The Pemberdeen Laser Cosmetic Surgery Clinic Limited

The Belvedere Private Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

The Belvedere Private Hospital is operated by Pemberdeen Laser Cosmetic Surgery 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 focussed follow up inspection following an inspection which took place in January 2020 and also in response to concerns which were raised about the service more recently.

We inspected this service using our focussed inspection methodology. We carried out unannounced visits to the hospital on 17th September 2020 and 6th October 2020.

Services we rate

We did not rate the hospital at this inspection, we were following up on concerns raised at our last inspection and concerns bought to our attention by former patients.

- The maintenance and use of facilities, premises and equipment was not sufficient to keep people safe.
- Although staff completed and updated risk assessments for patients some staff could not demonstrate how they would identify and or act upon patients at risk of deterioration. There was not sufficient guidance to support staff to care for critically unwell patients.
- Staff did not always keep detailed records of patients' care and treatment.
- 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.
- The service could not demonstrate it provided care and treatment based on relevant national guidance and evidence-based practice.
- The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance and there were no supervision meetings with them to provide support and development.
- The service could not demonstrate they treated concerns and complaints seriously or investigated them sufficiently or shared lessons learned with all staff.
- Leaders of the service could not demonstrate how their skills and knowledge translated into meaningful change or improvements. They told us they understood what was required to manage the priorities and issues the service faced, however, could not demonstrate that they had the capacity to make these changes.
- The service 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.

However, we found some areas of improvement:

- The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection.
- Pre-operative safety checks were being undertaken and recorded.
- Safety checks on the anaesthetic machine had improved.
- The service had improved its systems to store emergency medicines.

Summary of findings

Nigel Acheson

Deputy Chief Inspector of Hospitals London and South

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inspected but not rated	Surgery is the main activity within this hospital.There were several areas of concern, which impacted on the safety of people using the service. This included concerns about the operating theatre environment, patient records were not always fully completed, and there were concerns over the content within policies being in line with national guidance and staff recruitment procedures. Systems to monitor and respond to incidents and complaints were not fully developed, and the governance of the service was insufficient. The hospital had no effective system in place for managing and reducing risks.

Summary of findings

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Summary of this inspection

Background to The Belvedere Private Hospital

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

At the time of the inspection, the hospital did not have a registered manager. An application had been received from the service to register a new registered manager; however, this had been rejected by CQC.

The main services provided were cosmetic and plastic surgery. Procedures carried out included breast augmentation, breast uplift, removal of breast implants, breast reduction, change of breast implants, abdominoplasty, liposuction, blepharoplasty, rhinoplasty, otoplasty, mole removal, arm lift, face lift, thigh lift and gynaecomastia. 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.

The hospital had one ward area made up of seven separate patient rooms, one of which had two beds. This was located on the first floor, to which there was a lift for access and stairs. There was one operating theatre with a separate recovery area. There were three consulting rooms.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected seven times; the most recent inspection took place in January 2020.

Surgeons worked at the hospital under practising privileges. Practising privileges are where a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. There were also resident medical officers (RMO) who worked on an as required basis. There was one employed registered nurse at the time of inspection, they were working as the manager. The remaining clinical staff were bank or temporary workers, who only worked on days that surgery was taking place. All administration and reception staff were self-employed.

How we carried out this inspection

The team that inspected the service comprised of two CQC inspection managers and two CQC inspectors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

During the inspection, we visited the ward, theatre, consulting rooms and looked through five sets of medical records. We spoke with seven members of staff both clinical and non-clinical and one patient.

This was an unannounced inspection, which took place on 17th September and 6th October 2020.

Summary of this inspection

Areas for improvement

- The provider must ensure all patient notes are consistently completed and contemporaneous.
- The provider must ensure it completes all necessary pre-employment checks before hiring staff and maintain clear staff records.
- The provider must ensure training requirements for clinical and non-clinical staff are well defined and training is clearly recorded.
- The provider must develop its risk management systems and processes to ensure clear documentation of all risks and the mitigating actions is kept.
- The provider must ensure the complaints process is developed further, so that there is a full audit trail of each stage of the complaints procedure. Learning from complaints investigations must be shared with staff.
- The provider must ensure risks to patients are identified, assessed, mitigated and monitored, and that staff are aware of their responsibilities relating to risk.
- The provider must ensure the incidents management process is further developed to enable effective incident management.
- The provider must ensure policies and procedures reflect the service, are up to date, and reflect current national guidance.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inadequate	Inadequate	Good	Requires Improvement	Inadequate	Inadequate

Inspected but not rated

Surgery

Safe	Inspected but not rated
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Surgery safe?

Inspected but not rated

On this occasion we did not rate this domain.

Mandatory training

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Safeguarding

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Cleanliness, infection control and hygiene

The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection.

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.

The waiting room had furniture that was spaced out and there was a plastic screen to separate the reception desk from the waiting room, to protect staff and patients.

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

Environment and equipment

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

The theatre doors could not easily be closed to the theatre corridor. There were locks to secure the doors, but we noted these were not used until the patient was being anaesthetised, and not as soon as they had been bought into the room. We noted the doors to the anaesthetic room were not closing fully, the anaesthetic room had another door which led to

the theatre corridor which was also not closing fully. This meant the theatre environment could not be sufficiently managed to ensure patients were not exposed to risk of infection occurring or the impact of varying temperature control. The rate of surgical wound infection rates is influenced by operating theatre standards. A safe operating theatre is one which has an environment in which all sources of pollution and any micro-environmental alterations are kept strictly under control. Theatre doors must be closed during surgical procedures and only opened at other times as minimally as possible. This is because the direction of air flow could be reversed when the doors were opened or left open, especially if there was any temperature differential between the areas. The temperature in the operating theatre should be sufficiently high to minimise the risk of inducing hypothermia in the patient. There was a risk that patients who undergo surgery could develop hypothermia which could cause complications and harm. The hospital manager told us they had ordered automatic closers to ensure they remained secure. However, these were not on site and were not installed, and this was a problem we highlighted in our report following an inspection in January 2020.

A cabinet used to warm fluids used for surgical procedures or for treatment of the patient had a temperature display; however, we were provided conflicting information about the cabinet. Following our previous inspection, we were told a new warming cabinet had been purchased to ensure there was a functioning temperature display. On this inspection the hospital manager told us they wanted to replace the warming cabinet as it was old, and the temperature gauge did not always function. While on site we observed the gauge to be functioning, however, the hospital manager's comments meant this was not always the case. There were bags of fluid in the warming cabinet, none of these bags had been labelled with the time and date they were prepared and put into the cabinet, as a result, staff may not have been aware how long the bags had been in the cabinet for and whether they were still safe to use or if they should be discarded.

Theatre staff had a log book to record the temperature of the warming cabinet and the drug fridge in the anaesthetic room. They had not completed this check on the day we were on site and both fridge and warming cabinet were in use. We noted the warming cabinet temperature gauge was at 30.6 degrees, which was lower than NICE guidelines would suggest was safe. NICE Summary Clinical Guideline CG65 (2008; updated 2016) 6 Preoperative warming states that: "Intravenous fluids (500 ml or more) and blood products should be warmed to 37°C using a fluid warming device and irrigation fluids should be warmed in a thermostatically controlled cabinet to a temperature of 38°C to 40°C." If a patient's temperature had dropped during the intraoperative period, meaning they required warmed intravenous fluids to raise their core body temperature, the administration of fluids which were not at the required temperature could pose a risk of further harm.

Staff checked the resuscitation trolleys on days patients were scheduled for surgery. We found the checklists were complete and reflected the contents of the trolley.

Staff were now routinely completing the anaesthetic machine checks and log book on days surgery was scheduled. We reviewed the anaesthetic machine check log, which must be completed by the service each day surgery was taking place prior to the machine being used. We spoke with an anaesthetist who confirmed this was the case, and that they completed the checks.

There was CCTV throughout the hospital. We were told this was for security reasons and cameras were only in public corridors and externally. In one clinic room there was a camera which had been covered up. We asked whether this camera had the facility to hear and record what was being said, but this question was not answered. Therefore, we were not assured that patients' right to privacy was being maintained.

Assessing and responding to patient risk

Inspected but not rated

Surgery

Staff completed and updated risk assessments for patients. Some staff could not demonstrate how they would identify and or act upon patients at risk of deterioration. There was not sufficient guidance to support staff to care for critically unwell patients.

Theatre staff were now following processes which aligned with the World Health Organisation (WHO) surgical safety checklist. We observed staff pausing other activities to introduce themselves, identify the procedure to be undertaken, identify the patient and confirm this with the patient. This process also included re-checking with the patient whether they had any allergies. We also saw two members of staff checking surgical instruments prior to surgery starting. We were not present at the morning team brief but were told it had happened by different members of staff. We saw the hospital were now auditing completion of the presurgical checks.

We reviewed five sets of patient records and found that all necessary risk assessments were completed.

Staff told us they would call for an ambulance in the case of an emergency if a patient became unwell quickly. The resuscitation policy indicated that patients would be cared for by the local NHS hospital as per the service level agreement. 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. On the first day of inspection the hospital manager told us there was a service level agreement in place to transfer critically unwell patients to the local hospital. Following this, we requested to see the service level agreement and were sent an informal email which indicated that the agreement was not yet formalised. We were therefore not assured that there was a process in place, which met the providers own guidance, to transfer critically unwell patients to an NHS setting for ongoing care. There was a disconnect between the policy and staff's understanding of what was in place for patients who were deteriorating and needed emergency support.

Clinical staff were unable to tell us how they would care for a patient who was in need of a blood transfusion or blood products, they told us they would call an ambulance to transfer the patient to an NHS hospital. 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 would be 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. For example, there was no suitable fridge on-site in which blood or associated products could be stored. 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 situation staff would be able to act effectively as they were not aware of the resources available to them.

We did not see any clear signage in the waiting area or consultant rooms to indicate that patients could ask for and expect a chaperone, however the chaperone policy was framed behind the main reception desk. We noted there was one consultation clinic taking place at the time of our inspection visit on 6th October. There were no clinical staff provided for this clinic to enable chaperoning and the receptionist, if expected to fulfil this role, would have had to have left the desk to do so. Therefore, we were not reasonably assured the hospital was staffed to facilitate patients to have a chaperone, if requested. Following inspection, we were told patients were emailed prior to consultations to inform them they can have a chaperone. We were not provided with documentary evidence of this.

Staffing

Inspected but not rated

Surgery

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Records

Staff did not always keep detailed records of patients' care and treatment.

We looked at five sets of patient notes throughout the inspection. Three of the five sets of notes were completed; however, we found information missing in two sets of notes. In one there was no anaesthetic record and therefore no way of knowing what anaesthetic the patient had received during surgery and whether they had reacted to this medication. In another there was no record of post-operative follow up appointments. A member of the administration team who spoke with us confirmed the patient had attended for two follow up appointments. This meant the notes did not adequately reflect what the patient had discussed with the healthcare professionals and could not be followed up or actions taken forward to the next appointment.

Medicines

The serviced had improved its systems to store emergency medicines.

Resuscitation trolley checks had improved, and we found staff had checked them every day the hospital had carried out surgery. We found that the checklists reflected the equipment that was in the trolley and that all the contents were in their manufacturer use by dates. However, in the trolley on the ward we did find that some medicines were removed from their original boxes, which meant the checking procedures would not be fully completed if the items were required.

The resuscitation trolleys had been replaced. Staff now secured the resuscitation trolley on the theatre corridor with a tamper proof seal. The seal used was easily broken by staff in the event the trolley was needed but provided staff assurances that nobody had opened the trolley since it was last checked. The resuscitation trolley on the ward was not sealed with a tag. We spoke with a member of staff on the ward and they were unaware of the tags being used. This means that the trolley could be opened by an unauthorised individual and the contents could be tampered with, which was a concern we highlighted at the January 2020 inspection.

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.

The incident investigation process when incidents were serious was not robust, and no staff were able to tell us how they would follow up a serious incident they had reported. We were not assured of the processes in place to thoroughly investigate serious incidents that occurred on site and the mechanisms by which staff were informed of changes to practise following investigations was also unclear.

Staff told us they knew the mechanisms to report incidents and what needed reporting. They were able to tell us how they would be made aware of immediate actions if they were working on the day of the incident. We were given an example that if there had been an incident during a theatre list this would be discussed at the debrief at the end of the day. However, staff were unable to tell us how they would be informed about an incident and actions arising if they were not working on that day. This could mean incidents were repeated as the learning was not shared with all staff.

Inspected but not rated

Surgery

Safety Thermometer (or equivalent)

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Are Surgery effective?

Inspected but not rated

On this occasion we did not rate this domain.

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 saw that now some policies were dated and had renewal dates on them, we also saw version numbers on some of them. However, this was not implemented across all hospital policies and therefore we were not fully assured that staff could know they were reading the most recent version of a policy. This concern was increased by the fact that policies were stored in folders throughout the hospital and so version control was difficult to achieve. The hospital manager told us the funding for an electronic system to keep policies in was approved, however there was not a date for this to be started.

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. For example, staff who were not clinical would not need to read the clinical guidelines but there was no clarity about the policies they needed to read. 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.

We reviewed a number of hospital policies and procedures including the chaperone policy, the fat embolus policy and the sepsis policy. We found them all to lack in detail and some contradicted themselves. Policies described the topic they were written about but did not detail the safe clinical management pathways. For example, the fat embolus policy describes what a fat embolus is but had no detail about how to reduce the risk of fat embolus in surgery or the clinical management of a fat embolus. The resuscitation policy does not detail the management of a resuscitation scenario, nor does it detail how staff are to report it. We raised our concerns with the hospital manager who agreed there was a lot of work needed on the hospital policies to make them appropriate for purpose. The hospital manager told us as they employed staff who worked in the NHS they believed staff “don’t need to read policies to know what to do”. There was an over reliance on staff having knowledge and understanding based on them having substantive roles in the NHS, rather than the provider setting and out and stating the expected standards for their own services.

We observed out of date resuscitation council guidance on notice boards in the theatre corridor and on the ward. We highlighted this to the hospital manager, who acknowledged it and said they would remove them.

Nutrition and hydration

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Inspected but not rated

Surgery

Pain relief

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Patient outcomes

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance and there were no supervision meetings with them to provide support and development.

A patient co-ordinator, who is not a clinical member of staff, told us they had been trained to use their software to demonstrate to women how their breasts might look with different size implants. They explained this was a tool they could use to support women to make their decision and that all patients were required to speak to surgeons if they wanted to change their surgical plan following this. We were told the patient co-ordinators were trained by the developers of the software to use it, and that they had been able to have multiple training sessions. We asked for proof of this training following inspection. We were provided with a photograph of the patient co-ordinator at a conference and an email confirming that training had been booked. However, no confirmation from the manufacturer that training had been completed, or any certification of completion of this training. We were not assured as to the contents of the training or of the suitability of this task being performed by a non-clinical person.

The hospital manager showed us the spreadsheet they used to monitor staff training across a number of subjects including, life support, fire safety and infection control. We were told that staff who worked in the NHS would tell the hospital when they had completed training, and this would be noted on the spreadsheet. There was no stipulation as to the level of resuscitation training staff undertook, this was defined by their NHS role. We noted that 15 of 22 members of staff on the spreadsheet had at least one training course out of date, some were out of date by over 12 months. The provider was relying on staff undertaking essential training and additional competency based skills at the place of their substantive NHS role, without knowing the content of such training, the frequency or if the person successfully met the required level.

The service did not have an appraisal system for their staff. We were told this was because all staff were self-employed, and the hospital believed they weren't needed. This meant the hospital had no formal way of tracking staff were up to date with policies and procedures or formally logging that they were happy with the performance of staff members. The hospital manager told us they wanted to begin completing appraisals but were being told they could not by the chief executive, despite this it was logged as an action in the action plan.

The hospital manager told us since they started all staff had enhanced disclosure barring service (DBS) checks. DBS checks are carried out to inform a new employer if an employee has any criminal convictions, they should be repeated every three years. The hospital manager told us as the majority of staff were self-employed, they applied for their own DBS checks and then provided the hospital with the reference number so it could be checked online. We were told that as part of the recruitment process candidates must provide proof of DBS checks, however we found the recording of these DBS checks to be inconsistent and did not demonstrate to us that all staff who worked at the hospital had current DBS checks.

Inspected but not rated

Surgery

The recruitment process required all staff to have satisfactory references. We checked five staff files to ensure these references were collected. In all five files we found the hospital had requested references, however the completed references were only present in two of the files. The hospital was not following its own processes and chasing up references prior to staff starting their employment. We were not reasonably assured that the provider had a suitable system to ensure effective recruitment processes.

Multidisciplinary working

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Seven-day services

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Health promotion

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Are Surgery responsive?

Inspected but not rated

On this occasion we did not rate this domain.

Service delivery to meet the needs of local people

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Meeting people's individual needs

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Access and flow

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Learning from complaints and concerns

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

Inspected but not rated

Surgery

The hospital had a policy for responding to complaints within 28 working days and we noted that they were meeting their own standards. However, we found the complaints policy to be lacking detail. The policy briefly detailed who was responsible for each stage of the complaint, however it did not provide further information about what response should be provided at each stage. The final stage of the policy stated patients should approach a "local ombudsman" but did not give the complainant any information as to who to approach or how to. The hospital was not a member of an independent complaints scheme to facilitate this.

We reviewed three complaints and the initial response from the hospital to each of them. We were provided with evidence of each email chain and a spreadsheet detailing a summary of each complaint and the date it was made. We were not provided with any details of investigations into each complaint, only the responses. We therefore cannot be sure how the hospital was investigating complaints. On reviewing the complaint responses, we noted the letters were written in a matter of fact way with no attempt to apologise or understand the matter from the patient's perspective.

We asked the hospital manager about the response to one complaint, to understand how the response had been put together. We were told it was in line with the terms and conditions the patient had signed and that was what formed the basis of the response, we were not told any further discussion had happened with the patient or other staff members.

Are Surgery well-led?

Inspected but not rated

On this occasion we did not rate this domain.

Leadership

Leaders of the service could not demonstrate their skills and knowledge translated into meaningful change or improvements. They told us they understood what was required to manage the priorities and issues the service faced, however, could not demonstrate that they had the capacity to make these changes.

At the time of the inspection the hospital had no registered manager. A registered manager is a manager who takes on legal responsibility for the hospital under the Health and Social Care Act 2008 (regulated activities 2014). The hospital manager told us they had sent their application into CQC for approval. We had received an application which had been rejected in August, due to inconsistency of the proposed registered manager's name across documentation.

The hospital manager told us the plans and improvements they hoped to make in the hospital. However, they acknowledged the amount of work that was needed at the hospital was more then one person could manage. As other staff at the hospital are self-employed and only work as they need to the bulk of the work was the responsibility of the manager. This meant things took a long time to turnaround and progress was slow. Further, there were no other substantive clinical staff available to support the manager with areas of work requiring a clinical focus. This impacted on the ability to improve some of the areas requiring attention.

Following our first day on site inspecting we requested 28 documents from the hospital manager, as part of our inspection process. We had told the manager we would make these requests and that we would need them quickly. The manager did not respond to our information request within the time frame we set and was sent in three days after the deadline and the response did not cover everything we had asked for.

Inspected but not rated

Surgery

Vision and strategy

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Culture

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

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.

As explained in "environment and equipment" there were cameras throughout the public spaces in the clinic. We saw in one consultation room that a camera was covered up. Following our inspection, we asked the hospital manager whether this camera also had audio recording facilities. We were not provided an answer to this question. We also asked for proof of a "data protection impact assessment (DPIA) and a policy about use of CCTV. A DPIA should consider the impact on people's privacy and dignity of having recording facilities in place and is a required by the information commissioner's office (ICO). We were sent a CCTV policy however, this policy did not outline how long the footage would be stored, how and where it would be stored or who would have access to it. We were not provided with a DPIA. We were not assured that the footage was being stored safely and accessed only by individuals when necessary or that this had been considered by the hospital.

The hospital manager told us there was now a service level agreement with a local NHS trust for the supply of blood derived products and to transfer a deteriorating patient out. This meant if a patient becomes unwell very quickly or needed blood, or a blood derived product, the nearest NHS trust had agreed to support the hospital. As explained in "assessing and responding to risk" the service level agreement for emergency transfer out was not completed and signed as we were told, and the hospital were not meeting the terms in the service level agreement for blood derived products. We asked the hospital manager how the conditions in the blood products service level agreement were being met, specifically the training of staff and storage of products. We were told they planned to look into blood storage and were going to ask the NHS hospital if they would deliver the training. This directly contravened the agreement which stated the hospital would be responsible for training their own staff and maintaining a record of this. We highlighted this to the hospital manager who said they would outsource the training. This demonstrated a lack of understanding of the terms of the service level agreement, which had been in place since July 2020 and had not yet been completed.

The hospital had a medical advisory committee, which had met in March, April and June of 2020. However, these meetings had not all been attended by all the members and had not followed the formal agenda. The meetings did not follow the terms of reference set out for the group. Terms of reference are parameters which groups work within and define what is expected of them. We reviewed the minutes of the meetings and found there were key themes which were missed. These included complaints, incidents and our previous inspection and the following enforcement action taken. We were therefore not assured that the medical advisory committee is functioning as required to be effective and drive improvement in the hospital.

Inspected but not rated

Surgery

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 a number of policies and procedures and found they had not improved. The hospital manager 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.

The hospital's risk management policy had a note within it that staff who were required to write risk assessments "will be trained by Health and Safety". However, we note that there was no health and safety department and therefore were not assured that staff undertaking risk assessments were trained to do so consistently.

The hospital's risk assessment policy appeared to have been provided by another organisation and had not been amended to fit the parameters of the hospital itself. The policy mentioned risk assessments should be made known "to all staff and students affected by the activity assessed". The hospital did not have any students and therefore this was not applicable to them. This was a cause for concern as it demonstrated the hospital was using other documents obtained from external providers to construct their own policies and procedures. In doing so, they were not always accurately reflective of the service. The checking of such documents was insufficient, as errors were not being identified.

We requested a copy of the service's risk register and were provided with a document entitled "risk management". 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. However, there was no log of any of the risks we had highlighted at the previous inspection, some of which had not been actioned yet. There was no mention of the numerous problems the hospital manager told us they were aware of and working to fix. This lack of documented evidence means there were no assurances the hospital had oversight of all the risks which needed attending to and that they were doing so in a methodical way, making sure the highest risks were prioritised to keep patients safe. It also meant there was no log of how the hospital manager was reducing risks, even if they were not yet completely resolved.

The hospital manager shared with us a copy of their improvement action plan following our previous inspection in January 2020. This plan was divided into the five key questions we focus on and was further subdivided from there. The plan quality was variable, with some areas being very specific and others remaining vague. There were no completion dates projected for many of the action points and there was no consideration of which areas posed higher risks to patient and staff safety or care. We were not assured the plan was being implemented in a way which prioritised the safety of care.

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.

Inspected but not rated

Surgery

The hospital manager demonstrated a lack of understanding about the statutory notifications required by CQC. A previous patient and former employee of the hospital had made us aware of an incident that had required police involvement. This incident should have triggered a notification to CQC using one of our statutory notification templates, but this was not done. Further, we had not been officially notified when a patient sustained a diathermy burn, despite us raising this as a matter at the January 2020 inspection. These matters demonstrated a lack of understanding of reporting.

Managing information

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Engagement

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.

Learning, continuous improvement and innovation

This area was not included as part of this focused inspection. Please see the 2019 comprehensive report for details.