Wimpole Aesthetic Centre

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Wimpole Aesthetics Centre Ltd is operated by Wimpole Aesthetics (Medical) Ltd . The service did not provide in-patient facilities and patients did not stay overnight at the location. Facilities include two theatres with one being used as a recovery room, clinic rooms, treatment rooms and waiting area.

The centre provides elective non-major cosmetic surgery for adults. The centre did not treat any patient under 18 years old. We inspected the service under our cosmetic surgery core service framework.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 25 September 2018, followed by an announced visit to the centre on 4 October 2018.

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.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Summary

We rated Wimpole Aesthetic Centre Ltd as Inadequate overall. We inspected the service in March 2017 and did not have the power to rate the service at that time. We found areas of regulatory breaches and had concerns including; lack of screening new admissions, lack of governance structures, lack of employment checks and more which can be found in the previous inspection report. Although the service had improved in a limited way since our last inspection, we found some new areas of concern and there were still areas where the service still did not meet legal requirements.

We found the following:

- The centre had started providing mandatory training to all staff as it did not previously, however it was not ensuring staff were completing their training.
- The centre did not manage infection risk well. They did not screen patients for micro-organisms before procedures and did not monitor surgical site infection rates.
- The centre did not have a detailed policy regarding a deteriorated patient and did not have access to evacuation equipment.
- Staff did not complete VTE risk assessments for patients recommended by NICE guidance.
- Staff kept records of patients' care and treatment, however they were of variable quality and not all aspects of the pathway were recorded.
- Staff recognised incidents and reported them appropriately, however there was no formalised system of reviewing incidents or sharing the learnings.
- The centre did not collect safety information and use this to improve the service.
- The centre did not fully provide care and treatment based on national guidance and evidence of its effectiveness.
- Staff did not record any assessments or observations for patients regarding pain.
- The centre did not monitor the effectiveness of care and treatment.
- The provider did not appraise staff's work performance or hold supervision meetings with them to provide support and monitor the effectiveness of the service.
- The centre was unable to evidence that it took account of people's individual needs.
- Managers did not always have the right skills and abilities to run a service providing high-quality sustainable care.
- The centre did not have a vision for what it wanted to achieve.
- The centre still lacked a robust governance system and risk management system.
- The centre had limited engagement with patients regarding improving the service.

Summary of findings

However;

- Staff had training on how to recognise and report abuse.
- Staff kept themselves, equipment and the premises clean.
- The centre had suitable premises and equipment and looked after them well.
- Patients received the right medication at the right dose at the right time.
- Staff of different kinds worked together as a team to benefit patients.
- Staff always had access to up-to-date and accurate information on patients' care and treatment.
- The centre planned and provided services in a way that met the general needs of its patients.
- People could access the service when they needed it
- The centre treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The centre promoted a positive culture that supported and valued staff.

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

We told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices. Details are at the end of the report.

Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Inadequate** 	Cosmetic surgery was the main activity of the service. We rated this service as inadequate overall because it was inadequate in safety and in well-led, required improvement in effective and for responsive and we did not rate caring due to insufficient evidence.

Summary of findings

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Inadequate

Wimpole Aesthetics Centre

Services we looked at

Surgery

Summary of this inspection

Background to Wimpole Aesthetic Centre

Wimpole Aesthetics Centre Ltd is operated by Wimpole Aesthetics (Medical) Ltd . The service opened in 2007. It is a private centre in London. The centre primarily serves patients seeking cosmetic procedures across the UK. It also accepts patient from abroad, however these patients were a very small portion of the overall demographic.

The centre has had a registered manager in post since 2010. The centre offered cosmetic procedures under the regulated activities which included ultrasound guided liposuction and mole removals, the service also offered cosmetic procedures outside the regulated activities such as dermal fillers, intravenous vitamin drips, laser procedures. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, CQC assistant inspector, and a specialist advisor with expertise in field of cosmetic surgery. The inspection team was overseen by Michelle Gibney, Inspection Manager and Nicola Wise, Head of Hospital Inspection.

Information about Wimpole Aesthetic Centre

The service did not have in-patient facilities and is registered to provide the following regulated activities:

- Surgical procedures.
- Treatment of disease, disorder or injury.

During the inspection, we visited all areas. We spoke with all staff including; registered nurses, reception staff, medical staff, and managers. We did not speak to any patients or observe any patient care in relation to the regulated activities as no patients were present at the time of the inspection. During our inspection, we reviewed 16 sets of patient records.

There were no special reviews or investigations of the centre ongoing by the CQC at any time during the 12 months before this inspection. The service had been inspected once before in March 2017, which found that the service was not meeting all standards of quality and safety it was inspected against.

Activity (July 2017 to June 2018)

- In the reporting period there were 33 cases related to the regulated activities with 18 being liposuction and 15 being mole removals.
- 100% of patients were self-funded.

The service had one medical doctor who was the lead clinician and registered manager, two anaesthetists under practising privileges, two full time registered nurses, as well as having its own bank staff.

Track record on safety:

- No never events
- Four clinical incidents (not related to the regulated activities)
- No serious injuries

The service did not screen patients for micro-organisms or monitor surgical site infection rates.

There were no complaints reported in relation with the regulated activities.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- The centre did not ensure everyone completed mandatory training. We found that six out of eight staff had not completed training.
- The centre did not manage infection risk well. They did not screen patients for micro-organisms before procedures and did not monitor surgical site infection rates.
- The centre did not have a detailed policy regarding a deteriorating patient and staff did not have access to evacuation equipment.
- Staff did not complete VTE risk assessments for patients recommended by NICE guidance.
- Staff did not keep clear and accurate records, the records we observed were of variable quality and not all aspects of the pathway were recorded.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The centre did not fully provide care and treatment based on national guidance and evidence of its effectiveness.
- Staff did not record any assessments or observations for patients regarding pain.
- The centre did not monitor the effectiveness of care and treatment.
- The centre did not appraise staff's work performance or hold supervision meetings with them to provide support and monitor the effectiveness of the service.

Are services caring?

Not sufficient evidence to rate

We did not rate caring due to insufficient evidence. We found the following areas of positive practice:

- The centre had begun to monitor patient satisfaction by implementing a feedback survey.
- Patients could be referred to a local counselling or hypnotherapy service.
- Staff we spoke with told us how they would care for a patient in a respectful and kind manner.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

Summary of this inspection

- The centre was unable to evidence that it took account of people's individual needs.
- The centre did not have a formal exclusion criteria and did not keep accurate records, therefore we could not be assured that the needs of patients with body image issues, emotional issues or psychological issues were being met.
- People could access the service when they needed it.
- The centre treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

Inadequate

We rated well-led as Inadequate because:

- Managers did not always have the right skills and abilities to run a service providing high-quality sustainable care.
- The centre did not have a vision for what it wanted to achieve.
- The centre still lacked a robust governance system and risk management system.
- The centre had limited engagement with patients or other external sources regarding improving the service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Requires improvement
Well-led	Inadequate

Are surgery services safe?

Inadequate

Mandatory training

- **The centre did not provide mandatory training in all key skills to staff and did not ensure everyone completed it.**
- The centre had introduced a rolling mandatory and statutory training programme for all its staff. We spoke with six out of the eight staff employed at the centre and they confirmed the introduction of training on a wide variety of subjects.
- Mandatory training subjects included; basic life support, safe administration of medicines, first aid awareness, fire safety, health and safety, safeguarding adults, infection control, hand hygiene training, needle stick injury training, manual handling, Control of Substances Hazardous to Health Regulations training. Non-essential training which was offered included; diversity training, challenging behaviour, confidentiality, risk assessment and appraisal training. Apart from basic life support the training was provided electronically.
- The centre was unable to provide a compliance figure for mandatory training, however from the data provided we observed that six out of eight staff had not completed or started their mandatory training modules, furthermore the data was incomplete.
- The centre had a policy for sepsis management; the policy outlined what sepsis was and how to identify a case however the policy did not state what staff should do if a sepsis case was identified. Medical staff we spoke with told us that the service was not equipped to handle such cases and it was always practice referring the patient to the local NHS emergency department. Staff were not provided with sepsis training and the lead clinician told us that they had attended conferences where sepsis was discussed, however the centre could not provide evidence to support this.

Safeguarding

- **Staff understood how to recognise patients suffering abuse. Staff had training regarding adults on how to recognise and report abuse, however they were not provided training regarding children or female genital mutilation (FGM).**
- The centre had improved since our previous inspection and was now providing safeguarding training to all staff. We saw evidence to show that all clinical and non-clinical staff at Wimpole Aesthetic Centre Ltd had completed safeguarding training which was equivalent to safeguarding adults level one and two.
- Staff were not provided with training regarding children in line with statutory requirements.
- Staff were not provided with training regarding FGM.
- Nursing, medical and administrative staff we spoke with could explain how they would identify possible safeguarding cases for both adults and children (children's safeguarding training was not provided). Staff were open and honest in saying that they had never experienced such a case before.
- We observed that appropriate safeguarding referral pathways were displayed in clinic and treatment rooms and staff could direct us to them.
- We checked staff employment files for all eight staff members and found all had valid recent criminal record checks.

Cleanliness, infection control and hygiene

Inadequate

Surgery

- **The centre did not control infection risk well. Staff did not screen new admissions for micro-organisms and did not monitor surgical site infections, however staff kept clinical areas clean.**
- The centre did not conduct any screening for MRSA, C-difficile or any other micro-organisms before conducting any invasive cosmetic procedures, this was not in line with NICE guidance and meant that patients were at risk of becoming infected.
- All clinical and non-clinical areas we observed were clean and tidy. We saw evidence that daily cleaning schedules were in use and the theatre and clinic rooms were deep cleaned monthly.
- Daily cleaning was conducted by the cleaning service provided by the building management where Wimpole Aesthetic Centre Ltd was based. This was provided to the centre as part of their rental agreement. Staff we spoke with confirmed that if there were any issues around cleaning that the building management could be contacted. We saw evidence that showed regular cleaning schedules were being maintained.
- Staff had access to personal protective equipment such as gloves and aprons. We did not observe staff use these as no patients attended during our inspection.
- We saw the use of green valid in-date 'I am clean' stickers on equipment and furniture.
- We observed that all staff adhered to the bare below the elbow guidance when in a clinical environment.
- The centre had hand hygiene best practice guidance displayed above wash basins, however the service did not monitor compliance. We did not observe staff washing their hands as no patients attended during our inspection.
- We found there to be adequate hand washing facilities and hand-gels available. We did not observe staff utilising these facilities as there were no surgical patients during our inspection.
- The centre was not managing and decontaminating reusable medical devices in line with national guidance such as the DH Health Technical Memorandum on decontamination. Reusable surgical devises were being processed via washer-disinfector cycle, the service lacked continuous improvement plans as part of a larger risk management plan.

Environment and equipment

- **The centre had suitable premises and equipment and looked after them well.**
- All clinical areas we observed were suitable for their use, however the main theatre room did have excess equipment stored in the room and the corridors to access the theatre were constricted due to lockers and cupboards.
- The service conducted monthly infection control environment audit for the theatre areas. This audit checked compliance against best practice guidelines in relation to sharp bins, waste bins, trip hazards and general environment checks. Results for the period between July 2018 to September 2018 showed that the centre was compliant
- The service conducted a legionella risk assessment on water supplies once a month. We saw evidence to show that appropriate water safety testing was conducted on a regular basis.
- We found that all relevant equipment had valid up to date electrical safety testing.
- The centre had the relevant emergency equipment for the use of patient resuscitation. A defibrillator was available in the theatre area. Equipment and medication for resuscitation were kept in boxes in a storage cupboard in the theatre, this did not meet the best practice guidelines which required the use of tamper proof storage. All equipment was regularly checked and recorded.
- All equipment we observed was compliant with the Medicines and Healthcare Products Regulatory Agency requirements.
- Arrangements were in place for the handling, storage and disposal of clinical and domestic waste. Sharps bins were noted to have been signed and dated when assembled and were disposed of immediately when full.
- We observed that there were working emergency call bells in every clinical area and toilet.

Assessing and responding to patient risk

- **Staff did not complete and updated risk assessments for each patient. They did not always keep clear records of assessments. Staff did not have a detailed policy for deteriorating patients and did not have access to evacuation equipment.**
- Six out of the eight staff had completed basic life support (BLS) training provided by the centre, one registered nurse had a BLS certificate dated 2015 and the one medical staff had a BLS certificate dated 2016. There was no staff that had completed valid

intermediate or advance life support training. The centre told us after the inspection that the lead clinician and lead nurse were in the process of booking intermediate life support training.

- Staff we spoke with told us the centre was not suitable to care for a deteriorating patient and that patients would be stabilised and transferred to a local NHS hospital via 999 ambulance service. The centre had the relevant equipment for resuscitation if required, but no staff were trained in intermediate or advance life support this was not in line with the centre's own policy. The centre's policy was not detailed and did not provide instruction to staff in how to manage a situation of patient deteriorating, cardiac arrest or other issue.
- The centre did not have access to a lift and was situated in the basement of the building with a narrow staircase leading to the entrance. The centre did not have access to any equipment in case they needed to evacuate a collapsed patient. We did not see any evidence that the centre had done any risk assessment or mitigations regarding this.
- Consultations for procedures were done face to face with the lead clinician assessing and examining the patient and explaining treatment options, risks and expected outcome. All patients were asked to complete a medical history and health questionnaire before consultations or procedures.
- We were told that the lead clinician would assess and discuss every patients psychiatric and emotional health to determine if patients had body image issues. This was done in line with professional guidance and patients that were living these conditions were declined treatment and offered referral to counselling or hypnotherapy services, however this process was not formalised or regularly recorded.
- The centre did not have a formalised admission or exclusion criteria or policy. Staff we spoke with told us that they would not accept patients with major medical issues such as cancer or mental health issues.
- All patients had preoperative blood tests in line with NICE guidance.
- Before a procedure involving conscious sedation the anaesthetists with practising privileges carried out their own pre-operative assessment on the patient checking suitability for intravenous sedation and general fitness for the procedure. We saw evidence in patient records that this had been carried out in cases where the anaesthetist was involved.
- The service used the World Health Organisation (WHO) surgical safety checklist. We reviewed 16 records and found that only 25% had fully completed checklists, the remaining records had partially completed checklists.
- We found that patients were not receiving VTE and bleeding risk assessments on admission as per NICE guidance.
- The centre had not implemented a pain scoring system, did not use the national early warning scores or any observation tool and did not have a formalised escalation policy. Patients were kept in another theatre / treatment room for recovery post procedure, however physiological observations were not recorded. Although staff told us they observed patients we could not be assured the centre was compliant with NICE guidelines.
- Patients were provided with daily ten-day follow-up sessions with the lead clinician post procedure, however staff told us that patients often did not attend for the full ten days. In cases where patients did not attend the lead clinician would contact the patient to check on them and request them to attend the remaining follow-ups, if this could not be achieved then they would remain in daily contact via telephone or email. All patients were provided with a mobile number for the lead clinician which they could call any day and at any time.
- The lead clinician conducted all invasive cosmetic procedures, we were told the lead clinician stayed up to date with safety practices by attending conferences and local training events, however the centre could not fully provide us with evidence to support this.
- Patients were provided the mobile number of the lead clinician post procedure and they were able to call the number any day any time.

Nursing and support staffing

- **The centre had enough nursing staff, with the right mix of qualification and skills, to provide the right care and treatment.**
- The centre employed two full time nurses and two nurses on bank shifts. We spoke to all staff and they all told us that this was sufficient for clinical activity the centre had.
- We were told by staff that the centre had a small team and turnover was low, therefore they did not monitor staffing figures and statistics.

- The centre had improved since the last inspection as we found all relevant staff files contained suitable employment checks, criminal record checks and all nurses had valid registration.

Medical staffing

- **The centre had enough medical staff to provide the right care and treatment.**
- The centre had one full time medical consultant, who was also the lead clinician and registered manager. The lead clinician would conduct all invasive cosmetic procedures. We checked the relevant staff file and found that it contained suitable evidence of revalidation, registration, criminal record checks, indemnity insurance and fitness to practice.
- The centre also employed two anaesthetists by granting them practising privileges. They were contacted for cases where patients required conscious sedation. We were provided the practising privileges files for the anaesthetists after the inspection and found them to contain suitable employment checks, registrations and references. However, we found that some training records, fitness to practice records and criminal record checks were not within a valid date as the centre's policy stated that practising privileges were renewed every two years.

Records

- **Staff did not keep clear, accurate or detailed records of patients' care and treatment.**
- The centre used paper records which were stored securely in a locked cabinet in a locked room. Staff told us that the centre was looking to purchase a patient management system which combined an appointments system and electronic record system.
- We looked at 16 records of patients under the regulated activities. We found that there were no records of the initial consultation, staff did not regularly record what information was given to patients post procedure and staff did not regularly complete the WHO checklist. However, we did also see that all notes had completed patient medical history questionnaires, pre-printed record of the procedure with specific details written, record of any time the patient did not attend follow-up sessions and all notes had consent forms signed by the patient only.
- The anaesthetist conducted their own pre-procedure assessment and held separate records for patients when they were involved in cases, a copy of these were present in all relevant notes.
- Patients were asked verbally and via a tick box on the medical history questionnaire if they would consent to sharing the details of their treatment with their GP's. Staff told us that the lead clinician would write a letter to the GP and share notes if needed, however most patients did not consent to this and consequently the centre did not share any information with their GP's.

Medicines

- **Patients received the right medication at the right dose at the right time.**
- The centre did not store controlled drugs at the location. During our inspection we only looked at medicines related to the regulated activities.
- The centre stored various medicines and supplements on the premises. The centre purchased all medicines from wholesale pharmacy suppliers based in the UK and Europe and did not use a service level agreement.
- We observed that medicines related to the regulated activities were stored appropriately in a locked locker in the theatre. None of the medicines related to the regulated activities needed to be stored in a fridge.
- Medicines given to patients were recorded in the patient records, we saw that allergies were clearly documented.
- The centre had an electronic centralised medicines inventory system designed to record and manage the stock. A full inventory was taken monthly. When we checked the system, we saw that some drugs were highlighted as expired, however upon checking those drugs they were found to be in date. Due to this we were not assured the centralised inventory used to manage the centre's stock had accurate information.
- The centre had a medicine management policy, however it did not reflect the centre's working practices. We found that the centre did not have a medicines incident log as per their policy and after speaking to staff we were not assured the centre recorded incidents regarding medicines.
- The centre did not have any microbiology protocols which outlined the safe and effective administration of anti-biotics.

Incidents

Inadequate

Surgery

- **The centre understood how to manage patient safety incidents, however there was no formalised or robust system to disseminate learnings from incidents to staff.**
- There had been no never events or serious incidents at Wimpole Aesthetic Centre Ltd in the 12 months prior to our inspection.
- The centre had improved since our previous inspection as they had implemented an incident reporting process and policy, however none of the incidents we saw evidence for were in relation to the regulated activities.
- Staff we spoke with understood how to report incidents and were aware of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients of certain 'notifiable safety incidents' and provide reasonable support, truthful information and a written apology to that person. There were no incidents during the reporting period that met the threshold for duty of candour.
- At the time of the inspection we found that there was no formalised or robust system to disseminate learnings from incidents to staff. Speaking to staff we were told that there were weekly staff meetings where incidents, themes and their associated learnings were discussed but that these had not occurred since May 2018.
- The centre did not monitor surgical site infection rates.

Safety Thermometer (or equivalent)

- **The centre did not have a quality dashboard and did not monitor key quality outcomes**. In the provider information request (PIR) we were told for the period of July 2017 to June 2018 there had been no unplanned returns to theatre post-operatively, nor were any patients transferred to alternative care following treatment.

Are surgery services effective?

Requires improvement

We rated effective as **requires improvement.**

Evidence-based care and treatment

- **The centre did not fully provide care and treatment based on national guidance and evidence of its effectiveness**.
- The service had policies and procedures available to staff. Staff we spoke with knew how to access these polices. We found that some polices referenced practices the centre was not undertaking such as the consent policy referencing consent of children.
- Staff we spoke with told us the lead clinician researched NICE guidelines on a regular basis and disseminated relevant information to staff via staff meetings or informal discussions, however there was no formalised system of ensuring compliance to NICE guidelines.
- The service did not follow the NICE guidance regarding; VTE assessments, anti-biotic stewardship, sepsis management, physiological assessments and strategy on improving the service.
- The service did not follow the Royal College of Surgeons Professional Standards of Cosmetic Surgery regarding; contributing to national programmes, monitoring patient outcomes, auditing and recording initial consultations.
- We saw evidence to show that the service complied with the NICE guidance on preoperative tests and surgical site infections, the service had written policies in line with this guidance.
- Patients were provided with written information including detailed dietary information post cosmetic procedure this was in conjunction with a ten-day daily follow-up. Patients were provided with one liposuction garment and given detailed instructions to the importance and use of the garment, patients were given the opportunity to order additional garments through the clinic.
- The centre followed best practice guidance regarding post-operative care and provided patients with a mobile phone number for the lead clinician which they could use any day any time.
- Staff we spoke with assured us that the centre followed the Royal College of Surgeons best practice guidance in relation to assessing a patients' psychiatric history and discussing issues around body image. We were told that this was routinely discussed in initial consultations with the lead clinicians and patients that had a history of psychiatric issues or body image issues were declined treatment, however these cases were not always documented in the patients notes and records were not kept for patients who were declined treatment.

Inadequate

Surgery

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs.**
- Patients that were suffering from nausea post procedure were given anti-emetic medication by the lead clinician which was stored in the centre.

Pain relief

- **Staff did not formerly assess and monitor patients pain in line with national guidance.**
- Patients were given pain medicines to take home with them post procedure. Patients were told during follow-up that they should call the lead clinician if they experienced increasing pain.
- The centre did not use formal pain assessment tools. This meant that staff could not be fully assured of the level of pain a patient was in.

Patient outcomes

- **The centre did not monitor the effectiveness of care and treatment.**
- In the period of July 2017 to June 2018 the provider reported a total of 18 ultrasound assisted liposuction cases. There were no return to theatres or readmissions during this time.
- We were told by the lead clinician that the centre did not collect or review patient outcome data.
- The centre did not participate in Private Healthcare Information Network this was not compliant with their legal requirements regulated by the Competition Markets Authority.
- The centre did not contribute to national data bases for quality patient reported outcome measures (QPROMS). QPROMS are by the Royal College of Surgeons and involve the patient completing a pre and post-operative satisfaction survey based on the outcome of the cosmetic surgery.
- Although the centre had improved since the last inspection as they had implemented some audits, such as; infection control, complaints and tracking progress against the CQC key lines of enquiry. They still did not participate in national audits, accreditation schemes or conduct local quality audits checking working practices against written policies.

Competent staff

- **The provider did not appraise staff's work performance or hold supervision meetings with them to provide support and monitor the effectiveness of the service.**
- The centre had improved since the last inspection as we checked all eight staff records and found that all nursing staff had valid NMC registration, all staff had valid criminal record checks, all staff had valid photo identification on file and all staff had references on file.
- The lead clinician, who was also the registered manager, was the only full-time consultant employed by the service. The lead clinician had valid GMC registration, valid fitness to practice certificate and criminal record checks. It was explained to us that to remain up to date the lead clinician attended lectures, local consultant meetings and training events for general practitioners held by a local independent hospital, however the centre was only able to provide limited evidence to support this.
- The centre reported to us in their provider information request (PIR) that they had granted practising privileges to one consultant. This was an anaesthetist who assisted in cases where patients were consciously sedated, however during our inspection the centre told us they had granted practising privileges to another anaesthetist for periods when the primary anaesthetist was unavailable.
- We were provided with evidence to show that the centre held staff records comparable to those of permanent staff for those with practising privileges, however we found that some training records, fitness to practice records and criminal record checks were not within a valid date as the centre's policy stated that practising privileges were renewed every two years. This was corroborated with staff we spoke with during the inspection who told us that consultant information and checks were taken when they initially joined but not checked on a regular interval.
- We found that there was no formalised system to check and ensure staff who were granted practising privileges continued to be skilled and competent in carrying out their duties.
- Nursing staff were not provided with sepsis training and the lead clinician also had not completed any training. We were told by staff that the lead clinician had attended conferences where sepsis management had been discussed, however the centre was unable to provide any evidence for this.

- It was explained to us that no staff member had received a formal appraisal to date this was due to the lack of appraisal training, however staff performance and training needs were discussed informally. The centre aimed to initiate a regular appraisal programme from November 2018.
- All staff we spoke with told us they were encouraged to undertake continuous professional development and that they felt comfortable asking the registered manager, also the lead clinician, regarding external training. The registered manager told us that staff were regularly taken to external training sessions regarding a wide variety of clinical topics, staff we spoke with corroborated this.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**
- The centre staff mix consisted of the lead clinician who was a medical doctor, nursing staff and administrative staff. We observed a good working relationship between all staff members. The lead clinician told us that there was a horizontal structure and everyone should feel equal, this opinion was supported by the other staff.
- The lead clinician showed a willingness to work with patients GPs, however the clinician would only share information regarding a procedure with patients consent and this was rarely provided.
- Staff we spoke with all understood their own personal responsibility regarding patient care and understood that the overall responsibility belonged with the lead clinician.
- There was no evidence of formalised multidisciplinary team meetings. Staff we spoke with told us that they had staff meetings, however upon investigation we found that formalised staff meetings were not regular or minute and the last meeting was conducted in May 2018

Seven-day services

- The centre was open Monday to Saturday with different operating times each day. The service was able to open on bank holidays if there was patient demand.

Health promotion

- **Patients had access to information regarding national health priorities such as healthy living, anti-smoking and various diseases and treatments.**
- The centre provided detailed dietary information post liposuction treatment. Patients were regularly reminded about the effects of an unhealthy lifestyle on their bodies and what this may mean for their health and the effects it may have on their cosmetic results.
- Patients that were identified to have psychiatric issues or body image issues were offered a referral to a local counselling service or hypnotherapy clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- **Staff did not fully understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.**
- The procedure for ensuring patients were able to make informed decisions about treatment and consenting to treatment was described in the consent policy, however the policy referred to consenting under-18's even though the centre was not registered for the treatment of children. We asked the centre staff and they told us that this was a mistake in the policy.
- Staff we spoke with told us that the centre was compliant with the two-week cooling off period afforded to patients thinking of undergoing cosmetic procedures as per the Royal College of Surgeons Professional Standards of Cosmetic Surgery. However, the centre did not always record initial consultations and therefore some for some patients the cooling off period could not be verified.
- We checked 22 consent forms for differing procedures and found that all of them contained only the patients signature and date, this was not in line with best practice or the centre's own policy stating that both consultant and patient must sign the form.
- Staff we spoke with did not have a confident understanding of the Mental Capacity Act 2005 (MCA) and how to put it into practice. MCA training was not provided by the centre.
- We found that some staff were identified for DoLS training, however they had not yet completed the training module.

Are surgery services caring?

Not sufficient evidence to rate

Compassionate care

Inadequate

Surgery

- **We could not verify if staff cared for patients with compassion, because no patients attended during our inspection**.
- During our inspection we were unable to observe any clinical patient interactions as the provider did not have any patients receiving services under the regulated activities.
- Staff we spoke with demonstrated a good understanding of providing compassionate care to patients. They told us of examples where they would reassure nervous patients and allow for extra time during their appointments.
- Staff we spoke with confidently told us how they would ensure privacy and dignity of all patients. Staff were particularly careful when doing procedures in sensitive or intimate areas. The lead clinician ensured that patients always had staff of the same gender in the clinical area and that superfluous staff were not present for the patient's comfort.
- Patients could have a daily follow-up session with the lead clinician for ten days post liposuction treatment, these sessions allowed patients to talk about any changes or concerns and for the clinical staff to provide advice and support. Patients were also provided a mobile number for the lead clinician that they could use any day and at any time.

Emotional support

- **We could not verify if staff provided emotional support to patients to minimise their distress, because no patients attended during our inspection**.
- Staff explained that a patients mental and emotional health was assessed during their initial consultation with the lead clinician. Patients that were deemed to have mental or emotional health issues that may influence their decision to have cosmetic treatments, such as body dysmorphia, were declined treatment.
- The lead clinician told us they patients could be referred to a local counselling service that Wimpole Aesthetic Centre Ltd had a working partnership with, however the lead clinician told us that no patient had consented to a referral.

Understanding and involvement of patients and those close to them

- **We could not verify that staff involved patients and those close to them in decisions about their care and treatment, because no patients attended during our inspection.**
- Patients were advised of the cost and expectations of their treatment at the initial consultation with the lead clinician. Patients were given a cooling-off period after the initial consultation in line with best practice guidelines.
- Patients were provided with written information about the treatment, costs and expectations after the initial face to face consultation. Patients could communicate with the lead clinician via telephone or email anytime in the cooling-off period and post procedure.
- Staff we spoke with all told us that patient relatives or friends were welcome to attend consultations and that patients were encouraged to bring someone to attend on the procedure day as they would be required to have safe transport home. Staff were open and honest in telling us that due to the nature of the treatment most patients preferred to be alone.

Are surgery services responsive?

Requires improvement

Service delivery to meet the needs of local people

- **The centre planned and provided services in a way that met the general needs of its clients.**
- The centre was open six days a week and provided consultations and elective cosmetic surgery by appointment only. The centre had variable opening hours but generally operated between 9am and 8pm. Appointments were generally arranged on the phone.
- The centre provided elective cosmetic procedures to patients aged over 18years. No procedures conducted involved an overnight stay at the centre.
- The centre had adequate clinic rooms and seating for the number of patients seen on average. The waiting area had access to water, coffee and tea making facilities, newspapers and magazines. The centre could use a communal building wide waiting area if required.
- Patients had access to patient information leaflets outlining various treatments, local services and the complaints process.

Meeting people's individual needs

Inadequate

Surgery

- **The centre was unable to evidence that it took account of people's individual needs.**
- The lead clinician assessed a patients mental and emotional health during the initial consultation and patients that were assessed to be living with emotional or mental health issues which may affect their decision to have cosmetic procedures were declined treatment. We were told that these patients were offered referral to a local counselling service. However, this could not be evidenced as the centre did not have a formal exclusion criteria and did not keep clear, accurate or detailed patient records.
- The centre was unable to treat patients with a major physical disability due to the basement level location and the steps up to the front door of the clinic in the building they were located in. The centre did not have access to lifts or alternative facilities. Staff we spoke with were open and honest in telling us they had not experienced any contact with patients living with sensory loss, learning difficulties or mental health issues.
- The centre did not provide any interpreting services. Staff we spoke with told us most of their patients spoke English and in other instances patients would bring friends or family to interpret. The lead clinician told us that the service was looking to implement a telephone interpreting service.
- Patients were required to have safe transport home post procedure and were encouraged to bring someone to attend on the day, however for patients that did not bring someone the centre organised a taxi free of charge and called the patients home or hotel to assure themselves of safe return.
- The centre could make accommodation arrangements at favourable rates for patients traveling from long distances, this was needed due to patients having daily follow-up sessions with the lead clinician for ten days post procedure.
- The centre could be opened on bank holidays if it was the only time a patient was able to have treatment.

Access and flow

- **People could access the service when they needed it.**
- The service provided elective and pre-planned cosmetic procedures to self-referring patients. Patients could phone and book an appointment for a date and time that suited them. The lead clinician told us that there was rarely a waiting period for appointments, patients would only have to wait if the staff carrying out the procedure were on leave.
- Patients that waited for more than a month before deciding to proceed were consulted again before any cosmetic procedure was initiated.
- Administrative staff and clinical staff we spoke with told us that delays or cancellations were rare. All patient appointments were provided with a substantial time slot to avoid delays.
- The centre was currently utilising a basic electronic calendar to arrange appointments, however staff told us that the centre was in process to purchase and implement a patient management system which would centralise all patient information, appointments and provide an electronic record system.

Learning from complaints and concerns

- **The centre treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- The centre had a formalised process of handling complaints which was outlined in a written policy. The policy stated that all complainants will receive a written acknowledgement within two working days of the complaint and a written response within 20 working days or agreed timeframe.
- The service received no complaints in relation to the regulated activities in the period of July 2017 to October 2018.
- Staff told us that complaints and learnings were discussed at staff meetings and informal staff discussions. All staff told us that complaints were taken seriously and all staff wanted to learn from them and improve the service.
- Clinical staff told us that they always tried to handle a complaint informally, however the patient would always be referred to the complaints procedure if required.

Are surgery services well-led?

Inadequate

Leadership

- **Managers did not always have the right skills and abilities to run a service providing high-quality sustainable care.**
- The lead clinician was also the registered manager and operated as the chief executive officer and owned the centre. All staff worked closely and had daily contact with the lead clinician.
- The centre did not have an organisational structure and we found that there were no clear defined roles apart from that of the lead clinician. We were told by staff that it was a 'horizontal' working environment, which meant that they all felt equal.
- The centre had identified a lead nurse but staff were unable to tell us how the lead nurses duties differed from the other nurses.
- The centre had a business manager who was also named as the practice manager. The role was to manage the centre's marketing, accounts, bookings and developing the new systems the centre was looking to implement.
- The centre had a duty manager who also was the governance lead, however these were not formalised titles.
- We found there to be lack of clear line manager roles and duties, however all staff felt that the lead clinician was their line manager.

Vision and strategy

- **The centre did not have a vision for what it wanted to achieve.**
- We found that the centre did not have definable vision or strategy, however staff told us they aspired to provide a good level of service in their sector.
- We were told by staff that the service aimed to establish a positive and long-lasting relationship with their patients who would recommend the clinic to friends, family or colleagues.

Culture

- **The provider promoted a positive culture that supported and valued staff.**
- Staff told us they enjoyed working at the centre and that the small size of the team made communication easy and facilitated a positive working atmosphere.
- All staff we spoke with told us they enjoyed working with the lead clinician and that they appreciated the lead clinician's commitment to the service and staff well-being.
- We observed a positive working culture that was focussed in providing a tailored service to patients and valued staff well-being.
- We found that the provider had an open and honest approach to patients and did not make unethical claims. Patients were provided with adequate and honest information before and after procedures. Staff attitudes and opinions supported this.
- We saw evidence in patient records to show the centre provided patients with a statement which included the terms and conditions of the service and outlined the fees.

Governance & Managing risks

- **The centre lacked a robust governance system and risk management system.**
- The centre had shown some limited improvement from the last inspection regarding introducing a system of policies, incident reporting process and basic risk management. However, we still found that the centre did not have a robust governance system which regularly reviewed practices, incidents or delivery of strategy.
- We found that staff were unclear about the role of clinical governance within the centre and did not have a sound understanding of governance structures and its purpose.
- The staff we spoke with told us that there were staff meetings where aspects of governance such as incidents, risk and learnings were discussed but that these had not occurred since May 2018. We were shown a record of two meetings but these were not detailed minutes. This was not in line with the centre's own policy.
- The centre did not have a medical advisory committee to oversee governance or practising privileges.
- The centre's incident management structure is described in the 'safe' section of the report.
- The centre did not have a traditional style risk register, but recorded its risks on risk logs that were separate documents monthly, this meant that risks were not recorded on a continually updated centralised register where progress could be easily tracked.
- The risk with the highest severity rating on the October 2018 risk log was staff not completing their mandatory training in line with organisational policy. The risk logs recorded the location of risks, brief analysis, description, severity and likelihood rating, mitigation measures,

responsible person and target date to complete. We found that the risks the service had identified on the risk logs were not aligned with the risks we identified during the inspection.

Managing information

- **The centre did not collect and use information well to support all its activities.**
- The lead clinician told us that the centre had recently passed an audit by an external body for compliance with the General Data Protection Regulations.
- We were told that the centre hoped to further its security on patient data by implementing a new patient management system which would centralise all patient data held by the provider and be used as an electronic record system.

Engagement

- **The centre had limited engagement with patients regarding improving the service.**
- The centre did not have any formalised engagement with staff due to the small size of the workforce. All staff we spoke with were positive regarding staff well-being and all staff told us they felt their opinions were listened to by their colleagues and by the lead clinician.
- The engaged with patients by informal discussion regarding the service, by conducting patient feedback surveys and through the complaints system.
- The centre had conducted two patient satisfaction surveys in April 2018 and August 2018 and told us they had planned to complete two more by March 2019. However, the service had not calculated a response rate for the data collected and the data included patients that were seen for treatments that were outside the regulated activities.

Learning, continuous improvement and innovation

- **The centre lacked a robust approach to quality improvement.**
- The staff at the centre felt that the organisation had improved its stance towards governance, training, employment checks, patient feedback, written policies and was developing a range of audits to help monitor quality and safety. The centre had improved in some areas from our previous inspections, however the centre still lacked a robust approach to governance and quality improvement.
- Staff spoke positively about the environmental improvements the centre had recently undergone to improve the layout and design of the centre. The centre had also implemented a new air conditioning and filtration system for the clinical areas.
- We found the centre lacked reasonable challenge from internal or external sources regarding quality improvement, governance, safety and effectiveness.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure robust governance systems, incident management systems and risk management systems are in place. That staff understand their role and function within the governance system.
- The provider must ensure it is doing all that is reasonably practicable in minimising risk to patients including but not limited to; keeping accurate and detailed records, following national guidance on micro-organism screening, monitoring physiological condition, monitoring patient outcomes, implementing sepsis training and pathways, following national guidance regarding decontamination of medical devices, using tamper proof storage, implementing formalised pain monitoring systems, regularly checking staff competence and fitness to practice,

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that all staff complete mandatory training.
- The provider should ensure that the sepsis policy outlined what staff should do if they identify a case.
- The provider should ensure that all policies reflect working practices and are in line with national guidance.
- The provider should ensure that theatres and corridors are not constricted or cluttered due to equipment storage.
- The provider should ensure it has a formalised admission or exclusion criteria or policy.
- The provider should ensure the WHO checklist is fully and accurately completed and recorded.
- The provider should ensure they follow national and professional guidance in all areas of their practice.
- The provider should collect safety information and patient outcomes to help improve the service.
- The provider should ensure it formally records and observed a patient's physiological condition post procedure.
- The provider should appraise staff's work performance and hold supervision meetings.
- The provider should ensure that consent forms are completed in line with their own policies and national guidance.
- The provider should ensure that staff understand their roles and responsibilities in relation to the Mental Capacity Act 2005.
- The provider should take reasonable action to be compliant with the Disability Discrimination Act 2010.
- The provider should provide the training for managers to competently carry out their duties.
- The provider should outline a vision and strategy for what it wants to achieve
- The provider should further engage with patients to improve their service.
- The provider should implement a medical advisory committee to oversee governance and practising privileges.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment The provider must ensure it is doing all that is reasonably practicable in minimising risk in relation to patient care such as keeping accurate and detailed records, following national guidance on micro-organism screening, monitoring physiological condition or monitoring patient outcomes. Regulation 12 (1)(2)(b) doing all that is reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance The provider must ensure robust governance systems, incident management systems and risk management systems are in place. Regulation 17 (1)(2)(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of experience of the service user s in receiving those services). Regulation 17 (1)(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.