

AIG Aesthetic Care Ltd

AIG Aesthetic Care

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

Summary of findings

Overall summary

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

- The premises and equipment were unhygienic and in a poor state of repair. Processes and systems to manage infection control risks were not fit for purpose. Staff and leaders had not recognised the risks or acted to mitigate them.
- Decontamination processes did not meet national standards and presented a significant risk to patients.
- The service did not ensure the privacy and dignity of patients and there was CCTV in use throughout the clinic without nationally required control measures in place.
- Fire safety systems were unacceptable and did not keep patients and staff safe. The provider had not acted on risk assessments that had highlighted fire risks.
- Policies and standard operating procedures were out of date, not fit for purpose, and had been copied from another clinic with different facilities. Staff knowledge of policies was very limited.
- There was limited evidence of evidence-based practice. The provider did not use established systems and frameworks to benchmark, audit, or monitor clinical activities and patient outcomes.
- The provider did not have a clinical governance framework or risk management system. The leadership structure was vague and senior staff had a fundamental lack of understanding of risk.

However:

- Patients reported high levels of satisfaction with the service.
- Staff provided consistent follow-up care after treatment and worked with patients to meet their expectations.

Following the inspection, we took immediate action to suspend all regulatory activity at the provider for three weeks. In addition, we placed the provider in Special Measures.

Services placed in special measures will be inspected again within 6 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 6 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 6 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	We have not previously inspected this service. We rated it as inadequate. Please see the main summary.

Summary of findings

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Summary of this inspection

Background to AIG Aesthetic Care

AIG Aesthetic Care is operated by AIG Aesthetic Care Ltd and offers cosmetic hair transplant surgery and platelet-rich plasma (PRP) treatment. PRP is a treatment aimed at stimulating hair growth by injecting a patient's own blood cells into the scalp.

Services are provided from a single floor clinic in Walsall town centre. Care is provided on a private basis and patients self-refer or are referred by another organisation, which advertises in this clinic.

The provider registered with us in September 2022 to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury

The service has a registered manager.

We have not previously inspected this service. We rated it inadequate because it was not safe, effective, responsive, or well led. There was some evidence the service was caring.

How we carried out this inspection

We carried out an unannounced comprehensive inspection on 25 September 2023. As part of our inspection, we met staff on shift delivering care, spoke with the registered manager, and with patients. We considered over 60 other pieces of evidence to come to our ratings.

Our inspection team included a lead inspector, a nurse specialist advisor, and an off-site operations manager and deputy director.

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

Areas for improvement

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

Action the service **MUST** take to improve:

- The service must ensure that decontamination processes for surgical equipment are compliant with Department of Health and Social Care Health Technical Memorandum 01-01 in relation to the safe use of surgical instruments. Regulation 12(1) and 12(2)(b)(e).
- The service must ensure consistent standards of infection prevention and control throughout the clinic, including in all areas of the environment, auditing, and staff practice. Regulation 12(1) and 12(2)(a)(b)(c)(d)(e)(h).

Summary of this inspection

- The service must ensure safe water management processes are used to reduce the risk of Legionella build-up, in line with Department of Health and Social Care health technical memorandum 04-01. Regulation 12(1) and 12(2)(d).
- The service must ensure evidence of patient outcomes is collected and monitored. Regulation 12(1).
- The service must ensure appropriate safeguarding systems are in place to protect patients at risk of abuse or harm. Regulation 13(1) and 13(2).
- The service must ensure people are protected from the risks of fire and electrocution related to poor standards and knowledge of health and safety. Regulation 15(1)(d).
- The service must ensure regulated activities are delivered using up to date policies that are evidence-based and fit for purpose. Regulation 17(1) and 17(2)(d)(ii)(f).
- The service must ensure national requirements for the use of CCTV are fully met. Regulation 17(1) and 17(2)(d)(i)(ii).
- The service must ensure clinical governance and risk management systems are functioning, fit for purpose, and meet the needs of the regulated activities. Regulation 17(1) and 17(2)(a)(b)(c)(d)(i)(ii)(e)(f).
- The service must ensure senior staff are competent for their roles and have access to support for development and governance. Regulation 17(1) and (2)(d)(i)(ii).
- The service must ensure staff training meets the needs of patients. Regulation 18(1) and (2)(a)(b)(c).
- The service must ensure doctors perform duties in line with their competencies and training. Regulation 18(1) and (2)(a)(b)(c).
- The service must ensure all staff have access to suitable appraisal and supervision processes. Regulation 18(1) and (2)(a).
- The service must ensure that all staff have a full induction. Regulation 18(1) and (2)(a).

Action the service **SHOULD** take to improve:

- The service should ensure patients have the post-treatment information they need to help them manage recovery and side-effects. Regulation 9.
- The service should ensure all patients receive a 14-day cooling off period prior to surgical treatment. Regulation 9.
- The service should ensure that patients are cared for in an environment that ensures privacy and dignity. Regulation 10.

Our findings

Overview of ratings

Our ratings for this location are:

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

Surgery

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

Is the service safe?

Inadequate 

We have not previously inspected this service We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but completion and training topics were inconsistent amongst the team.

Staff received and kept up to date with their mandatory training although there were wide variances in the range of training they completed. Doctors completed 10 basic core modules while technicians completed between 12 and 27 modules. As the provider did not have a structure or policy to guide the training staff were required to complete, it was not clear why staff had such broad discrepancies between them. All training was delivered online, and staff were responsible for completing updates.

While the modules reflected the basic needs of the service, there was limited consistency. For example, while all staff had completed consent and hand hygiene training, some staff had no record of safeguarding training. The lack of a training structure from the provider meant there was little guidance or support for staff.

It was not evident that the quality of training was sufficient for staff to provide safe care. For example, mandatory modules included infection control, health and safety, and fire safety. However, we found significant and immediate risks in all 3 areas with very low levels of competence and knowledge amongst staff. Some technicians had completed electrical safety training but the profound risks of fire and electrocution we found during our inspection, suggested either training was insufficient, or staff were unable to voice concerns.

The provider's training policy had expired and did not include a list of mandatory training.

Safeguarding

Staff did not all have training on how to recognise and report abuse.

Surgery

Not all staff received training specific for their role and there was little consistency between staff with evidence of training. For example, while doctors completed safeguarding training, the provider could not evidence the level of their training. Amongst technicians, some had no evidence of safeguarding training while others had completed it to an advanced level.

The nature of the service meant safeguarding concerns were likely to be rare. However, the provider did not have sufficient processes in place to enable staff to identify risks. For example, staff told us it was common practice to allow patients who did not speak English to bring a friend or relative with them to provide interpretation. This meant the team would be unable to identify patients at risk of coercion or being treated against their will.

The interim lead surgeon was the safeguarding lead although staff knowledge of this was inconsistent, and the provider could not confirm their level of training. The safeguarding policy had expired 11 months before the inspection and named an individual no longer with the organisation as the lead.

Cleanliness, infection control and hygiene

There were substantial, uncontrolled risks of infection in the clinic. The service had limited systems to identify and prevent surgical site infections. Staff did not use effective control measures to protect patients, themselves, and others from infection. Equipment was not decontaminated properly before use and the premises were visibly dirty in places.

Clinical areas were not all clean and furnishings were not all suitable, clean, and well-maintained. For example, surgical equipment trollies were rusted, and the bases of treatment beds were visibly dirty. The kitchen used to prepare drinks and food for patients was also the staff room used by the team during breaks. The room and equipment were visibly filthy. Drawers used to store cutlery and dry food were stained and coated in old food debris. The fridge had a repugnant odour and had a thick layer of dried, congealed liquid coating the inside walls and floor. Staff used the fridge to store drinks and food for themselves and for patients. A microwave was in a poor state of repair, with rusted exterior components and thick dirt inside. A cleaning schedule was on display for the kitchen and had been completed on each day the clinic was open. However, the state of the kitchen did not provide assurance cleaning had taken place.

The service did not have a system in place to provide assurance of performance for cleanliness. Infection prevention and control (IPC) and hygiene audits were not fit for purpose. They did not take place frequently enough to provide on-going monitoring, did not include all staff, and were not detailed enough to highlight areas in need of more attention. For example, staff completed an IPC audit once every 6 months. This was superficial and did not include details of specific issues or problems. There was no more frequent monitoring system in place.

Staff completed a hand hygiene audit once each year. This was a whole-team audit and did not consider individual standards of practice. It did not provide assurance that each member of the team followed good standards.

Mops used to clean floors were colour-coded in line with national standards. However, all 3 mop heads were stored in dirty water. The mop heads were visibly dirty and emitted a strong odour. Staff did not keep documentation of how often mop heads were changed.

During our inspection staff correctly used personal protective equipment (PPE) although frequently moved between different areas of the clinic without changing gloves or washing their hands. There were no dedicated handwashing sinks in clinical areas or the kitchen.

There was no tracking or auditing system to show when equipment had last been cleaned.

Surgery

Staff told us there had never been a surgical site infection. However, there was a fundamental lack of understanding of effective IPC practice in the provider and the leadership team had not identified significant risks. There was therefore a lack of assurance that systems were in place to identify, document, and act on surgical site infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

The design of the environment did not follow national guidance and was not compliant with Department of Health and Social Care (DHSC) standards. The service had no dedicated hand washing sink for clinical staff and instead sinks were also used to clean equipment. Sinks were in a poor state of repair, such as 1 sink was partially sunk into the wooden bench, exposing an area in which bacteria could build up and present an infection control risk. None of the clinical sinks were compliant with DHSC standards because they had overflow outlets, which presents a risk of bacterial growth.

Procedures for the decontamination of surgical instruments did not meet the requirements of DHSC health technical memorandum (HTM) 01-01. There was no defined 'dirty to clean' flow or use of a deep soaking sink, which is standard safe practice for the decontamination of reusable instruments. Staff used a sink and two wash bowls to clean and rinse reusable equipment. Rinsing contaminated equipment under a running tap risks splashing harmful bacteria onto the hands or clothing.

Staff told us they changed the disinfectant solution in the wash bowls every 2 days although there was no documented evidence of this. A washbowl in use was visibly dirty. Staff said when they changed the water for disinfection they tipped the dirty water down the sink, which was also used for handwashing. We discussed this with the interim lead surgeon, who had very little knowledge of the cross-contamination risks this presented.

Staff had wrapped micropore tape around surgical instruments to denote which surgical room they belonged to. They kept the tape, which was frayed and dirty, in situ during cleaning. This presented a significant IPC risk, which the team had not recognised. Staff used an autoclave machine, which kills bacteria and viruses using high temperature steam pressure, to decontaminate equipment. However, the machine was dirty, had not been calibrated in line with manufacturer guidance, and was not used correctly. For example, staff placed surgical equipment in the machine that were contaminated with micropore tape and did not separate individual items, which is an important decontamination principle. They kept sterilisation logs of equipment, which was good practice, but this did not provide assurance of safety because the process used did not result in effective sterilisation.

Fabric chairs were in use in the clinic and were stained and dirty. The provider had no record of steam cleaning. Although periodic deep cleaning took place, staff did not have assurance this included fabric chairs. Fabric chairs in clinical environments are against best practice because they present a risk of bacterial growth and cross-infection.

Fire safety standards were poor and presented a risk to patients and staff. The service had not acted on urgent fire safety improvements documented in an action plan from a fire risk assessment in 2022. The assessment had expired, and improvements had either not been made or were inconsistently implemented. For example, the action plan required the provider to install emergency lighting in the clinic. While a single emergency light was in place, staff documented repeated testing failures and had not taken action to resolve this. The registered manager did not know who was responsible for testing the light and there was no risk mitigation in place.

Surgery

During our inspection 3 battery powered smoke alarms were emitting audible alerts, which meant the batteries needed changing. Staff ignored the sounds and 2 members of staff we asked did not understand the meaning of the noises. None of the staff we spoke with had an acceptable understanding of fire safety procedures. The interim lead surgeon told us it was “not his responsibility” to understand fire safety. The registered manager did not know there was no fire alarm system installed and instead showed us the security alarm when we asked to see the fire control panel.

Fire safety checks were inconsistent. There was no ownership of such practices amongst the team and documentation showed occasional, insufficient checks of equipment and premises. For example, fire extinguishers were the wrong type for the premises and annual planned servicing was overdue. The only exit from the premises was kept locked and while this was marked as a fire exit, there was no quick release mechanism or signage to guide people how to use the lock if they were unfamiliar with it.

Audits and documentation demonstrated inconsistent practice. For example, the policy directed staff to carry out checks of smoke detectors monthly. The last documented check had been 4 months previous. The last monthly emergency lighting check had taken place 8 months previously (or before the inspection date) and we noted the system had failed the check, with no follow up.

The fire safety policy was not fit for purpose. It did not apply to the premises, referred to areas of the building that did not exist, and had clearly been taken from another service. The registered manager was unaware of this. After our inspection we took action to suspend the service to keep people safe. In order to begin offering care to patients, we told the service it must improve fire safety.

Staff did not consistently manage health and safety risks and there were several unmitigated hazards in the clinic that reflected exceptionally poor levels of fire prevention practices. This included boxes and equipment stacked high and on top of each other, an electrical heater used in close proximity to clothing and boxes, and multiple trip hazards. Staff routinely used trailing extension cords for electrical equipment in clinical areas. In addition to a trip hazard, the extensions were not surge protected and the last fire safety inspection required the service to remove these immediately. Power sockets were fitted adjacent to sinks in 3 rooms. In 1 room, staff used a 3-way extension plug in a wall socket next to the sink and trailed electrical cables over the sink and next to the taps. We spoke with the team about this but found no awareness of the risks of electrocution or fire.

The service was not compliant with the Control of Substances Hazardous to Health (COSHH) Regulations. While staff stored some chemicals in a locked cupboard, bleach was stored in an unlocked cupboard in the toilet and was accessible to patients. We spoke with staff on the day of the inspection and were not assured the team had sufficient training to understand the risks. For example, the chemical product was still in situ when we left the building. The service had a labelled, locked COSHH storage unit but there was missing information about the contents. For example, an unlabelled spray bottle was kept in the unit. It was full of a clear liquid, but staff could not tell us about the contents. This meant patients and staff were at risk of harm from the potential unsafe use of a chemical.

The clinic had some equipment to manage medical emergencies including an automatic external defibrillator (AED), oxygen, and resuscitation medicines. There was signage in place for the location of the AED and oxygen, which was good practice. However, the location of first aid kits was inaccurate. There were 3 cupboards in the clinic labelled as such, but none contained a first aid kit. We asked a member of staff for the location of this, and they did not know. The service did not keep an anaphylaxis kit. All staff had basic life support training and doctors held immediate life support training, which was appropriate for the nature of the service.

Surgery

The service was not compliant with DHSC HTM 04-01 in relation to water safety. For example, the registered manager arranged an annual Legionella check of the water system. However, the most recent check indicated the external testing company were unaware there was a low use outlet in the office. Low use outlets need to be flushed more frequently because they present an increased risk of bacterial growth. The service had not identified this risk. While a Legionella policy was in place, it referenced a GP practice in London and did not apply to this clinic.

The registered manager said the team carried out regular water flushing of all outlets. However, documented evidence was inconsistent, with only 6 'monthly' checks taking place in the previous 12 months. In each case staff noted the checks had included all taps but there were no variances in temperature for any outlet, indicating a need for a more accurate and thorough audit tool.

Staff disposed of clinical waste safely. The provider used hazardous waste disposal practices that were fully compliant with the DHSC HTM 07-1 Safe Management and Disposal of Healthcare Waste 2013.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The nature of the service meant this was a rare occurrence. Where patients had felt unwell during a treatment, staff had acted quickly to keep them safe. For example, when a patient felt dizzy after a treatment, staff monitored their blood pressure, elevated their legs, and increased ventilation to the room. Staff worked to a clear threshold of the conditions they could manage, and at which stage they would contact 999 for emergency help.

Staff provided patients with detailed post-treatment instructions, including contact details for a duty doctor in the event of pain or unexpected side effects. They discussed with patients what to expect and when to seek urgent help, such as if they had symptoms of an infection.

Staff completed risk assessments for each patient at the pre-treatment stage. This included a check of existing medical conditions that might impact treatment, such as high blood pressure, diabetes, or a mental health condition. Staff required approval for the procedure from the patient's GP if they had pre-existing conditions of concern.

Staffing

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

The clinical team comprised of 3 doctors and 7 technicians, including the dual role registered manager. Doctors were registered with the General Medical Council (GMC) and at the time of our inspection 2 were active in the service.

Doctors did not have named mentors and the provider did not have a system in place to assess standards of clinical practice other than patient feedback.

The service did not have a minimum staffing level and instead scheduled the team based on planned procedures.

The provider was compliant with recruitment legislation. The senior team obtained 2 references for each new member staff and ensured each individual had an appropriate Disclosure Barring Service (DBS) check. All 5 staff files we checked during our inspection included the required evidence.

Surgery

Records

Staff kept variable records of patients' care and treatment.

Patient notes included completed health questionnaires and details of ongoing issues, such as high blood pressure. While staff documented each patient's name, date of birth, and confirmation of identification check in each record, the service did not use individual identifiers. This meant the service did not have a reliable and risk-free method of identifying specific patients. After our inspection the provider told us the system was equipped to assign an individual ID to each patient.

Staff completed paper notes and then transcribed or scanned them into the electronic records system. While standards of completion were mostly consistent amongst the sample we looked at, there was no system in place to audit standards of completion. In 1 record we reviewed staff had not documented contact details or the patient's date of birth. Although staff had documented the procedure undertaken and a signed consent form was attached to the record, there was no assurance treatment had been planned or a cooling off period followed. We raised this as a concern with the registered manager who later found the patient's details written on a scrap of paper in the office.

There was 1 computer with access to patient records in the clinic. Records were stored securely by the system, but the provider had unclear access to policies. During our inspection the registered manager could not access the secure system and needed to use a colleague's credentials to gain access. After our inspection the provider confirmed the manager had their own log in and access.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. They completed medicines records accurately and kept them up to date.

Staff documented prescribed medicines in each patient's treatment record. In all 12 examples we looked at, this included batch numbers, dosage, and expiration dates. This reflected good practice.

Staff followed National Institute for Health and Care Excellence (NICE) guidance on antibiotic prophylaxis for hair transplant treatment. However, they did not audit practice to provide assurance of good standards.

Incidents

The service had vague systems in place to manage patient safety incidents. There had been no documented clinical incidents or near misses since the service began regulated activities. There was no structured process to ensure patient safety alerts were implemented and monitored.

Staff said they would report incidents to the registered manager. However, there was no evidence this was an assured process, and the provider did not have an incident monitoring system in place. There had been 1 entry in a health and safety accident logbook when a member of staff had fallen from a surgical stool.

The incident management policy had expired and was not specific to this service.

Staff had limited understanding of the duty of candour and said they would defer to the registered manager in the event of an issue. Not all staff completed duty of candour training and amongst the clinical team only 2 doctors, 1 of whom was out of the service for several months, had completed training. The provider did not have an up-to-date policy and there was no assurance the team was equipped to appropriately manage such incidents.

Surgery

The provider did not have a formal policy to monitor national patient safety alerts. The registered manager said doctors monitored updates themselves and the senior team received updates from the Medicines and Healthcare products Regulatory Agency. There was no record of regular checking.

Is the service effective?

Inadequate 

We have not previously inspected this service. We rated it as inadequate.

Evidence-based care and treatment

The service had no structured or formal auditing system to establish or provide assurance of evidence-based care and treatment. The provider required staff to follow national guidance but did not check this. Policies and standard operating procedures were not fit for purpose.

Staff had no knowledge of local policies and standard operating procedures (SOPs). They were unfamiliar with the content and instead they followed instructions from the provider regarding care. We asked the provider to send us evidence of the national guidance and best practice they expected staff to follow when delivering care. The senior team sent us details of prescribing and clinical standards from the National Institute for Health and Care Excellence (NICE) and UK Health Security Agency. However, the guidance was not specific to this type of service and the provider had no audits or other means of assurance that use of the guidance was effective. The provider told us they followed industry standards from the International Society of Hair Restoration Surgery although there were no audits or policies to establish formal links or monitoring.

Key policies and standard operating procedures had expired. This included the medical emergency policy and NICE guidelines to recognise and manage sepsis. There was no provider-level system in place to monitor policy updates. The provider had unclear access to policies.

There was limited understanding of the markers of evidence-based care, or strategies to achieve these, amongst the staff team. After our inspection the provider began recruitment for a patient liaison officer, who they said would establish benchmarking against other similar clinics to identify opportunities for learning and improvement.

Doctors completed a maximum of 2500 hair grafts per clinical session. This was an informal, nationally accepted standard kept by comparable services.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. All treatments took place using local anaesthetic and doctors administered dosage based on individual needs.

Staff used a pain management plan for each patient based on their medical history and current medication. This included guidance on how to manage post-treatment pain and the effective use of follow-up care. Staff included non-pharmacological pain management in recommendations, such as the use of ice packs and exercises to reduce inflammation.

Surgery

The service had acted on patient feedback to improve pain management. For example, patients who underwent platelet-rich plasma treatment said they felt some pain during administering of the treatment. As a result, the service introduced numbing cream, which staff applied prior to the treatment.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The service had no clinical audits and there was no system in place to monitor the effectiveness of care.

The service used patient feedback and 'before and after' treatment photographs as the only measure of evidence-based care and patient outcomes. Staff discussed consent for photography during the pre-treatment process and most patients agreed to this process to help measure the success of working towards their outcome expectations. While this reflected good practice in patient-centred care, the lack of a comparable measure of outcomes and treatment effectiveness at a clinical level meant the provider had limited assurance.

Patient feedback suggested outcomes met expectations. A recent patient noted, "Everyone has commented on how neat my hairline looks and it's not even grown yet." Another patient said, "[I'm] happy with the results and I am already getting on with my normal routine."

Competent staff

The service did not have a clinical education or competency system. There was no staff supervision process.

Staff were qualified but the provider had limited assurance they had the right skills and knowledge to meet the needs of patients. For example, technicians completed a trichology course that enabled them to extract hair in preparation for transplant by a doctor. However, there were no training opportunities for the team as a whole and the interim lead surgeon told us he did not know what sort of training technicians had. This meant there was no assurance surgical teams were appropriate and effective.

There was no documented evidence of inductions or a mentoring programme, no regular supervision, and no appraisals. The provider had no assurance of the continuing professional competencies of staff.

The registered manager led monthly team meetings, which provided staff with the opportunity to meet during protected time to discuss concerns and needs.

There were discrepancies around the supervision and appraisal of doctors. The registered manager told us each doctor underwent an appraisal as part of their GMC registration with an approved responsible officer. However, the senior member of staff responsible for monitoring this process was unfamiliar with it and there was no documented evidence appraisals had been checked.

While all staff held appropriate qualifications, there was limited assurance of consistent specialist training for cosmetic hair transplant surgery. For example, the provider did not have a standard requirement for technician training and the interim lead surgeon had no clinical area of specialty.

The service had no evidence of appraisals in the previous 12 months, although our inspection took place at the end of the first year of operation. The registered manager said they planned to complete appraisals in November 2023.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. There was inconsistent evidence of a standard 14-day cooling off period.

Staff clearly recorded consent in patients' records. The consent process included details of photographing and videoing treatment, including for the use of 'before and after' photos to help patients track the progress of treatment against their goals.

The pre-treatment health questionnaire included a check of mental health needs. Where patients disclosed a diagnosed condition or concern, the service required a letter of approval for treatment from the patient's GP or a mental health professional.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. However, evidence of the standard national 14-day cooling off period was inconsistent and not all patient records we looked at included this information.

Is the service caring?

Requires Improvement 

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

Compassionate care

Staff treated patients with compassion and kindness although there was a need for improved privacy and dignity.

Staff did not always ensure care and treatment was delivered with privacy and dignity. The room used for platelet-rich plasma (PRP) injections had a floor to ceiling window to the street. While the service had a roller blind in place, the treatment bed was still visible from outside. In addition, we saw staff did not always close doors to surgical rooms during treatment and treatment was visible to those passing by. Staff did not use privacy or 'do not enter' signs in clinical areas, which meant patients were not assured of privacy and dignity.

Patients said staff treated them well and with kindness and we observed this in practice during our inspection. A patient told us they felt safe and respected in the clinic and that they looked forward to their treatments.

Staff used personal mobile phones around the clinic, and it was not clear how they managed confidentiality and privacy risks associated with this. For example, a doctor left their personal mobile phone in a clinic room with a patient whilst they attended to other tasks.

CCTV was present throughout the clinic but there were no signs in place to explain its use or purpose to patients. A patient we spoke with said they noted a CCTV camera in the treatment room, but staff had not discussed this with them. This reflected a lack of standards in privacy and dignity.

Emotional support

Patients said staff provided emotional support to minimise their distress.

Surgery

All treatment was cosmetic and elective without diagnostics. This meant the need to provide emotional support was limited in scope. Feedback from patients was consistently positive. A recent patient noted, “[Staff] were all very professional and put my mind at rest before and during the procedure. Reminding me that any time I feel uncomfortable they would stop.” Another patient said, “I would like to thank everyone that worked on me on the day, they really did make me feel at ease.”

Understanding and involvement of patients and those close to them

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

Staff made sure patients understood how their care and treatment worked in practice. A patient during our inspection told us they felt staff had been transparent about their care options and managed their expectations. They said staff had spent time discussing costs and potential side effects and they felt happy with this.

There was evidence of inconsistencies in how the service involved patients in their care. For example, patient feedback repeatedly mentioned how happy individuals had been with staff communication whilst on site. However, most feedback also asked follow-up questions that followed a theme of insufficient information, such as questions about why shedding had not stopped or when they needed to schedule follow-up appointments. A recent patient noted, “Great experience at your clinic, the staff gave me 100% of their attention from the moment I got there.”

Is the service responsive?

We have not previously inspected this service. We rated it as inadequate.

Meeting people’s individual needs

The service had very limited scope to manage individual needs.

The treatment cycle was designed to provide patients with a calm and unhurried experience. Staff gave patients a break between each stage, such as between the initial incisions made in the scalp and then at stages during the implant process.

Staff recognised the importance of managing patients’ expectations and discussed these using photographs and potential outcomes before treatment commenced.

The clinic was accessible by those with reduced mobility and the provider had an equality and diversity policy in place. However, this was not fit for purpose. It referred to premises with a lift and mobility support rails in the bathroom, neither of which existed in this single-floor clinic.

The service had no provision for patients who could not communicate verbally or in English. Staff said they relied on friends or relatives who patients brought with them to interpret or translate. This presented a risk because the service did not have assurance the person providing interpretation had an accurate understanding of medical terminology, including to communicate the potential risks associated with treatment. Staff did not have access to resources or training to support good communication. However, members of the team spoke Hindi, Urdu, Punjabi, and Spanish and could support patients with these languages. After our inspection the provider told us they would arrange for a translator if clinical staff could not communicate with a patient although this contradicted what we were told on site.

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The service had no provision for patients living with learning disabilities, dementia, or any other type of mental health condition that could impact understanding and communication. The provider said they only accepted “healthy” patients for treatment, which reflected a fundamental lack of understanding of the abilities of people living with diverse conditions. There was no formal policy that guided treatment acceptance and staff made decisions on a case-by-case basis.

Access and flow

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

A separate organisation provided referrals to the clinic and carried out an initial check of suitability for treatment. The service also accepted self-referrals from patients. The service opened 6 days per week and provided patients with flexibility in treatment times, such as opening later on request so patients could attend after work.

Hair transplant patients committed to a minimum of 5 follow-up appointments over 12 months following the completion of treatment, 3 of which involved in-person reviews in the clinic.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received but we could not establish how the service investigated or resolved complaints. The service did not have a system for referring unresolved complaints for independent review.

The service clearly displayed information about how to raise a concern in patient areas. However, the complaints policy had expired, there was no named complaints lead, and there had been no documented clinical complaints. This meant the provider did not have assurance the complaints system was fit for purpose.

Staff had acted on the feedback of a patient who requested more choice of sandwiches and provided a greater range.

Is the service well-led?

Inadequate 

We have not previously inspected this service. We rated it as inadequate.

Leadership

Leaders could not evidence they had the skills and abilities to run the service. They did not understand and managed the priorities and issues the service faced. However, they were visible and approachable in the service for patients and staff.

The registered manager had joined the service 3 months prior to the inspection and had not received a formal handover from their predecessor. They were supported by the managing director who was based off site and staff said this individual visited regularly.

The leadership structure was informal, and the provider did not have a clear framework for responsibility. During our inspection we were unable to establish clear lines of accountability or roles and asked the provider to supply us with documented evidence of the structure. This did not exist and although the provider tried to prepare a visual leadership structure, this was inaccurate. This reflected an urgent need for improvements at provider level.

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The interim lead surgeon had unclear management responsibilities and the working relationship with the provider was poor. For example, the interim lead surgeon was disinterested and unclear on a number of areas of importance, including local fire rules and responsibility for infection control.

Vision and Strategy

The service had a tenuous vision for what it wanted to achieve. Leaders and staff had limited understanding of vision and strategy.

The provider told us the vision of the service was to “provide high quality, safe, professional services.” However, there was limited evidence this applied in practice or was supported by a strategy specific to the provider.

The clinic building was wrapped in advertising for another organisation under a marketing agreement. A crumpled A4 notice on the entrance door was the only indication this was the address of the provider. Notices inside the clinic referred to another organisation, which staff told us was a patient-facing administrative group that identified potential patients for treatment. There was no indication of a strategy specific to AIG Aesthetic Care.

After our inspection the provider told us they were developing a vision and strategy.

Culture

Staff felt respected, supported, and valued. However, there was not a coherent or identifiable culture that focused on patient care and staff development.

Staff told us they enjoyed working in the service and felt supported by the provider.

There was not a cohesive, team-oriented working approach in the clinic. The registered manager had little support from the interim lead surgeon, who had very limited knowledge of local procedures and policies. For example, when we asked the interim lead surgeon about the fire safety issues, he said, “That’s the manager’s job, not mine.” Similarly, when we asked him about concerns with chemical storage, he said, “I’m not a cleaner I don’t know.” This reflected a fundamental lack of training and basic safety knowledge and reflected a culture of working in silos with poor cross-team support and attitudes.

Governance

Leaders did not operate effective governance processes.

At the time of our inspection the provider had no structured governance system, framework, or plan. There were profound and significant gaps in governance that reflected a lack of competent leadership, provider oversight, and organisational integrity.

All policies and standard operating procedures (SOPs) in the clinic had expired in October 2022, 11 months before our inspection. Policies in place reflected a different clinical environment and had been copied from a GP practice. The staff named in policies did not work in this service and current staff were unable to identify them. This presented a significant safety risk because key guidance for staff had expired and was not fit for purpose. For example, the sepsis referral and management policy was based on national guidance but had not been updated for 11 months, which meant it did not reflect the latest understanding of this condition.

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The senior leadership team had not managed policies and SOPs effectively. The registered manager was aware policies had expired but said they had not had time to update them. They said they were unaware the policies did not reflect this clinic specifically. The provider had not given the registered manager support or resource to update the policies. The policies and SOPs had expired several months before the registered manager took up their post and the provider had not taken timely action before this to address the risk.

There was a lack of integrity in the provider. For example, fire safety documentation included inaccurate, false information relating to required improvements following a risk assessment. In addition, 1 doctor was working outside of the requirements of their GMC registration. We reported this to the GMC. Such discrepancies presented a significant unmet risk caused by inadequate governance, transparency, and honesty.

There were no audits in place other than occasional infection control audits and no comparable system through which the provider established quality assurance. After our inspection the provider introduced a rolling schedule that included 46 monthly or quarterly audits, which reflected a move towards improvement in standards.

Management of risk, issues, and performance

There were no systems to manage performance effectively. The leadership team had very little understanding of risks and issues.

There was a fundamental lack of knowledge of risk management across the whole team, which was exacerbated by a lack of oversight and leadership at provider level. The service had no overarching risk register or system to identify, escalate, and mitigate risks. For example, staff we spoke with, including the interim lead surgeon, were unconcerned by the unsanitary state of the kitchen. Staff did not monitor the temperature of the fridge used to store food for patients and staff routinely provided sandwiches for patients that were stored in a visibly dirty area.

Throughout the inspection we raised concerns about safety and risk with staff, including the registered manager and interim lead surgeon. There was very little understanding of these risks and nobody on the staff team had recognised the issues or escalated them.

The registered manager did not have access to staff training records during our inspection and did not have knowledge of the training their team completed. This reflected poor risk management because the provider did not have assurance staff had been trained in the areas in which we found serious cause for concern, such as infection prevention and control (IPC).

The provider's risk management system for the decontamination of instruments was not fit for purpose. Staff used an autoclave machine to sterilise reusable surgical instruments, which they believed was sufficient as an IPC process. However, instruments were packed too tightly together and covered in micropore tape, which meant sterilisation did not occur. The provider required staff to check the temperature of the steam produced by the autoclave machine during sterilisation and used the temperature documentation to evidence a safe process. However, as a single measure of the process this was insufficient to provide assurance of safe practice.

Risk management and clinical governance systems were not functioning effectively. For example, we found a number of concerns relating to water safety and the need for Legionella risk reduction during our inspection. The registered manager was unable to locate key documentation and we asked the provider to send us this afterwards. The most recent Legionella risk assessment had taken place in May 2022 leaving a gap significantly more than the recommended 12

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months between assessments. This risk was increased by the poor quality of the previous assessment, which misidentified responsible staff and highlighted 5 areas of information deficiency in the provider. This included a lack of competent and trained staff. The provider had not recognised the need to take action following the assessment and had not corrected documentation for accuracy.

Information Management

The service did not collect or analyse data to understand performance, make decisions and improvements. There were significant areas of concern in relation to data security.

The registered manager told us named staff were leads for data protection, confidentiality, and information security. However, policies were overdue for review by 11 months and there was no evidence of audit or recent work to establish assurance of good practice. Staff were unfamiliar with the named leads and further discussion identified the staff members no longer worked in the service.

Information management systems for the use of CCTV in clinical areas were inadequate and not compliant with the Data Protection Act. For example, the service had not completed a privacy impact assessment. The named data controller no longer worked for the organisation and the policy had expired 11 months previously. The registered manager did not know who was responsible for CCTV or how or when they accessed recordings.

An annual CCTV checklist was blank and there was no signage in situ to advise people that they may be recorded. Although the provider was registered with the Information Commissioner's Office (ICO), standards of practice were not in line with the ICO Code of Practice. The policy stated the service had installed CCTV due to an increase in violent attacks on staff in the reception area. However, the service did not have a staffed reception area and the policy did not reflect this specific environment. Staff said there had been no incidents of attacks or threats against them.

Engagement

Leaders and staff actively and openly engaged with patients.

Staff routinely engaged with patients after treatment and there was evidence all patients completed this process. Feedback indicated patients were consistently happy with this process and found the provider easy to reach by e-mail or phone.