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	Good
Are services safe?	Good
Are services effective?	Not sufficient evidence to rate
Are services caring?	Not sufficient evidence to rate
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

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 a waiting area.

The centre provides elective non-major cosmetic surgery for adults and provides treatment for Lyme disease. The centre did not treat any patient under 18 years old in the reporting period. We inspected the service under the cosmetic surgery core service, we did not inspect the Lyme disease service under the medical core service framework.

We carried out an unannounced inspection on 22 August 2019. We inspected this service using our comprehensive inspection methodology to see if improvements had been made since the service was placed in special measures after the previous inspection conducted in 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 good overall. The service had improved since our last inspection conducted in October 2018 where we had placed the service into special measures; however, there were still some areas where the service could improve

We found the following areas had improved since the previous inspection:

- The centre had improved by providing mandatory training in all key skills to staff and ensured everyone completed it.
- The centre controlled infection risks and kept clinical areas clean. However, staff had only recently started to monitor surgical site infection rates and screen new admissions for micro-organisms and could not provide data regarding this.
- The centre had improved by ensuring staff completed and updated risk assessments for each patient and removed or minimised risks.
- The centre had improved by ensuring staff kept suitable and appropriately detailed records of patients' care and treatment.
- The centre understood how to manage patient safety incidents, staff recognised and reported incidents and near misses. Incident learnings and outcomes were shared and discussed with the wider team.
- The centre had improved by providing care and treatment based on national guidance and evidence of its effectiveness. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- The centre had improved by ensuring staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and development. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The centre had improved by ensuring managers had the right skills and abilities to run a service providing high-quality sustainable care. The centre promoted a positive culture that supported and valued staff. The centre had improved its governance system and risk management system.

However, we found the following areas that required improvement;

- The provider did not formally monitor the effectiveness of care and treatment.
- The centre was still developing a strategy for what it wanted to achieve but had developed formalised values.
- The centre did not collect or use information for the purpose of service management and improvement
- The centre lacked a formalised regular approach to quality improvement.

Summary of findings

We found sufficient improvement to remove the service from special measures.

Dr. Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Cosmetic surgery was the main activity of the service. We rated this service as good overall because it was good in safe, responsiveness and it was well-led. We did not rate effective or caring as we did not have enough information.

Summary of findings

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Good

Wimpole Aesthetics Centre

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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 also offers 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 and a CQC assistant inspector, 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.
- Diagnostic and screening

During the inspection, we visited all areas. We spoke with all staff including; registered nurses, reception staff, medical staff, and managers. We spoke to one patient that was treated in the last month before our inspection in relation to the care and treatment provided regarding the regulated activities. During our inspection, we reviewed three sets of patient records.

The service was last inspected in October 2018 and the report was published in December 2018. The service was placed in special measures as a result of our findings and this inspection was undertaken to see if the service had improved.

Activity (July 2018 to July 2019)

- In the reporting period there were three cases related to the regulated activities with all of them being liposuction.
- 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
- No clinical incidents
- No serious injuries

The service had just started to screen patients for micro-organisms and monitor surgical site infection, and therefore did not have any data to share with us.

The service did not receive any complaints in the reporting period.

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?

Good

We rated safe as good because:

- The service provided mandatory training in all key skills to staff and ensured everyone completed it.
- Staff had started to monitor surgical site infection rates and screen new admissions for micro-organisms and could not provide data regarding this.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- Staff kept suitable and appropriately detailed records of patients' care and treatment.

However:

- Not all staff had training regarding female genital mutilation which should be part of safeguarding training.

Are services effective?

Not sufficient evidence to rate

We did not rate effective as we had insufficient evidence to rate. We found:

- The provider did not monitor the effectiveness of care and treatment.

However, we found the following areas of improvement;

- The centre provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- The centre had improved and ensured staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and development.

Are services caring?

Not sufficient evidence to rate

We did not rate caring as we had insufficient evidence to rate, we found the following areas of good practice:

- We could only speak to one patient over the telephone and they told us staff treated them with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The centre monitored patient feedback, however the data was mixed with patients treated outside of the regulated activities.

Summary of this inspection

- Staff we spoke with told us how they would take care of patients' emotional needs and were able to refer them to local counselling services.

Are services responsive?

Good

We rated responsive as good because:

- The service planned and provided services in a way that met the needs of its clients.
- The service took account of patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff

Are services well-led?

Good

We rated well-led as good because:

- Managers had the right skills and abilities to run a service providing high-quality sustainable care.
- The centre promoted a positive culture that supported and valued staff.
- The centre had improved its governance system and risk management system.
- The centre had appropriate engagement with patients and staff 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	Good	Not rated	Not rated	Good	Good	Good
Overall	Good	Not rated	Not rated	Good	Good	Good

Good

Surgery

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Good
Well-led	Good

Are surgery services safe?

Good

Mandatory training

The centre had improved and provided mandatory training in all key skills to staff and ensured everyone completed it.

- The centre had improved since our previous inspection conducted in October 2018 by introducing a rolling mandatory and statutory training programme for all its staff. The training was provided as a mix of electronic and practical training.
- The centre had improved by ensuring all staff had completed basic life support training and that appropriate staff had intermediate and advanced life support training.
- 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.
- We saw evidence to show that 100% of staff had completed their mandatory training.
- The centre had a policy for sepsis management; the policy outlined what sepsis was and how to identify a case, sepsis flowcharts were displayed in clinic rooms which showed what staff should do in such an occurrence. Medical staff we spoke with told us that the service was not equipped to handle such cases and it was always practice to refer the patient to the local NHS emergency department. Staff were provided with informal sepsis training and we saw evidence to show that it was discussed in staff meetings.

Safeguarding

Staff understood how to recognise patients suffering abuse. Staff had training regarding adults and children on how to recognise and report abuse, however not all staff had training regarding female genital mutilation.

- The centre had improved since our previous inspection and was now providing safeguarding training in relation to adults and children 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 and children level one and two.
- The lead nurse was the only member of staff to have formalised training in relation to female genital mutilation.
- Nursing, medical and administrative staff we spoke with could explain how they would identify possible safeguarding cases for both adults and children. 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 seven staff members and found all had valid recent criminal record checks.

Cleanliness, infection control and hygiene

Good

Surgery

The centre had improved by starting to monitor surgical site infection rates and screen new admissions for micro-organisms but could not provide data regarding this. Clinical areas were kept clean and tidy.

- The centre had improved since the last inspection by starting to conduct screening for MRSA, C-diffcile or any other micro-organisms before conducting any invasive cosmetic procedures, this was in line with the centre's action plan to improve.
- 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. The centre had improved since the last inspection by regularly conducting hand hygiene audits the results of which showed that all staff were compliant for the reporting period.
- We found there to be adequate handwashing facilities and hand-gels available. We did not observe staff utilising these facilities as there were no surgical patients during our inspection.
- The provider had improved by introducing a policy to outline the decontamination of reusable medical devices in line with national guidance such as the DH Health Technical Memorandum on decontamination. Reusable surgical devises were being processed by washer-disinfector cycle.
- On the day of inspection we found sterilised equipment had handwritten dates of expiry written on them and it was difficult for staff to determine the date, however staff corrected this by implementing a printed label system after the inspection and changed the organisation policy to clearly define the period any equipment is considered sterilised.

Environment and equipment

The centre had suitable premises and equipment and looked after them well.

- All clinical areas we observed were generally suitable for their use.
- On the day of inspection 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, however, staff provided photographic and written evidence post inspection to show that all excess equipment was now removed from clinical areas and all equipment was stored appropriately. Staff also implemented a check as part of the regular infection control audit to monitor ongoing compliance.
- On the day of inspection, we found that corridors contained loose and boxed intravenous fluid bags, however staff provided photographic and written evidence post inspection to show that all intravenous fluids were now stored in secure and appropriate areas.
- The centre conducted monthly infection control environment audits for the theatre areas. This audit checked compliance against best practice guidelines in relation to sharps bins, waste bins, trip hazards and general environment checks. Results for the period between May 2019 to July 2019 showed that the centre was compliant.
- The centre 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 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 stored tamper proof storage bags. All equipment was regularly checked and recorded.

- 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

The centre had improved, and staff completed and updated risk assessments for each patient and removed or minimised risks.

- 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 patient's psychological and emotional health to determine if patients had body image issues. This was done in line with professional guidance and patients that were living with mental health conditions were declined treatment and offered referral to counselling or hypnotherapy services.
- The centre had improved by adopting an exclusion criterion, which clearly outlined patients that were not able to be treated by the centre for liposuction, which included patients under the age of 18, patients with complex medical histories and those living with complex 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 centre used the World Health Organisation (WHO) surgical safety checklist. We reviewed three records and found that all had completed checklists.
- The centre had improved by implementing a pain scoring system and implementing the use of the national early warning scores, it also introduced a formal escalation policy and staff were aware of the process.
- Patients were offered daily follow-up sessions with the lead clinician post procedure for ten days, 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.
- 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.

Nursing and support staffing

The service had enough nursing staff, with the right mix of qualification and skills, to provide the right care and treatment.

- The centre employed three full time equivalent theatre nurses. We spoke to all staff and they all told us that this was enough for clinical activity the centre had.
- The centre did not use any bank or agency nursing staff.
- The centre reported 0% sickness rate for the period between July 2018 to June 2019.
- 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 service 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 registration, criminal record checks and fitness to practice, however we did find that the indemnity insurance had recently expired.
- 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, criminal record checks, indemnity insurance and fitness to practice.

Records

The centre had improved, and staff kept suitable and appropriately 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 three records of patients under the regulated activities. We found that all notes contained records of the initial consultation, completed WHO checklists, 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 appropriate consent forms.
- 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 GPs. 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 GPs.

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 relating 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 improved by implementing a medicine management policy in line with its working practices and national guidance.

Incidents

The centre understood how to manage patient safety incidents, staff recognised and reported incidents and near misses. Incident learnings and outcomes were shared and discussed with the wider team.

- There had been no never events or serious incidents at Wimpole Aesthetic Centre Ltd for the period of July 2018 to June 2019, but the centre did report two near misses.
- 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.
- We found that the centre had improved by formally introducing incident learnings as part of team meetings. Team meetings were held regularly, and incidents were a standing agenda item. This was appropriate for the size of the centre.

Good

Surgery

- The centre had improved by beginning to monitor surgical site infections in line with their action plan following the previous inspection, the centre did not have any data to share with us at the time of this inspection.

Safety Thermometer (or equivalent)

The service did not have a quality dashboard and did not monitor key quality outcomes.

- For the period of July 2018 to June 2019 there had been no unplanned returns to theatre post-operatively, nor were any patients transferred to alternative care following treatment.

Are surgery services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

The centre had improved and provided 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. Most polices were aligned with national and professional guidance. We found that some polices referenced practices the centre was not undertaking such as the consent policy referencing consent of children.
- The centre's governance manager researched NICE guidelines and disseminated relevant information to staff through staff meetings. We saw that the centre's policies and working practices were in line with the relevant NICE guidance.
- 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 o 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.
- We found 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.

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

The centre had improved, and staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

- 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 improved by implementing formal pain assessment tools. This meant that staff could be assured of the level of pain a patient was in.

Patient outcomes

The provider did not formally monitor the effectiveness of care and treatment.

- In the period of July 2018 to June 2019 the provider reported a total of three 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 formally collect or review patient outcome data. Patients were followed-up regularly and results from the procedure were noted and discussed informally.
- The centre did not participate in Private Healthcare Information Network, which is an independent

government-mandated source of information about private healthcare, this was not compliant with their legal requirements regulated by the Competition Markets Authority.
- The centre did not at the time of this inspection contribute to national data bases for quality patient reported outcome measures (QPROMS). QPROMS are set 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. Managerial staff told us that this was one of the objectives for the centre.
- The centre conducted audits in relation to infection control, complaints and tracking progress against the CQC key lines of enquiry. They did not participate in national audits or accreditation schemes which was appropriate for the size of the centre.

Competent staff

The centre had improved and ensured staff were competent for their roles. Managers appraised staff's work performance and held meetings with them to provide support and development.

- All staff records and found had valid NMC or GMC 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. 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, we found evidence to support this.
- We were provided with evidence to show that the centre held staff records comparable to those of permanent staff for those with practising privileges.
- The centre had improved by implementing a regular system to check and ensure staff who were granted practising privileges continued to be skilled and competent in carrying out their duties.
- The centre had improved by providing all staff with sepsis training and we saw evidence of this in staff records.
- The centre had improved by completing appraisals for all staff in the period of July 2018 to June 2019 in line with their action plan following the previous inspection. The appraisals were conducted by managerial staff and all staff we spoke with told us that they found the process helpful in identifying their learning and development goals.
- 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.
- Due to the size of the centre there was no need of any formalised multidisciplinary team meetings, any discussion that was needed was held informally or in the regular staff meetings.

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 understood 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.
- We saw evidence in patient records 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.
- We checked three consent forms in the patient records that we reviewed, and all were completed in line with the centres policy and best practice guidelines.
- The centre had improved by introducing training in relation to Mental Capacity Act 2005. Staff we spoke with had an understanding of the Mental Capacity Act 2005 (MCA) and how to put it into practice.

Are surgery services caring?

Not sufficient evidence to rate

Compassionate care

We could only to speak to one patient over the telephone as no patients attended in relation to the regulated activities during the inspection, as such we were unable to witness any interactions between staff and patients. The patient we spoke to told us that staff treated them with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- 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, however we spoke to one patient by telephone who had recently received treatment.
- The patient we spoke to told us that staff were kind, compassionate and considerate in their approach. The patient explained that staff were reassuring when the patient was nervous, and that staff protected the patient's privacy and dignity.
- 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.
- The service had improved since the last inspection by conducting regular patient satisfaction surveys, however the service had included patients that were seen for treatments that were outside the regulated activities and were not able to separate data for patients treated under the regulated activities.

Emotional support

We could only to speak to one patient over the telephone as no patients attended in relation to the regulated activities during the inspection, as such we were unable to witness any interactions between staff and patients. The patient we spoke to told us staff understood their personal, cultural and religious needs.

- 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 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.
- The patient we spoke with told us that staff provided appropriate emotional support, considering their personal and cultural needs. The centre provided information on how to access emotional support from external organisations.

Understanding and involvement of patients and those close to them

We could only to speak to one patient over the telephone as no patients attended in relation to the regulated activities during the inspection, as such we were unable to witness any interactions between staff and patients. The patient we spoke to told us staff supported and involved them and their families to understand and make decisions about their care and treatment.

- 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.
- The patient we spoke with told us that staff explained the details of the treatment and expected results in a clear way, staff gave time to the patient to ask questions and involved the patient's family members. The patient told us that information about the cost of treatment was provided in writing in a timely manner.

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

The centre planned and provided services in a way that met the needs of its clients.

- The service 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 18 years. No procedures conducted involved 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

The centre took account of patients' individual needs.

- 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 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.

- 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 lead clinician assessed a patient's 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. These patients were offered referral to a local counselling service.
- 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 utilised a patient management system to arrange appointments, the system centralised all patient information, appointments and provided 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.
- We observed that complaints leaflets were available to patients in waiting areas. The leaflets contained the appropriate information and contained information on how patients could escalate the complaint to external organisations.
- The service received no complaints in relation to the regulated activities in the period of July 2018 to June 2019.
- Staff told us that complaints and learnings were discussed at staff meetings and informal staff discussions. All staff told us that due to the small size of the centre 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 locally, however the patient would always be referred to the complaints procedure if required.

Are surgery services well-led?

Good

Leadership

The centre had improved, and managers had 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 improved by implementing an organisational structure and we found that roles were now defined appropriately for the size of the centre.

- The centre had improved by identifying a lead nurse and defining the role of the lead nurse. The lead nurse was the point of escalation for deteriorating patients, safeguarding and had managerial duties over 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 improved by defining the role of the duty manager and formalising the mangers role to include clinical governance.

Vision and strategy

The centre was still developing a vision for what it wanted to achieve but had developed formalised values.

- We found that the centre did not have a formalised vision or strategy, however staff told us they aspired to provide the best level of service in their sector in line with their organisational values. 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.
- The centre had improved by developing formalised values based around patient centred care, customer service and excellence. The values were developed with the collaboration of all staff employed by the centre.
- We observed posters regarding the centres values and staff we spoke with were able to clearly explain the values.

Culture

The centre 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.
- Staff we spoke with told us they felt that their well-being was taken seriously and told us that the lead clinician was very supportive of their professional ambitions.
- 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. 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 had improved its governance system and risk management system.

- We saw evidence of an improvement in overall quality of the centre's policies, however we found that some polices did not have an issue and review date.
- We found that the centre's incident reporting process had improved and was now electronic, the incidents were now reviewed regularly by managerial staff and the learnings were discussed in monthly team meetings. We found this system to be appropriate for the size of the centre.
- We saw evidence of appropriate action taken in response to incidents and that learnings and outcomes were discussed and recorded.
- The centre had improved by introducing a risk register, we found that it contained appropriate risks and that it was in line with risks we had identified. Risks were reviewed regularly by the lead nurse and compliance manager and were discussed during team meetings. We found this system to be appropriate for the size of the centre
- We found that staff understanding of the role of clinical governance within the centre had improved. Staff we spoke with told us that the centre was now committed to having a sound governance system.
- The centre did not have a medical advisory committee to oversee governance or practising privileges, instead it was overseen by the lead clinician, lead nurse and compliance manager. We found this to be appropriate for the size of the centre.

Managing information

Good

Surgery

The centre managed information appropriately, however it did not collect or use information for the purpose of service management and improvement.

- We saw evidence to show all staff had completed information governance training which covered topics surrounding confidentiality and General Data Protection Regulation.
- The centre had implemented a new patient management system which stored patient information securely and allowed the management of appointments. The system also allowed the use of an electronic patient record system, however the centre used paper records and stored them securely in a locked cabinet in a locked room.
- The centre did not monitor or report on service performance metrics due to the size of the centre.

Engagement

The centre had appropriate engagement with patients and staff regarding improving the service.

- The centre had improved by conducting regular team meetings where all staff were encouraged to raise concerns and talk about experiences. 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 centre did not conduct a staff survey due to the size of the team.
- The centre engaged with patients by informal discussion regarding the service, by conducting patient feedback surveys and through the complaints system.

Learning, continuous improvement and innovation

The service had improved since the previous inspection but lacked a formalised regular approach to quality improvement.

- We found the centre had improved since the previous inspection in line with its' action plan. We found that staff were more positive towards learning and improvement and were committed to further development in this area, however the centre did not have a formalised regular approach to continuous quality improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should outline a vision and strategy for what it wants to achieve
- The provider should seek to gather and use information to improve service delivery.
- The provider should have formalised access to an interpretation service.