The Pemberdeen Laser Cosmetic Surgery Clinic Limited

The Belvedere Private Hospital

Inspection report

Knee Hill
London
SE2 0GD
Tel: 02083114464
www.belvedereclinic.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

The Belvedere Private Hospital is operated by The Pemberdeen Laser Cosmetic Surgery Clinic Limited. The hospital has eight beds. Facilities include one operating theatre and three consulting rooms, one of which is used for post-operative procedures.

The hospital provides surgery. We inspected surgery as a focused follow up inspection following inspections, which took place in September and October 2020, and in response to concerns which were raised about the service more recently.

We inspected this service using our focused inspection methodology. We carried out an unannounced visit to the hospital on 25 March 2021.

Focused inspections are only used when there is no other appropriate mechanism to address concerns and the risk is so significant (potential regulatory breach) that it cannot wait to be addressed as part of the next scheduled business as usual inspection. **As part of this focused inspection we updated ratings at key question level and aggregated this to service/location level.**

At the time of inspection, there was no registered manager or nominated individual in place, as a result of the previous manager leaving the service with little notice. Whilst there was a temporary 'bank' nurse overseeing the theatre operating list, they made it clear they were not there in the capacity of a manager. There was nobody overseeing day-to-day management of the whole service. This meant we were unable to follow up on several concerns identified in the previous inspection report. This also meant we had to ask the provider for information post-inspection as we were not always able to gain enough information during the on-site inspection. We took account of this when using our enforcement powers.

As a result of this inspection, we took urgent action to suspend the registration of the provider for an initial period of six weeks. A further extension to this suspension was appealed and considered, resulting in several regulatory conditions being imposed on the providers registration. A condition of registration places a limit or a restriction on what a provider or registered manager can do. It may be linked to a location, regulated activity, service type, or specific activity.

After this, a further review of evidence will take place to ensure all areas of concern have been resolved and the risk of harm to patients has been removed. At this point, a review of information will be held to determine if the conditions remain in place or is lifted.

We are 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.

Summary of findings

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 asked the provider to submit an action plan outlining how they are addressing the concerns identified from this inspection, which was subsequently provided. On inspection we found:

- Not all staff had received up-to-date mandatory training. It was not clear where staff received their mandatory training. There were gaps in the completeness of mandatory training requirements.
- Not all staff understood how to protect patients from abuse. Some staff had gaps in their training on how to recognise and report abuse and there was no clear process for reporting safeguarding concerns.
- The service did not always control infection risks. There were no controls to protect patients from COVID-19 from staff travelling internationally.
- The maintenance and use of facilities, premises and equipment did not always keep people safe.
- The service lacked effective control measures to respond to patient risks.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- The service did not manage patient safety incidents well. There was no evidence of serious incidents having been fully investigated, or any guidance for how to investigate them. There was limited evidence of lessons learned being shared with the whole team.
- The service did not provide all care and treatment based on relevant national guidance and evidence-based practice.
- The service could not demonstrate they treated concerns and complaints seriously or investigated them sufficiently or shared lessons learned with all staff.
- In the absence of a manager overseeing day-to-day activity, the service could not demonstrate effective leadership of the service.
- The hospital still did not have a systematic approach to improving service quality and safeguarding high standards of care. There remained a lack of overarching governance.
- There were no effective systems in place for managing risks, and there was no evidence risks and their mitigating actions were discussed with the team.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to The Belvedere Private Hospital

The Belvedere Private Hospital is operated by The Pemberdeen Laser Cosmetic Surgery Clinic Limited.

The hospital opened in 1985. It is a private hospital in south east London. The hospital primarily serves the communities of the London and north Kent areas but also accepts patient referrals from the whole country.

This was an unannounced inspection, which took place on 25th March 2021.

At the time of the inspection, the hospital did not have a registered manager. A nominated individual had been appointed; however, this person was not present during the inspection and we were told another person would be submitting an application to take on this role.

We inspected surgery as a focused follow up inspection following previous inspections which took place in September and October 2020, and in response to concerns which were raised about the service more recently.

The hospital also offers cosmetic procedures such as dermal fillers. We did not inspect these services, as they do not come under the requirements of current regulations.

How we carried out this inspection

The team that inspected the service comprised of one inspector, one inspection manager, a clinical fellow working for CQC, a specialist advisor and a pharmacy inspector. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

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

Areas for improvement

Action the service MUST take to improve:

- The provider must take prompt action to address concerns identified during the inspection in relation to: safeguarding, incident recording and reporting, and the governance of the service.
- The provider must ensure there are measures in place to minimise the risk of coronavirus infection from staff travelling from overseas.
- The provider must ensure they have measures in place to protect patients from the risk of harm following the use of photography taken on staff's personal devices.
- The provider must ensure mandatory training is completed by all staff, checked and reviewed regularly.
- The provider must ensure the premises and equipment is sufficient to keep people safe.
- The provider must ensure there are clear processes in place in the reporting of a potential safeguarding concern.
- The provider must ensure there are clear processes in place for recording and reporting incidents.
- The provider must ensure complaints are handled in line with their own policy and demonstrate concerns are taken seriously and are investigated sufficiently, and share any lessons learned with all staff.

Summary of this inspection

- The provider must ensure there is a registered manager in place.
- The provider must ensure there is adequate daily oversight of the management of the service.
- The provider must ensure there are effective systems in place for managing risk.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Surgery

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

Are Surgery safe?

Inadequate

Inspection findings limited this key question to an inadequate rating.

Mandatory training

Not all staff had received up-to-date mandatory training. It was not clear where staff received their mandatory training. There were gaps in the completeness of mandatory training requirements.

The Belvedere Private Hospital training policy and procedure (GPRO6) provided to us on 18 February 2021 was noted to be a single A4 page with very limited information described. The document did not include details of the required mandatory training subjects, the frequency as to the completion of these, how such training would be delivered and/or by whom, or if it was acceptable for training to have been provided within a substantive position elsewhere. A training matrix had been provided to CQC on the 18 February 2021. This listed the following subjects by way of examples: intermediate life support for one member of the theatre staff, basic life support for all other clinical staff; Health and safety; infection control; fire; manual handling; Covid-19, complaints and information governance. Whilst the frequency of training was not stated, the matrix did record by way of colour coding the expiry of such training. It was noted that there were numerous gaps in training, including three staff who worked in theatre whose basic life support training expired, two in 2020 and one in 2019.

Clinical staff personnel records were inconsistent in completion of information. For example, there was no training recorded for an outpatient/reception staff member. However, required and completed training had been indicated on the training matrix provided to us on 18 February 2021, as well as expiry dates.

The practising privilege files for seven medical personnel, (referred to as consultants here) who held practising privileges at the hospital. We reviewed these to see what information if any was recorded for the completion of training. Files were inconsistent in content, although there was a standard index. Reference was made to basic life support training and advanced life support in four out of seven files. However, apart from one consultant who had provided a printout from the NHS trust where they also worked, there was a lack of evidence to indicate what mandatory safety training medical personnel had completed. A printout of an email from the then hospital manager and sent to consultants showed that they were informed the hospital was re-opening for surgery on 13 February 2021 and asked them for training certificates.

Inadequate

Surgery

As we had not been able to speak with a manager during our inspection, after our visit we asked the provider to supply us with information relating to mandatory training. We asked them to provide us with the latest training matrix which identified each staff group and the frequency training was to be renewed. We also asked them to provide us with written evidence that all staff working at the registered location had completed their required mandatory training. Additionally, we asked for a copy of the mandatory training policy.

The provider responded and provided a training matrix and a mandatory training policy. On review of the training matrix we noted it listed some staff names but did not include the consultant surgeons or anaesthetists. None of the names of surgeons or anaesthetists were identifiable on the training matrix. We were unable to determine the roles of each staff member as these were not recorded on the training matrix. This means, we were unable to verify which specific roles had completed the required training. Service users will or may be exposed to the risk of harm if staff employed by the provider do not have the necessary training required to provide regulated activities. We could not be assured the provider had oversight as to whether staff had the necessary training.

Whilst the training matrix listed various mandatory subjects staff were required to complete and the frequency of this training, there were multiple gaps in the record. As a result, we could not be assured that staff had completed all the required mandatory training. The provider failed to provide any evidence that staff completed their required mandatory training. Further, the provider did not provide any evidence as to who had access to the training matrix or who was responsible for information contained therein. As a result, we could not be assured that staff had the necessary mandatory training, or that the provider-maintained oversight of staff's mandatory training. Service users will or may be exposed to the risk of harm if staff do not have the required training in order to carry out their roles.

The mandatory training policy, sent to us post inspection, did not state time frames or frequency for training. As a policy for staff to follow, the content fails to indicate all the required mandatory subjects, such as basic or advanced life support, or training specific to staff roles. Further, the policy does not indicate any requirements for training, or the subjects to be covered by consultant surgeons or anaesthetists. Therefore, we are not assured the provider had adequate oversight of staff's level of mandatory training compliance or what subjects are mandatory for staff to complete. There is a risk that staff working at the location may not have been trained to a sufficient standard, and as a result, patients may be at risk of harm.

Safeguarding

Not all staff understood how to protect patients from abuse. Some staff had gaps in their training on how to recognise and report abuse and there was not a clear process for reporting safeguarding concerns.

During the inspection we asked staff what they would do in the eventuality they had a safeguarding concern. We spoke with six members of staff in total. Two members of nursing staff told us they were unclear on the process for reporting a safeguarding concern. One member of nursing staff could not articulate what constituted a safeguarding concern. Both members of staff told us they would highlight it to the manager in charge; however, in the absence of a manager, as at the time of inspection one was not in post, the two members of staff told us they would contact a member of staff who was at the hospital as a bank member of staff. It was unclear what staff would do in the absence of this person.

Four other members of staff were able to tell us what they considered to be a safeguarding concern and showed us an app on their personal phones which allowed them to report any concerns to the local safeguarding authority.

Inadequate

Surgery

The safeguarding policy directed staff to contact the registered manager to discuss any potential safeguarding concerns before formally reporting them. However, at the time of inspection, there was no registered manager in place, therefore this policy was unworkable. It was unclear what the process staff were to follow if they had a safeguarding concern.

During the inspection, practising privileges files for seven consultant surgeons and anaesthetists were reviewed and only one contained evidence of safeguarding training at level two in July 2017. There was no indication in the safeguarding policy for training what evidence of training consultants were required to demonstrate, or the frequency required.

Post inspection, the provider sent us a safeguarding policy in relation to a request by CQC for further information. The safeguarding policy referred to some staff roles that were not applicable to the service, for example, paramedics and pharmacists. Therefore, we are not assured that the safeguarding policy has been adapted to the providers type of service.

The safeguarding policy contained contradictory information related to the level of safeguarding training required of the registered manager. The policy states the CQC registered manager should receive level three safeguarding training; however, the appendices stated the safeguarding lead should be trained to level four. Further, the policy is not clear on the person with overall responsibility; it refers to the registered manager in parts and the safeguarding lead in others. It is therefore not clear who would be responsible where the safeguarding lead is different to the registered manager. There is no information to indicate who would be the responsible person in the absence of there not being a designated safeguarding lead or registered manager.

The training matrix supplied to us on 6 May 2021, identifies numerous gaps in training for several staff. There are seventeen staff listed on the training matrix; out of these, six have adult safeguarding training listed but the level they have been trained to is not known. Five staff have safeguarding children listed, but the level they have been trained to is not known.

No certificate of training for the safeguarding lead was supplied as requested by CQC post-inspection. Therefore, it is not known if the designated person with responsibility for safeguarding has undertaken the necessary training. Service users will or may be exposed to the risk of harm if staff do not have an understanding of safeguarding; do not have safeguarding training (or are not trained to the required level); and if the safeguarding policy is not clear. We cannot be assured that staff would know what to do if faced with a safeguarding concern. This may prevent safeguarding concerns being appropriately acted upon or reported.

During our inspection we observed a surgeon taking photographs on their personal phone of an unconscious patient's exposed chest area. When we questioned the use of photography, the surgeon reported that they emailed patients post-surgical pictures so they can assess the results for themselves. We were concerned with this practice as the risk of photographs being put into the public domain is substantially higher where personal phones are used to take them.

Following our inspection, we wrote two letters to the CEO of the hospital to ask for assurance that patients were not being exposed to the risk of harm by the potential of photographs of very vulnerable women being mismanaged or used for purposes other than those as outlined in the consent form. The consent form for surgery which each patient signs, outlines that photographs can be taken for medical, legal and educational purposes. However, there appears to be no further explanation regarding who takes the photograph, how such images would be taken and on what camera device, where the images would be stored, their retention period or the procedure for securely sending photographs to patients.

Inadequate

Surgery

The provider was unable to provide us with a policy which outlined the use of photography at the hospital. Therefore, we were not assured the provider had adequate processes in place to protect patients from the risk of harm from mismanaged photography. The provider told us they would be investigating this specific incident but were unable to tell us how often this practice occurred.

Post-inspection, the provider supplied us with an action plan which set out various measures the provider intended to implement regarding the use of photography. The actions relating to these concerns outlined on the action plan had a target date of 30 April 2021, however, the provider did not supply any evidence that showed these concerns had been mitigated or that processes or policies had been put in place to address the concerns identified, despite having been suspended for six weeks. We are therefore not assured that the provider has measures in place to reduce the risk outlined above.

Cleanliness, infection control and hygiene

The service mostly controlled infection risks. Staff used equipment to protect patients, themselves and others from infection. However, there were inadequate measures in place to ensure that patients were protected from the risks of Coronavirus by staff who travelled internationally between places of work.

Staff followed COVID-19 precautions, set out in a specific infection control policy. All patients were asked to wear face masks while on site, we saw patients being given a face mask if they did not bring one. Visitors to site also had their temperature checked on arrival and were asked to sign to confirm that this had happened.

Staff working in the operating theatre followed the required infection prevention and control measures.

We noted three alcohol-based hand-gel dispensers were empty, one in the reception area and two in the ward area.

During the inspection, we spoke with one surgeon who regularly travels from Italy to carry out work at The Belvedere Private Hospital. The surgeon described undertaking regular PCR (polymerase chain reaction) testing for Coronavirus. The surgeon told us he remained in the UK for three days post-surgery so any complications could be managed. However, the surgeon was unable to tell us information regarding their exemption rights to travel to the UK to perform non-essential cosmetic surgery. They were also unable to tell us whether they quarantined on arrival from Italy and what guidance they were following to ensure their travels were allowed under current government travel restriction rules.

Following this, we sent two letters to the provider outlining our concerns that staff were travelling internationally into the UK to perform non-essential surgery at The Belvedere Private Hospital. As part of our communications with the provider post-inspection, we provided the CEO with an opportunity to outline how patients were being kept safe and how the exposure to coronavirus was being kept to a minimum, given that at least one surgeon we were aware of does not appear to be quarantining on arrival to the UK. The response from the provider did not outline the reasons for the surgeon's travel exemptions and did not provide assurance that staff and patients were safe from the spread of coronavirus at the hospital.

Environment and equipment

The maintenance and use of facilities, premises and equipment was not always sufficient to keep people safe.

On the last inspection we noted the theatre doors could not easily be closed to the theatre corridor. However, during this inspection we noted the theatre doors were now closing correctly and therefore the risk to patients was reduced.

Inadequate

Surgery

On the morning of our inspection visit, we were informed by a member of staff acting in the capacity as theatre lead for the day, that all operations on the day had been cancelled on the morning of our arrival. We were informed by this member of staff that there were several items missing or damaged in the theatre area, which meant carrying out surgery would be considered unsafe. We were told that a light fitting above the operating table was damaged, we were also shown a picture of the damage and told this ''could cause death'' to the patient underneath it. We were informed that the damage had been caused some time ago, possibly as far back as three weeks prior to our inspection visit. It was unclear why the damaged light was deemed a serious risk to patient safety on the day of our visit but had not been considered a high risk in the weeks prior to our visit when the damage was present. We checked what other equipment was deemed to be missing which meant it was unsafe to do surgery but could find no evidence of missing equipment. When we spoke with staff on the morning of our inspection visit it was unclear whether operations were going ahead or had been cancelled as staff did not appear fully informed on the latest developments. We then observed patients being prepped for theatre and subsequent operations taking place throughout our visit.

Post-inspection we asked the provider to explain to us why operations had been cancelled and then re-commenced on the same day and to give us assurance that they were satisfied their theatre area was safe for surgery. The provider did not outline a clear reason as to why they felt the light fitting was damaged enough that this would cause a potential risk of harm to patients. The provider gave us evidence of the light fitting having been repaired on 15 March 2021 which was prior to our inspection visit. The provider also sent us cancellation letters which were sent to patients on the day of our inspection visit which outlined an 'equipment shortage' was the reason their surgery was cancelled. It remains unclear as to the rationale behind some patient's operations being cancelled and not others, on the day of inspection.

We visited the ward in response to concerns which had been raised with us. These concerns included the patient adjustable electronic beds, which were said not to be functioning properly. We checked the beds in all rooms used by patients, six in total. Of these one was not fully functional. This room had been occupied by a patient, although they were in the operating theatre at the time. When we asked one of the nurses about this bed, they told us there had been an electrical problem the previous day, which they understood related to the room lights, and was subsequently repaired. However, they had not realised the plug sockets in the room were not working. This same nurse told us that faulty equipment was reported to a member of administrative staff. Whilst there was a 'handyman' for some repairs for electrical matters a contractor would be required.

There was evidence of various contracts and servicing of equipment held within folders in the administration office. However, as there was no registered manager or nominated individual on site, we were not able to check if there was a clearly defined schedule for equipment maintenance checks or timelines for replacement when items had reached their expected lifespan or depreciated.

We had also been told the environment in which patients were being nursed were not sufficiently clean. Our observations of the ward were that the rooms, including toilets and shower facilities were visibly clean and tidy. The person responsible for cleaning provided us with a check list of tasks to be completed throughout the day. It was not clear from this checklist what the required standards were for each area and if the cleaner was required to use different colour coded equipment in different areas.

The reception area and adjoining consultation room and treatment room were visibly clean and tidy. Appropriate signage was used when cleaning of floors was in progress. Only one toilet was functioning in the reception area. This was used by staff and visitors. It was noted that whilst toilet cleaning fluid had been squirted into the water, the toilet had not been cleaned thoroughly.

Inadequate

Surgery

Paper divisional curtains used to separate the bed space in two patient rooms where they were used for double occupancy were clean and dated as having been hung in November 2020. The hospital had not been open to surgical activity then or in December, so it was reasonable that the curtains had not been changed more recently. It was noted that sticky residue was left on the bed ends, as a result of having patient name labels stuck on them. This prevented the beds from being cleaned as fully as would be expected. The cleaning of beds was said by the cleaner to be their responsibility.

In one room in the ward area the toilet was a separate room in the bedroom. It did not have a handwash basin therein, which meant the patient would have to cross the room to go to the shower facility to handwash.

A hand sanitiser was empty in one bedroom and one which was located in a communal part of the ward area was also empty.

We were told by the cleaner that the operating theatre was cleaned by staff in theatres. Our observations indicated that the environment of the operating room and recovery were visibly clean and appropriate for use.

Whistleblowing information had indicated to us that equipment was being used when it was out of date. We looked at a range of equipment which would be used for patients. Resuscitation equipment, oxygen masks and tubing were all in date. The portable suction device stored by the resuscitation trolley on the ward area had been serviced but, needed a thorough clean. The emergency resuscitation trolly and equipment had been checked on days when the hospital was open; however, as we had found on previous inspections this was not securely locked and medicines held within the trolley were readily accessible. The security tag had been applied incorrectly and although sealed had not been engaged through the closure device.

Some single use syringes and scissors used for wound dressings on the ward were found to have expired. We highlighted this to a member of staff who removed these items from use and ensured their safe disposal.

We asked one of the ward nurses if there were any difficulties getting supplies of equipment or if they had been told to use up expired products before new items could be ordered. They confirmed the latter was not the case but added that because of the lack of a ward manager on a permanent basis, that it was difficult to know if and who had ordered equipment. They confirmed by way of example that sometimes it was not known until the day that items were not available, in this case on the day of our visit, pregnancy tests were in short supply. A member of administrative staff had to obtain these. This same nurse told us when equipment was found to be faulty this was communicated to a member of the administrative staff.

A concern regarding the suitability and availability of theatre equipment was raised to CQC prior to this inspection. A concern regarding the availability of difficult airway equipment formed part of these concerns. During our inspection we noted there was appropriate difficult airway management devices including a tracheostomy kit available in the theatre resuscitation trolley.

There was a clear audit to show anaesthetic machines were checked each day prior to surgery commencing. We also noted the anaesthetic machine was serviced and not due for re-inspection until 16/02/2022 Back-up oxygen and air was available on the anaesthetic machine alongside piped gases. We noted suction devices were in working order. Emergency drugs were present and a bag valve mask for the safe ventilation of patients. However, a second anaesthetic machine, which was to be used as a back-up did not have a service book or checklist to show when it had been last inspected. Staff said they checked it periodically to ensure it worked.

Inadequate

Surgery

Assessing and responding to patient risk

Control measures to assess and respond to patient risk were not sufficient.

Following the inspection carried out in January 2020 we told the provider they must arrange a service level agreement or contract for the emergency transfer out of patients to the NHS as this did not exist as the policy suggested it should. During the October 2020 inspection, we requested to see the service level agreement and were sent an informal email which indicated that the agreement was not yet formalised. However, the provider has now provided details of a service level agreement with a local NHS trust for the emergency transfer out of patients.

One of the required actions following our previous inspection was that the registered provider was to ensure there was a service level agreement or contract in place for obtaining blood or blood products. We were provided with a copy of the service level agreement. We reviewed this document and noted there were several expectations of the provider to meet their commitments to the agreement. This included for example: staff received training by The Belvedere Private Hospital; their competencies checked; and suitable arrangements would be in place to request blood products and to manage such items. The provider had not taken steps to fulfil the requirements of the terms of the service level agreement or to make staff aware of it. There had not been any arrangements to develop the required training, either internally or from an external provider. A policy to support the process of requesting and managing emergency blood products had not been written or agreed. We were not satisfied that in an emergency staff would be able to act effectively as they were not aware of the resources available to them.

On the last inspection, we did not see any clear signage in the waiting area or consultant rooms to indicate that individuals could ask for and expect a chaperone. However, during this inspection, we saw signs offering patients a chaperone if requested.

Staffing

At the time of inspection, the provider did not have a registered manager in post. Staff were unaware of who oversaw running of day-to-day activities. A nominated individual submission had been approved by CQC. This individual was not on-site on the day of inspection and no staff member referred to them during our discussions. During a telephone call with the CEO on the day of inspection they advised us a new person would be submitting their application to be the nominated individual. They did not tell us if the aforementioned person had left the post or who was in charge on the day of our inspection. The provider has subsequently sent to CQC an application for a nominated individual, it is however, unclear the capacity this person will be working in or the duties of this person once they commence their role. Post inspection, the provider told us they would be looking to recruit a registered manager by the end of April 2021. We were also made aware that a person had been appointed on a consultancy basis to manage the service after our inspection.

Medicines

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

We found a number of out-of-date tablets in the ward area of the hospital. This was bought to the attention of nursing staff working on the day and was removed and disposed of.

Inadequate

Surgery

One whistleblowing concern bought to our attention prior to the inspection was that controlled drugs (CD's) were not stored correctly. Of particular concern was the security of CD's. However, during the inspection we found CD's were correctly stored and placed in a secure cupboard which was locked and only accessible by staff with authorised access. We also found CD usage was correctly documented and all drugs accounted for.

On the day of inspection there were no drugs available for the management of local anaesthetic systemic toxicity. A drug named Intralipid, a lipid emulsion therapy which mitigates the toxic effects of local anaesthetics and can reverse both neurologic and cardiac toxicity, was not present. An anaesthetist working on the day of inspection told us they would arrange delivery of this from a local pharmacy if required. However, this is unlikely to be an effective way of managing this type of patient in an emergency situation. It is also doubtful that this drug would be stored in a local community pharmacy. Following the inspection, we informed the provider of our concerns regarding this and asked for assurance that this would be rectified. The provider has supplied information showing that an order of Intralipid has been placed.

Incidents

The service did not manage patient safety incidents well. There was a lack of evidence of serious incidents having been fully investigated, or any guidance for how to investigate them. There was limited evidence of lessons learned being shared with the whole team.

During our last inspection we noted the incident investigation process was not sufficient, and staff were unable to tell us how they follow up serious incidents they had reported. During this inspection, we found there was no clear mechanism by which staff were informed of changes to practice following any investigations. It was also unclear who investigated incidents in the absence of a hospital manager or how incidents were investigated. We found four incidents relating to cancellation of patients, missing or defective equipment and medical equipment ordering issues. None of these incidents appeared to have been investigated, it was unclear what the outcome was, and only partial information was documented making it difficult to understand what the exact incident was or if the incident had generated any learning to minimise it happening again. This demonstrated a lack of oversight of the providers incident investigations processes.

We spoke with two members of staff who were unclear on the process for reporting incidents in the absence of a hospital manager.

Post-inspection, the provider supplied us with a copy of their incident and reporting policy. This policy did not describe the skills of the registered manager in relation to their role as an investigator. There was no description of the incident investigation process. Again, this demonstrated a lack of oversight over the systems and processes in place at the service. There was no mention of any independent review or oversight of incidents at a medical advisory committee (MAC).

Post-inspection, the provider supplied us with a copy of their incident and near misses log. There were no incidents identified in 2021, and eleven risks identified in 2020. There were no attached investigation reports, or narrative provided on how the incidents were investigated or by whom. There was no information supplied on the log of any learning from incidents or any additional information to show that actions had been taken and learning was shared with staff. Service users will or may be exposed to the risk of harm if learning is not identified from incidents, in order to prevent recurrences.

Inadequate

Surgery

Are Surgery effective?

Inadequate

Inspection findings limited this key question to an inadequate rating.

Evidence-based care and treatment

The service could not demonstrate it provided all care and treatment based on relevant national guidance and evidence-based practice.

We reviewed several policies prior to the inspection and during the on-site inspection. We noted that the provider had hired an external company to support them in having policies relevant to the service. However, these policies were not always tailored specifically to the service and did not inform or instruct staff how to carry out a specific duty at the hospital. For example, the safeguarding policy directed staff to inform the hospital manager if they had a potential safeguarding concern; however, the policy did not outline who this person was and how contact should be made, or who to contact in their absence. In the absence of a hospital manager at the time of inspection, the policy was unworkable and did not detail enough specific information. An incident referral policy also made reference to GP reporting via The National Reporting and Learning System (NRLS) which is not relevant to the service.

Post inspection, the provider supplied us with further policies which could not be located during the on-site inspection. However, these policies were not always detailed enough to be assured that the service had adequate oversight. For example, the mandatory training policy does not state time frames or frequency for training. As a policy for staff to follow, the content fails to indicate all the required mandatory subjects, such as basic or advanced life support, or training specific to staff roles. Further, the policy does not indicate any requirements for training, or the subjects to be covered by consultant surgeons or anaesthetists.

The provider supplied us with a copy of the incident and reporting policy. This policy did not describe the skills of the registered manager in relation to their role as an investigator. There was no description of the incident investigation process. Again, this demonstrates a lack of oversight over the systems and processes in place at the service.

As noted in our previous inspection, staff signed front sheets of policies to demonstrate they had read them. The front sheets did not have enough signatures on to demonstrate all members of staff had read the policies, nor did they specify which employee groups needed to read which policies. The front sheets also did not note which version of the policy had been read. Therefore, if a policy was updated but the front sheet not changed, staff may not refresh their knowledge of the new policy.

Policies were available through an online portal only, staff told us that paper copies did not exist. However, staff in the ward area told us the computer there was unable to access the policies and they would need to go to a different area if they needed to access a policy. This meant staff working in this area did not have timely access to policies.

Competent staff

The service did not always make sure staff were competent for their roles.

Inadequate

Surgery

Prior to the on-site inspection, CQC received specific information of concern relating to the competence of surgical staff working at the location. We were alerted to the potential that surgeons undertaking procedures did not possess the correct training credentials to be carrying out cosmetic surgery. We also received information that several medical staff were not on the General Medical Council (GMC) register. During the inspection, we reviewed seven personnel files relating to medical staff working at The Belvedere Private Hospital. Files were inconsistent in content, although there was a standard index. Reference was made to basic life support training and advanced life support in four out of seven files. However, apart from one consultant who had provided a printout from the NHS trust where they also worked, there was a lack of evidence to indicate what mandatory safety training medical personnel had completed.

Post inspection the provider supplied us with a document which showed a list of consultants and anaesthetists who hold practising privileges at the hospital. We noted that a check of the GMC register had been completed for these staff. However, it was noted one GMC registration was showing as lapsed for an anaesthetist on the document provided, however, a further check of the GMC register by the inspection team showed the staff member had a valid GMC registration.

We had received a concern that breast augmentation surgery was being completed quickly, indicating that safe care and treatment was not being applied. However, a check of the theatre log showed that operations were being completed in a satisfactory time and did not appear to be unreasonably short in duration.

Are Surgery caring?

Good

On this occasion we did not rate this key question. This key question remains rated as good.

Understanding and involvement of patients and those close to them

Post inspection, we asked the provider to send us the contact details of patients who had received surgery at The Belvedere in the previous six months. We contacted nine former patients as well as patients who had contacted CQC with concerns regarding the service. Four former patients told us they had a positive experience at The Belvedere and felt their care and treatment was in-line with their expectations and they had received all of the information required to make informed choices prior to their surgery. Three patients told us they had received follow up care and advice in a timely manner and with the consultant who carried out their surgery.

Are Surgery responsive?

Requires Improvement

Inspection findings limited this key question to a requires improvement rating.

Learning from complaints and concerns

People were able to give feedback and raise concerns about care received. However, the service could not demonstrate they treated concerns and complaints seriously or investigated them sufficiently or shared lessons learned with all staff.

Inadequate

Surgery

During the inspection, we reviewed five paper-based complaints. It was unclear if the complaints we reviewed were the only complaints received into the service or whether complaints were handled through a different system. However, the five paper-based complaints we reviewed did not detail how the complaint was handled and did not show any response sent to the complainant, nor did it detail an outcome or resolution. As a result, we were not assured that there was sufficient oversight over the complaints process. We could not be assured that the provider was using any complaints received to inform learning to improve the quality of your service or improve the experience of service users.

Post-inspection, the provider sent us a copy of their complaints policy which contained detail that was not relevant to the registered providers location. For example, the policy states that contact with Independent Sector Complaints Adjudication Service (ISCAS) can be made, however, the provider is not currently a member of ISCAS. This demonstrated a lack of general oversight.

Post-inspection, CQC requested further information, including a copy of the responses to each complaint received by the provider within the previous six months and any learning associated with these complaints. The provider did not provide these. Therefore, we were not assured there was adequate oversight of the complaints process.

Access and Flow

Four patients we spoke with post-inspection told us they had received mixed communications from The Belvedere in respect of their surgery. They reported being told their surgery date was on a particular day to then have it re-arranged or moved, often at short notice, to another day. Three patients we spoke with had problems arranging a follow up appointment post-surgery but did state they eventually did have one with their operating surgeon. One patient we spoke with was unable to gain any follow up appointment after being told there was no member of staff available to see the patient. This patient ended up receiving care in their local NHS hospital following post-surgical complications.

Are Surgery well-led?

Inadequate

Inspection findings limited this key question to an inadequate rating.

Leadership

In the absence of a manager overseeing day-to-day activity, the service could not demonstrate effective leadership of the service.

On the day of the inspection there was no nominated individual, although we were informed by the CEO by telephone soon after our arrival that a new person had been appointed and would be submitting their notifications later in the day. A nominated individual should be someone who has responsibility for supervising the management of the regulated activity. They should be an employed director, manager or secretary of the organisation.

There was no registered manager and the provider had not had a substantive post holder in this role since December 2019. There had been several changes in appointments to this role, all of which had either not submitted their application

to CQC, did not complete the form correctly, or left before the process of registration was undertaken. The person appointed as registered manager should be in day-to-day charge of carrying on the regulated activity or activities they apply to be registered for. After registration, a registered manager has a legal role in enabling and monitoring compliance with essential standards across all regulated activities.

We were greeted by a member of bank staff who was previously known to us in the post holder of a registered manager. They advised that they were there purely in the capacity of a member of the theatre team and not as the person in charge of the service. This individual was well known to staff and as a result was named by the staff in discussion as the person they would inform if there were any problems on the day.

The provider made us aware after the inspection that they had appointed a manager in April, as a result of the previous manager leaving. Further, they advised us they were seeking to employ a suitable person to take up the role of registered manager.

The provider had appointed a nominated individual in September 2020, and they left their post at the start of March 2021. We checked some administration files to review some of the systems and processes around governance, which were in place or had been started after their appointment. We noted there had not been any Medical advisory Committee meetings since November 2020. There were no minutes from this meeting within the folder and we were unclear what had been discussed, including what information had been shared in relation to previous inspection findings or other important matters, including for example, the providers intentions around operating during the most recent wave of the pandemic.

Governance

The hospital still did not have a systematic approach to improving service quality and safeguarding high standards of care. There remained a lack of overarching governance.

During the two previous inspections we were not assured that the former managers understood what information was required within the policies and procedures to ensure the safe and effective delivery of care. We reviewed several policies and procedures and found they had not improved.

The previous hospital manager had told us they knew the policies and guidelines were not satisfactory and that they were working to develop them. However, we saw no evidence of progress with this.

Managing risks, issues and performance

There were no effective systems in place for managing risks, and there was no evidence risks and their mitigating actions were discussed with the team.

We were provided with an updated copy of the service's risk register. This log was now updated and included COVID-19 as a risk, with the ways the hospital would reduce this risk to patients and staff. Other risks were mentioned such as equipment and supply ordering issues, reduced availability of muscle relaxant drugs (which we found there was plenty of stock of during the inspection) and no stock of intralipid. The risk register had different columns including reference, description of risk, date for review, lead, risk assessment, risk rating, risk minimisation and next review date. However, in

the absence of a registered manager or any person who was overseeing the day-to-day management of the hospital, a number of these columns were left blank. For example, the risk owner, indicated in the 'lead' column was often blank. Therefore, we were not assured the provider had adequate measures in place to reduce the risk items on the log. This was a similar issue found in our previous inspection report.

During the inspection, one member of staff working under a bank contract and working as theatre supervisor for the day was adding items onto the risk register whilst the inspection team was present. The oversight and inclusion of items onto the risk register would not be in the duties or responsibilities of this person.

Post-inspection, in response to a CQC request for information, the provider sent us a copy of an updated risk register. Out of the 16 hospital risks identified, only six had a designated risk lead. We noted that an ex-employee of the registered provider was currently shown as responsible for 15 theatre risks. We also noted that a bank member of staff is listed as risk lead. One risk had no description and eight risks had no date listed. Three risks had review dates which have passed, and the rest of the risks did not have a review date listed. There was no clear criteria for how risks are identified and rated. Therefore, we do not have adequate assurance that the provider has oversight of current risks, mitigations for these and plans to reduce the risk. Service users may or will be exposed to the risk of harm if you do not have clear processes in place for the management of risks or have oversight of this.

As mentioned in our previous inspection, the hospital continued to advertise fat transfer procedures on their website, such as the Brazilian butt lift. We were again told the hospital did not carry out such procedures, due to the risks associated, however they were still listed on their website. We were concerned the provider did not appreciate the significance of the risk of this procedure. The British Association of Aesthetic Plastic Surgeons (BAAPS) have advised members to observe a moratorium on this procedure, as it carries a high mortality rate. This had not changed since our previous inspection.

In the absence of a hospital manager or a registered manager at the hospital we could not be assured that statutory notifications required under the Health and Social Care Act regulations were being completed and sent to CQC. This was a concern also noted in the previous inspection report.

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	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment