

Medispa Cheshire Limited

Cheshire Hair Transplant Clinic Limited

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?

Insufficient evidence to rate



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Inadequate



Summary of findings

Overall summary

We rated the service inadequate because:

- The registered manager did not have good oversight of the safety and quality of the service.
- Some staff did not complete training in key skills including safeguarding.
- The service did not always control infection risk well.
- Staff did not always complete and update risk assessments for each patient, identify and remove risk.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- The service did not have clear processes to monitor the safety and effectiveness of the service and make improvements.
- The service did not always have up to date and accurate policies to govern the service and guide staff to deliver the service safely and did not ensure staff read them.
- The service did not operate robust recruitment processes for all staff and managers did not always check staff were competent for their roles.
- Staff did not always keep detailed, clear and up to date records and not all staff could access them.

However:

- The service planned care to meet the needs of patients. Patients had appointments at the time they wanted them, and they were able to get advice when they needed it.
- Staff provided emotional support to patients if they needed it.
- Staff treated patients with compassion and kindness.
- The design and layout of the service met relevant guidance.

Following this inspection, we served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The warning notice told the provider they were in breach of Regulations 12 and 17 and gave the provider a timescale to make improvements to achieve compliance. The principles we use when rating providers requires CQC to reflect enforcement action in our ratings. The warning notice identified concerns in the safe, effective and well-led domain. This means that the warning notice we served has limited the rating for safe, effective and well-led to inadequate.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	We rated this service Inadequate. See the overall summary above for details.

Summary of findings

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Summary of this inspection

Background to Cheshire Hair Transplant Clinic Limited

Cheshire Hair Transplant Clinic Limited is operated by Medispa Cheshire Limited. The provider operates multiple clinics offering a variety of cosmetic procedures. However, not all cosmetic procedures are regulated by CQC because some are outside the scope of CQC registration. As part of our inspection, the provider confirmed hair transplant surgery is the only regulated activity provided by Medispa Cheshire Limited and the surgery is only performed at Cheshire Hair Transplant Clinic. Therefore, the service is registered to provide surgical procedures and treatment of disease, disorder, or injury at this location.

The service uses the follicular unit excision (FUE) method of hair transplant surgery. In FUE, individual hair follicles are extracted and then implanted into small incisions made in the patient's scalp. The British Association of Hair Restoration Surgery (BAHRS) and British Association of Aesthetic Plastic Surgeons (BAAPS) consider hair transplant surgery to be a 'clean' surgical procedure used to treat male and female pattern hair loss.

The service registered with CQC when it began to deliver hair transplant surgery in June 2021. The service's registered manager is directly employed by the provider and worked at the clinic before taking on the role of registered manager for the regulated activity.

Four other staff are directly involved in the delivery of the hair transplant activity at the clinic on a self-employed basis. These included a nurse, hair transplant technician, and a doctor who performed the surgery. During our inspection staff told us the fourth member of staff fulfilled an administrative role, we saw in patient records, they were referred to as the hair transplant consultant.

The hair transplant service is delivered from an area of the clinic separate from the other, non-regulated, cosmetic procedures offered at the clinic.

We have not previously inspected the service.

How we carried out this inspection

We inspected the service using our comprehensive inspection methodology. We carried out an unannounced inspection on 10 May 2023. The inspection was overseen by Karen Knapton, Deputy Director of Operations.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

During our inspection we spoke with the registered manager and the 4 staff involved in the delivery of the hair transplant surgery either in person or by video conference. We spoke with 2 patients by telephone. We reviewed staff files, a sample of patient records and other documents related to the delivery of the service.

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>.

Summary of this inspection

Outstanding practice

We did not find any outstanding practice.

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 they have systems and processes in place to meet the requirements of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and any other relevant guidance to reduce the risk to patients from infection (Regulation 12(2)(h)).
- The service must ensure that medicines are prescribed, administered, recorded, and stored safely (Regulation 12(2)(g)).
- The service must ensure that staff complete training in key areas, including safeguarding, to a level appropriate for their role and that staff can correctly identify and report abuse (Regulation 12(2)(c)).
- The service must ensure staff assess, record, and mitigate the risks to patients (Regulation 12(1)(2)).
- The service must ensure that appropriate policies, systems and processes are in place to govern the service, support staff to do their roles safely and manage the risks to patients (Regulation 17(2)(a)(b)).
- The service must ensure staff keep complete and accurate patient records and store them safely (Regulation 17(1)(2)(c)).
- The service must ensure that robust recruitment processes are in place to ensure staff are 'fit and proper' to fulfil their role (Regulation 17(2)(d)).
- The service must ensure patients receive all the information they need, at the right time and from the right staff, to make informed decisions about their treatment (Regulation 11(1)).

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

- The service should ensure effective systems are in place to monitor the effectiveness of the service and drive improvements (Regulation 17(2)(a)).
- The service should ensure staff receive an induction, supervision, and appraisal to support them to perform their role and identify training needs (Regulation 18(2)(a)).
- The service should consider introducing processes to ensure the service is accessible to all patients, including those with protected characteristics.
- The service should consider subscribing to an independent complaints review body.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate

Surgery

Safe	Inadequate 
Effective	Inadequate 
Caring	Insufficient evidence to rate 
Responsive	Requires Improvement 
Well-led	Inadequate 

Is the service safe?

Inadequate 

Mandatory training

The service did not provide mandatory training in key skills to all staff and make sure everyone completed it.

The service did not have a mandatory training schedule aligned to the UK core skills for health framework. Some staff, including the doctor, had completed relevant mandatory training such as fire safety, infection prevention and control, resuscitation, and information governance. However, staff told us they completed these courses as part of their employment at other services or for their own development. Some staff had completed little or no mandatory training. These staff were not directly involved in the hair transplant procedure but were involved in the pre-assessment and aftercare of patients.

The hair transplant nurse took a lead role in collecting training certificates for staff and gave these to the registered manager. However, the provider could not evidence the registered manager had oversight of what mandatory training was needed for the different staff roles or how often the training should be completed.

The provider could not evidence staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff did not always receive training on how to recognise and report abuse.

The service did not have guidance about the level of safeguarding training required for each staff role. The registered manager and doctor completed adult safeguarding level 3. The hair transplant technician completed adult safeguarding level 2. The hair transplant nurse completed adult safeguarding level 1. The provider could not evidence the hair transplant consultant completed any adult safeguarding training.

The doctor and hair transplant technician completed children's safeguarding level 3, other staff did not complete children's safeguarding training. However, the service did not treat patients under 18 therefore the risk from this was low.

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The service had a safeguarding policy. However, some staff told us they didn't know if the service had a safeguarding policy. The registered manager acknowledged they could not be sure all staff had read the policy, or they had the knowledge required to recognise and report abuse. Staff told us they would tell the registered manager if they identified a safeguarding concern.

Cleanliness, infection control and hygiene

The service was visibly clean. However, the service did not always control infection risk well.

The provider had a contract in place with an external cleaning company to clean the whole premises 3 times per week. Staff stored cleaning materials in lockable cupboards in line with control of substances hazardous to health (COSHH) guidance. We inspected all the areas staff used to deliver hair transplant activity. All the areas appeared visibly clean and well-maintained.

However, we saw the hair transplant nurse kept a log of dates they cleaned the hair transplant areas, which they told us aligned to dates surgery took place. However, the log did not show specifically which areas were cleaned or if they were cleaned before and after the procedure.

The treatment room had an adequate supply of personal protective equipment (PPE). Staff told us they followed infection control principles including the use of PPE and hand hygiene. However, the registered manager told us they did not complete infection prevention control audits such as hand washing audits.

We saw a desktop steriliser in the hair transplant treatment room. For this type of service, desktop sterilisers are not compliant with the Department of Health Technical Memorandum 01-01: management of surgical instruments (medical devices). The guidance recommends desktop sterilisers should only be used as a last resort. If used, there 'should be measures in place to audit each use of the steriliser and identify which cycles are for the steriliser's routine validation and which are for surgical decontamination'. Staff told us they did not use the desktop steriliser as all the equipment they used for hair transplant surgery was single use. The service had packs of single use hair transplant instruments such as forceps, implanters, and blades. However, the packs did not include punches. In the follicular unit extraction (FUE) method of hair transplants, the doctor uses a punch to remove individual hair follicles from the donor area. Staff told us they used single use punches for all FUE transplants but that they did not have any in stock at the time we inspected.

The doctor and hair transplant technician completed infection prevention and control training (IPC). The provider could not evidence other staff completed IPC training however, they were not involved in the procedure itself therefore the risk from this was low.

During our inspection, the registered manager gave us a copy of the provider's IPC policy specific to cleaning. However, some staff did not know if the service had an IPC policy. The registered manager confirmed they did not know if hair transplant staff had read the policy.

Staff showed us two documents they gave to patients to take home. These included information about how patients should care for their hair in the 3 weeks following their hair transplant and when to take the antibiotics the service prescribed for them. However, the documents did not provide information about the symptoms of infection or what to do if they experienced them. Staff told us they discussed the risks and symptoms of infection with patients during their consultation. However, the records did not always evidence these discussions. Although there was information about the risk of infection on the consent form, the provider could not clearly evidence all patients received information about how to recognise possible infections and when to seek support.

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Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service delivered all hair transplant activity from the lower ground floor of the clinic. The area included a treatment room, consultation room, bathrooms, and an office space. The service had appropriate health, safety and fire risk assessments and checks in place. However, the registered manager acknowledged the stairs to the lower ground floor would make accessibility for patients with mobility issues difficult and staff would need to assess the risks to patients with mobility issues on an individual basis.

The design and layout of the clinic met the standards for hair transplant surgery published by the Cosmetic Practice Standards Authority (CPSA). This included an adjustable clinical couch and adequate lighting, ventilation, and work surfaces for the hair transplant technician to perform graft trimming and sorting.

The doctor performed most hair transplants manually using the follicular unit extraction (FUE) method. However, the clinic had a robotic hair transplant machine the doctor could use if they felt it was appropriate for a procedure. The doctor and hair transplant technician completed external training about how to use the machine. The training provider also serviced the machine.

The clinic kept records of portable appliance testing (PAT) for all electrical equipment.

Staff disposed of clinical waste safely. The treatment room had a sharps container and clinical waste bin. Staff stored used clinical and sharps waste in a locked area until the clinical waste contractor collected it.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient, identify and remove risk and act upon patients at risk of deterioration.

Staff told us the hair transplant nurse identified patients' risks through a health questionnaire they completed with patients during their initial consultation. The nurse told us they discussed the risks with patients and recorded them in their consultation notes. However, 2 of the 5 records we inspected did not include a health questionnaire and consultation notes showed limited evidence of complete or consistent risk assessments. There was a risk staff did not discuss patient risks such as allergies, blood-borne viruses, and existing medical conditions, including mental health, with all patients. The nurse told us they would discuss patients' risks with the doctor by telephone if they needed to check if a patient would be suitable for a procedure. However, the service could not provide evidence of the discussions and decision making. Furthermore, one patient told us their consultation was with the staff member whose role, staff told us, was administrative. The provider could not evidence this staff member had completed training relevant to healthcare or hair transplants and therefore had the right knowledge, skills or experience to identify patient risks.

The nurse was able to verbally describe how they would manage some risks and what medication, or conditions would exclude some patients from being able to have the procedures. However, the service did not have a documented set of exclusion criteria to inform patients what risks would prevent them from being able to access treatment. There was a risk this was not clear to patients. Staff told us the doctor met with patients immediately before their procedure and the procedure would not go ahead if the doctor had any concerns. However, the provider could not evidence the doctor was given all the information they needed to fully assess the patient's risk.

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Staff recorded patients' vital observations at the start of each procedure. However, the service did not have a process to record these again during or after the procedure. Staff were not able to explain why this was. During our inspection, the registered manager gave us a copy of the provider's escalation policy. However, some staff did not know if the service had an escalation policy. The registered manager confirmed they did not know if hair transplant staff had read it. Staff told us they would ring emergency services if any patient became unwell during a procedure. The doctor and hair transplant technician completed resuscitation training in the 2 years before our inspection which minimised the risk if a patient deteriorated.

The service had an emergency resuscitation trolley in the treatment room. There was a list of the recommended contents for the trolley staff printed from the internet. The contents of the trolley did not match the list; however, the contents met the cosmetic practice standards authority (CPSA) standards which recommend an EpiPen, oxygen and automated external defibrillator should be accessible. We found 1 ampoule of adrenaline in the trolley which expired in April 2023. Staff told us they checked the trolley on days they worked at the clinic, and they would have identified the expired adrenaline before the next procedure was due to take place. However, the service did not keep a record of the dates staff checked the trolley.

Staffing

The service had enough staff with the required qualifications. However, managers did not provide staff with an induction and did not always check staff had the knowledge, skills, and experience to fulfil their role.

Four staff were directly involved in the delivery of hair transplant surgery and worked at the clinic on a self-employed basis. These included a nurse, hair transplant technician, and a doctor who performed the surgery. During our inspection staff told us the fourth member of staff fulfilled an administrative role, we saw in patient records, they referred to them as a hair transplant consultant. The service's registered manager was employed by the provider and worked at the clinic before taking on the role of registered manager when the service began to deliver the regulated activity.

At the time of our inspection, there was no mandatory accredited training requirement for hair transplant surgery in the UK. However, a General Medical Council (GMC) licensed doctor must perform the surgical steps of the procedures. The doctor who performed hair transplant procedures at the clinic was GMC registered. The doctor was not on the voluntary register of hair transplant surgeons operated by the Joint Council for Cosmetic Practitioners (JCCP) however, this was not mandatory.

The hair transplant technician completed a suite of mandatory training through their employment at a similar service. They told us the doctor was present with them throughout any patient procedure and they had a good understanding of their role and responsibilities as the technician.

The hair transplant nurse and hair transplant consultant were not directly involved in the hair transplant procedure. However, we found they led patients' initial consultation and aftercare. The cosmetic practice standards authority (CPSA) standards state; staff fulfilling the role of a patient advisor must not make surgical recommendations including hair transplant surgery design, graft number estimations or donor harvesting method, however they can provide general information about hair loss, treatment options and hair transplant surgery. Following our inspection, we were not assured the hair transplant nurse and consultant's practice was in line with this guidance. The provider could not evidence these staff completed training relevant to healthcare or hair transplant surgery. However, the hair transplant nurse was registered with the Nursing and Midwifery Council and was a qualified non-medical prescriber (NMP) and there is no mandatory accredited training required for the role of patient advisor.

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The service provided us with a staff induction booklet. However, we inspected staff files and did not find completed induction booklets for hair transplant staff. Some staff told us they did not have an induction. During our inspection, the registered manager acknowledged they did not have good oversight of the skills, training and experience of all staff delivering the hair transplant activity.

Records

Staff did not always keep detailed, clear and up to date records and not all staff could access them.

Patient notes were not always comprehensive or complete. On the day of our inspection, staff told us hair transplant patient records recently moved to an electronic patient record system. Therefore, staff printed a sample of patients' records from the electronic system for us to inspect. We inspected 5 records. None of the records were comprehensive and clear. We saw 2 of the 5 records we inspected did not include a patient health questionnaire. One record did not include any notes of the patients' consultation. Staff recorded notes from the day of surgery handwritten on the corner of some pages, some notes were not clear and did not include details such as observation scores, medicines or plans for the procedure. Some records appeared to have incorrect dates on them. For example, one record included a prescription for medicine used during the procedure dated January 2022 however the procedure notes were dated December 2022. On the day of our inspection, the registered manager confirmed they were unable to find some of the information we said was missing from records.

The doctor and hair transplant technician told us they did not have access to the electronic patient record system. The doctor told us they gave paperwork they completed during procedures to other staff to store, however they were not sure how they stored them or what the process was for uploading them to the electronic record. Therefore, the provider was not able to evidence the service had a system to ensure staff always had access to the information they needed about patients or that staff stored all patient records securely.

Medicines

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

Staff did not always store medicines safely. As a qualified non-medical prescriber (NMP), the hair transplant nurse told us they prescribed and ordered medicines a few days before a patient's procedure. They told us they would then store medicine in either a locked cupboard or the medicines fridge, dependent on the manufacturer's recommended storage temperature. Staff recorded a minimum and maximum temperature viewed on a digital fridge thermometer in a notebook each day the hair transplant service was open. However, the temperatures they recorded often significantly exceeded the expected range of a medicine's fridge, 2 to 8 degrees centigrade. For example, staff sometimes recorded the maximum temperature as more than 18 degrees. Staff told us they were not sure if the fridge had been this temperature and therefore could not be sure they stored medicines in line with guidance.

We reviewed the provider's medicines management policy. The policy advised fridge temperatures should be between 2 and 8 degrees and provided information about what to do if the temperature was outside of this range. However, the registered manager told us they did not know if hair transplant staff read the policy. Following our inspection, the provider produced a fridge temperature log template for staff to use.

Staff did not always prescribe and record medicine safely. The hair transplant nurse prescribed and ordered medicine before patients' procedures. However, two of the records we inspected did not contain detail about the type and dose of

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anaesthetic the doctor administered during the procedures. Staff told us all patients received antibiotics on the day of their procedure and staff gave them a course of antibiotics to take home. However, one of the records we inspected did not show if the patient received antibiotics on the day or to take home. Two records did not contain detail on the type and dose of antibiotics staff gave to the patients.

The provider's medicines management policy stated prescribers should only prescribe medication for patients following a face-to-face consultation. However, one patient told us the hair transplant consultant led their consultation. Therefore, the provider was not able to evidence the prescriber saw all patients they prescribed medicine for.

The registered manager received patient safety alerts from the Central Alerting System (CAS). CAS alerts include important safety information from the Medicines and Healthcare products Regulatory Agency (MHRA). Services should use these to learn from safety incidents and improve practice. The registered manager told us they read all alerts they received however, prior to our inspection, they didn't receive any alerts relevant to the hair transplant element of the service.

The service did not prescribe, store, or administer controlled drugs.

Incidents

Staff did not always know how to raise concerns and report incidents and near misses in line with the service's policy.

The registered manager gave us a copy of the provider's incident management policy. The policy described the steps staff should take if there was an incident, accident or near miss or if staff felt there was a risk that may lead to an incident. The policy stated staff should report these through the providers electronic risk management system. However, some staff did not have access to the provider's electronic systems. They also told us they did not know if the provider had an incident management policy. Staff said they would report an incident to the registered manager or hair transplant nurse however, they told us there had not been any incidents in the time before our inspection. The registered manager told us, if there was an incident, they would report and investigate it in line with the provider's incident management policy and share learning with staff.

Is the service effective?

Inadequate 

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

Staff did not follow up to date policies to plan and deliver high quality care according to best practice and national guidance. The provider had some policies in place to govern service delivery, including non-regulated activities, at the clinic. However, some policies we reviewed were generic and did not include reference to the specific practices of the clinic or guidance staff should follow. For example, the provider's General Data Protection Regulation (GDPR) Policy gave general information about what GDPR is, however there was no information about how the service would manage patients' information or identify or report a data breach.

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All the policies we inspected had an issue date of January 2021 and reviewed date of January 2023. However, it was not clear if staff updated the policies during the review. None of the policies referred specifically to the regulated activity or relevant best practice guidance such as the Cosmetic Practice Standards Authority (CPSA) standards for hair restoration surgery. At the time of our inspection, staff, including the registered manager, told us they were not aware of the CPSA guidance. Some staff did not know if the provider had any policies and told us they had not read any.

The CPSA guidance includes consideration for the mental and emotional health of patients. Providers should use appropriate screening tools to identify patients who may require psychological or emotional support. However, the service's health questionnaire did not include a screening tool. One question asked patients if they experienced anxiety or depression. Staff told us they were mindful of patients' mental health and the need for them to manage any unrealistic expectations patients might have about surgery. They told us they would contact a patient's GP if they had concerns about a patients' mental health, however the service could not provide evidence of a time this happened. The doctor and hair transplant technician completed mental health awareness training online in February 2023. However, they told us they completed training as part of their employment at similar services.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Staff provided patients with refreshments if they wanted them. Staff were able to order food from local businesses and collect them ready for breaks in patients' surgery.

Pain relief

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

Staff told us they regularly asked patients if they were in pain during their procedure and that doctors would prescribe pain relief if it was safe to do so. However, they told us this was not common during procedures as the procedures took place under local anaesthetic. We reviewed the information staff gave patients to take home. The information did not include information about what patients should do if they experienced pain, however staff told us they gave patients a number they could ring if they experienced any problems.

Patient outcomes

The service did not monitor the effectiveness of care and treatment well.

The service did not have a clear process for collecting, collating, acting on and learning from patient outcomes. There are no mandatory national audits related specifically to hair transplant surgery. However, best practice guidance recommends services monitor complication and transection rates for procedures. Transection occurs when the hair follicles are cut or damaged during the procedure. The British Association of Hair Restoration Surgery (BAHRS) describe an acceptable transection rate as 10% with the gold standard being below 5%. The service did not monitor transection rate. The doctor told us they did not keep a log of how many procedures they completed through their work at the clinic, and they were not routinely involved in the aftercare of all patients. They told us the hair transplant nurse and consultant led on aftercare for patients and would involve them if they had any concerns. Staff did not know if the service collected data about infection rate or how often patients had experienced any complications during or after their procedure. However, the patients we spoke with said they were happy with the treatment they received.

The registered manager told us they intended to complete routine audits of the hair transplant service, such as record keeping or infection prevention control, however they said they did not complete these prior to our inspection.

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Competent staff

The service did not always make sure staff were competent for their roles, appraise their performance or meet with them to provide support and development.

The registered manager told us they did not have good oversight of what training staff completed or if staff completed training to suit the role they fulfilled within the clinic. On the day of our inspection, the registered manager did not know if any of the hair transplant staff were members of relevant professional bodies such as the British Association of Hair Restoration Surgery (BAHRS) or the International Society of Hair Restoration Surgery (ISHR).

The doctor and hair transplant technician completed additional training relevant to their role through their employment at a similar service. The doctor attended training and events related to hair transplant surgery in 2022 and 2023. However, they told us they completed this for their own development.

The provider could not evidence staff involved in the initial consultation and aftercare for patients had the right knowledge and skills to provide effective care and support to patients.

We reviewed the provider's training and development policy. The scope of the policy stated it applied to all staff, including contractors. However, the policy stated only staff directly employed by the provider could apply for funding to attend external training. The policy stated all staff should attend performance review and appraisal meetings with their line manager. However, it was not clear if this also applied to staff working on a self-employed basis. Staff told us they did not have meetings with the registered manager about their roles, performance, or development.

Multidisciplinary working

The provider could not evidence staff worked together to provide good care.

Hair transplant staff told us they did not have formal team meetings to discuss important parts of service delivery such as risk, patient outcomes or incidents. Following our inspection, the service produced a team meeting agenda template. However, the template did not specify what topics staff should discuss.

The doctor and hair technician told us they only attended the clinic on the days of procedures. It was not clear how much information they received about the patient or their procedure before the day. Staff told us they would seek advice from the doctor if they had any concern before they booked a patient's procedure. However, staff told us there was at least one occasion they needed to cancel a procedure on the day as the patient was not suitable. However, they could not remember the reason for this when we spoke with them. Some staff told us they relied on other team members to fulfil their roles well and communication needed to improve.

Staff told us they would speak to patients' GP if they had any concerns about their suitability for treatment or about their mental health. However, the provider was not able to evidence a time when this happened.

Seven-day services

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

Staff offered patients review appointments at 1, 3, 6, 9 and twelve months after their surgery. Staff told us they gave patients a phone number they could ring to contact hair transplant staff at any time if they had any concerns. Patients were also able to contact the clinic reception during opening hours. Patients we spoke with did not raise concerns about their ability to contact the clinic.

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Health promotion

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

The service provided patients with instructions about how to adapt their lifestyle and care for their scalp in the days after their procedure. This included general advice such as to avoid smoking or consuming alcohol whilst they were taking antibiotics.

Consent

The provider could not evidence staff obtained informed consent from patients in line with national guidance.

There was a risk patients did not receive all the information they needed, at the right time and from the right staff, to make informed decisions about their treatment.

The British Association of Aesthetic Plastic Surgeons (BAAPS) recommends cosmetic surgery services implement a two-week cooling off period to allow patients to reflect and consider their treatment options. On the day of our inspection, staff told us patients attended their consultation with the hair transplant nurse to discuss their treatment options. They told us they then encouraged patients to think about their decision and contact the service again if they wanted to book a procedure. Staff told us they were aware of the need to allow patients a cooling off period however, there was no formal process to ensure they did not book a patient's procedure for within two weeks of their consultation. Records we inspected suggested some procedures took place within two weeks of a patients' consultations. For example, one patient record showed the service prescribed and ordered the medicine for a patient's procedure 3 days after their consultation and their procedure took place 3 days later.

The service's consent form contained information about the possible risks of the hair transplant surgery. The British Association of Aesthetic Plastic Surgeons (BAAPS), the Royal College of Surgeons (RCS), Cosmetic Practice Standard Authority (CPSA) and the General Medical Council are clear that the doctor performing the surgery should discuss and obtain consent from patients. Staff told us patients signed their consent forms with the doctor on the day of their procedure. This meant, the provider could not evidence patients read and understood all the information from the consent form before the day of their procedure. Furthermore, it was not clear at what stage patients agreed the details of their hair transplant, such as the number of grafts required to achieve the outcomes they wanted. The Cosmetic Practice Standard Authority (CPSA) states the doctor should agree this with patients. However, patients did not meet with the doctor until the day of their transplant. There was a risk patients did not receive all they information they needed to make an informed decision before the day of their procedure.

The doctor told us they discussed and signed consent forms with all patients before their procedure. However, we saw a different member of staff had signed 3 consent forms we reviewed on the electronic patient record system.

We reviewed the service's consent to treatment and examination policy. The policy contained generic information about consent and mental capacity. However, the policy did not reference guidance specific to cosmetic procedures or practice at the clinic and did not include what the service's consent process was or guide staff on how to follow it.

Surgery

Is the service caring?

Insufficient evidence to rate 

On the day of our inspection, we asked the provider to contact between five and ten patients to gain their consent for us to speak with them about their experience of the service. We made multiple requests to follow this up with the provider after our inspection however, we only received accurate contact details for 3 patients. Of the 3 patients we contacted, only 2 responded. Therefore, we were not able to obtain feedback from a representative sample of patients to form a judgement for this domain.

Compassionate care

Staff treated patients with compassion and kindness.

Patients said staff treated them well and with kindness and staff took time to interact with them in a respectful and considerate way. One patient told us their experience was good and they would recommend the service to others.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us they understood the personal and social impact hair loss can have on patients and they took time to provide them with emotional support.

Staff gave patients and those close to them help and advice when they needed it. Patients told us the service responded quickly to any questions they asked.

Understanding and involvement of patients and those close to them

The 2 patients we spoke with did not refer to attending the service with their family, friends or carers.

Is the service responsive?

Requires Improvement 

Meeting people's individual needs

The service could not evidence they made reasonable adjustments to help patients access the service or that staff understood the personal, social, cultural and religious needs of patients.

The registered manager told us there was no formal arrangement in place to support patients with communication needs to access the services, such as a large print leaflets or a hearing loop. However, they told us they would try their best to accommodate any patients if they needed support and would explore options if a patient with communication needs made an enquiry about using the service. The service did not have a contract in place with a translation service, but the registered manager told us the clinic's reception staff would use online translation systems if they needed to.

Surgery

Two staff were not able to give an example of a time they needed to adjust care, or treatment based on the personal, social, cultural and religious needs of a patient and were not able to provide an example of what these might be.

The provider had an equality and diversity policy. The policy described the need to promote equality and inclusion, eliminate discrimination and provide reasonable adjustments to those who needed them. However, the policy did not include information about how staff could do this. The policy stated the need for staff to complete equality and diversity training, it was not clear if this included self-employed staff. One of the hair transplant staff completed equality and diversity training in the 12 months before our inspection.

Patients could choose food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it.

The doctor and hair technician were employed at other services, therefore the service arranged procedures around their availability. However, staff told us the demand for the service was low following the pandemic and they were able to offer patients appointments when they wanted them. Patients told us they were able to choose appointment times to suit them.

The service offered patients a structured programme of follow up appointments up to 12 months after their procedure. However, staff told us some patients were reluctant to attend follow up appointments later in their journey once they saw positive results. Staff told us they would phone patients who did not attend appointments and emailed them if they could not reach them by phone. However, the service did not have a formal process for contacting patients who did not attend appointments.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff. The service included patients in the investigation of their complaint. However, the service did not have a system for referring unresolved complaints for independent review.

Patients told us they received a feedback questionnaire from the clinic after their appointments. They told us they found it easy to contact staff if they needed to and they received responses in good time.

The provider had a complaints policy. The policy contained information about how patients could raise a complaint and how the service would respond to, manage and investigate them. However, the policy did not reference a system for the service to refer unresolved complaints for independent review. On the day of our inspection, the registered manager told us the provider did not subscribe to an independent review body.

Following our inspection, we received an updated complaints policy from the provider. The updated policy advised patients 'not wishing to follow the company complaints policy' they could contact the Independent Sector Complaints Adjudication Service (ISCAS). However, ISCAS only review complaints from patients if the provider subscribes to ISACS and where patients have been through the provider's complaints process and feel their complaint is unresolved. After we received the updated policy, we were unable to find the provider listed as a subscriber on the ISCAS website.

Surgery

The clinic received a complaint about the hair transplant service the day before our inspection. The registered manager passed the complainant's details to the hair transplant nurse to make initial contact with them. This was in line with the provider's policy. The registered manager told us they would investigate the complaint in line with the policy and they would share learning with staff. They told us the service had not received any complaints about the hair transplant service before.

Is the service well-led?

Inadequate 

Leadership

The provider was not able to evidence the service was managed well. Leaders did not demonstrate they had the skills or insight to effectively manage the service.

The Health and Social Care Act 2008 states that registered providers must have a registered manager to carry out the management of regulated activities. During our inspection, we found the registered manager did not have good oversight of the hair transplant activity at the clinic or the service's ability to adhere to the standards we inspect against. They told us they relied on the 4 self-employed hair transplant staff to run most of the hair transplant service and they acknowledged they were not aware of many of the issues we raised during our inspection.

The registered manager and hair transplant nurse told us they previously planned for the hair transplant nurse to take on the role of registered manager. However, they did not proceed with these plans as the hair transplant activity was a small part of the clinic's overall business and the hair transplant nurse could not commit to a role which would require them to be involved in overseeing activity impacting the whole clinic, such as cleaning, servicing and clinical waste contracts and governance.

When we spoke with the registered manager and hair transplant nurse, neither were aware of the standards and guidance for hair transplants produced by relevant professional bodies.

Vision and Strategy

The provider did not have a formal vision and strategy for the service.

The service did not have a documented vision and strategy for hair transplant surgery. However, the manager told us the provider had planned to add additional related procedures to the service, such as scalp micropigmentation. They also wanted to expand the marketing of the procedure to increase demand.

Culture

Staff felt respected and valued. They were focused on the needs of patients receiving care. However, staff did not feel part of a team.

Staff said they had a positive working relationship when they worked at the service together but that it was difficult to have a team culture as hair transplant procedures did not take place often. Staff told us there was sometimes a 2-month gap between procedures. The hair transplant staff were not part of the day to day running of the clinic and did not have team meetings. For this reason, one staff member we spoke to said they felt like an 'outsider'. All staff said they would feel comfortable to raise concerns to the registered manager if they had any.

Surgery

All staff said they were keen to ensure patients felt comfortable and confident with the service and achieve good results. Patients said they had a positive experience.

Governance

Leaders did not operate effective governance processes.

The service did not have a programme of clinical audits to monitor and improve the safety of hair transplant surgery. For example, the service did not perform infection prevention control or record keeping audits.

The provider had a suite of policies available for inspection. However, some of the policies we inspected did not include up to date guidance, relate specifically to the activity the clinic delivered or contain accurate guidance for staff to follow. For example, the service's adult safeguarding policy signposted staff to the local clinical commissioning group to make safeguarding referrals. However, staff should make safeguarding referrals to the local authority safeguarding team. Clinical commissioning groups no longer exist, integrated care boards replaced them in 2022. Furthermore, some staff did not know what policies the provider had and had not read them.

Management of risk, issues and performance

Leaders did not always manage risk and performance effectively. However, they had plans to cope with unexpected events.

The service did not monitor performance well. The service did not have clear systems in place to monitor and improve outcomes for patients. For example, the provider did not collate data about transection or infection rates. There was no formal process in place for the clinicians in the service to take part in peer review or to receive any feedback on their clinical performance.

The provider could not evidence they had robust recruitment processes in place to safeguard patients and ensure staff were competent to fulfil their role. On the day of our inspection, the service was not able to provide all the recruitment documentation for the hair transplant staff. Following our inspection, the service provided some further documentation. This included a staff matrix which indicated what documentation the service held for each staff member or what the staff members' status was. However, the information collected by the service was not standardised as they held different information for different staff members. For example, we saw the service only held references for one of the hair transplant staff.

Some information on the staff matrix was not accurate. For example, two members of staff were registered with the nursing and midwifery council (NMC). However, their registration expiry dates, shown on the provider's matrix, were different to the expiry dates on the NMC register.

Providers employing doctors under practising privileges arrangements should ensure they can provide evidence that those medical practitioners are complying with the General Medical Council (GMC) framework for appraisal and revalidation. The GMC annual appraisal should cover the whole scope of practice of the doctor. The provider had a practising privileges policy. The policy listed what evidence the provider required for their medical director to grant practising privileges. This included 2 references, a copy of the doctor's appraisal and a new enhanced Disclosure and Barring Service (DBS) certificate which should be renewed every 3 years. The provider was not able to evidence they checked these documents for the hair transplant doctor. The doctor's DBS certificate was over 3 years old. We requested a copy of the doctor's appraisal; however, the service did not provide it.

Surgery

The service had a business continuity plan in place. The plan outlined the procedures staff should follow in the event of unexpected events such as staffing shortages, IT failure or failure of electrical supply. The plan included relevant emergency contact numbers and contingency plans to support the continued provision of services. The service had relevant environmental plans and risk assessments, such as fire risk assessments and fire alarm testing.

Information Management

The provider could not evidence the service collected and analysed data or managed information well.

The provider was not able to evidence the service kept complete and accurate records and stored them securely.

The provider could not evidence they collected and analysed data to improve the service delivered to hair transplant patients.

The service did not have a full suite of up to date and effective policies or standard operating procedures to govern the delivery of hair transplant surgery and ensure compliance with legislation and best practice guidance.

Engagement

The service did not always engage with patients well and engagement with staff was limited.

The provider had a public website which provided information about the clinic and the services they offered. Patients could submit enquiries via the provider's website or by telephoning the clinic. The 2 patients we spoke with told us the service communicated with them well.

However, the provider told us they had 34 patients due to attend follow up appointments in the 12 months following our inspection. We made multiple attempts to obtain patient consent and contact details from the provider, but they were unable to fulfil this request. Therefore, we were unable to obtain feedback from patients about the service's level of engagement with them after their procedure. Staff told us some patients can be reluctant to attend follow up appointments once they begin to see positive results from their surgery.

The service did not have formal supervision and appraisal processes in place for hair transplant staff and they did not hold team meetings. Leaders held a meeting with some hair transplant staff in February 2023 to talk about how they could expand the service.

Learning and continuous improvement

During our inspection, the provider was unable to assure us that managers and staff were aware of the actions they needed to take to ensure the service met regulatory requirements. Following our inspection, managers told us they were committed to making improvements to ensure they delivered good follow up care to patients. In response to our initial inspection findings the service told us they did not plan to take on new patients for hair transplant surgery and would only provide an aftercare service for patients who had already undergone their procedure.