The Pemberdeen Laser Cosmetic Surgery Clinic Limited

The Belvedere Private Hospital

Quality Report

Knee Hill
Abbey Wood
London SE2 0GD
Tel:0208 311 4464
Website:www.belvedereclinic.co.uk

Date of inspection visit: 4 & 5 August 2015
Date of publication: 23/02/2016

This report describes our judgement of the quality of care at this hospital. 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.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Belvedere Private Hospital provides cosmetic surgery to private patients. The Pemberdeen Laser Cosmetic Surgery Clinic Limited owns and manages the service.

The service carries out about 400 cosmetic procedures a year, predominantly breast augmentation. Most procedures are day cases, with a small number of overnight admissions. There are no critical care facilities available at the service.

Services are available to people paying for one-off treatment.

We carried out a comprehensive inspection of The Belvedere Private Hospital on 4 and 5 August 2015. The inspection formed part of a pilot programme of inspections in independent healthcare settings. The inspection reviewed surgical services as this is the one core service provided by the service from the eight that that are usually inspected by the Care Quality Commission (CQC) as part of its approach to hospital inspection.

We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those hospitals that provide solely or mainly cosmetic surgery services.

We identified the service for inspection based on a history of non-compliance with regulations.

Overall we found the quality of care was unsatisfactory and needed urgent improvement. Our key findings are as follows:

Are services safe at this hospital/service

• There were continuing breaches of regulations with regard to infection prevention and control. We found clinical waste from the previous day in the ward bins after patients had been admitted to the ward. There was no action plan to remedy issues found in an external audit in June 2015. The domestic assistant cleaned the theatre regularly and disposed of clinical waste, but had not received training in the specific requirements for infection control and prevention in theatres or in waste disposal.

• The provider had commissioned external companies to carry out a fire risk assessment and a health and safety risk assessment. However, there was no formal plan to address the issues identified in these assessments and audits.

• The systems for the investigation of incidents and dissemination of learning from incidents were insufficiently robust and failed to ensure that the risk of recurrence was minimised. The incident policy had not been updated to incorporate the duty of candour.

• There was no backup anaesthetic machine and no plans to purchase one at the time of our inspection. One of the resuscitation trolleys jammed and would not fully open during our inspection. The manager immediately ordered a replacement. There were regular checks on theatre and other equipment. The manager had put in place processes ensure there were sufficient instrument sets and consumables to carry out planned procedures.

• The staffing levels were appropriate for the type procedures undertaken, and surgery did not take place without a full theatre team. Staff received mandatory training.

• Medicines were stored safely and there were regular, recorded checks of the temperature of the fridges storing medicines.

• Patient records were sometimes incomplete or contained inaccuracies.

• A nurse assessed all patients before surgery was confirmed.

• Surgical, medical and theatre staff followed the 'five steps to safer surgery' to ensure that safety checks were followed.

Summary of findings

• Nurses monitored patients post-operatively and referred to the resident medical officers (RMO) on duty if necessary. On the rare occasions when recovery was not straight forward, patients went to the nearest NHS hospital emergency department. However, the RMOs on duty at the time of our inspection did not have advanced life support training: the anaesthetist in theatres was the only person on site with this training. There had been no practice emergency scenarios, and the service did not have a resuscitation lead.

Are services effective at this hospital/service

• The registered manager reviewed guidance, and maintained an overview of practice standards in theatres. There were checks in place to support adherence to these standards.

• The surgeons working at the service took professional responsibility for following national and Royal College of Surgeons guidance.

• There was no clinical audit programme to identify the standards the provider expected to meet or to monitor adherence to these. When there were audits, it was not clear whether these were new audits or re-audits and whether the service was ensuring the implementation of actions arising from them.

• The provider did not collate information about outcomes for patients, and the process for identifying areas for improvements relied on surgeons each reviewing outcomes and discussing these informally. When the Medical Advisory Committee (MAC) made decisions about changing practice, these were not always disseminated to surgeons.

• The MAC was responsible for granting and overseeing practicing privileges for the surgeons who carried out procedures. We were not assured that surgeons working privately were adhering to the General Medical Council (GMC) revalidation process.

• The manager and deputy manager had received appraisals and some training was identified as a result. There was a lack of clinical supervision or peer support for the manager. The manager checked that agency, bank and locum staff had appropriate qualification before engaging them. There was no assurance that domestic and administrative staff had the competencies required to undertake their allocated tasks.

• Surgeon's consultations with patients were sometimes brief, without evidence of discussions about risks or the expectations of the patient. Administrative staff provided further information to patients. None of the administrative or nursing staff had training in the Mental Capacity Act 2005 or were able to explain how the Act might be relevant to people seeking cosmetic surgery. There was always a waiting period, with time for the patient to reflect between their consultation with the surgeon and the signing of consent for the procedure.

• There were processes in place for the management of patients' pain. Staff supported patients to eat and to drink enough fluids.

Are services caring at this hospital/service

• Patients we spoke with during the inspection confirmed that staff were kind, considerate and respectful.

• We observed interactions between the staff, consultants and patients and saw that staff were attentive and caring in their attitude, providing assurance and support when needed.

• Prospective patients were given written information about cosmetic surgery, including fees.

Are services responsive at this hospital/service

• The facilities and premises were appropriate for the services provided.

• The provider planned its services around patient demand. At the time of this inspection surgery was carried out over two (occasionally three) days every fortnight.

• Patients sometimes experienced delays because of the limited opening hours of the service, and procedures were sometimes at cancelled at late notice. There had been 27 operations cancelled over the past year.

Summary of findings

• The written information given to patients was in English and there was no provision to provide interpreters for patients who did not speak and/or read English.

• The service had a complaints policy and procedure in place and there was information available for patients about how to raise concerns. Twelve complaints made in 2015 had been recorded and responded to. Most of these related to either cancelled operations or poor outcomes.

• Staff gave patients questionnaires so that they could feed back their experience of care. The majority of feedback from patients was positive.

Are services well led at this hospital/service

• The safety and quality of service was reliant on the manager, who was responsible for clinical governance, running the service, and managing risk. There was a history of instability, with a high turnover of managers, and of failure to set up processes and systems to support continuity.

• There was no system in place to identify, record, and address or mitigate risks. There was a disconnection between risk assessment and the identification of the resources to reduce the risk. The manager had identified areas for improvement, but the provider had no strategy to implement these. The provider did not have a credible business plan and there was evidence of poor financial standing with contractors.

• We were unable to establish that appropriate quality measurement systems were in place as relevant documentation was not available.

• Staff commented favourably on the changes made since the current manager took up her post. They felt she was approachable, visible and provided strong leadership. Feedback from patients was positive.

There were areas of poor practice where the provider needed to make improvements.

Importantly, the provider must ensure:

• A risk register is established, which records existing and potential risks, and identities action to address and mitigate the risks.

• There are effective systems to assess, monitor and improve the quality and safety of the services provided.

• There are processes in place to integrate information about risk and identified improvements with financial information in order to support decision-making.

• All incidents are recorded and appropriately investigated and, where required, notified to the Care Quality Commission.

• A programme of complete clinical audit cycles is established to monitor and improve quality of care.

• The medical advisory committee (MAC) reviews information about doctors and surgeons with practicing privileges and ensures they are complying with GMC requirements for registration.

• Lessons learnt from incidents or near misses, and decisions made at the MAC meetings and staff meetings are shared with staff.

• Policies and procedures are up-to-date, relevant to the provider and put into practice at the hospital.

• The registered manager has appropriate support to carry out her duties and to ensure the service operates safely in her absence.

• All staff are appropriately trained for the roles they perform.

• Long-term bank and agency staff receive an annual appraisal and regular supervision.

Summary of findings

• Staff participate in simulation exercises so they are aware of the action they need to take in an emergency.

• There are infection prevention and control systems and processes in place.

• The hospital has sufficient equipment for the procedures it performs and for the safety of its patients.

• Appropriate risk assessments are carried out, recorded, reviewed and, where remedial action is identified, this is taken.

• Records are accurate, fit for purpose, and retained for an appropriate duration.

• Training and support is provided so that all relevant staff are familiar with the Mental Capacity Act 2005 and understand how they should apply it in practice.

• There is appropriate security in high-risk areas.

• There is a review the changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and, in particular, the duty of candour.

In addition the provider should:

• Provide evidence that surgeon's consultations with prospective patients meet professional standards.

• Set up a forum for staff to give feedback.

• Review the staffing structure so staff share lead roles rather than all of them sitting with one person.

• Review its website to ensure all information provided is accurate and meets Advertising Standards Authority **(**ASA**)** and professional standards.

• Provide access to interpreter services for patients whose first language is not English.

• Establish lines of communication to ensure good practice guidelines and safety alerts are shared with all staff.

CQC has issued formal warnings to The Pemberdeen Laser Cosmetic Surgery Clinic Limited telling them that they must make improvements at the Belvedere Private Hospital in the following areas by 4 November 2015:

Regulation 12: Safe care and treatment. The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

Regulation 17: Good governance. The service was failing to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery		The provider's reliance on the registered manager for all aspects of management was a risk to people using the service and to staff. The current manager had introduced improvements since her appointment in January 2015, but she did not have time to undertake all the tasks necessary to ensure the service was safe and reliable. The manger had identified some risks, but there was no risk register to record and manage identified risks. Financial information was not integrated with information about risk to support decision-making. The provider continued to breach regulations relating to infection prevention and control. The manager was highly visible and accessible, and staff commented positively on her leadership role and the changes she had implemented. However, the high turnover of managers and the absence of processes to ensure continuity contributed to the difficulties of managing the service. The manager did not have access to data from 2014, such as incidents and complaints. Governance arrangements were unclear, and processes were not in place to ensure clinical standards were met. Many policies were out of date, and in some cases not relevant to this provider. Staffing levels at the time of this inspection were adequate for the type of surgery undertaken at the service. Procedures were sometimes cancelled, however, when there were not enough staff to meet these levels. The provider had a poor standing with a number of contractors, which affected access to staffing when replacements were required at short notice. Staff had received mandatory training, but domestic and administrative staff were undertaking tasks without evidence of competence. The risks of surgery were reduced because the theatre team followed checks and processes to promote safe practice in theatre. Staff assessed patients appropriately post-operatively and met patients' pain, nutritional and hydration needs. Patient satisfaction questionnaires indicated a high percentage of patients considered the care and support they received was good. However, surgeons'

Summary of findings

consultations with patients about cosmetic surgery did not always meet the recommended standards. Procedures were sometimes cancelled with little notice to the patients.

CQC has issued formal warnings to The Pemberdeen Laser Cosmetic Surgery Clinic Limited telling them that they must make improvements at the Belvedere Private Hospital in the following areas by 4 November 2015:

Regulation 12: Safe care and treatment. The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

Regulation 17: Good governance. The service was failing to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

The Belvedere Private Hospital

Detailed findings

Services we looked at
Surgery

Detailed findings

Contents

Background to The Belvedere Private Hospital

The Belvedere Private Hospital is the only registered location operated by The Pemberdeen Laser Cosmetic Surgery Clinic Limited. The hospital provides privately funded surgical cosmetic treatments for adults. It is in South London and draws its clientele from a wide geographic area.

The hospital has eight beds, predominantly for day cases, but it can accommodate overnight admissions where required. It has one theatre, in which operations take place on alternate weeks. Preferred days for surgery are Tuesday, Wednesday and/or Thursday. Access to the hospital is either via an unmade and very uneven road, or via a steep flight of stairs from the car park.

The hospital manager was appointed in January 2015 and the Care Quality Commission (CQC) registered them in May 2015.

Our inspection team

Our inspection team was led by:

Inspection Manager: Margaret Lynes - Care Quality Commission.

The team included CQC inspectors, a consultant plastic surgeon, and two theatre nurse specialists. Those members of the team who were not CQC inspectors had the same authority to enter registered persons' premises as the CQC inspectors.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to peoples' needs?
- Is it well led?

Before visiting we reviewed a range of information we held about the hospital. We invited patients to contact CQC with their feedback. We visited the hospital on 4 and 5 August 2015 to undertake an announced inspection.

As part of the inspection visit process, we spoke with the nominated individual and individual staff of all grades.

Detailed findings

We spoke with inpatients and people attending the outpatient clinic. We looked at comments made by patients when completing the hospital satisfaction survey and reviewed complaints made to the hospital.

We inspected all areas of the hospital over two days. Our inspectors and specialist advisers spent time observing care across the hospital, including in the operating theatre. We reviewed patient's records where necessary to help us understand the care that they had received. We also reviewed maintenance, training, monitoring and other records held by the hospital, where these were available.

Facts and data about The Belvedere Private Hospital

At the time of the inspection visit, there were three surgeons and one anaesthetist working at the hospital under practicing privileges. There were two substantive registered nurses. All other staff were either bank, locum or employed on zero hour contracts.

The hospital informed us there had been two overnight patients in the reporting period April 2014 to March 2015; and 392 day cases during the same time frame. It was unable to provide us with data for the number of visits to theatre in that same reporting period.

The hospital does not treat children and young people under 18 years of age.

The service has been granted an exemption with regard to the requirement to have a controlled drugs accountable officer.

Are services safe?

Our findings

We found serious concerns about safety. Previous CQC inspections had found breaches of infection prevention and control regulations. During our recent inspection, we also found breaches of the regulations. Furthermore, the service had failed to put in place an action plan to remedy issues found in an external audit in June 2015. The domestic assistant cleaned the theatre regularly and disposed of clinical waste, but had not received training in the specific requirements for infection control and prevention in theatres or in waste disposal. There was clinical waste from the previous day in the ward bins.

The provider had commissioned an legionella assessment, which had found a lack of water temperature monitoring and staff did not run taps on a regular basis. We found on our inspection that temperature checks were carried out and recorded in a diary, but there was no record that taps were run on a regular basis.

The provider had also commissioned external companies to carry out a fire risk assessment and a health and safety risk assessment. However, there was no evidence of a plan to address the issues identified.

The systems for the reporting, analysis and dissemination of learning from incidents were insufficiently robust. The Belvedere Private Hospital had an incident reporting policy, and staff knew about the process for reporting incidents. However, the policy had not been updated to include information about, for example, the duty of candour.

The registered manager had informed the director that she had decommissioned the second anaesthetic machine, but there was no record of plans to replace it. One of the two resuscitation trolleys was jammed during our inspection. The manager immediately ordered a replacement. There were regular checks on theatre and other equipment. The manager had put in place processes ensure there were sufficient instrument sets and consumables to carry out planned procedures.

Patient records were not always complete and there were some inaccuracies. Medicines were stored safely and there were regular, recorded checks on temperature of the fridges storing medicines. The provider did not have arrangements with an external pharmacist to audit medicines. Oxygen cylinders were available by each bed space but were being stored inappropriately on the floor.

There were processes in place to assess risk to patients. A nurse assessed all patients before the date for surgery was confirmed. Theatre staff followed 'Five Steps to Safer Surgery' and gave us examples of when the WHO surgical safety checklist had been effective. Staff monitored patients post-operatively and nursing staff were clear they would escalate concerns to the Resident Medical Officer (RMO). There was a protocol in place to address the rapid deterioration of a patient, but there were no practice scenarios. The service did not have a resuscitation lead and nursing staff and the RMO on duty at the time of our inspection had only basic life support training.

The registered manager ensured there were sufficient staff in theatre to provide a safe service and surgery did not take place without a full team. If a post-surgery overnight stay for a patient was indicated, the manager booked additional nursing and medical staff prior to surgery. There was no process in place to mitigate the risk of not having additional medical staff at short notice.

Staff received mandatory training, the details of which were on their files.

Incidents

- There was an Adverse Incident Management Policy, but this had not been reviewed.

- The policy stated that all adverse incidents and near misses (clinical and non-clinical) would be reported, actions taken where appropriate to reduce the risk of the incident or near miss occurring again, and feedback provided to ensure all personnel learnt from the experience. It had not been updated to include the duty of candour, which was a requirement for all registered providers since April 2015. Qualified staff were able to tell us the process in place to report an incident. Theatre staff gave examples of incidents and near-misses, such as a missing suture (subsequently found).

- We asked for a record of reported incidents for the year 2014/2015. There was no data available for incidents between April 2014 and January 2015; three incidents had been recorded between February and March 2015. These related to equipment failure; cancellation of surgery due to the late delivery of implants, and the transfer of a patient to the nearest NHS service when they deteriorated.

- The hospital could not provide evidence that it had carried out appropriate investigations following incidents. The hospital had no recorded investigations for the

incidents we reviewed. The registered manager had looked into the serious incident of a deteriorating patient by talking to staff and reviewing records. She had concluded that the locum anaesthetist had not carried out his duties adequately and had informed the agency of his poor performance. Theatre staff described discussions at a pre-list brief about this incident. Nevertheless, there was no formal record or root cause analysis of the investigation so we were unable to assess whether this action was appropriate.

• There was contact with a patient by email and 'phone following this incident and the registered manager demonstrated an understanding of being open with patients. However, the patient did not receive a formal letter, which is the expectation of the duty of candour.

• We discussed the expectation that registered services inform CQC of serious incidents, as we had not received any notifications in the previous year. The nominated individual and registered manager were unaware of this requirement and assured us that they would report such incidents in the future.

Cleanliness, infection control and hygiene

• Patients, staff and visitors were not adequately protected from the risks of infection.

• When the CQC undertook a review of the provider's documents in August 2014, we did not find evidence that the systems put in place for prevention and control of infection were being followed. There was an audit tool, but no records of audits since April 2014.

• During our recent inspection, we saw evidence of an internal audit dated March 2015, with completed checklists for infection control standards for environment, waste disposal, sharps handling, equipment, disinfections and antiseptics, vaccines, hand hygiene, and clinical practice. The audit found 100% compliance. Nevertheless, we found examples when the service did not meet these standards when we inspected. For example, we saw a mop left standing in a bucket of water in the sluice and staff with jewellery below the elbow.

• The registered manager had recognised the need for external support and had arranged an external infection control audit in June 2015. This had highlighted 25 areas of non-compliance, including the re-use of single use equipment and the lack of waste consignment notes for the transportation of hazardous wastes. We asked for, but did not receive, evidence to indicate how the service had addressed, or was planning to address, these concerns.

• The domestic assistant had responsibility for cleaning the theatres, and we observed him cleaning during our inspection. However, he did not have training in the specific requirements for infection control in theatres. We were told an external company undertook deep cleaning and decontamination of theatres every six months, but the last date this was documented was January 2015. The service outsourced the sterilisation of theatre equipment. Its policy stated dirty surgical instruments would be transported in a box of one colour, and clean instruments collected in a different coloured box, but staff were not following this policy.

• The ward and outpatient areas were visibly clean on the first day of our inspection. There was a cleaning schedule for the housekeeper, but staff on duty on the wards were unable to provide it when we requested this. The deputy manager informed us that she checked the cleanliness of the ward areas at the beginning of each shift, prior to patients being admitted, but did not record this. We observed that the bottom of a dressing trolley outside one of the patient rooms and a shelf in the medicines and equipment storage area were very dusty. Both consultation rooms, including the one in which staff carried out post-operative wound checks, had carpeted floors. The carpets are vacuumed daily by the housekeeper and were deep cleaned every six months.

• There was a foot operated clinical waste bin available in each room in the ward area. On the morning of the second day of our inspection, we inspected the rooms before patients were admitted. We saw waste was present in almost all the clinical waste bins, including gloves and blood stained pads and dressings from the previous day's procedures. The deputy manager was not immediately available and by the time we were able to speak to her, a patient had been admitted to the room and staff were preparing them for surgery. The deputy manager was unaware that the bins had not been emptied.

• Equipment on the wards, such as blood pressure machines, did not have a sticker to indicate staff had cleaned them between patients and we observed a blood pressure cuff resting on the floor. Staff immediately cleaned

the cuff when we pointed this out to them. The pat slide board used to transfer patients was also stored on the floor next to the hand-washing sink, which potentially exposed patients to greater infection risks.

• The domestic assistant oversaw waste disposal at the service, but had not received any training on safe waste management. He was able to show us the different colour-coded cleaning equipment and bags for waste disposal. He was unaware, however, of how the service disposed of body parts and he informed us that the yellow bags available in the storeroom were never used.

• A Legionella microbiology check carried out in June 2015 had highlighted a number of areas of concern, including repairs required to the water tanks and a lack of water temperature monitoring. We saw that temperature checks were recorded in a diary, but there was no record that taps were run.

• Wall-mounted alcohol hand gels were available at the entrance to each room and in the corridors. There was one sink available for hand washing in the ward area, with a poster displaying correct hand washing techniques displayed next to the sink. There was a basin to scrub for theatre. There was personal protection equipment available, such as gloves, gowns for theatre staff and aprons for ward staff. Most staff were observing the policy of 'bare below elbow, but we observed an surgeon in theatre who was not observing this policy. The domestic assistant acted as theatre porter. We noted he wore the same scrubs in theatre, transferring patients and while moving around the service, which increased the risk to patients of cross infection.

• The records we reviewed showed all patients underwent routine screening for methicillin-resistant staphylococcus aureus (MRSA). The nurse in charge of pre-operative assessment told us that if the results came back positive, patients were referred to their general practitioner for treatment and their surgery was postponed. An MRSA audit was carried out in June 2014 and January 2015, the service recorded 100% compliance with good practice guidelines.

Environment and equipment

• An external adviser had been commissioned to undertake a health and safety risk assessment in April 2015. There was no plan in place to address the issues identified.

• The manager had decommissioned the second anaesthetic machine because it was not safe. She had informed the director but it had not been replaced. During our inspection we found it was not possible to open one of the drawers of the resuscitation trolley in the recovery area. The manager immediately ordered a new trolley and we saw evidence of the purchase. The manager had identified improvements to the environment and equipment. This included the purchase of an electrocardiogram (ECG) machine to enhance the patient pre-surgery assessments, and an Automatic External Defibrillator (AED) machine to replace the manual one. She had also identified the need to obtain wipeable patient chairs, to replace hand opened waste bins with foot operated ones and to replace torn mattresses. New bins had been delivered just before this inspection. The provider was not able to demonstrate if and when other improvements would be implemented.

• The service had a contract with an external company for maintenance and servicing of all equipment. The equipment in use on the ward had a sticker indicating it had been serviced in the past six months. A member of theatre staff completed a daily checklist for anaesthetic equipment, and we saw evidence of these checks. There were adequate supplies of instrument packs for procedures and theatre staff confirmed that sets were always available. Theatre staff or the domestic assistant checked the surgical instruments packs were ready for the next list. Theatre staff gave examples of when they had made a suggestion for an additional item of equipment (for example a holder for diathermy) and the manager had ordered this.

• There were systems in place for checks by an external company on the environment in the operating theatre, in line with relevant regulations, (Building Regulations 2000, England and Wales, approved document F1: Means of Ventilation and Heating and ventilation systems: Health Technical Memorandum, 03–01: Specialised ventilation for healthcare premises, A, HTM03/01 B, Health and Safety at Works Act 1974). Service Checks on the ventilation and air conditioning systems were due the week before our inspection, but staff could not provide records to show that these had taken place.

• The resuscitation trolley in the ward area was clean, fully stocked and all items on the trolley were in date. The nurses told us they had access to the equipment and materials needed to provide post-operative care in the ward area.

Are services safe?

• A fenced off area, adjacent to the entrance to the building, housing the theatre ventilation system and medical gases, was left unlocked for the duration of our inspection, which increased the risk of unauthorised entry. Staff told us this was the fire escape route from theatre and therefore had to be left open during theatre activity. We pointed out that the door lock could be changed to allow easy opening from the inside and staff informed us they would look into this.

Medicines

• The service had an undated medicines administration policy that stated a pharmacist would routinely check the controlled drug and medicines stock, but the service was not following this policy. There were no external medicines audits.

• We saw evidence that staff checked stocks regularly and that medicines were stored safely and appropriately in the theatre and in other areas. In the theatre area we noted that one ampule of Atropine (a drug used in surgery) in the general medicine cupboard was out of date and staff had already removed this from the box and put it to one side in the cupboard ready for disposal. The remaining medicines were all in date.

• Controlled drugs (CD) were stored in a separate locked cupboard and checked twice daily. There was a clear process for administration of controlled drugs, which staff were aware of and followed. We reviewed the contents of the CD cupboard against the CD book and did not find any discrepancy. Staff carried out and recorded temperature checks on the medication fridges on the days when the theatre was in use.

• The resident medical officer (RMO) prescribed all medicines on the ward and we saw that medication charts were clear and legible and staff had recorded allergies. However, in all the records we reviewed, patients were not prescribed oxygen despite observation charts indicating that they were on oxygen.

• Oxygen cylinders were available by each bed space but were being stored inappropriately on the floor. The domestic assistant was responsible for checking them but did not have training to do so.

• We asked the deputy manager to describe the process to obtain blood products, should a patient require a blood transfusion post-operatively. She explained that for large cases where the risk of blood loss was high, the patient would have a test to determine their blood group at pre-operative assessment. Staff would send this information to the local NHS hospital and the service would collect blood when required. There was no process in place should a patient need a blood transfusion in an emergency.

Records

• Patient records we reviewed were not always complete and there were some inaccuracies. We observed that the theatre checking-in section in the patient pathway document was blank in a number of patient records. We reviewed the theatre ledger and found errors relating to the patient's date of birth in two of the 13 patient details we reviewed.

• Each patient record contained detailed information about the surgery they had undergone and the post-operative notes had follow up plans, such as an appointment and take home medicines.

• In most records, we saw evidence that the consultant completed an assessment, including a discussion of risks. However, the consultation records for the two patients undergoing surgery on the first day of our inspection, comprised of a very brief documentation from the surgeon, mainly about implant sizes. The legibility of some patient records was poor making it difficult to determine what had been discussed or what treatment provided.

Safeguarding

• Staff we spoke with had undergone safeguarding training in the past year and there was a clear process in the ward area for staff to follow should they have safeguarding concerns about a patient. Staff were able to describe the process and give examples of when they might raise a concern.

• The service had a safeguarding policy that included the local authority contact number. There were copies of Belvedere Statement of Purpose Handbook in waiting room and in patient rooms with an explanation of the policy.

Mandatory training

• There was a spreadsheet to record the attendance of permanent and bank staff at mandatory training. This, along with staff records, indicated that training was up-to-date.

Are services safe?

• We reviewed ten staff records. These confirmed staff had attended training in, for example, health and safety, fire, and infection prevention and control.

Assessing and responding to patient risk

• The manager and consultant surgeons informed us that they only treated low risk patients and would not accept people with medical conditions or a high body-mass index (BMI). Staff contacted the patient's GP to determine if they held any information that would make the proposed surgery unsuitable and asked patients to sign a disclaimer if they did not wish their GP to be contacted.

• The deputy manager carried out assessments before the date for surgery was confirmed. There was a standard checklist, designed with anaesthetist input, for her to follow. There was no anaesthetist available at pre-assessment for the small number of patients were identified as requiring further assessment. The patients returned on a day when surgery took place, when an anaesthetist was available before the start of the list to review them.

• The manager told us that venous thromboembolism (VTE) (blood clots in a vein) assessments were carried out for every patient at pre-assessment. Most operations were short and patients mobilised immediately afterwards, so there was not need to use compression stockings.

• Theatre staff completed safety checks. We saw a checklist folder for both the theatre and recovery areas. Both were completed and up to date. Staff followed the 'five steps to safer surgery' before, during and after surgery to enhance the safety of patients. Theatre staff told us that everyone participating in procedures adhered to the five steps, and they gave examples of when it had been effective. For example, on an occasion when the surgical count of swabs, needles and instruments found a discrepancy, the patient was kept in theatre until the discrepancy was accounted for. There had been no reports of cases of retained objects post-surgery. A safer surgery checklist audit was carried out in March 2015, on 180 out of 360 checklists. The outcome of this indicated 90% compliance. Identified failings included staff not attending the debrief (the fifth step), staff not signing out, and incomplete information about the check list in patient notes. Theatre staff told us they all took responsibility to improve compliance with the five steps, but there had been no repeat audit to check whether this improvement had happened.

• Nurses reviewed patients on return to the ward from theatre and they recorded observations at regular intervals, including pain scores. The service was not currently using a recognised early warning score to determine when escalation was required. Staff we spoke with told us that they would escalate to the RMO in the first instance, who would then go to theatre and speak to the anaesthetist if required. They were unaware of the process in place for a post-operative anaesthetic review if the anaesthetist was unable to leave the theatre because another procedure was taking place.

• The service did not have the facilities to manage patients who required critical care support and we were told that should a patient's condition deteriorate, staff would call an ambulance for them to be transferred to the nearest NHS hospital. This had happened on one occasion in the last six months. In the event of a cardiac arrest post-operatively (which had not happened in the previous year), the nursing staff informed us that they would press the crash button and start CPR. However, on the days of our inspection, nursing staff and RMO were trained to basic life support level only; they said they would call the anaesthetist if necessary.

• The service's clinical emergency policy stated staff would undergo scenario training, but none of the staff we spoke with had undergone scenario training on responding to a clinical emergency. As they had not experienced a clinical emergency for a long time, the staff we spoke with were unsure of what the response would be in practice.

• The nursing staff were able to tell us about their criteria for discharge and assured us that patients stayed on the ward for as long as required. However, we observed in one patient's post-operative record that staff had started the patient on an intravenous infusion at 8pm, and at 8.05pm they took a set of observations as the patient was shaking and feeling dizzy when attempting to stand. The next entry at 8.40pm indicated that staff were discharging the patient and no further observations were recorded on the charts. In addition, the entry made no mention of whether the dizziness and shaking had stopped or about the amount of intravenous fluid given. The deputy manager was unable to explain how the service had ensured a safe discharge in this case.

• There were 24-hour cover arrangements. Staff gave patients an on-call contact number that connected them to either the manager or the deputy manager. If they had

concerns about the patient, they advised going to an NHS service. Post-surgery, all patients were seen for a follow up by a surgeon and then at 6 weeks. The two surgeons we spoke with told us they provided cover for each other if one of them was not available. The patients we talked to who had come for a post-operative check told us they were satisfied with the treatment and care they had received.

Nursing/theatre staffing

• We found that the staffing establishment levels agreed by the manager were appropriate for the type of procedures undertaken.

• With the exception of the manager and deputy manager, both registered nurses, all staff were bank, locum or agency. There was evidence from interviews with staff and the review of staff records that new bank and agency staff had an induction on their first day.

• There were two registered nurses on the wards on days when surgery took place, one of whom was usually the deputy manager and the second nurse either bank or agency. There were three theatre staff and a recovery nurse (all registered practitioners), who were agency or bank staff. Theatre staff had worked at the service regularly over the last three months and they told us they were familiar with the theatre, other staff and the type of procedure provided. The surgeon was supported by the scrub nurse. We were assured that a surgeon assistant was not necessary, in line with guidance from the Association for Perioperative Practice.

Surgical/medical staffing

• There were four surgeons who had been granted practicing privileges to work at the Belvedere Private Hospital. There was one anaesthetist with practicing privileges and the provider also used agency anaesthetists. The RMO was always from an agency. We were assured that the service, where possible, tried to use the same agency staff but, on both days of our visit, the RMOs had never worked at the service before. We saw the manager had completed a recruitment checklist for the RMOs, which included a CV, confirmation of GMC registration, list of qualifications and referees. Rotas for the last three months showed one RMO had worked for more than 24 consecutive hours on three occasions. We were told they were able to sleep on night duty and patient records indicated the nurse on duty at night rarely found it necessary to refer to the RMO, except prior to discharge in the morning.

• There were occasions when the anaesthetist, the RMO or a member of the theatre staff did not attend when booked. We saw that the manager either worked in theatres herself, or cancelled surgery if the agreed staffing establishment was not met.

• If a post-surgery overnight stay for a patient was indicated, the manager booked additional nursing and medical staff prior to surgery. There was no process in place to mitigate the risk of not having additional medical staff at short notice in the case of a patient not recovering as quickly as expected. Very few patients stayed overnight and there was no arrangement for surgeons to be available out of hours following surgery.

• The rotas for May, June and July 2015 demonstrated that the staffing levels were at establishment levels when surgery took place.

• The two surgeons we spoke with said they covered for each other, in case their patients needed to be seen post-operatively and they were not available.

Major incident awareness and training

• The staff we spoke with told us they had not undergone any emergency training such as fire evacuation drills.

• There was a ski pad board available for evacuation of patient in an emergency, with instructions of how to use this available in the nurses stations. However, staff we spoke with informed us that they had not had any training on how to use it and were therefore unsure what they would do in an emergency.

Are services effective?

Our findings

The hospital was not monitoring the effectiveness of its services.

The registered manager reviewed guidance, and maintained an overview, of practice standards in theatres. There were checks in place to support adherence to these standards. The surgeons working at the service took professional responsibility for following standards of the Royal College of Surgeons. However, there was no audit programme to identify the clinical standards the provider expected to meet, or to check adherence to these standards. The manger had undertaken some audits relating to clinical practice during 2015, such as record keeping and compliance with safety checks in theatre, but there was no data to indicate whether these were new audits or re-audits and whether actions arising from audits were monitored.

The provider did not collate information about outcomes for patients to help in identifying areas for improvements. Surgeons told us they reviewed outcomes for their own patients and discussed these to establish whether to introduce changes to practice. When the Medical Advisory Committee (MAC) made decisions about changing practice, these were not always disseminated to surgeons.

There was evidence in some records that surgeons had followed the Royal College of Surgery standards on the items to be covered in a consultation, but other records did not document these discussions. We did not see evidence of a consideration of the mental capacity of the patient to make a decision to undertake cosmetic surgery. There was routine contact with GPs to ask for information about the suitability of the patient for surgery. There was always a waiting period between the consultation and the taking of consent for the patient to reflect, in line with professional standards.

The manager and deputy manager had received appraisals and some training identified as a result. There was a lack of clinical supervision or peer support for the manager. The MAC was responsible for the overview of professional standards of surgeons who worked at the service. We were told that there were regular checks on evidence of the surgeons' competence. However, we were unable to find revalidation for one of the surgeons and there was no evidence that the MAC checked that surgeons had a date for revalidation. There was no process to review domestic and administrative staff competencies or to identify the training they needed to undertake their allocated tasks.

Patients' pain control was effectively managed and staff took prompt action where a patient was identified as requiring analgesia. Patients were supported to maintain adequate nutrition and hydration following surgery.

Evidence-based care and treatment

• The manager told us she received electronic updates relating to good practice guidelines including The National Institute for Health and Care Excellence (NICE) guidance on pre-operative tests, NHS Controlled Drug requirements, Nursing and Midwifery Council (NMC) medicines management and NMC nursing standards. We saw some audits relating to records, and medicines management, but we did not see evidence of a planned audit programme of guidelines or an action plan arising from these. The manager also received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), but there was no protocol for sharing the alerts with staff.

• Consultant surgeons were each responsible for adhering to national guidance. The two consultant surgeons we interviewed demonstrated an understanding of good practice in cosmetic surgery. One of these was the chair of the Medical Advisory Committee (MAC) and advised the manager on practice issues. No anaesthetist attended the MAC or had a role advising the provider about safe peri-operative care.

• Decisions made at the MAC were not disseminated to staff. For example, the MAC chair told us he had introduced a protocol to prevent one patient having combined procedures on the same day, which might result in the need for a blood transfusion. However, the next surgeon we spoke with said he was performing such an operation the following day.

• In some of the records we reviewed there was not enough information for us to ascertain if the surgeon's consultation with patient met recommended standards.

• Since taking up her post in January 2015 the manager had carried out audits such as patient records audits and audits in theatres. The service did not have data to show if these were re-audits thereby completing the audit cycle.

Pain relief

Are services effective?

• Patients were routinely prescribed pain relief and their pain score was recorded at regular intervals. We saw evidence of the RMO prescribing additional pain relief when a patient's pain scores were still high.

Nutrition and hydration

• Patients were asked to be nil by mouth from 6am. The pre-operative letter given to patients said they could have clear fluids up to two hours before surgery, in line with good practice.

• Patients were offered food and drink as soon as they were able to tolerate these post-operatively. We observed nursing staff providing patients with water, tea and toast on the ward.

• The RMO prescribed IV fluids for patients as required.

Patient outcomes

• Surgeons took individual responsibility for patient outcomes and discussed these informally with colleagues. The service had introduced a policy of review of all patients and held a patient post surgery clinic. There were methods to gather patient feedback, such as an evaluation form completed on day of surgery and satisfaction questionnaires. However, the provider did not collate information about outcomes for patients to help in identifying areas for improvements. We saw no information about whether the outcome of surgery was a success compared with what the patient wanted or expected. In a minority of the cases we reviewed, there was some dissatisfaction with the outcome of surgery and some revisions were performed.

• There was no data available for unplanned transfers between April 2014 and January 2015. There had been one unplanned transfers between February and July 2015.

• There was no data was available for unplanned returns to theatre for the period March 2014 to January 2015. There had been no returns to theatre between January and July 2015.

Competent staff

• The manager was an experienced theatre nurse and had managed theatres in previous posts. She had recently completed an infection prevention and control course. The manager had received an appraisal from the Nominated Individual, but she did not have formal supervisory, clinical or peer support.

• The deputy manager described training needs identified at her recent appraisal with the manager, and said she had already attended a course to meet some of her learning needs.

• The deputy manager was not aware of any policy on performance management. If there was an issue with an agency staff performance, she explained they would not book that staff member again for future shifts.

• The bank staff we spoke with had been working at the service for a number of years but had never had an appraisal or any feedback on their performance.

• There was no assessment of staff competencies recorded in the 10 staff files we reviewed. One nurse told us she gave IV medicines and that she received training for this. However, she had not been asked to provide evidence of this. The domestic assistant had not had a competency assessment for the tasks he undertook, such as waste disposal, and had not had an appraisal. There was no evidence to indicate that the administrators who spoke with prospective patients had received training specific for this role.

• We were told that if there were concerns regarding consultants with practicing privileges, they would not continue with their services. The manager told us the provision of an up to date appraisal was part of the agreement to grant practicing privileges, and there were checks on this. However, one surgeon's file we looked at contained only one completed appraisal, from 2011, and an incomplete and unsigned appraisal for 2013. This surgeon was not on the specialty register for cosmetic surgeons. Furthermore, we could find no assurance that the this surgeon, who only worked privately, was following the GMC revalidation process or had a revalidation date.

Multidisciplinary working (in relation to this core service only)

• All the staff we spoke with said there was good working relations. We observed staff working in theatre sharing

information. Theatre staff said there was a respectful relationship with each of the surgeons and they were able to adapt the patient pathway to meet the agreed protocol for each surgeon.

• The manager had established productive contacts with some staffing agencies and other suppliers of goods, but acknowledged there was a limited pool from which she was able to request services.

Access to information

• Qualified staff had access to information about the patient from the patient record.

• In the one recent incident where a patient had to be transferred to the local emergency department, there was a transfer letter with all relevant clinical information, which was given to the ambulance crew. There was no named contact at the local emergency department, but the nurses told us that they would always call ahead and inform the nurse in charge of the transfer.

• All patient records we reviewed demonstrated communication with the patient's GP by means of a standard letter pre and post-operatively. The standard letter sent to the patient's GP on discharge provided information on the surgery performed and the prescribed medicines on discharge. If patients were not registered with a GP or preferred not to have their GP informed they were asked to sign a disclaimer.

• Staff recorded implant tracking details in the patient record and a separate book so that this information was available if required, for example if there were concerns about the quality of the product.

Consent, Mental Capacity Act

• Surgeons saw prospective patients to assess them and to give them information about the risks and benefits of the procedure. We observed variation in the consultation time spent with patients during our inspection, with some sessions lasting less than 20 minutes. The CQC had received two complaints about the short length of consultations in 2014/2015. The patient records of one of the surgeons did not demonstrate that he was adhering to the Royal College of Surgeons' standards on the topics of the consultation. These should include:

▪ an unambiguous, objective description of what the patient is trying to change

▪ the patient's understanding of the procedure

▪ the patient's expectations of the outcomes

▪ the history and outcome of previous cosmetic procedures

▪ the history and nature of body image and appearance concerns, including impacts on psychological well being

▪ recent significant life events

• There was a waiting period of more than two weeks between the consultation and the signing of the consent form on the day of surgery. This meant that prospective patients had time to reflect before reaching a final decision about surgery, in line with good practice. There were signed consent forms in all the patient case notes we reviewed.

• Nursing and administrative staff we spoke with did not have training in the Mental Capacity Act 2005 and were unable to give examples of how the act might relate to their practice, for example in providing information about the service.

Are services caring?

Our findings

Patients told us staff were kind, considerate and respectful. We observed interactions between the staff, consultants and patients and saw that staff were attentive and caring in their attitude, providing assurance and support where needed.

The surgeon explained the planned procedure to their patients. The administrator had an appointment with each prospective patient and a gave them written information about fees and what to expect from surgery. Patients were provided with questionnaires so that they could provide feedback about their experience of care. An audit of responses received between April 2014 and March 2015 indicated feedback was predominantly positive.

Compassionate care

• We saw patients were spoken to in a calm and respectful manner during the pre-operative visits from the anaesthetist and surgeon.

• Patients' privacy and dignity were respected by keeping the door to each room closed and we observed staff knocking prior to entering patient rooms.

• Patients we spoke with were complimentary about the care they had received from their initial consultation through to the inpatient care. One patient told us that the 'staff were all fantastic, could not have asked for more.' Another patient described how staff in theatre had held her hands and stroked her hair when she was nervous prior to surgery. They had also been proactive in managing her fear of vomiting by prescribing prophylactic anti-emetic medication.

Understanding and involvement of patients and those close to them

• Following a consultation with the surgeon, prospective patients had a longer appointment with a member of administrative staff who answered questions, gave written information and explained the fees. Patients could also request a second consultation with the surgeon, if they were unsure whether or not to proceed. Further information was given at pre-assessment.

• At the pre-operative assessment, staff gave patients written information about their procedure and associated risks, which they were able to take away and read prior to signing the consent form on admission. Patients were given the service's contact details and staff encouraged them to call if they had any questions. Patients could also speak to the surgeon on the morning of their surgery prior to providing written consent.

• Patients were asked to complete a satisfaction questionnaire post surgery. We saw that the service had audited the feedback and results were positive. One hundred questionnaires had been sent out between April 2014 and March 2015, with a response rate of 45%. The service achieved high satisfaction rates, for example 89% of patients considered the care and support they received were excellent; whilst 94% said staff were excellent at maintaining their dignity and privacy.

Emotional support

• Patients were given a contact number that they were able to call 24 hours a day if they had any questions or concerns.

• The manager told us that if they identified a patient who needed psychiatric input post surgery, they would be referred back to their GP. We saw one patient notes that indicated this had been done.

• Surgical staff told us there were no processes for referring patients to specialist psychologists or psychiatrists, but all patients were specifically asked pre surgery if they had any relevant health issues, and if they had concerns they would contact the patient's GP.

• One consultant told us they would offer a patient a second consultation to help with the decision making if the patient was unsure.

Are services responsive?

Our findings

Service planning was based on demand. At the time of this inspection surgery was carried out over two (occasionally three) days every fortnight. The facilities and premises were appropriate for the services provided.

We noted there had been 27 cancellations over the past year. These were for a variety of reasons and we did not identify any trends. Patients sometimes experienced delays because of the limited opening hours of the service, and procedures were sometimes cancelled at late notice. Nevertheless, patient surveys indicated a high level of satisfaction with the service.

There was no special provision for patients who required an interpreter or who were unable to read. The service had a complaints policy and procedure in place and there was information available for patients about how to raise concerns. Most of the 12 complaints recorded in 2015 related to either cancelled operations or poor outcomes. We saw that each complaint had been recorded and responded to.

Service planning and delivery to meet the needs of local people

• The service planned its operative schedule in accordance with patient bookings and demand. The theatres were utilised two or three times every fortnight.

• The manager stated that she would request additional staff if an overnight stay was anticipated for any patient and we saw instances where this had been the case.

Access and flow

• Consultations took place on the days the service was open, two or three days every fortnight. We observed that patients did not have long waiting times before seeing a surgeon for the consultation.

• There had been 27 cancellations in 2014/15. These were for a variety of reasons, including for clinical reasons when the patient was not fit for surgery on the day, and occasions when there was no anaesthetist available. We did not identify any trends. Patients had complained to the service and to CQC about cancellations at late notice and about confusion over the scheduling of follow up corrective surgery.

• As the surgery was elective and planned in advance unplanned surgical interventions were not expected. The service could not supply us with data relating to the number of returns to theatre during the past year.

Meeting people's individual needs

• The Belvedere private hospital is an older building adapted for use as a cosmetic surgery service. We saw throughout the building that reasonable adjustments had been made to enable people with disabilities equal access to the facilities once on site. Access to the building via the steep stairs was not suitable for people with mobility difficulties.

• Patients' individual needs and requirements were assessed and documented during the pre-assessment clinic appointment. Staff stated the service had not treated anyone with a learning disability.

• There was no provision for patients who required an interpreter or who were unable to read. Staff said they would read information to patients when they asked. The service relied on family members to interpret, including when consenting to surgery, which is not recommended practice.

Learning from complaints and concerns

• We found that patients concerns were listened to and action taken as a result, however it was less clear if any learning from the complaints, both formal and informal, had been disseminated to staff.

• Patients were provided with information on how to raise concerns and the service had a complaints policy and procedure in place.

• There was not data available for complaints made about its services in 2014. We reviewed a spreadsheet detailing the 12 complaints made since January 2015. Each entry included a summary and the outcome/response. Most related to either cancelled operations or poor outcomes. The service responses provided either a summary of the reason for cancellation, or an offer of revision surgery in some instances at no additional cost.

• If complaints were made about agency staff we were told that they would no longer be used by the service.

• The manager told us she tried to deal with complaints as soon as possible to stop them escalating, but if she could not then they were passed to the Nominated Individual.

Are services responsive?

The manager had not established that there was a theme to the complaints, but said most were to do with finance. The Nominated Individual confirmed complaints relating to finance or dissatisfaction would be escalated to her. If it was determined that revision surgery was required this would be carried out without charge. In the pre-inspection information request we asked how and when complaints were discussed at senior management level but the provider did not respond to this question. There was no record that complaints were discussed at Medical Advisory Committee in the notes of their meetings.

• The wards and theatre did not keep a record of informal complaints and concerns raised. This was a missed opportunity for learning from minor issues and concerns raised by patients.

• The manager told us that unless they were directly involved in a complaints investigation they did not receive information related to learning from complaints.

Are services well-led?

Our findings

The safety and quality of service was reliant on the manager, who was responsible for clinical governance, running the service, and managing risk with little guidance from the provider. This was not sustainable. The provider was aware of the high workload of the manager and had taken some action, but with little effect. In the manager's absence, there were no-one with the appropriate qualification and skills to take responsibility for the running of the service. There was a history of a high turnover of managers, and of failure to set up processes and systems to support continuity. We were unable to establish that appropriate quality measurement systems were in place as relevant documentation was not available.

There was no system in place to identify, record, and address or mitigate risks. There was a disconnection between risk assessment and the identification of the resources to reduce the risk. The provider did not have a credible business plan and there was evidence of poor financial standing with contractors.

Staff commented favourably on the changes made since the current manager took up her post. They felt she was approachable, visible and provided strong leadership. Feedback from patients was positive.

Vision, strategy, innovation and sustainability for this core service

• The manager was undertaking the key governance roles within the service, in addition to taking the lead role for all areas of the service, including estate management, supplies, booking agency staff, overseeing theatres (and covering in theatre if understaffed) and administration relating to the vetting of new staff. The nominated individual recognised that this was too much for one person to manage and was not sustainable. She told us of plans to appoint a deputy manager for theatres, an infection prevention and control adviser and a healthcare assistant/housekeeper. However, at the time of our inspection, the provider had not made these appointments and there was no analysis of the many tasks the manger was undertaking in order to identify other ways of reducing her workload.

• There had been four managers in post since April 2014. Two of these left the provider before their registration as manager had been approved by CQC. There were no systems to guarantee continuity between managers. When the current manager began working in January 2015, she found the previous manager had left her job suddenly and there was no handover. Documents were missing for parts of 2014. The previous manager had contacted the CQC in November 2014 because she was unable to find the information, such as the spreadsheet to track staff training and supervision, which an earlier manager had sent to CQC. She informed us that the nominated individual was unable to locate these documents.

• The business continuity policy and procedure and a business plan, both dated May 2013, had incomplete sections and did not provide evidence that the business was sustainable. There was evidence of poor financial standing with contractors, including information sent to CQC from a staffing agency who had been asked to make out an invoice to two different companies. The invoices were unpaid and the agency was informed the company was insolvent. On her appointment the registered manager had made arrangements with some staffing agencies to be paid in advance in order to get the staff she needed. However, this was not always effective, and surgery was sometimes cancelled because of lack of staff. Surgery had to be delayed on the second day of our inspection because an anaesthetist could not be sourced.

• The manager had implemented a number of changes, and had identified others that would improve the service further. However, due to the sheer quantity of these it was evident that subsequent reviews and audits were not always taking place.

• The provider had a statement of purpose that outlined its goals and values. These included wishing to become pioneers in its field; to leave patients with a lasting positive impression; to make a difference to the quality of life of its patients and to develop excellence in individual staff members. The statement included the provider's aims and objectives; its clinical governance strategy, the complaints process, and guidance on recognising abuse. Copies of the statement were available for patients and staff, although staff we spoke with were not familiar with it.

Governance, risk management and quality measurement for this core service

• There was no system in place to identify, record, and address or mitigate risks. The registered manager stated this was one of her outstanding tasks, and that she wished

to develop a risk register and give priority ratings. She had identified a number of areas of weakness in response to our pre-inspection information request. These included no on-site pharmacy service and incomplete clinical incident records for 2014. She had identified other risks associated with the environment, facilities and equipment, and had commissioned an outside companies to undertake an infection control audit and a health and safety assessment. The manager did not have authority to make purchases to address risks identified by internal or external checks and audits or to make improvements to the service. The manager told us that when she identified a risk to patient safety, for example when the resuscitation trolley needed replacing, the nominated individual made sure the funds were available. However, when the manager informed the provider of other requirements, such as those identified by the fire risk assessment, she received no response. It was not possible to prioritise effectively because risks were not discussed in the light of resources available to address them.

• We could not establish that appropriate quality measurement systems were in place as relevant documentation was not available, and the manager did not have information to enable her to monitor issues effectively.

• The service did not have a robust governance framework in place. The manager referred to the surgeon on the medical advisory committee (MAC), but there was no anaesthetist on the committee and there was no arrangement for accessing pharmacy advice. The MAC met every six months, chaired by the manager and attended by a consultant surgeon and other members of staff. They were responsible for overseeing the granting of practicing privileges to surgeons and anaesthetists. The notes of these meetings were brief and did not include a review of incidents or complaints. However, the most recent minutes identified the need for improved pre-surgery screening of patients' blood pressure. It was not clear how decisions were disseminated, implemented and monitored. For example, a surgeon we spoke with was not aware of a decision made by the MAC.

• We saw that a number of policies, such as the adverse incident policy, had the name of a different provider and were not always applicable to the service. A flow chart on display for staff outlined the steps to take if a patient needed to return to theatre. This included contacting a surgical standby team, although the hospital did not actually have one. Policies such as legionella, sharps Injury and fire safety were out of date and had not been reviewed. The manager did not have time to review the policies or to ensure they were embedded, and staff were provided with out of date or irrelevant policies and procedures.

Leadership/culture of service

• The manager was highly visible and accessible and staff commented positively on her leadership role. All clinical staff we spoke with said the manager was supportive and they could ask her for advice. Staff told us of the friendly and respectful atmosphere at the service. The RMOs and agency nurses told us that they always felt welcomed and were able to ask for assistance whenever required. Consultant surgeons and anaesthetists told us there had been a big difference in the atmosphere within the service and credited the change in management for the positive improvement.

• The manger was in frequent email contact with the nominated individual However, because there was only one location, the manager did not have access to the expertise of other cosmetic surgery services or any peer support. Nursing and theatre staff had little contact with the nominated individual. We asked how and when complaints were discussed at senior management level but the provider did not respond to this question.

• When we looked at the website before the inspection, it stated all surgeons were on the specialist register for plastic surgery, but a check of the GMC register showed one surgeon was not on the register. We raised this with the provider who told us they would amend their website.

Public and staff engagement

• All patients were asked to complete a service satisfaction survey post surgery. We saw that the service had audited those received between April 2014 and March 2015 and the results were positive. There were no other forums identified where the service engaged with the public. We noted that The Belvedere Private Hospital website provided much information about the cosmetic surgical interventions and the surgeons available. The information was misleading with regard to all surgeons being on the GMC speciality register.

• The service held quarterly staff meetings. We saw that meetings had taken place in February and March 2015, and

Are services well-led?

were attended by the manager, deputy manager and three members of administrative staff. The manager also discussed issues arising from complaints and the day-to-day running of the service with her deputy and other staff. Because it was a small service, communication was straight-forward, and staff gave us examples of when they had passed on or received information, and asked for advice from the deputy manager or manager. However, there was an absence of formal processes to collate information and to disseminate learning points to the staff team.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The provider must ensure:

• A risk register is established, which records existing and potential risks, and identities action to address and mitigate the risks.

• There are effective systems to assess, monitor and improve the quality and safety of the services provided.

• There are processes in place to integrate information about risk and identified improvements with financial information in order to support decision-making.

• All incidents are recorded and appropriately investigated and, where required, notified to the Care Quality Commission.

• A programme of complete clinical audit cycles is established to monitor and improve quality of care.

• The medical advisory committee (MAC) reviews information about doctors and surgeons with

practicing privileges and ensures they are complying with GMC requirements for registration.

• Lessons learnt from incidents or near misses, and decisions made at the MAC meetings and staff meetings are shared with staff.

• Policies and procedures are up-to-date, relevant to the provider and put into practice at the hospital.

• Records are accurate, fit for purpose, and retained for an appropriate duration.

• The registered manager has appropriate support to carry out her duties and to ensure the service operates safely in her absence.

• All staff are appropriately trained for the roles they perform.

• Long-term bank and agency staff receive an annual appraisal and regular supervision.

• Staff participate in simulation exercises so they are aware of the action they need to take in an emergency.

• There are infection prevention and control systems and processes in place.

• The hospital has sufficient equipment for the procedures it performs and for the safety of its patients.

• Appropriate risk assessments are carried out, recorded, reviewed and, where remedial action is identified, this is taken.

• Training and support is provided so that all relevant staff are familiar with the Mental Capacity Act 2005 and understand how they should apply it in practice.

• There is appropriate security in high-risk areas.

• There is a review the changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) and, in particular, the duty of candour.

Action the hospital SHOULD take to improve

• Provide evidence that surgeon's consultations with prospective patients meet professional standards.

• Set up a forum for staff to give feedback.

• Review the staffing structure so staff share lead roles rather than all of them sitting with one person.

• Review its website so that all information provided is accurate and meets Advertising Standards Authority **(**ASA**)** and professional standards.

• Provide access to interpreter services for patients whose first language is not English.

• Establish lines of communication to ensure good practice guidelines and safety alerts are shared with all staff.

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 18 HSCA (RA) Regulations 2014 Staffing 2 (a) and (c) The provider had not ensured that staff were provided with appropriate support, professional development, supervision and appraisal. The provider had not ensured that staff continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. On this inspection we found there was no back-up anaesthetic machine as the second anaesthetic machine had been decommissioned when the current manager commenced work at the hospital in January 2015 and has not been replaced. 2. During that inspection we found that it was not possible to open one of the drawers of the resuscitation trolley in the theatre area. 3. Previous inspections found the service was non-compliant in relation to infection prevention and control as effective systems to reduce the risk and spread of infection were not in place, and this remained the case on the inspection on 4 and 5 August 2015. 4. We were not provided with all the information we requested prior to the inspection because records were missing for parts of 2014. For the period April to December 2014, the hospital could not provide data relating to never events; clinical incidents; serious incidents requiring investigation; unplanned transfers; data for the number of visits to theatre; a quarterly breakdown of day cases or data for VTE screening. The manager had not received a handover from her predecessor and was unable to access records for 2014. We were provided with data post December 2014.We asked how and when complaints were discussed at senior management level but the provider did not respond to this question. 5. The domestic assistant (SP) was responsible for the waste management at the hospital but had not received any training on safe waste management. He was

This section is primarily information for the provider

Enforcement actions

unaware of how the clinic would dispose of body parts. The theatre was cleaned by SP, who had not been given training in the specific requirements for infection control and prevention in theatres.

6. A fenced off area, adjacent to the hospital entrance, housing the theatre ventilation system and medical gases, was left unlocked for the duration of our inspection.

7. Taps were not run on a regular basis, in line with the clinic's legionella policy.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. On this inspection we found there was no risk register in place and although some risk had been identified verbally by the manager, such as the fire safety risks and the lack of a second anaesthetic machine, there were no mitigation plans. 2. The external fire risk assessment of April 2014 had identified 16 moderate risks. Although the registered manager had made the nominated individual aware of these risks, there had been no action plan put together as a result. The service was therefore unable to show how these risks had been addressed or mitigated. The staff we spoke with told us they had not undergone fire evacuation drills and we found no evidence of these in the records. 3. The second anaesthetic machine had been decommissioned in January 2015 but there has been no agreed plan to purchase another machine. The service did not have a risk assessment in place to mitigate the risk of the only anaesthetic machine failing during a procedure. 4. We were not provided with all the information we requested prior to the inspection because records were missing for parts of 2014. For the period April to December 2014, the hospital could not provide data relating to never events; clinical incidents; serious

This section is primarily information for the provider

Enforcement actions

incidents requiring investigation; unplanned transfers; data for the number of visits to theatre; a quarterly breakdown of day cases or data for VTE screening. The manager had not received a handover from her predecessor and was unable to access records for 2014. We were provided with data post December 2014.We asked how and when complaints were discussed at senior management level but the provider did not respond to this question.

5. Policies such as Legionella, Sharps Injury and Fire Safety were in place, but were out of date and not being adhered to.

6. A small number of incidents were reported by staff but there was no system in place to investigate these incidents. Staff were unable to tell us about learning that happens as a result of incidents.