London Hair Transplant Clinic Ltd

London Hair Transplant Clinic

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

Summary of findings

Overall summary

This was our first inspection of the service. We rated it as inadequate because:

- The service was not able to evidence they had enough staff to care for patients and keep them safe. There was no clear plan to define which training was required for staff. Staff lacked training in protecting children from abuse and did not proactively manage safety well. The service did not control infection risk well. Staff inconsistently assessed risks to patients and there was no evidence they acted on identified risks. Staff kept poor care records. Medicines were not managed well and safety incidents were not all reported.
- Staff were not auditing the quality of care they provided. They did not have clear policies and protocols to guide them how to deliver care consistently and in line with national guidelines. Managers could not demonstrate how they knew staff were competent for their roles.
- The service took account of only some patients' individual needs and did not make it clear how to complain. Managers were unclear on their complaints policy and processes.
- Leaders were ineffective and did not make it easy for staff to be clear about their roles and responsibilities. Governance processes were ineffective and the service lacked accurate data to identify performance issues and make changes. Managers were not clear about the risks facing the service or how to manage them.

However:

- Staff were observed to wear personal protective equipment (PPE) and some of the environment was designed to meet national guidelines.
- Staff treated patients with compassion and kindness and respected their privacy and dignity while they were having treatment.
- Appointments were booked with patients when they wanted them.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	This was the first time we have inspected this service. We rated it as inadequate, see the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to London Hair Transplant Clinic

London Hair Transplant Clinic is a cosmetic surgery service run by London Hair Transplant Clinic Ltd. The service is an independent healthcare service and does not offer any NHS care. The service mostly carried out hair transplants, but in the 12 months before inspection had also begun to offer more invasive cosmetic surgery procedures including breast augmentation, rhinoplasty, liposuction and abdominoplasty. The service provided care to privately paying adults, but also offered rhinoplasties to young adults aged 16 and above.

The service had a registered manager, who was also the lead clinician. We had not previously inspected this service.

As a result of this inspection, we used our enforcement powers to serve an Urgent notice of decision to impose conditions to the provider, under Section 31 of the Health and Social Care Act 2008. We took this urgent action as we believe a person will or may be exposed to the risk of harm if we did not do so.

We also used our enforcement powers to serve a Warning Notice to the provider under section 29 of the Health and Social Care Act 2008. This was served for failing to comply with Regulation 17: Good Governance.

As a result of these enforcement notices, the provider must demonstrate to CQC, compliance with the concerns identified in the notice of decision and warning notice by set dates. A future inspection will be carried out to check compliance.

How we carried out this inspection

We used our unannounced comprehensive inspection methodology. 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 they improve the accuracy and completeness of patient records, including ensuring all entries are signed and dated so staff are clearly accountable for actions and decisions. (Regulation 17 (2,c)).
- The service must ensure they have a record of consent for all service users, and that these are stored safely. (Regulation 17 (2,c)).
- The service must ensure all employment records are easily accessible, complete and up to date. Regulation 17 (2,d)).
- The service must ensure they maintain accessible and complete training and competency records for all members of staff. Regulation 17 (2,d)).
- The service must ensure there are clearly defined minimum staffing levels for procedures and that these are met. (Regulation 12 (2, a)).

Summary of this inspection

- The service must improve their recording of the World Health Organisation safer surgery checklist, ensuring it is clear who completes it. (Regulation 17(2,c)).
- The service must implement measures of effectiveness for all clinical procedures carried out. (Regulation 17(2,a)).
- The service must ensure they are reporting all relevant information to all required national bodies. (Regulation 17(1)).
- The service must ensure they are managing and monitoring risks. (Regulation 17(2, a, b,)).
- The service must develop clinical policies or protocols for each patient pathway. (Regulation 17(2,a)).
- The service must ensure they have a clearly defined deteriorating patient policy to support staff to identify and care for deteriorating patients. (Regulation 12(2, a, b,)).
- The service must ensure they have a complete evacuation procedure that includes how to safely care for patients, or evacuate them, in an emergency. (Regulation 17(2, b)).
- The service must ensure they maintain patient confidentiality at all times, including online interactions. (Regulation 17(2, e)).
- The service must ensure decontamination equipment is serviced and staff are trained to use it safely. (Regulation 12(2, c, e)).
- The service must ensure all equipment and medical devices are serviced in line with manufacturer guidelines, and that records of servicing are up to date and accessible. (Regulation 12(2, e)).
- The service must improve their medicines management and ensure medicines are stored securely and can be accurately reconciled. (Regulation 12(2, g)).
- The service must ensure cleaning schedules are clear and that cleaning is effective and that appropriate cleaning products are used. (Regulation 12(2, e)).
- The service must ensure they make arrangements to make the service accessible to all, including ensuring there is access to translators. (Regulation 17(2, a)).
- The service must ensure they improve their management of incidents and share any learning with the wider team. (Regulation 17(2, a, b)).
- The service must ensure they can evidence they are regularly checking emergency equipment. (Regulation 12(2, e)).
- The service must ensure they dispose of clinical waste safely. (Regulation 12(2, e, h)).
- The service must review its complaints policy and ensure it is complying with it. (Regulation 17(2, e)).
- The service must define inclusion and exclusion criteria. (Regulation 17(2, b)).

Action the service SHOULD take to improve:

- The service should check that all staff are clear about circumstances in which patients can be cared for overnight.
- The service should consider strengthening their safeguarding policies and training.
- The service should monitor the clinical environment, so that it fully complies with national guidance.
- The service should document checks of patient call bells.
- The service should store medical gas cylinders safely, to reduce the risk of them falling and injuring somebody.
- The service should define inclusion and exclusion criteria.
- The service should check all staff are clear about all incidents that need reporting and maintain a complete list of all incidents that happen at the service.
- The service should check there are mechanisms in place to share learning or changes to practice following incidents with all staff.
- The service should check policies about consenting young adults are clear and direct all staff to the support available, if required.
- The service should check meeting minutes are detailed enough to reflect discussions.
- The service should review their document control systems and processes and check documents are saved with names that are reflective of their contents.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Surgery

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

Is the service safe?

Inadequate

This was the first time we inspected safe at this service. We rated it as inadequate.

Mandatory training

The service provided mandatory training in some key skills for some staff. However, they did not monitor training compliance for all staff and records about training completion were poorly managed.

Staff were not clear about what their training expectations were and we were told there was no document that set out the training requirements for different staff groups. Following the inspection, we were told there was a list of expected training embedded in the electronic training system, it was unclear how effective this was as staff were not aware of it. We were sent some training certificates for substantive members of the team, the dates on most of these certificates were after the inspection date. Therefore we were not assured members of staff had not been up to date with training at the time of the inspection.

We were told most staff worked in the NHS and completed their mandatory training in their roles there. The service asked NHS providers for proof of this training being completed. However, it was not clear how the service knew the training staff received in the NHS was applicable to their roles in this service. For example, manual handling training may have been with different equipment or information governance may have been using different technology. Therefore, it was not possible to know whether the training was wholly appropriate. Following the inspection, we requested training compliance records for all staff. However, we were only provided with the certificates of those who worked in substantive roles. There was no evidence the service was requesting up to date proof from those members of staff who worked in the NHS.

NHS training records were not saved in a consistent place. The service manager was not able to find staff training records. We were told training records were sent in by staff using email, but the certificates were not easily retrieved and there was no documentation identifying when training needed to be repeated, or to ensure it was in date.

Non-clinical staff, and staff who were not employed in the NHS were offered online training using a reputable training website. We were told this was monitored by the service manager; however, as there was no list of expected training to be completed, it was unclear what was being monitored.

Inadequate

Surgery

Safeguarding

Staff were not fully trained to protect all patients from abuse.

We were told the clinical lead was the safeguarding lead for the service. They told us they were trained to either level two or three for both adults and children. When we reviewed their training records, they were only trained to level two and their training for children had lapsed in June 2021. Therefore, there was no evidence they were trained to the level required to be safeguarding lead.

Training records we were sent for other members of staff showed they had completed level one safeguarding training for adults only, and that this training had been completed after the inspection dates. There was no record of child safeguarding training, even though the service was available for young people, under the age of 18 to use.

There was a safeguarding policy which detailed the types of abuse that were possible and who to report any concerns to, within the service. There was no plan for what staff were to do if the clinical lead was not available to report urgent concerns to. Staff were not wholly compliant with the policy. The policy required that staff completed safeguarding training and this was not done by most staff until after the inspection date.

Cleanliness, infection control and hygiene

The service was not able to evidence they controlled infection risk well. There were no systems to identify surgical site infections. Staff tried to use equipment and control measures to protect patients and themselves from infection however, procedures were unclear, staff were not trained to use decontamination equipment and equipment was not checked to ensure it was performing correctly. Equipment and the premises were not visibly clean.

The theatres were not all kept clean or tidy. The service had multiple theatres. One was used for hair transplants, another used for all other invasive surgical procedures and three were not in use by the service. The theatre used for invasive surgical procedures had multiple pieces of equipment and trolleys covered in dust, indicating they had not been cleaned recently. The surgical light, which sat over the patient during surgery for visibility, was also dusty and parts of it were covered in cling film which increased infection risk. The surgical couch covering was not fully intact and had been mended, this also increased the risk of infection.

The theatre used for invasive surgical procedures also had rubbish throughout. There were multiple used water bottles left on surfaces and on surgical devices. In one corner of the theatre, there was a pile of rubbish, which had not been disposed of.

Patient rooms appeared clean but there was no way to indicate if linen or equipment was clean or dirty. The service had two patient rooms and both appeared visibly clean. However, both beds were partially made and there was no indication of whether the linen on the beds was clean or dirty. In one en-suite bathroom there was a flannel hanging over the sink that appeared used.

Equipment was not labelled to indicate when it was last cleaned and there were no daily cleaning records. We only found one piece of equipment labelled with a date it was last cleaned. This label indicated the blood pressure machine was last cleaned in November 2022. There were no other mechanisms in place to identify when equipment or rooms had been cleaned.

Inadequate

Surgery

We were told there were no audits to confirm environmental cleanliness. However, following inspection, we were sent a tick list completed by an externally contracted cleaning company. We were told that the company completed the deep cleans of the theatres twice weekly, but the list of cleaning did not constitute a deep clean.

The service decontaminated their own surgical equipment when it was not single patient use. The equipment they used had not been validated by an authorised decontamination engineer, nor was it regularly serviced. The staff who used the equipment had not undertaken training in decontamination procedures. This meant patients were being exposed to a risk of cross contamination between surgeries. Following the inspection, we were sent a document showing the equipment had been validated, but no additional contracting for ongoing servicing or staff training.

Staff were not clear which urine bottles or bed pans were used and we were told waste was disposed of in a way which increased infection risk. For example, in one patient room, there was a plastic, reusable bedpan and urine bottle. We were told these should not be used, and only disposable urine bottles and bed pans were used. However, we did not find these in patient rooms. The patient rooms were on the first floor of the building and the sluice, where patient waste from bed pans were disposed of, was on the ground floor. We asked how waste was safely transferred to the sluice. We were told it was tipped into the en-suite toilets and then the empty urine bottle or bed pans were taken downstairs to the macerator. This method meant used bottles had to be carried in a lift or down a flight of stairs, that were shared with other organisations in the building. This posed a potential infection risk.

There were no identifiable systems for staff to monitor how well the service prevented infections. Surgical site infections were not proactively monitored.

Staff followed personal infection control principles including the use of personal protective equipment (PPE). We observed staff caring for a patient having a hair transplant. All staff delivering care were wearing appropriate PPE and were bare below the elbow.

Staff did not have access to the cleaning products they needed to effectively clean theatres.

The design of the sinks was not in line with guidance. Sinks in clinical areas had overflow pipes. The national guidance states these should not be used in clinical areas, as they can be an area for bacterial growth.

Environment and equipment

The design and maintenance of premises and equipment did not wholly keep people safe. Staff were not trained to use equipment. Staff did not manage clinical waste well.

The theatre used for invasive surgical procedures was mostly designed well to meet requirements. However, as noted above the clinical sinks did not meet the national guidance. The theatre was laminar flow, meaning air circulation was controlled.

The room hair transplants were carried out in met the requirements for a clean procedure.

There were two patient rooms and both had call bells. However, staff were unclear when the call bells were tested.

The theatre used for invasive surgical procedures had a lot of equipment in it. The clinical lead told us this was because they wanted to have a backup for everything in case a piece of equipment failed. However, the service did not have a

comprehensive equipment register and therefore could not tell us where all the equipment was, when it was last serviced or when it next needed servicing. The service did ensure all equipment that was plugged into the mains had portable electrical testing that was in date. Following inspection, we were sent a new equipment register that had been started. However, the register was incomplete, and detailed equipment that was overdue for a service.

Clinicians who worked at the service were able to bring their own equipment into theatres to use. We were told one machine in the theatre had arrived that morning. The clinical lead was not sure where it had come from, or when it had been tested. We were told the machine would not be used until it had been tested and staff were trained, but there was no note on the machine to stop people using it.

We identified two fire extinguishers that had not been serviced since 2018.

Not all medical gas cylinders were stored securely. Throughout the service, there were gas freestanding cylinders, without appropriate racking or trolleys. This posed a health and safety risk as they were heavy and could be knocked over.

There was an emergency resuscitation trolley in the theatre where invasive procedures were completed. However, this was on the first floor and it was unclear how this would be brought down to the ground floor if a patient were to deteriorate there. The trolley did not hold all the equipment required for resuscitation. Medicines were kept in a fridge in the theatre. The service did not keep evidence the trolley had been checked to ensure it held everything it needed for a resuscitation and that equipment was in date.

Staff did not dispose of clinical waste safely. We found inappropriate waste in sharps bins, empty medicines containers were put in them. Additionally, the sharps bins were not labelled and signed when they were put together.

Assessing and responding to patient risk

Staff were not consistently completing and updating risk assessments for each patient and therefore staff were not able to remove or minimise risks. Staff told us they knew how to identify and act upon patients at risk of deterioration, but there were no systems or processes to support consistent decisions. The service made sure patients knew who to contact to discuss complications or concerns.

Staff did not consistently complete thorough risk assessments for each patient prior to admitting them for surgery. We reviewed six paper patient records and four did not have their pre-assessment information complete. The clinical lead told us this information was stored in electronic records, but these were not available for all staff. When we reviewed electronic records there was no extra information included.

Staff did not always know about specific risk issues. When pre-assessment paperwork was completed, it did not indicate that all potential surgical risks had been considered. For example, there was no mention of venous thromboembolism (VTE) risk assessments. VTE risk assessments assess a patient's likelihood of developing a blood clot.

It was not clear who completed patient risk assessments or what level of risk could be safely accepted by the service. Of those patients who had risk assessments completed, there was no signature to confirm who had completed them or date to confirm when they had been completed. The service also had no defined inclusion or exclusion criteria to make it clear what risk factors could safely be cared for by the service, and what risks were not able to be safely managed. Following inspection, we were sent a generic document giving a standardised risk level that could be safely cared for, but there was no detail about any individual risk factors that may not be safely managed in the service. This was also not mentioned to us by members of staff or referenced in notes, so it was unclear whether staff knew about this document.

Inadequate

Surgery

During surgical procedures, staff used a nationally recognised tool to identify deteriorating patients. However, following surgical procedures, observations were taken at inconsistent times and there was no clarity about when staff were expected to escalate patients as there was no policy detailing expectations. This was because there was no national tool in that part of the patient record nor was there clear guidance for staff to follow.

Staff did not routinely record, complete, or arrange, psychological risk assessments for patients to assess their psychological safety to have cosmetic surgery. We were told surgeons were all experienced and so would not perform surgery on patients who had underlying mental health conditions. However, this assessment was not recorded in any patient records we reviewed.

The service completed invasive surgery and blood loss was a potential outcome. However, they did not have a supply of blood products on site, in case of emergency. Nor did they have a contract with a supplier to be able to quickly access blood products in an emergency.

Staff did not hand over information about patient care safely. We identified one patient record where a patient was unexpectedly cared for overnight. Most members of staff we spoke with were unaware a patient had been cared for overnight and did not know what the care arrangements were or would have been.

The service had an incomplete fire evacuation plan. The plan was missing pieces of information such as who led fire evacuations and the number of staff needed to safely complete an evacuation. There were comments throughout the plan highlighting other inaccuracies. Staff we spoke with were not clear about how to evacuate patients in the event of a fire.

Staffing

It was not possible to confirm that the service had enough staff with the right qualifications, skills, training and experience to care for patients.

The service used a flexible staffing model and only booked theatre staff when they were needed to support surgical cases. We were told staffing numbers were agreed based on the surgery booked and how complex it was. However, we were not told what these numbers were or how they were calculated.

Nurses, operating department practitioners and health care assistants did not sign into theatres or routinely sign patient notes. Therefore, it was not possible to work out staffing numbers for each procedure based on patient notes and there was no record of this elsewhere in the service.

Following the inspection, we asked the service to detail the proportion of bank and agency staff vs their substantively employed staff. They were not able to do this.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to care for patients.

The service had enough medical staff to care for patients during surgical procedures. Medical staff were employed using practising privileges and appointments were booked in line with surgeon and anaesthetist availability. Surgeons and anaesthetists were identifiable in patient records.

Inadequate

Surgery

One patient was kept overnight by the service, following surgery. The clinical lead for the service provided the care for this patient but it was unclear how this had been risk assessed to be safe to do, or what support the clinician had access to if the patient had deteriorated.

Records

Records of patients' care and treatment were not detailed or comprehensive. Records were not clear or easily available to all staff providing care but were stored securely. Staff were not able to record all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Patient notes were not comprehensive, and all staff could not access them easily. Patient notes were inconsistent and lacked detail. We were told that records were created on paper, were scanned into an electronic record and the paper copy was kept for five years. The lead clinician told us they allowed consultants to manage their notes in whatever way they preferred, and this was the cause of the inconsistency and that any detail missing was in the electronic record. We reviewed the electronic records, but they were no different to the paper records.

Access to electronic records was held only by the service manager. They had to send a code to authorise access for other members of staff. Although this improved security, it meant if they were not on site, staff were not able to access records immediately and had to request the code.

The service manager told us they were attempting to register with the BCIR, but that their password was not working and they had not yet been able to record any implants on the national register. We were told there was a record of all implants used and the corresponding patient details for when the service gained registration with the BCIR.

Medicines

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

There was a medicines management policy, but it contradicted itself at times and was not fully being complied with by all staff. The policy was not complete, there were comments in it that showed there was still information missing. For example, there was no information about how to dispose of out of date medicines and the list of medicines typically kept in stock did not match the number of medicines we observed while we were on site. There were multiple points throughout patient records that medicines could be prescribed. This meant it was difficult to identify what had been prescribed, by who and when. It also meant it was difficult to identify when medicines were given to patients. We were told patients were given medicines to go home with, following surgery. However, these were not always clearly prescribed in all the notes we reviewed.

Most medicines were not stored safely. We found medicines throughout the service in unlocked cupboards and drawers, including medicines to anesthetise or sedate patients. As medicines were kept in multiple places it was not possible to maintain good stock rotation to minimise wastage. Additionally, some medicines were removed from their boxes and were kept in plastic boxes, meaning it was difficult to identify batch numbers. However, the service did follow good practice for storing and recording their controlled drugs.

Medicines fridges were not routinely checked to ensure medicines were kept at safe temperatures.

On review of record we could not be assured that medicines supplied on discharge were in line with best practice.

Inadequate

Surgery

Following the inspection, we were sent a document demonstrating the service had tried to reconcile medicines and check what was on site. They found they had fewer medicines on site than expected, demonstrating inaccurate prescribing in patient records.

Staff told us they acted on safety alerts. However, it was unclear how they would thoroughly check all medicines as staff were not sure where they were all stored. This might mean some recalled medicines remained in circulation, posing a risk to patients.

Incidents

The service was not able to evidence it managed patient safety incidents well. Three incidents were reported in the 12 months before inspection and it was unclear how learning was shared.

We were told by the clinical lead that there were incident reporting systems and processes and they felt incidents were well managed. However, following the inspection, we requested the incident reporting policy, the number of incidents for the past 12 months and the reports or incidents reviewed. We were only provided with a blank incident reporting form, and three records of incidents and no policy to outline what constituted an incident. There was limited evidence that managers investigated incidents.

There was evidence that when things went wrong, they were not reported. For example, we were told about a patient who had become unwell following surgery, but this was not reported. Additionally, not all patient records were complete, and some had consent forms missing. We were told the managers were aware of this and surgeons were taking the forms away and had been asked for them to be returned. However, this had not been reported or investigated.

Managers did not share learning with all staff about incidents. We were told if an incident was identified, managers would discuss and identify improvements with the individual involved. However, staff were not able to describe learning from any incidents and managers did not identify any mechanisms to share learning any wider than those directly involved with the incident.

Managers told us they understood the duty of candour. They knew they needed to be open and transparent and give a full explanation if and when things went wrong.

Is the service effective?

Inadequate

This was the first time we inspected effective this service. We rated it as inadequate.

Evidence-based care and treatment

There were no formal protocols or patient pathways. Managers did not check to make sure staff worked in line with national guidelines or best practice. The service was not meeting all cosmetic surgery standards published by the Royal College of Surgeons.

There were no clinical policies to direct staff to plan and deliver high quality care according to best practice and national guidance. We were told by the clinical lead that the consultants who worked for the service were experts in their areas and they did not need to be told how to do their jobs.

Inadequate

Surgery

The clinical lead told us whenever they offered a new surgical option, they thoroughly discussed the patient pathway and decided whether they could manage this safely. However, there was no evidence of this. There were no meeting minutes and there were no policies or protocols outlining safety precautions or inclusion and exclusion criteria for each procedure.

The service was not meeting all the cosmetic surgery standards, published by the Royal College of Surgeons. For example, they did not have an audit programme to ensure patients were cared for safely and consistently and that outcomes were consistently good.

Nutrition and hydration

Patients fasting before surgery were not without food for long periods.

Patients were not kept waiting for long periods of time if they needed to fast before surgery. Surgical lists were booked to ensure patients were not kept waiting, therefore they only needed to fast for minimal amounts of time.

Patients who were undergoing hair transplants, which can take hours, were offered food and drink throughout the day. However, in the kitchen area used for patients, we found unwrapped and uncovered food on the side. This could pose a health risk to patients, as food was not kept safely.

Pain relief

Staff assessed patients to see if they were in pain, and gave pain relief, however, this was not completed at regular intervals and it was not clear how pain levels were assessed.

Staff assessed patients' pain at irregular intervals and did not use a recognised tool. It was unclear how staff decided which pain relief was to be prescribed for patients. Patient notes we reviewed indicated all patients were given high strength pain relief.

Patient outcomes

The service did not formally monitor patient outcomes.

The service did not formally monitor patient outcomes. We were told they felt they were doing a good job because they received lots of positive feedback, but this was not formally recorded or monitored.

The service did not routinely audit their clinical performance. They were not able to provide information or data about their surgical site infection rate, complication rate or readmission rate for all surgical options they offered.

Competent staff

There were no records to demonstrate that the service made sure clinical staff were competent for their roles. Managers could not evidence that they appraised staff's work performance and held supervision meetings with them to provide support and development.

The service was not able to provide evidence staff had been trained to use specialist surgical equipment and devices. We were told if a new piece of equipment was brought into the service, a training session would be organised. However, there was no log of who was trained to safely use which pieces of equipment.

Inadequate

Surgery

Managers told us new staff were given a full induction and a staff handbook, to support them into their new role, but were not able to provide evidence of this happening routinely. We were told clinical staff they employed were experienced and did not need detailed inductions. The induction checklist we were shown was not role specific and did not detail how clinical staff were orientated into their new role and trained to use specialist equipment. Following inspection, we requested the staff handbook be sent to us and the service did not provide this.

We were told by managers that poor clinician performance would be managed internally and if there were ongoing concerns, the respective clinician would be asked not to return. However, the manager was reluctant to say they would report their concerns to the clinician's NHS employer or the General Medical Council (GMC).

The service was unable to provide any evidence of recently completing appraisals for substantive staff. We were sent a "personnel log" which stated that staff had probation meetings, supervision meetings and appraisal meetings but these were not dated so it was not possible to know when staff had most recently had an appraisal, or how this was tracked.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team.

We observed staff working together from different professional backgrounds.

Seven-day services

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

The clinic's opening hours were 9AM to 6PM Monday to Saturday. There were facilities to care for a patient overnight, in the event of an emergency, however there were no formalised arrangements to arrange staffing for overnight care. The service provided patients with a telephone number to contact if they needed support or guidance outside of the clinic's opening hours. We were told this number was monitored by either a clinician or a patient co-ordinator. The service was not able to provide training records for the non-clinical patient co-ordinator to demonstrate that they were trained to assess patient's conditions over the telephone.

Health promotion

There was no health promotion throughout the service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff told us they supported patients to make informed decisions about their care and treatment, however this was not routinely recorded in patient records.

Staff did not always clearly record consent in the patients' records. Three of the six patient records we reviewed did not have consent fully completed and signed. We were told that some clinicians took their consent forms home with them. Managers were confident that consent would have been completed and they had asked those consultants to return the forms. It was therefore not possible to confirm whether all patients were correctly consented for their surgery.

Staff told us they followed good practice guidelines and patients had a 14-day cooling off period between agreeing to surgery and surgery happening, in case a patient changed their mind. However, it was not possible to confirm this was routinely happening, as patient notes were not signed and dated. Therefore, the service could not demonstrate, or check, there had been a gap between the consultation and the surgery.

Inadequate

Surgery

Staff told us they understood Gillick Competence and Fraser Guidelines and knew how to support children who wished to make decisions about their treatment. We were told the service had close links with a child psychologist and if they had any concerns, they could refer a young person to them for review. However, this was not mentioned in the consent policy, and it was unclear how applicable surgeons were made aware of this care provision.

Is the service caring?

Good

This was the first time we inspected caring at this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness and mostly respected their privacy and dignity while they were having treatment.

Staff were discreet and responsive when caring for patients on site. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients we spoke with were enthusiastic about the care they had received. We were told by a patient, that during the consultation, the service did not take a “pushy sales approach” but instead the surgeon took their time to explain the procedure and why it was right for them.

Emotional support

Staff provided emotional support to patients to ensure they were not distressed.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients undergoing hair transplants were in the theatre for a long time, under local anaesthetic and awake. Patients told us staff were supportive and constantly checked they felt fine throughout the day.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us clinicians took time to explain the procedure to them. In particular with hair transplants, we were told clinicians explained the process and likely success rates.

Patients could give feedback on the service and their treatment online. The majority of feedback online we reviewed was positive.

We were told patients were informed of the price of their course of treatment during the consultation and the surgeon doing the consultation would break down the cost for patients to make it clear. However, this discussion was not documented in any patient records we reviewed.

Inadequate

Surgery

Is the service responsive?

Requires Improvement

This was the first time we inspected responsive at this service. We rated it as requires improvement.

Meeting people's individual needs

The service was not wholly inclusive but took account of some patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was no system for referring patients for psychological assessment before starting surgery, if necessary.

The service had access to a hearing loop, for patients who suffered from hearing loss. They did not have access to an interpretation service for patients who did not speak English as a first language.

The clinical lead explained to us they had not made any further adjustments for patients with physical disabilities as they did not believe patients with physical disabilities would want to access their service.

The service did not have a system for referring patients for psychological assessment before offering cosmetic surgery if a consultant was concerned about their capacity to make the decision. The clinical lead told us all the surgeons were experienced in making these decisions and if there was a concern about a patient's capacity to make a decision, they would not perform the surgery.

Access and flow

People could access the service when they wanted to, and at a time convenient for them.

The service only offered elective cosmetic surgery and managers did not monitor waiting times as appointments were booked in line with patient and surgeon availability. We were told the clinic was popular for hair transplants and, at the time of inspection, they approximately had a two-month waiting list. We were told patients were told about any waiting lists in their consultations, however, this was not documented in any patient records we reviewed.

The service had a telephone number patients could call outside of clinical hours if they were concerned following surgery. The service did not monitor how quickly they responded to contacts from concerned patients.

We were told staff started planning each patient's discharge as early as possible, and that patients did not stay overnight. However, when we highlighted one patient's notes where a patient had been cared for overnight, we were told this did sometimes happen and was decided on an ad hoc basis. It was not clear from the patient's record when or why this decision had been made, whether it was risk assessed and whether it was pre-planned. Following inspection the lead clinician clarified the overnight stay was not planned, but was as a result of the patient's clinical needs.

Managers were not able to track and monitor the total number of cancelled appointments due to limitations in the booking system. If appointments were rebooked, they were no longer counted as a cancelled appointment. Following the inspection, we were sent data that showed the majority of appointments that were cancelled were patient-led cancellations. Reasons given were mostly that the patient had changed their mind or were sick. It was not possible to calculate exact numbers for those appointments that were cancelled by the service.

There was no policy to follow up on patients who did not attend for appointments, to ensure they were well.

Inadequate

Surgery

Learning from complaints and concerns

Patients said they knew how to give feedback and raise concerns about care received. However, complaints were not taken seriously or investigated thoroughly.

The service had a complaints policy; however, it was not aligned with information we were told on inspection by the service managers. The policy appeared to be new, and was not signed off for use, or dated.

Patients, relatives and carers said they would be happy to raise a concern, if they had one, and would raise it directly with their surgeon. However, the service did not display information about how to raise a concern or a complaint in patient areas or on their website.

Managers were dismissive about some complaints and told us that in the cosmetic industry "patients complain about everything". However, we were told when a complaint was genuine, they investigated it. Following inspection, we requested the number of complaints and examples of responses to complaints. We were provided with two complaints; the outcomes were short and there was no detail to make it clear how they had been reached and who had been involved in the investigation. We were not provided with any follow up letters or emails, to detail how patients were informed of the outcome of their complaint.

The service manager and clinical lead both told us the service was signed up to a service for escalation of complaints if they were not able to be managed internally. However, the service the managers told us about was not a complaints escalation service. The complaints policy quoted a different escalation service, Independent Sector Complaints Adjudication Service (ISCAS), that was a body that worked as an arbitration service. The service did not appear to be registered with ISCAS, as it was not possible to search for them on the ISCAS website. Therefore, managers were not clear where they needed to send a complaint if a patient disagreed with their response, or the complaint needed escalating.

Is the service well-led?

Inadequate

This was the first time we inspected well-led at this service. We rated it as inadequate.

Leadership

Leaders lacked the skills and insight to run the service. They did not identify or understand the issues the service faced. They were visible and approachable in the service for patients and staff.

The clinical lead was an experienced clinician and we were told they were a skilled surgeon. They were also the CQC registered manager. However, they were not aware of the concerns we identified at the service. When we pointed out the concerns to them, they did not recognise the significance of them.

The clinical lead told us they allowed their fellow surgeons to run their patient pathways as they wished, and that they felt it was "rude" to try and standardise their approach. They relied heavily on their surgeons' experience and did not recognise that the lack of leadership and standardisation was a risk and could conceal concerns with performance.

The service manager was employed at the service part time. They described their role as supporting with administration and IT and explained they were not clinical by background and did not try to influence the clinical care. They saw their role as supportive and not managerial.

Inadequate

Surgery

Throughout this inspection the clinical lead gave us conflicting messages. They regularly gave one response and then changed this when shown evidence or something that contradicted it. This demonstrated either a lack of understanding of their own service or an attempt to misdirect the inspection.

There was a lack of understanding from the service managers about regulatory requirements.

Both managers were regularly available for staff on site and staff told us they were approachable.

Vision and Strategy

The service had a vision for what it wanted to achieve but no formalised strategy to turn it into action.

The service had a vision statement that outlined what they wanted to achieve. However, there was no clear strategy to achieve this. There was a document called provider values, however, this contained an unsigned theatre room rent contract.

Culture

Staff felt respected, supported and valued. They told us they were focused on the needs of patients receiving care, however they did not identify or raise any of the concerns we identified on this inspection. The service did not have an open culture where all patients were able to raise concerns without fear.

There was no formal staff survey, but staff we spoke with told us they were happy to work for the clinic and felt they put patients first. However, the service employed a large proportion of professionally registered staff who had either not noticed the concerns in the service or had noticed them but not raised them.

The service did not have a wholly open culture when it came to patient complaints. They were dismissive of complaints and shared information about consultations and outcomes if a patient complained online. This meant patients may have been hesitant to complain to the service.

Finances impacted on the quality and safety of patient care. Throughout our inspection, the clinical lead referenced the cost of delivering care and how it was difficult to maintain a practice that was competitive with other, European practices. For example, when we raised concerns about the decontamination of equipment and explained why they were not meeting requirements, we were told the service was concerned about the cost of sending equipment off for decontamination, which is why they did it in house.

We were told by the clinical lead they did not give patients terms and conditions to manage their expectations. However, in one set of notes we reviewed, there were terms and conditions signed that were branded with the company logo, therefore, there were inconsistent processes with managing patient expectations.

Governance

Leaders operated ineffective governance processes, throughout the service and with partner organisations. There was a lack of clarity about roles and accountabilities and few opportunities to meet, discuss and learn from the performance of the service.

There was a lack of clarity throughout the service about responsibilities and accountabilities, recording of information and whether information could be accessed or not. Throughout the inspection process, we were given conflicting information from different members of staff and it was clear there were gaps in processes and knowledge.

Inadequate

Surgery

We were told a lot of information was only accessible by the service manager, who was on leave the first day we inspected the service. This meant there was no immediate access to patient records, policies and procedures or some data. We were told if the service manager was off, information would still be accessible, but there was no contingency planning for wider access to information, if the service manager was not accessible in an emergency.

We were told by the clinical lead that there was one regular monthly meeting where everything about the service was discussed. There were terms of reference for this meeting and a brief agenda, however, these were saved in a document called "pricing policy". We found the terms of reference were not being followed. They stated all staff members were required to attend the monthly meetings but there were routinely only three members of staff who attended. The clinical lead told us the team were invited to attend but it was not mandatory. Meeting minutes were very brief and did not detail any of the discussions that were had. There were no meetings to discuss patient pathways.

Processes for recording information were inconsistent and there were no clinical pathways or policies, this meant audits could not be accurately completed.

The service was unclear about their contractual arrangements with third party providers. For example, it was not clear who was responsible for which aspects of cleaning and whether it was being completed properly.

The clinical lead was unclear about their rental agreements with another service who used their space. We were told one theatre was rented by another healthcare provider, and that this provider was responsible for the care in there. We were also told that this space was used by a healthcare professional who worked under practising privileges. Following inspection, we were sent a "Theatre Room Rent" document, which was unsigned by the third party and did not define who was responsible for the care of patients in the rented room.

The service had poor document control. Following the inspection, we requested a number of documents and information from the service. Not all the information requested was provided. The information that was provided was often saved under the wrong document name. For example, the file called "staff feedback form" actually contained blank decontamination training records. Therefore, it was unclear how staff were able to locate any document or information they were looking for, as they were incorrectly named. Some of the documents we were sent had been written after the date of the inspection. The document creation dates were after the final inspection date; therefore, the information had not been available for staff at the time of the inspection.

Management of risk, issues and performance

Leaders were not using systems to manage performance effectively. They were not identifying or mitigating risks and there was no risk. There were no plans to cope with unexpected events.

The clinical lead told us the risk register was discussed at monthly meetings, however, when we asked to see the risk register, we were told it did not exist. Meeting minutes did not detail risk discussion and other members of staff who attended the monthly meetings did not know what a risk register was, or what it might contain. Following the inspection, we requested the risk register. We were sent a document called "risk register policy", which outlined what a risk register should contain and how it would work. The document was generic and did not identify any risks.

There was a performance management policy, which outlined how to manage a poorly performing member of the team. However, when we spoke with the clinical lead about this, they did not describe a process that aligned with the policy, and were reluctant to say they would refer a member of staff to their professional body. This meant any concerns

identified by the service may not be addressed and poor practice could continue elsewhere. The clinical lead was dismissive of the professional body's decisions. One of the consultants they had employed under practising privileges had conditions on their practice. The clinical lead said they would comply with them but felt they were unnecessary, and the clinician had been targeted.

The service did not have plans to manage unexpected events. For example, it was unclear how patients on the first floor would be evacuated in the event of an emergency. There were no plans to manage patients who required blood transfusion and there were no agreements with local NHS hospitals to take over care of deteriorating patients.

Information Management

Staff were not able to find the data they needed to make clinical judgements nor were they clear about what data the service collected. Data or notifications were not consistently submitted to external organisations as required. The information systems were secure.

We were told the only member of staff who had access to all the clinical information and data was the service manager. They were not available on the first day of our inspection. It was clear that other members of the team were not able to access data nor were they clear about what data was collected and how it was used. This meant it restricted members of the team to make changes to the service based on information.

The service was not submitting data consistently to all required external agencies. They were not signed up to the Private Healthcare Information Network (PHIN) and submitted no data or notifications to them, as mandated by the Competitions and Markets Authority (CMA). The service was also not submitting implant codes to the implant registry.

The service was signed up to the Information Commissioners Office (ICO) and we observed good information governance procedures being followed by staff, such as locking computers when not in use. As described above, the service limited the information staff could see, to protect patient privacy. However, this was followed to an extreme level and meant staff did not have access to relevant patient information immediately.

Engagement

There was limited engagement with patients, staff and local organisations to plan and manage services.

Managers were not able to describe any engagement with external care providers and there was limited engagement with staff and patients to influence the care delivered at the clinic. We were provided two examples of staff giving feedback on the service, but they were from different times of the year and did not follow the same format.

Learning, continuous improvement and innovation

There was no identifiable attempt to continuously improve the service.