Epilium & Skin Ltd

Epilium & Skin

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We have not previously rated this service. We rated it as inadequate because:

- Staff did not have up to date training in key skills that helped them to keep people safe. The service did not have measures in place to control infection risk. Staff did not assess risks to patients and care records were inconsistent.
- The service did not follow required legislation in relation to recruitment or registration of staff providing regulated activities.
- There were no medicines management systems in place. There was no system in place to manage safety incidents.
- The service did not monitor the effectiveness of care and there was no system to ensure the competence of staff.
- Governance systems were not functioning, and the provider did not have a good understanding of the service or their responsibilities in relation to risk and leadership.

Following the inspection, we took immediate action to suspend all regulatory activity at the provider for 3 months.

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Dr Sean O'Kelly

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	We rated this service as inadequate because it was not safe, effective, responsive, or well led.

Summary of findings

Contents

Summary of this inspection

Background to Epilium & Skin

Epilium & Skin is operated by Epilium & Skin Ltd. The service provides private cosmetic treatments from clinical premises which are also used for unregulated aesthetic treatments. The clinic offers treatments such as blepharoplasty (eyelid reduction), labiaplasty (labia minora reduction), gynecomastia (male chest lift), fat transfer, and hair transplant. The service has 1 operating theatre, 1 recovery room, 1 consultation room and a waiting area. Procedures are carried out under local anaesthetic only.

The provider registered this location in January 2011. A registered manager is in post and the service is registered to carry out the following regulated activity:

- Surgical procedures

We last inspected the service in June 2018. At this inspection we did not have a duty to rate and instead published a narrative report. We found 3 breaches of the Health and Social Care Act (2014) in relation to Regulation 12 and issued requirement notices to the service. The notices reflected a lack of training for doctors, a lack of surgical equipment, and a lack of assurance of safety checks of equipment.

At this inspection we found the service had not made improvements and demonstrated a significant deterioration in governance and safety standards.

We rated this service as inadequate because it was not safe, effective, responsive, or well led. As no regulated activity was taking place at the time of our inspection, we did not inspect caring.

How we carried out this inspection

We carried out an unannounced inspection using our comprehensive methodology of the service on 20 December 2022. Our inspection team consisted of a lead inspector and a specialist advisor. The inspection was overseen by Nicola Wise, Head of Hospital Inspection.

There were no patients using the service at the time of our inspection. To come to our ratings we inspected the environment, spoke with staff, and reviewed records.

After our inspection we asked the provider to send us additional evidence of working standards and assurance. They did not provide us with the requested information.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure that staff providing clinical care have up to date, appropriate training. (Regulation 12)
- The service must ensure premises and equipment are cleaned, sanitised, and disinfected in line with national requirements. (Regulation 12)
- The service must ensure decontamination facilities or services are available to ensure the safe use of surgical equipment. (Regulation 12)
- The service must implement and maintain consistent, safe medicines management. This must include safe procedures in line with national requirements that include storage, stock management, prescribing, administration, and destruction. (Regulation 12)
- The service must ensure medical emergency equipment is available and maintained. (Regulation 12)
- The service must implement clinical monitoring and outcome processes. (Regulation 12)
- The service must ensure it fully complies with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe recruitment of staff. (Regulation 12)
- The service must ensure surgeons follow safe surgical practises, such as the World Health Organisation surgical safety checklist. (Regulation 12)
- The service must ensure clinical governance processes are fit for purpose, contribute to the safe running of the service and enabled the registered manager to gain assurance risk and performance. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure that patients have access to a formal language translation service on request.
- The service should ensure clinicians make it clear to patients who is responsible for their care and treatment at each stage, including the relationships between providers and organisations.
- The service should ensure consent processes are adapted to meet the needs of patients whose care or treatment is recorded or livestreamed for entertainment or promotional purposes.
- The service should consider how to guide clinicians on signposting patients with anxiety disorders or diagnoses to an appropriate service for risk assessment prior to treatment.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Are Surgery safe?

Inadequate

We have not previously rated safe.

We rated it as inadequate.

Mandatory training

The service did not provide mandatory training in key skills to all staff and had no assurance staff providing clinical care had up to date training.

Staff did not receive or keep up-to-date with mandatory training. The provider did not have a training system that ensured staff were up to date.

The service did not ensure doctors working under practising privileges maintained up to date mandatory training. Training for 2 surgeons with practising privileges were significantly out of date. For example, updated training for basic life support for 1 surgeon had expired in April 2018 and immediate life support for both surgeons expired in May 2019. Other training certificates indicated training had expired at various points between May 2018 and May 2020.

The service had not checked the training completed by the doctor actively providing care, which meant there was no assurance the individual had appropriate training to keep people safe. This doctor did not have practising privileges in place and there was no record of their training.

Safeguarding

The service could not demonstrate staff understood how to protect patients from abuse and exploitation. Staff did not have up to date training.

The service could not demonstrate appropriate levels or recency of training for clinical staff. The service held no evidence that a surgeon currently providing care had up to date safeguarding training. Out of 2 surgeons registered to deliver care, 1 had advanced safeguarding training that was due for renewal in May 2021. The service could not provide evidence of safeguarding training for the second surgeon.

The service could not evidence that a surgeon delivering care without practising privileges between September 2022 and December 2022 had completed safeguarding training. This individual had delivered care to patients who disclosed mental health needs or vulnerabilities, which meant there was a risk the service had failed to protect patients from harm.

Inadequate

Surgery

Patient records indicated the service delivered care and treatment to patients who may be vulnerable, including those with anxiety disorders. A surgeon asked patients for consent to film and/or photograph their procedures with the option of livestreaming it to undisclosed online entertainment platforms. The consent form did not state what the filming would be specifically used for. The provider had no oversight of this process and had no safeguarding structure in place to ensure patients were not being exploited.

Cleanliness, infection control and hygiene

The service could not evidence if they controlled infection risk well. There were no systems in place to identify and prevent surgical site infections. Not all equipment and premises were clean.

Clinical areas were not all clean and some furnishings were poorly maintained. Equipment and elements of the environment in theatre were visibly dirty or rusted. For example, a metal power socket directly underneath the surgical procedure table was damaged and rusted. A metal trolley used to lay out medicines and surgical instruments had remnants of tape on the surface, which was dirty.

We found surgical instruments used for dermatology procedures were dirty and rusted. They were stored in a tray with a variety of medicines and dermatology products that were partially used, and some had expired. Bottles were sticky and visibly dirty. Staff we spoke with stated they were aware of the concerns and the responsible doctor had been warned previously about their infection control standards. After our inspection we spoke with the registered manager, who said they would ensure the issues were resolved.

The service contracted an external company to carry out cleaning and decontamination of clinical areas. Records were limited and the service did not have assurance of the standard of cleaning that took place or confirmation that essential areas were cleaned and sanitised. Cleaning checklists were vague and did not include specific details of the cleaning that took place and did not demonstrate consistent, adequate standards.

The service did not keep records of surgical site infections, which meant the registered manager was unable to identify if clinical staff followed safe infection control procedures during surgery.

Environment and equipment

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

The design of the environment did not follow national guidance. There were no decontamination facilities for surgical equipment and staff were unable to explain how reusable equipment was cleaned ready for use. There were no audit records to provide assurance of such processes. Staff used the same utility room to handle both clean and contaminated materials during surgery. This was not in line with best practice.

Arrangements for the storage and management of chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) did not follow required national standards. Staff stored some products unsecured on the floor and not in locked cabinets. The storage area was cluttered with boxes, items of luggage, and other equipment that restricted access and reduced fire safety.

Safety checks on specialist equipment did not always provide an appropriate level of assurance. For example, a diathermy machine was in use in theatre. A diathermy machine uses an electrical current to cut or coagulate tissue during surgery. The machine had no UK safety test documentation and staff told us it had been tested in France before being brought to the clinic. Therefore, we could not be assured it was working to UK safety standards.

Inadequate

Surgery

At our previous inspection we told the service it must have a suction machine in place in theatre. A suction machine, or aspirator, removes obstructions such as mucus or blood from a person's airway. The device is an important part of surgical safety. The service had not yet secured such a device.

Emergency medical equipment was not fit for purpose. The service had a resuscitation trolley that was unsecured and used to store non-emergency medicines and equipment. This meant access to emergency items would be slowed. Emergency medicines and equipment, including an EpiPen for anaphylaxis, Ventolin for asthma attacks, local anaesthetic, aspirin, glucose, adrenaline for cardiac arrests, cannulas, and syringes had all expired. Expiry dates ranged from February 2022 to November 2022. Expired products may not be effective in an emergency situation and must be discarded immediately on reaching this date. This was raised with the registered manager who said a member of staff who left the service in September 2022 had been responsible for stock checks and this role had not been reallocated. However, most of the expired items had passed their use by date prior to September 2022. This demonstrated the service had no effective stock check and control system for emergency items for some time.

There was not enough equipment to provide emergency care in the event a patient deteriorated. Resuscitation Council UK guidance was displayed next to the emergency trolley and was the standard staff were expected to follow. However, the emergency trolley did not have enough equipment for staff to be able to follow the guidance. For example, only 1 laryngeal airway mask was stored. This was suitable only for patients who weighed between 50 – 70kg and would not support patients outside of this range.

The service had an automatic external defibrillator that was serviced and in date. However, there was no signage to indicate its location and at the time of our inspection it was stored behind a stack of boxes. Staff said it was moved and put in place prior to a procedure taking place. Therapeutic and emergency oxygen were available and in situ.

The provider had a service level agreement in place for the management of hazardous waste. Staff managed sharps bins in line with national guidance.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient. There was no policy for staff to identify and act upon patients at risk of deterioration. The service did not make sure patients knew who to contact to discuss complications or concerns.

The service did not have assurance staff used a nationally recognised tool to identify deteriorating patients and escalate them appropriately. While regulated care was not being undertaken at the time of our inspection, patient records did not include evidence of pre-surgery risk assessments or the use of a tool to monitor each patient's condition during surgery.

Pre-surgical records required patients to self-disclose their medical history and any risk issues. However, there was no documented evidence staff assessed these and adjusted clinical care accordingly.

There was no risk assessment or inclusion/exclusion criteria in place that enabled staff to identify if a patient was unsuitable for cosmetic surgery. This presented a risk to safety because it meant staff had not assessed patients' known health issues, including mental health needs, prior to carrying out surgery.

The service did not have a standard operating procedure for the management of patients who deteriorated. There was no guidance for the actions staff should take if a patient deteriorated or the threshold at which staff would arrange an urgent transfer to another facility or call 999. Staff said there had been discussions about this, but no policy was yet in place.

Inadequate

Surgery

The service did not keep a theatre log and there was no overarching record of the procedures that took place on a day to day basis, which doctor had led care and treatment, and the procedures carried out. This meant the senior leadership team did not have appropriate oversight of activities that might present a risk to the safety of patients and staff.

One of the surgeons who had performed treatment at the service since September 2022, maintained records that partly reflected the World Health Organisation (WHO) surgical safety checklist. However, these were completed inconsistently and did not include all the requirements of the WHO standards. For example, team names and roles were not clearly detailed in all checklists and in 3 records we reviewed, the surgeon had not documented any other members of the surgical team. In 1 example that took place in October 2022, a gynecomastia correction (male chest lift) procedure took place with only the operating surgeon listed as present. This meant there was no clinical support staff in the theatre.

Staffing

The service could not evidence it had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not employ nurses or healthcare support workers. Doctors and surgeons working under practising privileges brought their own theatre support staff with them on operating days. Staff told us the dermatologist brought a nurse with them when they performed minor surgery. However, the service did not keep records of these staff and were unable to confirm if they were trained, accredited professionals.

Two surgeons held current practising privilege agreements with the provider and were able to deliver regulated activities. While they held approval that allowed them to practice, they rarely delivered care in the clinic. Neither surgeon had undertaken care or treatment in the clinic in the previous 12 months. Documentation relating to the employment and expected standards of each surgeon were not up to date. The service did not have documented appraisals for either surgeon. The most recent Disclosure Barring Service (DBS) checks were dated 2017.

The service's website listed 3 other doctors as providing care. However, the registered manager told us none of these staff were currently providing care. There were no local records relating to these doctors and the service could not provide assurance about their current status.

A surgeon currently providing regulated care in the service was doing so without a practising privileges agreement. The service had not carried out background checks on his individual and was in breach of Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which assures providers of the propriety and suitability of new staff. The service had obtained references for the person that differed from the practising privileges documentation. References were either undated or did not reflect professional competency. One of the referees documented for the individual said they had no knowledge of them. This presented an immediate and significant risk to patients.

Records

Staff kept inconsistent records of patients' care and treatment. Records were not always clear, up-to-date, or stored securely.

Patient notes were stored in hard copy in various files. There was no tracking system and the service did not maintain an overall record or archive of patient care and treatment. Therefore, the registered manager did not have assurance of patient safety or care and treatment outcomes.

In the previous 12 months, 1 doctor had delivered regulated care. Records were inconsistent and varied in completion and detail. For example, patients self-declared their medical history, including whether they had previously had the same

treatment. There was no documented evidence the doctor assessed suitability for treatment. There was no record of a pre-surgical consultation other than a patient completed proforma about their health and where the procedure would take place. Some records were undated and unsigned, and others were missing key information, such as the batch numbers and expiry dates of medicines and medical consumables.

Patient records for 1 of the surgeons were branded with the paperwork of another organisation, based outside of London. It was not evident that patients knew care and treatment was delivered under the registration of another organisation. Staff said they had no information about this arrangement. The registered manager was unable to provide assurance of a formal arrangement or agreement between the 2 organisations. This meant there was no assurance patients knew they were being treated outside of regulation.

Records were stored securely in an area with restricted access.

Medicines

The service did not have systems and processes to safely prescribe, administer, record and store medicines.

There was no medicines management system in place. Medicines were stored in various drawers, cupboards, and trolleys. There was no stock control or tracking system. While access to the theatre was controlled with a coded, locked door, medicines were not stored in locked cabinets. This was not in line with national best practice.

Staff did not follow systems and processes to prescribe and administer medicines safely. Staff told us doctors brought their own medicines to the clinic, including Controlled Drugs (CDs). However, there was no standard operating procedure for this, and the service did not keep a record of the medicines brought on site and who prescribed them.

The surgeon performing treatment since September 2022 did not use a safe system for prescribing, dispensing, and administering medicines. In surgical records, the surgeon was the only person documented as managing medicines with no second-check process in place. In the sample of 17 records we checked, 5 included no batch numbers or expiry dates of the medicines issued. In 2 patient records, the surgeon had documented the use of saline solution that had expired in the previous month. After our inspection we raised this with the registered manager, who after speaking with the surgeon's team said it was an administrative error and the saline solution had been delivered specifically for the procedures and was in date. However, we could not verify the accuracy of the checks. This highlighted the lack of a checking system in theatre.

We found 3 boxes of medicines, including a class C CD and prescription painkillers, prescribed to named individuals. These were stored in a drawer of other medicines that staff told us were "ready to use" by any clinician working in theatres. There was no tracking system and staff were unable to establish why the medicines were in the theatre. 1 box of medicine was prescribed to a member of staff employed by the surgeon who had been delivering care since September 2022. This demonstrated a significant lack of safety controls in the service.

A labelled medicine was available which was not in English, so we were unable to determine what it was. The label did not follow the legal requirement for labelling a medicinal product. For example, the name and address of the supplying pharmacy, name of the medicine, and precautions relating to the medicine (e.g. for external use only) were not printed in English. There was no outer packaging which might have had an over label with all the information in English but that was not available either. This medicine had expired 4 months previously. The service was unable to provide evidence about where it had come from, when it had been used, or who administered it. Staff told us it was part of the dermatologist's medicine stock but there was no tracking information available.

Inadequate

Surgery

Incidents

The service could not demonstrate how they managed patient safety incidents. There was limited evidence staff recognised and reported incidents and near misses. There was no evidence when things went wrong staff apologised and gave patients honest information and suitable support. There was limited assurance that actions from patient safety alerts were implemented and monitored.

The provider had an incident reporting policy, no incidents were documented in the previous 12 months. There was limited monitoring of clinical activity, which meant the provider was not assured they would always be aware of an incident in the service. For example, we could not establish that staff accompanying surgeons understood the incident reporting procedure and there was no evidence surgeons had undergone instruction or training in the incident reporting system.

The provider had an up to date duty of candour policy that reflected good practice. However, there was a lack of oversight of clinical practices that took place on the premises, which meant the registered manager would not usually be aware of circumstances that required the use of the policy. For example, during a review of patient records we found a surgeon had carried out surgery using expired saline. We asked the registered manager to investigate this to identify if it required a duty of candour response. The registered manager assigned this to the surgeon's team, who responded that the documentation of the expired product was an administrative error. This demonstrated gaps in the provider's duty of candour policy as it relied on auditing, surgeon competence, and surgeon transparency to work effectively.

Are Surgery effective?

Inadequate

We have not previously rated effective.

We rated it as inadequate.

Evidence-based care and treatment

The service had no benchmarks, audits, or standard operating procedures to provide care and treatment based on national guidance and evidence-based practice in surgery. The service could not demonstrate they met cosmetic surgery standards published by the Royal College of Surgeons.

Staff did not follow national best practice guidance, including that issued by the National Institute for Health and Care Excellence (NICE). For example, surgeons did not carry out warming in the surgical suite in line with NICE clinical guidance 65 to reduce the risk of perioperative normothermia. They did not use equipment such as flatiron boots to reduce the risk of venous thromboembolism (VTE) during lengthy procedures.

It was not clear how surgeons operating under practising privileges accessed policies or national guidance. The registered manager did not have assurance each individual providing care had read the most recent version of a policy, procedure, or guidance. This meant there was no system in place to ensure care was evidence-based.

Pain relief

There was no evidence to provide assurance that staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Inadequate

Surgery

Surgical procedures took place under local anaesthetic although records indicated some lengthy, invasive procedures had taken place in theatre. These would more usually be carried out under general anaesthetic although there was no record general anaesthetic had been provided and no risk assessment to ensure local anaesthetic was appropriate.

Patient records indicated the surgeon had administered pain relief during procedures and various pain relief medicine was stocked in theatre. However, there was no evidence the surgeon monitored pain relief using a standard tool. They did not document levels of pain during treatments.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The service did not monitor patient outcomes. There was no system for auditing, reporting, or benchmarking.

Staff did not monitor or track instances of patients who returned to theatre (RTT) or the reasons for them. This meant the service was not assured clinical treatment was carried out safely and consistently as there was no auditing process for patient outcomes.

The service had not implemented the NHS England National Safety Standards for Invasive Procedures (NatSSIPs) or the Local Safety Standards for Invasive Procedures (LocSSIPs). Both were introduced nationally in 2015 to drive improvements and cross-provider learning in surgical services. The provider had no equivalent system in place to monitor outcomes.

Competent staff

The service did not have a system to make sure staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff did not undergo annual appraisals. There was no record of appraisals for surgeons with practising privileges within the last 5 years.

There was no evidence permanent support staff had undertaken developmental opportunities or continuing professional development.

Multidisciplinary working

There was no evidence of multidisciplinary working to provide good care.

Surgeons treated patients independently, outside of wider care pathways and the provider did not keep a record of patient details. Staff did not hold multidisciplinary meetings and there was no evidence they liaised with other professionals to coordinate care and treatment.

Where patients documented medical history or current conditions in their records, doctors did not document if they held multidisciplinary meetings with other clinicians involved in the patient's care. This meant there was a lack of assurance procedures were carried out effectively with regards to other health conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We were not assured staff supported patients to make informed decisions about their care and treatment. They did not consistently follow national guidance to ensure patients gave consent in a 2-stage process with a cooling off period of at least 14 days between stages.

Inadequate

Surgery

All care was elective and paid for by patients. While consent processes were in place, there was a lack of assurance surgeons followed best practice. Patient records did not indicate a cooling off period, which meant there was no assurance patients had time to change their mind about a planned procedure.

The surgeon actively providing treatment maintained records of signed consent. This included details of the procedure, potential side-effects, and expected results. Consent forms included notification that surgical procedures may be livestreamed, filmed, and/or photographed for entertainment, advertising, and education purposes and required patients to consent or decline. Where patients consented to any of these, they had the option to do so with their identity hidden. However, the consent form did not provide further details of the purposes for which the surgeon might film or photograph procedures or details of the website through which they would be livestreamed. This meant there was limited assurance patients fully understood the non-medical purposes for which their care was being captured.

One patient consent form indicated they had received free treatment in exchange for promoting their surgery on social media channels. This was handwritten on a piece of paper and there was no evidence the surgeon had carried out due diligence with regards to their health and wellbeing.

The provider had no policy or standard operating procedure in place with the surgeon for this activity, which meant there were no controls in place to ensure patients were not being exploited or coerced.

The service did not maintain evidence of consent to care and treatment from the dermatologist.

Are Surgery responsive?

Requires Improvement

We have not previously rated responsive.

We rated it as requires improvement.

Meeting people's individual needs

The service was not inclusive and did not take account of patients' individual needs and preferences. There was no system for referring patients for psychological assessment before starting treatment, if necessary.

There were no systems in place to help staff make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The nature of treatment provided meant it was unlikely a patient living with dementia would present in the clinic. However, staff did not have formal training or policies to help them in such an event.

All areas were accessible step-free although clutter and storage boxes in exit pathways and near the emergency exit meant rapid evacuation of people with reduced mobility would not be possible.

There was a lack of assurance surgeons adequately supported patients with known vulnerabilities to ensure the service met their needs and to protect them from harm. For example, the surgeon providing care at the time of our inspection

required patients to complete a medical history document that included health conditions, previous surgery, and any other relevant information. In 1 recent medical history, the patient disclosed an anxiety disorder along with multiple previous cosmetic surgery procedures. There was no evidence the surgeon had discussed this with the patient or identified steps to ensure the procedure was clinically appropriate and did not exacerbate their anxiety.

The service did not have a language translation service available. Staff told us patients could bring a friend or relative who would translate for them during consultations or procedures. This was not in line with good practice. It presented a risk of inaccurate translation if the person interpreting did not have a good knowledge of medical terminology. It also presented a safeguarding risk as staff would be unable to detect issues such as coercion.

The service had no processes to assess the appropriateness of care and treatment for patients with vulnerabilities or needs relating to learning disabilities and other mental health needs.

Access and flow

People could access the service on demand.

Patients accessed the service by booking directly with a specific doctor for a particular treatment. Doctors also consulted with patients outside of the provider and then booked space for consultations or surgery in the clinic. The registered manager coordinated this to ensure space was available.

The surgeon performing treatment since September 2022 provided patients with a programme of 6 follow-up consultations. These were a combination of remote video meetings and in-person consultations. While this process ensured patients received appropriate aftercare, there was no evidence the surgeon provided patients with 24/7 contact information in the event of post-surgical complications or care needs.

Learning from complaints and concerns

It was not evident the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. There was no system to refer unresolved complaints for independent review.

There was no information displayed or available in the clinic that detailed how to make a complaint. The provider's website did not include their complaint's policy.

Are Surgery well-led?

Inadequate

We have not previously rated well led.

We rated it as inadequate.

Leadership

Leaders did not have the skills and abilities to run the service. They failed to understand and manage the priorities and issues the service faced.

Inadequate

Surgery

The managing director was the registered manager and a medical director was in post. The registered manager coordinated booking procedures and was present in the clinic whenever regulated activities were taking place. The medical director had practising privileges to deliver regulated care and treatment although had not delivered care within the previous 12 months. Both directors were based substantively outside the UK and a duty manager was responsible for the day to day operation of the clinic, including unregulated services.

We were not assured of the abilities of the senior team. There were gaps in understanding of governance, operational safety, and the measures needed for safe clinical practice. Leaders could not evidence they understood challenges to quality and sustainability. They had not acted substantively to address quality issues.

The service did not have a system to ensure staff and those working under practising privileges were supported with performance, met and trained together, and had access to human factors training to underpin the delivery of safe care. This would usually be included in work to follow the National Safety Standards for Invasive Procedures (NatSSIPs) but the service did not take part.

The service did not have a leadership strategy or development programme although contingency plans were in place for the absence of the registered manager and staff spoke highly of the senior team.

As part of our inspection process we issued the provider with a data request. We did not receive a response or any of the information we asked for.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on building loyalty in the beauty care sector.

The provider's vision focused on a long-term presence in London providing beauty-focused surgical care and treatment using French standards of aesthetics to achieve people's goals. The philosophy was based on working with people to enhance their natural appearance using surgical techniques.

Staff and those working under practising privileges rarely met as a group and there was no cohesive communication strategy in place.

Culture

Staff felt respected, supported and valued. The fragmented nature of staffing in the service meant there was a lack of cohesion and communication between staff.

Staff we spoke with said they were happy working in the service. They said they felt supported and respected and cared about people's experiences. During our inspection regulated activity was not taking place. We saw staff were kind and friendly to visitors attending for aesthetic treatments.

A number of professionals worked in the clinic on an ad-hoc, limited, or temporary basis. There was an overall lack of understanding of, or adherence to, national standards and guidance. This included the Royal College of Surgeons professional standards for cosmetic surgery.

Cosmetic surgery services are required to follow guidance from the Advertising Standards Authority, under the Committee of Advertising Practice Ltd, to ensure marketing is not misleading and is responsible and accurate. The service did not carry out any auditing or benchmarking to provide assurance they met these standards.

Inadequate

Surgery

There were no mechanisms for providing staff at every level with development and high-quality appraisals.

There was no structure or system to promote diversity and equality and the service did not have a strategy to ensure it was meeting the requirements of the Equality Act (2010).

Governance

Leaders did not operate functioning governance processes.

The governance system was not fit for purpose. The provider and registered manager were not compliant with their regulatory responsibilities and did not have processes in place to ensure safe standards of working. A surgeon had carried out 30 procedures between September 2022 and December 2022 without a practising privileges arrangement in place. We raised this with the registered manager after our inspection, who provided a completed practising privilege agreement dated 30 December 2022. It was not signed by the provider and contained information that contradicted details provided elsewhere. This meant the provider did not have assurance staff were of good standing. They had not carried out appropriate checks on the surgeon before enabling them to provide care and treatment under their registration.

A dermatologist provided outpatient care and minor surgery in the clinic and the provider told us this was under their registration. However, this care was not within the provider's regulated activities, which meant it was not being delivered with appropriate regulatory controls in place. The provider did not monitor the clinical activity of the dermatologist and there were no records of care provided, patient outcomes, complications, or risk assessments. This represented a significant gap in governance to ensure the safe operation of the service within legislative requirements.

Management of risk, issues and performance

There was no system to manage performance effectively.

The service did not have comprehensive assurance systems and there were no processes to monitor cosmetic surgery services. The service did not have systems for continuous improvement in infection prevention and control. There were no surveillance systems in place and no evidence of multi-agency working.

The provider was not aware of the issues we identified, had no risk register, and demonstrated a lack of awareness of severity of the issues and the impact on patient safety. While 3 doctors on the service website appeared to be actively accepting appointments, the provider was unable to provide assurance of either their practising privilege status or confirmation they no longer worked in the service.

Vague and inconsistent processes for accessing the service and treatment meant the provider did not have assurance of safe risk management processes. For example, recent patient documentation indicated patients were assessed and consented by a different organisation and then seen in this clinic for treatment. There was no written agreement between the organisations, such as a service level agreement or contract for the treatment of patients. Staff were unsure of the arrangement and were not aware of any risk assessments to ensure planned procedures could be safely accommodated in this service. For example, doctors pre-booked clinical space for their patients and then delivered care and treatment under this provider's registration. However, the service did not check in advance the type of care and treatment planned, which meant there was no system in place to ensure the facilities and resources were adequate.

Dermatology services took place under the provider's registration, but staff were unaware of the procedures taking place. The doctor brought their own records and IT equipment with them and there was no local record of the procedures that had taken place. This meant there was no system in place to assess risk and ensure patient safety.

Inadequate

Surgery

The service did not have assurance surgeons practiced with up to date medical indemnity insurance. Out of the 2 surgeons with practising privileges, the service held a certificate for indemnity insurance valid in France, its territories, and the European Union, and expired in December 2019. The second surgeon held the same insurance cover that expired in 2021. The service's website listed 3 other doctors as currently available, but staff told us they were unsure if they stilled provided regulated care. The registered manager said the 3 doctors did not provide regulated care but could not explain why they remained on the website. This was representative of the lack of governance and risk management in place in the service.

Information Management

Information was not managed appropriately.

The service did not have a holistic understanding of performance that included people's views with information on quality, operations, and finance. There were no associated processes to measure improvements or baseline assurance.

The service did not have systems to monitor quality and sustainability. There were no performance measures and no reporting system for operational or patient outcomes.

The provider had a data protection policy and staff were aware of this. However, there was no evidence surgeons had recent training. We asked the provider for information on auditing of information governance but did not receive a response. The provider was unable to demonstrate they managed data and information in line with data protection legislation.

Engagement

There was limited evidence leaders and staff actively and openly engaged with patients and each other.

Staff told us they felt well informed by the registered manager. They said the registered manager maintained communication with them by phone and e-mail when they were away. However, there was little clarity amongst staff about the scope and delivery of regulated activities, which were fragmented and poorly governed.

It was unclear whether external partners were engaged in the service. We asked the provider to send us information about stakeholders and their involvement in the running of the service and its strategy but did not receive a response.

The service did not collect patient feedback or details of satisfaction.