we do not currently assess this area.

# Improvement Plan

The following actions highlight the areas for improvement from the mock inspection carried out on 9, 10 and 12 December 2025. This can be used alongside the current action plan and service improvement plan.

**Table Key –**

- **Improvement:** The task to be completed.
- **R1:** The staff member responsible for completing the task.
- **R2:** The staff member responsible for checking and ensuring the quality once the task is complete.
- **Target date:** The target date R1 is to follow to complete the task.
- **Date completed:** The actual date the task is completed.

## Safe

| Improvement | R1 | R2 | Target date | Date completed |
|---|---|---|---|---|
| We saw that all staff had received suitable basic life support training. However, for three staff this had expired five days before the first day of our mock inspection. We recommend the service prioritises the delivery of this training to ensure that staff knowledge is current and up to date. | | | | |
| Within the service's documentation file relating to audits and checks were some examples which included the address of one or more of the provider's other sites. We recommend that, for clarity, the service includes the London site's address on all documentation relating to work at this site, and/or provides notes to make clear that this is the case. | | | | |
| We saw that the provider's evacuation chair had not been recently serviced, and staff had not been trained in its use. This had been placed on the service's organisational risk register and additional guidance had been provided for staff. We recommend that the service ensures that the chair is properly serviced, with staff training completed, as soon as possible. | | | | |

## Caring

| Improvement | R1 | R2 | Target date | Date completed |
|---|---|---|---|---|
| We recommend that the provider considers formalising a set of behaviour standards and expectations for patients and prospective patients and establishes a policy and/or set of guidelines to be shared with staff, patients, and others. This would further support the service's positive commitment to workforce wellbeing. | | | | |

## Responsive

| Improvement | R1 | R2 | Target date | Date completed |
|---|---|---|---|---|
| The provider was in the process of collating and analysing staff survey results from early 2025 at the time of our mock inspection. We recommend that the service continues to develop and embed a suitable staff survey process, which will enable comparison and analysis of results over time. | | | | |

# Sign Off

The report and improvement plan has been written based on the research conducted prior to visiting the site and the findings during the mock inspection. Any failings, or improvements made at the service thereafter will not be included.

By signing off the report and improvement plan you are accepting the detail and content written within.

Manager's Name: _____
Date: _____

| | |
|---|---|
| Delphi Executives: | Client Lead (1): Adrian Cavendish |
| | Client Lead (2): Ryk Izycki |
| Date: | 12 December 2025 |