2025

Signature Medical Limited:

Signature Clinic Manchester

Mock Inspection

Report and Improvement Plan

Site visit dates: 3 & 4 November 2025

Scope

Delphi Care Solutions were commissioned to complete an independent, evidence-based mock inspection of the Signature Medical Limited site, Signature Clinic Manchester, 93A Manchester Road, Rochdale, OL11 4JG

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

Overview

We carried out an announced on-site mock inspection at Signature Clinic Manchester over two days. The service was most recently inspected by the Care Quality Commission (CQC) in October 2024 where it received a Requires Improvement rating overall, with Requires Improvement ratings for 'Safe', 'Responsive' and 'Well-Led'; and Good ratings for 'Effective' and 'Caring'.

Signature Clinic Manchester 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 activity: Surgery and Treatment of Disease, Disorder, or Injury. 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 room area on the ground floor, with two theatres and recovery areas for patients on the first floor. The site has bathroom and toilet facilities, dedicated storage areas, and a staff room.

Safe

Learning culture: Score 3

Managers told us that the service prioritised a culture of openness and honesty. We found that managers and staff were motivated to describe and evidence improvements their service had made in the last 12 months.

The service used the Radar Healthcare electronic platform to support daily activities and governance. We found policies and procedures to be well-structured, for example policies for sepsis management, safeguarding (including abuse and neglect), and chaperoning (including promoting dignity and respect). We found all policies to be in date, with the exception of the sepsis management policy which was due for review in August 2025. Managers told us this would be reviewed, updated, and signed off during November 2025.

We reviewed incident reports, which showed that actions and learning was shared in weekly clinical governance meetings and cascaded to other meetings, such as team meetings.

The duty of candour policy and procedure was accessible, and management and staff could properly explain reporting and the follow-up procedures to include any safeguarding, CQC or police involvement where required.

Managers told us they were currently reviewing and updating the service's overarching continuous improvement plan.

We recommend the service carries out the planned review and update to the sepsis management policy.

Safe systems, pathways and transitions: Score 3

We saw that people received comprehensive, detailed consultations to help determine if surgery was appropriate and safe for them. The service provided thorough information and explained this where necessary.

We saw that staff monitored patients during their procedures to ensure safety and to manage any risks.

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 and procedure complexity and risk. Those judged ineligible for surgery were did not receive it. 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 life support training.

Safeguarding: Score 3.

Management and staff demonstrated a strong understanding of safeguarding and where to report concerns. Managers demonstrated their knowledge of the safeguarding process, with a systematic approach to reporting concerns, which was used to inform service delivery through staff meetings.

Training records indicated a 96% training rate for safeguarding training, which included both adult and child safeguarding (as children may attend the service site with an adult).

The service had a safeguarding policy which included a flowchart for protecting children and adults, and this was last updated in July 2025. The policy included who the designated, provider safeguarding leads were.

We saw that dedicated safeguarding meetings were held quarterly. We reviewed the minutes of these meetings and found examples of where safeguarding incidents had been handled appropriately. For example, in September 2025 three incidents were discussed and notified to other agencies (Police, CQC and GP), with associated learning discussed in team meetings. The service had a planned meeting for December 2025 to complete an overarching safeguarding assurance report for the year.

We saw that there was an appropriate governance and oversight process for safeguarding, including informing the Board of Directors. This included consideration and analysis of incidents to identify any trends and risks. 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 people to manage risks and deliver safe care and treatment. Staff carried out comprehensive assessments of risks as part of the consultation and assessment process.

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 demonstrated that they understood how to identify and manage risks.

People were subject to comprehensive consultations prior to undergoing surgery, in order to identify key risks and to determine whether they were eligible. We saw that this was an ongoing, continuous process and included assessments on 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 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, including coded entry for certain areas. The service was undergoing some renovation work, and some rooms were out of use, with unused equipment awaiting collection. Some rooms were being used as storage facilities but did not have labelling or signage to identify the stored items.

Clinical areas were not accessible by wheelchair because they were located on the first floor, and the service did not have a lift. However, managers told us that patients with mobility needs not compatible with the site were suitably assessed as part of consultation processes and were offered treatment at one of the provider's other locations.

We found the service to be free from potential risks, with well-maintained equipment, facilities, and technology. We reviewed documentation which showed us that staff ensured the premises, equipment, facilities, and technology supported the proper delivery of safe care.

The service employed a dedicated estates and maintenance professional who knew the site well, and who could respond both proactively and reactively to building and environment concerns and risks.

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. All required safety certificates were present and correct, and up to date.

The service had a 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 (or in the process of being updated where audits had been carried out very recently).

The service did not have a fire assembly point identified and did not have designated Fire Marshalls. However, we saw that these actions were being addressed as part of the service's fire action plan, including having training scheduled for prospective Fire Marshalls. 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 care delivery, for example power outages.

Managers and staff, we spoke with demonstrated that they understood the importance of maintaining a safe environment to support proper care.

We recommend that the service ensures that the audit calendar (including where due and where completed) is kept up to date in real time. And that the service appoints and trains dedicated Fire Marshalls and identifies and communicates a suitable fire assembly point.

Safe and effective staffing: Score 3.

All staff within the team at Signature Manchester were on a 40-hour contract. The 'Deputy' electronic system manages staff rotas, requests for annual leave, sickness, and requests for maternity and paternity leave. The clinic manager oversees this system.

Agency staff were used within the service to cover shortfalls in staffing. The HR Manager advised that one external agency, 'Novella' is utilised who had a pool of staff who have experience within the industry.

Rotas are completed six weeks in advance by the clinic manager. 'Deputy,' was used for staff to pick up shifts, request shift swaps and request annual leave.

A sample of 30% of staff personnel files were evidenced, each of which followed the same clear and orderly process, to include DBS check, ID, interview documents, references, PIN numbers, other professional registrations, health declarations, and application forms.

Not all staff are on the DBS update service, though the HR Manager had implemented a system where she was able to check daily to avoid DBS certification becoming invalid.

Interviews were held via a panel; at least one other clinically qualified team member interviews clinical staff. There was a standardised scoring system in place, which was processed by the HR team to navigate the onboarding process.

The training matrix was evidenced, and mandatory training was at 96% compliant on the final day of our mock inspection. This matrix is managed by the HR manager and mapped to National Standards. Complaint Handling is the only module where there was a slight deficit at 88% compliancy.
Autism and learning disability training, and both adult and child safeguarding training, was included within mandatory training. The Acting Registered Manager and Clinical Director both held Safeguarding Level 3.

Additional training such as drain removal is to be sourced by the clinic manager. Swabs competency is observed and signed off within the team of qualified professionals.

Signature pay for all training and pay staff for each training day attended. The company has a growth strategy amongst its team and two staff interviewed were on career progress pathways, to include a business management course and a clinical procedural course.

The service did not use any volunteers.

New staff inductions were run over a two-week period, following a detailed agenda process. A supervision was then held with the staff member, and the induction was then either extended to meet the need of the employee, or the employee commenced shifts within the rota with the support of a mentor or shadowing process.

Supervisions were held monthly with an annual appraisal taking place. The supervision matrix was evidenced as being compliant and is overseen by the HR Manager. The supervisions followed a strategic approach, focusing on the staff members learning, practices, concerns/issues, and their wellbeing. All were signed off by the employee, dated and stored electronically.

In addition to supervisions 'speak up' is prevalent and the staff room evidenced contact details for this service; it is also a discussion point within team meetings.

Though there was no current dedicated 'open door policy,' it was evident within the 'freedom of speech' policy that the service does support this process, and staff we spoke with confirmed this.

There are some champions in place to extend the learning culture within the team. For example, the Acting Registered Manager was the 'civility champion,' who focused on the culture and respect within the team.

We recommend the service implements a process for DBS certificate expiration alerts, for when the HR Manager is absent.

Infection prevention and control: Score 3.

The Infection Prevention and Control (IPC) Policy and Procedure was evidenced, it was in depth, signed off and reviewed by the governance panel.

PPE was stored appropriately and was evidenced as being used whilst the inspection took place. This included scrubs and shoe covers. There was no evidence of any recorded recent accidents or incidents relating to IPC.

We saw evidence including that the IPC processes were embedded and audited, and that practice was observed by managers and documented as part of appraisals and supervisions.

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 data sheets available to view. Within the governance work plan there was an action to put cleaning schedules on each room door for daily cleaning. In addition to daily cleaning, staff deep clean the clinic at least once every two weeks when there is a non-surgical day. Furthermore, an external company visit site to undertake a deep clean on a six-monthly basis. A certificate of compliance was in place.

All hand was basins were appropriately signed with the five stages of hand washing. Soap dispensers were full, as were the paper towel dispensers and bins were all pedal operated.

We saw confirmation that an external company (Symclean) had conducted deep clinical cleans every six months, most recently in June 2025.

The air fans had been recently changed to meet requirements in line with the actions on the service's continuous improvement plan. Curtains around the clinical beds were all dated September 2025.

The service had recently implemented a process for sterilising surgical equipment, which was carried out by an external specialist organisation (Steris). Equipment was collected, sterilised, and returned in sealed storage.

Medicines optimisation: Score 3

Within the clinic the medicines store was orderly, clean and medicines were stored appropriately, with proper labelling and protocols evident.

We saw that medicine records had no discrepancies, and that no incidents had been reported in relation to medicine errors. Medicine records from the day of surgery were noted as being paper based, however they are then scanned on to the electronic system. Records we reviewed were legible.

Mandatory training for medicines administering was shown to be 100% compliant. Staff had also received training in safe handling of medicines. Weekly drop-in sessions were offered to staff where experienced practice staff educated others.

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 was a controlled drugs cabinet which was secure, locked and had a suitable controlled drugs document to accompany it.

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

Medicines administering nursing staff were observed as locking the medicines store upon departure and taking drugs or prescriptions with them into the operating theatre or to the recovery unit. Medicines remain with nursing staff throughout the process.

Risk assessments were in place to include varying dosages.

The provider’s Pharmacist described to us how the service orders medicines on a monthly programme. Nurses and other medically trained staff monitor Saline and cold compresses in fridges. Fridge and room temperatures and internal audits were evidenced confirming this.

Effective

Assessing need: Score 3.

We saw that people were subject to comprehensive consultations 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 medical history and patient 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 a comprehensive needs assessment process. Suitable policies and procedures were in place to support this process.

Managers told us the service prides itself on being a minimal non-evasive and convenient solution for surgical treatments. The operating theatre was available from 7am to 8pm and at weekends to allow for patients to attend in line with their work or other commitments. Aftercare was nurse-led and was available from 7am to 11pm daily.

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

Delivering evidence-based care and treatment: Score 3.

Feedback indicated that people felt staff were professional, knowledgeable, and followed best practice principles. 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, 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.

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. We saw that staff could access 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 teams at the service met regularly, including dedicated weekly meetings and twice-daily provider-wide sessions. 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 medicines, infection control, and safe practice.

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 provided suitable expertise and support, for example infection control and medicines/pharmacy.

Supporting people to live healthier lives: Score 3.

We saw that patient wellbeing was considered holistically as part of planning, including their health, lifestyle, and aspirations. We saw an example where a returning patient was carefully and sympathetically advised about the potential negative impacts of a procedure he wished to have because of previous procedures.

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 practice. Evidence we reviewed (including feedback forms, internet reviews, thank you cards and patients we spoke with) indicated overwhelmingly positive feedback.

The service and provider had recently implemented an improved, more comprehensive approach to gathering, analysing and communicating feedback to support improvements. This included greater analysis of trends, and commensurate improvement action planning and communication to staff. 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.

The service had comprehensive processes for acquiring informed, written consent.

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 and again on the day of procedure. This is in line with Royal College of Surgeons guidelines.

Caring

Kindness, compassion, and dignity: Score 3.

During our visit we saw staff treating patients with kindness, compassion, respect, and dignity. People we spoke with told us staff were respectful, patient and kind, and praised the quality of information they were given relating to all aspects of their consultations, treatment, and aftercare.

We saw numerous 'thank you' cards from patients which praised the kindness, compassion and professionalism staff had displayed when interacting with them.

Staff and managers, we spoke with demonstrated a clear understanding of the principles of kindness, compassion and dignity, and evidenced 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, 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.

One patient we spoke with told us the surgeon had guided him through the process, advised him on the best outcomes, and gave advice on how to follow his aftercare plan. He told is he was impressed with the service overall, that the quality was excellent, and the balance of professionalism and friendliness was exceptional. He said his privacy was protected.

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 delivered. There was evidence 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 parson 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. We saw that reception staff were consistent. There was a chaperone process in place which patients could request at any time, and we saw that this was clearly communicated.

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 (including evenings and weekends), 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 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 people to make their own decisions.

People we spoke with told us the service had properly discussed their needs and preferences, whilst providing transparent and clear information to them at all stages of the process in a way that they could recognise and understand. 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.

Responding to people's immediate needs: Score 3.

People we spoke with told us they were kept informed at all stages of their procedure, including where staff responded to questions and provided reassurance in a measured, 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 provided information in relation to values and their responsibilities, for example treating their colleagues respectfully.

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.

We saw evidence that staff views were addressed as part of supervision sessions and appraisals, and as part of staff meetings. The service had implemented a basic staff survey and was further developing this at the time of our visit. Staff were supported by a programme of regular meetings, including twice-daily catch ups across the provider's sites to discuss and share information, concerns, and best practice.

We saw evidence that staff were able to have suitable, regular breaks and access to appropriate rest areas.

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.

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.

Responsive

Person centred care: Score 3.

We found from patient feedback and by speaking with people 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.

We saw where the service had responded to people enquiring about procedures for those having experienced Female Genital Mutilation (FGM), which refers to procedures that involve removal of external female genitalia or other injuries to female genital organs for non-medical reasons, and which is considered a violation of human rights and a form of child abuse. The service had considered appropriate safeguarding implications and had provided information relating to suitable charities.

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. Daily schedules and activity were considered as part of the twice-daily, service-wide meetings process which clinicians attended.

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.

Managers 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 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 data breach in the last 12 months, which we saw was handled properly.

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 12 months.

The provider had recruited dedicated, experienced 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 recently developed and implemented a comprehensive, structured, and documented approach to gathering and responding to feedback and complaints. 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 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 using this process to audit and review all previous complaints received since January 2025, as well for processing and dealing with new complaints.

Managers were able to describe how complaints were divided between those relating to process, and those relating to surgical outcomes. 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 overwhelmingly positive.

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.

Equity in access: Score 3.

People we spoke with and 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.

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

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.

Managers and staff 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.

Well-led

Shared direction and culture: Score 3.

We found that the service had a clear vision, mission and accompanying values, and that managers and staff understood and consistently worked to these. The service 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.

Provider and service priorities were considered as part of ongoing meetings, including at governance and operational levels.

Consistent objectives and associated performance indicators were included throughout the organisation, from senior leadership level to individual staff performance and conduct.

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 and infection control) 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 reduce 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 nurse manager.

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.

We saw examples of where conduct and performance had been addressed appropriately using supportive performance management processes. This included formal disciplinary processes where needed. 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, 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 freedom to speak up champions if needed. These guardians worked across the provider's sites.

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, where staff at all levels were treated equally.

Staff recruitment processes demonstrated adherence to equal opportunities principles and reasonable adjustments could be made where required. For example, we saw evidence where flexible working patterns had been considered and implemented where this was judged to be beneficial and appropriate.

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.

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.

Governance, management, and sustainability: Score 3.

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

The service had an overarching governance work plan (which acted as a continuous improvement plan) which we reviewed and found to be up to date. This included consideration of operational and clinical 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 the service's patient selection criteria; patient-reported outcomes and associated satisfaction with these; and COSHH audits and findings. 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 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 14 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 safeguarding and freedom to speak up.

Managers 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.

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 productive working relationships with the provider's other locations.

The service had implemented a relationship in September 2025 with a homecare service provider who could visit patients at home as part of aftercare where patients did not return to the service. There was a standard operating procedure in place and monthly meetings to promote quality and best practice. Managers told us this arrangement was working well and that patients were satisfied with the services provided.

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, and comprehensive reviews of incidents.

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 we spoke with demonstrated a willingness to learn and improve and could cite examples of where this had taken place.

Environmental sustainability / sustainable development: Score N/A

We do not currently assess this area.

Improvement Plan

The following actions highlight the areas for improvement from the mock inspection carried out on 16 October 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 recommend the service conducts the planned review and update to the sepsis management policy.				
We recommend that the service ensures that the audit calendar (including where due and where completed) is kept up to date in real time.				
We recommend that the service appoints and trains dedicated Fire Marshalls and identifies and communicates a suitable fire assembly point.				
We recommend the service implements a process for DBS certificate expiration alerts, for when the HR Manager is absent.				

Caring

Improvement	R1	R2	Target date	Date completed
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): Karen McCarthy

Date: _________10/11/25_______________________