The Belvedere Private Hospital

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	
Are services responsive?	
Are services well-led?	Inadequate

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.

The hospital provides surgery. We inspected surgery as part of a focused follow up inspection following an inspection which took place in June and July 2019, following which we issued the service with a warning notice requiring them to address concerns highlighted.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 29 January 2020.

Summary of findings

Following the inspection the service has worked to implement the changes required as identified within this report. This work continues and will be reviewed when the service is next inspected.

Services we rate

Our rating of this service went down. We rated it as **Inadequate** overall.

We took urgent enforcement action in response to our concerns. The provider was asked to send us evidence demonstrating how they were addressing the areas of concern relating to the following areas:

- The maintenance and use of facilities, premises and equipment was not sufficient to keep people safe. Staff were trained to use equipment but could not always demonstrate compliance to guidance and procedures for checking equipment was safe to use.
- Staff completed and updated some risk assessments for patients but could not demonstrate risks were removed or minimised. Some staff could not demonstrate how they would identify and or act upon patients at risk of deterioration.
- The service could not demonstrate effective systems and processes to safely record and store medicines.
- The service did not managed patient safety incidents well. There was no evidence managers fully investigated incidents. There was a lack of evidence to show lessons learned were shared with the whole team.
- The service could not demonstrate it provided all care and treatment based on relevant national guidance and evidence-based practice or that managers checked to make sure staff followed the guidance that was in place.
- Staff did not always complete in full, detailed records of patients' care and treatment.
- The service could still not demonstrate they treated concerns and complaints seriously or investigated them sufficiently or shared lessons learned with all staff.
- Leaders of the service still did not have the necessary skills and knowledge to run a service providing high-quality sustainable care. They did not understand what was required to manage the priorities and issues the service faced.
- The service did not have a strategy to turn the vision and strategic objectives into action. The vision and strategy were focused on sustainability of services. Staff did not understand or know how to apply this in practice or how progress was monitored.
- The service still did not have a systematic approach to improving service quality and safeguarding high standards of care. There remained a lack of overarching governance.
- The risk assessment system used by the service was ineffective and there was no evidence the risk assessment system included discussions with the team about risks and mitigating actions.
- The service could still did not demonstrate it had a systematic approach to learning from when things went wrong and continuously improving**.**

However, we found areas of improvement:

- Records when completed were clear, stored securely and easily available to all staff providing care.
- Staff were now recognising and reporting incidents and near misses.
- We found it was easy for people to give feedback and raise concerns about care received in the service.
- The service now had a vision for what it wanted to achieve.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and the South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Inadequate** 	Surgery is the main activity within this hospital. The service was rated as inadequate because there were several areas of concern, which impacted on the safety of people using the service. This included concerns about the operating theatre environment, lack of safety checks on equipment and poor maintenance of some equipment items. Expected risk assessments and safety checking procedures were not always undertaken. Patient records were not always fully completed. Systems to monitor and respond to incidents and complaints were not fully developed, and the governance of the services was insufficient.

Summary of findings

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Background to The Belvedere Private Hospital

Belvedere Private Hospital is operated by Pemberdeen Laser and Cosmetic Surgery Clinic Ltd.

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

This was an unannounced inspection, which took place on 29 January 2020.

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, at the time of the inspection that person had not commenced their employment with the hospital.

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.

Our inspection team

The inspection team included a CQC inspection manager, lead inspector,one other CQC inspector, and a specialist advisor with expertise in cosmetic plastic surgery. The inspection team was overseen by Carolyn Jenkinson, head of hospital inspection.

Information about The Belvedere Private Hospital

The main services provided are cosmetic and plastic surgery. During the period from January 2019 and January 2020 the service carried out 403 surgical procedures, which 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, gynaecomastia and fat transfer.

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

During the inspection, we visited the ward, theatre and medical records department. We spoke with 11 staff including registered nurses, a consultant, an anaesthetist, an operating department practitioner, administration and reception and the hospital director. We spoke with two patients.

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 six times; the most recent inspection took place in June and July 2019.

Seven surgeons worked at the hospital under practising privileges, this is 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. Three regular resident medical officers (RMO) worked on an as required basis. There was no employed registered nurse at the time of the inspection as the registered manager had recently left the hospital and the newly recruited registered nurse had not commenced work yet but was due to start shortly. The remaining clinical staff were bank or temporary workers, who only worked on days that surgery was taking place. All administration staff and reception staff were self-employed. The accountable officer for controlled drugs (CDs) would be the registered manager.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	N/A	N/A	Inadequate	Inadequate
Overall	Inadequate	Inadequate	N/A	N/A	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Caring	
Responsive	
Well-led	Inadequate

Are surgery services safe?

Inadequate

Our rating of safe went down.We rated it as **inadequate.**

Mandatory training

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

Safeguarding

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

Cleanliness, infection control and hygiene

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

Environment and equipment

The maintenance and use of facilities, premises and equipment was not sufficient to keep people safe. Staff were trained to use them but could not always demonstrate compliance to guidance and procedures for the use.

At the previous inspection we found the service had suitable premises. However, it was unclear if some equipment was in use or out of action.

When we returned to the service for the follow up inspection, we found there was a hospital rules document within a folder provided to us. This contained the policies and procedures for the service. Part of the document had reference to reporting defective equipment but, did not say if they received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) Central Alerting System (CAS). At the time of the inspection the service were not able to provide evidence that the location received medical device and medicine alerts, or if such information was received, how it was acted upon. Following the inspection the service provided us with evidence they received MHRA alerts and evidence these alerts were acted on.

During our checks we found the resuscitation trolley on the ward was unlocked and brakes had not been applied, resulting in the trolley running down the slope it was located above. We found one item of equipment which was out of the safe use date in the resuscitation trolley and was reported to the nurse, who later replaced the item with a new one.

The resuscitation trolley for the theatre area was stored in the corridor outside the theatre. During our review of the trolley we found the checklist had been completed; however, there were several inaccuracies within the checklist. A nasopharyngeal airway number five was checked within the checklist as being present but was not within the trolley. A macular blade size three was on order but was ticked as being present in the draw. We also found items of single use consumables which had damaged packaging and therefore posed a risk to patients of contamination.

We reviewed the anaesthetic machine check log, which should be completed by the service each day surgery was taking place prior to the machine being used. We compared the dates the anaesthetic machine check log had been completed this with the register of operations that had been undertaken. We saw evidence that routine anaesthetic machine checks had not taken place on all the dates where surgery had taken place. We identified several gaps in the recording of safety checks on the anaesthetic machine between September 2019 and 29 January 2020.

The Association of Anaesthetists of Great Britain and Ireland stipulate that a pre-use check to ensure the correct functioning of anaesthetic equipment is essential to patient safety. Following the inspection the service informed us they had purchased an new anaesthetic log book.

Checking of the anaesthetic machine for appropriate functioning prior to its use is essential to ensure patient safety. A staff member told us the “ECG connector to the anaesthetic machine did not work well and had been a concern for a while” They could fail to deliver the correct level of gasses to the patient during the anaesthetic. Furthermore, exposure to trace anaesthetic gases released into the operating room during the conduct of general anaesthesia may be harmful to staff. We noted the front cover of the anaesthetic machine check log had a label which had the following written on it. "Temp anaesthetic machine logbook. New logbook on order. NB circuit to be changed every 4th list (indicated in Book)". We saw no evidence in the log that the circuit was changed every fourth list. There was a risk of harm to both patients and staff if anaesthetic machines were not working correctly.

During the inspection we found the theatres doors could not be fully closed. This meant theatre environment was not 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 infections 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 doors were opened or left open, especially if there was any temperature differential between the areas. The temperature in the operating theatre and anaesthetic room 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.

During the inspection we observed a warming cabinet was being used within the operating theatre. There were three bags of fluids within the warming cabinet, all of which had been pre-prepared and were connected to the intravenous (IV) giving sets. There was no temperature display on the warning cabinet and there was no indication of the time and date the fluids had been connected to the giving set and placed in the cabinet. This was not safe practice.

The pre-preparation of the IV fluids attached to giving sets without any labelling of the time this was set up and therefore the time it should be discarded if unused posed a risk of harm to patients because it was not clear how long the fluids and the IV giving sets had been opened. There was a risk of infection as the sterility of the fluid and the giving set would have been compromised once it was opened.

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.” The absence of the temperature on the fluid warming cabinet meant there was a risk patients could receive fluids which were either too warm or too cold. 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.

Assessing and responding to patient risk

Staff completed and updated some risk assessments for patients but could not demonstrate risks were removed or minimised. Some staff could not demonstrate how they would identify and or act upon patients at risk of deterioration.

During the previous inspection we found staff completed and updated risk assessments for each patient. They kept clear records of assessments. However, on this focused follow up inspection we found that there were areas of concern.

The admission policy identified the appropriateness of acceptance into the service and indicated the patient conditions which would not be accepted; this included those who did not have mental capacity.

We reviewed two patient records for individuals who received surgery prior to our inspection visit but since the last inspection to see if risk assessments and safety checks had been carried out correctly. One set of records had gaps

in areas which related to risk assessment. The pre-operative screening form did not contain a recording of the patients' blood pressure or pulse. This would be required as part of standard pre-assessment practices for assessing fitness for surgery. The screening test for their vulnerability to pressure area risks had not been completed.

Two patient records were reviewed related to individuals who had surgery on the day of our inspection. These were completed to a good standard and contained all the necessary information, including for example; patient risk assessments; observations safety check list, consent and narratives on progress.

During our previous we found the service used the World Health Organisation (WHO) surgical safety checklist and we saw evidence this was being used on all patient records we viewed. During this focused follow up inspection, we observed a patient being brought into theatre. The WHO check list was not discussed verbally prior to surgery starting. The anaesthetist sought confirmation from the nurse that the instruments were in place and then commenced anaesthetising the patient. We challenged the staff in the theatre because this conversation was not in accordance with the WHO steps to be taken prior to the commencement of surgery.

There was no evidence the staff had gone through the relevant pre-operative points of the checklist prior to commencing the surgery. There had been no confirmation of the time into surgery, confirmation of the surgery to be undertaken and no verbal confirmation in the theatre of the patient's identity. We asked the theatre staff to see the WHO safety checklist and we saw the staff ticking the boxes whilst the surgery had already commenced.

Our inspectors were told the theatre briefing had taken place prior to our arrival on site. However, we were told on our arrival the nurse who was leading the theatre team had not arrived yet. We met with them once they came on site and prior to them going to the operating theatre. This meant that an essential member of the team was not present for this briefing or the briefing had not actually been carried out as suggested. The UK National Health Service's NPSA (National Patient Safety Agency) five steps to patient safety includes a briefing or huddle before the start of the operating list. This provides an opportunity to check there were enough of the right resources, including staff and equipment, and if there were any patient related issues that needed to be considered by the team.

We requested a copy of the hospitals policy on the use of the WHO safer surgical checklist, the service was unable to provide us with a copy of this policy. The absence of a policy on this, added to the fact that we did not observe the checks being undertaken prior to surgery being undertaken, indicates that the hospital was not supporting the required safety practices.

We requested copies of the most recent audit of the WHO safety check from the service. The service was unable to provide any audits of the WHO safety check. The absence of audit of staff compliance with the WHO safety checks indicates that there was a lack of understanding of the importance of this safe practice and a lack of oversight of staff's compliance. Therefore, patients were at risk of avoidable harm.

Following the inspection the service provided us with evidence to demonstrate they were now complying with the WHO checklist completion.

The resuscitation policy dated September 2018 indicated all patients would be blue lighted to the local NHS hospital as per the service level agreement. We were told there was no formal service level agreement in place for such a transfer.

Staff used a recognised assessment tool to monitor the patient's condition following surgery. The ward staff were able to explain what they would do should a patient deteriorate. This included calling the resident medical officer and letting the admitting consultant know. However, there were no protocols to guide staff in identifying and responding to sepsis.

Nursing and support staffing

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Medical staffing

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Records

Staff did not always keep detailed records of patients' care and treatment. Records when completed were clear, stored securely and easily available to all staff providing care.

During the inspection we spoke with the office manager about the records management policy. They told us the receptionist pulled the medical notes for the surgeon on the days needed and then would file them afterwards. Records were kept for 10 years and then they were destroyed. We asked who disposed of the records and were told they went to an archive company. They added that they had records longer than 10 years (back to 2002/3) because they had not been destroyed or archived. They recognised they needed more space and told us they were working to put all records into separate card folders. We were told there was no current arrangement in place for an external agency to archive or destroy relevant records.

We reviewed two patient records for individuals who received surgery prior to our inspection visit but since the last inspection to see if staff were documenting information fully. The first patient had undergone abdominoplasty and liposuction. We found there were gaps in the documentation, including; page three of the operation notes was missing the name and details of the patient – although this was stapled together, if it became separated, they would not be able to identify which patient it related to. There was no anaesthetic chart present, or anaesthetic checklist and no inter operative care record. Therefore, it was uncertain what interventions had been provided or how the patient responded to these.

The second record related to a patient who had a bilateral breast augmentation. In addition to the absence of some risk related information, there was no surgeon named on the first page, post-operative review notes had only been completed once.

Medicines

The service could not demonstrate effective systems and processes to safely prescribe, administer, record and store medicines.

During the previous inspection we found out of date emergency medicines on the resuscitation trolleys; both on the ward and in theatre. During this focused follow up inspection, we found errors in recording of the numbers of medicine items in the resuscitation trolleys in the theatre area and on the ward. The resuscitation trolley outside the ward was unsecured and medicines could be easily accessed by unauthorised persons, as medicines were not contained within tamper-proof case.

A bag of intravenous fluid had an expiry date of 12/20 but the checklist it was recorded as being 02/20. The check sheet stated there were eight adrenalines 1:10,000 pre-filled syringes but there were only seven in the draw. The check sheet had been completed and stated there were two amiodarone 30 mgs ampules but there were seven in the draw. We looked at the grab and go bag for responding to patients who suffered a severe allergic reaction (anaphylaxis) and found there were two hydrocortisone 100mg ampules, but these were not listed on the sheet. This lack of clarity with regards to the numbers of medicines within the trolley and the incorrect date demonstrated that staff were not accurately checking the trolley. The service could not be assured that medicines were not being used inappropriately as they did not have accurate records of the number of items with the trolley.

In our review of the hospital's policies and procedures we did not see any protocols for the management of fluids requiring warming for use during operative procedures. We asked for copies of any audits undertaken around fluid warming at the hospital and were not provided with any. Therefore, we were not reasonably assured that checks were undertaken to see if staff followed safe practices regarding preparation, storage and monitoring of fluids used within surgical procedures.

Incidents

Staff were now recognising and reporting incidents and near misses. Despite this, the service did not manage patient safety incidents well. There was a lack of evidence of incidents having been fully investigated. There was limited evidence of lessons learned being shared with the whole team.

During the previous inspection we found that the services incident reporting process was very poorly development and needed urgent improvement, to ensure patients were protected from harm.

On this focused follow up inspection, we found that an incident reporting form had been developed and was now being used by staff. All staff we spoke with were aware of the form and told us they knew how to complete it. We

reviewed incidents in the incident folder and found that investigations have been undertaken following the reporting of incidents. There was, however, limited evidence of feedback to staff following the incident. There was limited evidence that learning from the incident had been identified and discussed or shared with staff. We did not see the service had any process in place to identify trends in incident reporting. Although we recognised that the service had started to implement a process for recording incidents, the service could not demonstrate a well-embedded system for the investigation, learning from and identification of trends in incidents.

As part of the incident reviewing process, we reviewed the duty of candour (DoC) policy. This was dated 2018, with had a review date of August 2020. The policy referred to the board and senior director's responsibility. It also highlighted what constituted a DoC matter and what type of incidents would require a response under this regulation. Whilst the policy referenced other sources and support for the person, there were no specific timelines stated for the process up to final response. We did not see or review any incidents which would have met the need for DoC to be completed.

Safety Thermometer

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Are surgery services effective?

Inadequate

Our rating of effective went down.We rated it as **inadequate.**

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. Managers checked to make sure staff followed the guidance that was in place.

During the previous inspection we found the service had policies and procedures; however, the vast majority of these were well past their review date by at least two years. Staff did not have easy access to policies and procedures. They were stored away from the theatre and ward area in the administration annex building. We saw no evidence policies had been updated in line with changing national guidance.

On the focused follow up inspection, we spoke with the nominated individual as there was no registered manager in post at the time of the follow up inspection. In our discussion about the changes that had been made since our previous inspection, we were told the policies and procedures have been installed on a shared drive, so the staff were aware of these and had access.

We were provided with a folder, which was said to contain the hospitals policies and procedures. We were told by one of the nurses on the ward the same information was also available on the computer, although we did not see this to verify, as the nurse was busy with patient activities.

Within this folder we saw there was a statement of purpose and general overview of the service. This was undated, and it was unclear if this was new or old.

The folder also contained a copy of the hospital rules, which indicated they had been updated in August 2017, with a review date of August 2021. Within this document we saw the inclusion of multiple embedded references sources, such as; the chaperone policy; clinical audit; quality improvement; additional maintenance and equipment; authority to access; data security, the disciplinary procedure and grievance procedure. We reviewed all the available policies and procedural guidelines contained within the folder. Polices had been reviewed and updated or had created dates and most now contained a date for the next review. In all cases we did not see evidence of version control or ratification by either the nominated individual or otherwise.

Our review of the content of some of the policies and procedural guidelines showed a lack of detail. This included for example, the safeguarding adult's policy, created August 2019, which had no review date and did not include any information on female genital mutilation. This would be an important factor to be considered by staff, particularly as the service undertakes hymen repair procedures. The policy indicated the staff would report to the safeguarding lead, but did not define who held this responsibility, and they would have help from human resources, despite the location not having such a department.

Inadequate

Surgery

We noted there were no specific policies or protocols for managing risks related to post-operative nausea and vomiting or pain management. There was no protocol for managing anaesthetic toxicity.

We reviewed the resuscitation policy and found it did not make any reference to resuscitation equipment or the emergency trolleys, including the level of medical equipment and medicines required on the trolley and security of these. We looked to see how the information in the policy translated into the working environment. Upon the walls in the area of the resuscitation trolley we saw advice to staff was displayed. This included the UK Resus council adult basic life support guidelines 2010. These had been superseded by guidelines since 2015. Therefore, we could not be certain staff were following the most up to date practices.

We asked the nominated individual how they ensured staff had read the policies including hospital rules and how did they audit or check staff knowledge with this regard. We were told the plan was that this would be ongoing, and once the service had a registered manager in place, they would "hold continuous meetings with the nurses and theatre team to ensure everyone has good understanding".

We identified during the inspection there was a lack of several policies and procedures which would be expected for this type of service. We requested but were not provided with the following policies: sepsis, fat embolus, post-operative nausea and vomiting, post-operative pain management or difficult intubation. We were not reasonably assured the staff in the service would be able to respond to these situations should they arise.

During the previous inspection we found some audits had been undertaken for example, world health organisation safer surgery checklists, hand hygiene and infection prevention and control audits, however when we reviewed these, we were unsure of the outcome of the audits. There were no action plans and information regarding the audit results was not shared with staff.

We requested all audits which had taken place since our previous inspection. The service was unable to provide any evidence that any audits had been undertaken since August 2019.

Nutrition and hydration

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Pain relief

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Patient outcomes

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Competent staff

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Multidisciplinary working

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Seven-day services

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Health promotion

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Are surgery services caring?

This domain was not included in this follow up inspection. Please see the previous inspection report for further details.

Are surgery services responsive?

On this occasion we did not rate this domain.

Service delivery to meet the needs of local people

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Meeting people's individual needs

Inadequate

Surgery

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Access and flow

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Learning from complaints and concerns

It was easy for people 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.

During our previous inspection we found the complaints systems was not sufficiently developed to provide assurance that such matters were managed effectively. Complaints were not recorded and investigated fully. Correspondence with the complainant was not documented to an adequate standard. Learning identified from the complaints process was not clearly identified or shared with staff.

On our follow up inspection, we spoke with the ward nurses. We asked if feedback from complaints was shared with them and were told they saw feedback forms and there was discussion around negative feedback. If there was a complaint that involved staff, then 'they' (the senior staff) contact us and speak to us about it and ensure they get the other side. "If there is something we haven't done right, then we will discuss it.''

We saw within the staff meeting minutes for 11 December 2019 reference to complaints and a post- operative questionnaire. The latter was used to gain feedback from patients.

We reviewed three patient complaints in detail and checked the other complaints in the complaints folder given to us during the inspection. During the review of the patient complaint files, we found the service had introduced a front sheet to each complaint. This sheet was entitled 'complaints chain', this sheet had space to document the date the initial complaint was received and dates of contact with patient and when the complaint was closed.

Within the files we reviewed, the original complaint letter or email from the patient had not been stored. This made it difficult to identify what the complaint was about. We saw emails to the patient within the file but there were gaps where emails had not been saved so the file email trail was not complete. There was no evidence of an investigation having taken place. In two out of the three files where was no formal complaints resolution letter to the patient informing them of the outcome of their complaint. We were not assured patient's complaints were being investigated and the service's complaint procedure was being followed.

There was limited evidence within the service of learning from complaints being identified. There was a department meeting which took place in November 2019 but learning from complaints was not an item on the agenda.

As we identified during the previous inspection the service still did not analyse complaints information to identify trends.

Are surgery services well-led?

Inadequate

Our rating of well-led stayed the same.We rated it as **inadequate.**

Leadership

Leaders of the service still did not have the necessary skills and knowledge to run a service providing high-quality sustainable care. They did not demonstrate they understood what was required to manage the priorities and issues the service faced.

During the previous inspection we identified that the leaders of the service did not have the necessary skills and knowledge to run a service providing high-quality sustainable care.

Since our previous inspection the service had recruited a new manager who remained in post for a short time before leaving the service. When we carried out our follow up inspection there was no manager in post, although a submission had been made to CQC to register a new manager. There was no designated person with clinical expertise having oversight of the services being provided at the location.

Vision and strategy

The service had a vision for what it wanted to achieve. They did not however have a strategy to turn the vision and

strategic objectives into action. The vision and strategy were focused on sustainability of services. Staff did not understand or know how this applied to them and how progress would be monitored.

During the previous inspection we reported that the service did not have a documented vision, strategy or values; however, the owner of the service had a vision for development of the service.

During the follow up inspection the service provided us with the vision and values for the service. They included

- People are central to everything we do
- Openness: we listen to and act on what people tell us; we are open to challenge; we value honesty and transparency
- Safety: we out safety first in everything we do
- Trust: we are trustworthy and act with integrity
- Value: we value care, compassion, respect, dignity and diversity
- Excellence: excellence is our standard

The service also provided us with the following as their strategic objectives

- Provide the best possible care and support
- Demonstrate best value
- Deliver safe, sustainable services
- Make Belvedere Clinic a great place to work.

During the follow up inspection we asked staff if they knew what the vision for the service was and none were able to tell us what was included in the vision for the service. There was strategic plan document to demonstrate how the service intended to achieve their strategic objectives.

Culture

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Governance

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

During the previous inspection we found the service did not have a systematic approach to improving service quality and safeguarding high standards of care. There was a lack of overarching governance. There had been limited formal governance arrangements in place to promote the safety and quality of care. We found there was a reliance on a non-structured approach across the service.

During the previous inspection we were not assured the managers understood what information was required within the policies and procedures to ensure the safe and effective delivery of the regulated activity. For example, following our previous inspection feedback, the nominated individual told they had arranged for an external consultant to review and rewrite the service's policies and procedures. Our evidence showed the process had not been carried out to a high standard. Whilst we recognised the policies and procedures had been reviewed by the manager, we were not assured they had been reviewed and agreed by an appropriate individual or group.

During the previous inspection we reported that the previous registered manager had not established a well-developed and embedded system to evidence that appropriate governance processes were in place. For example, we were told that audits were completed; however, there was no system to demonstrate the outcome of the audits or use the findings to drive service improvements. We could not see any improvement in this area since our last inspection. The service could not provide when requested any evidence that any audits had been undertaken since the previous inspection had taken place.

During the previous inspection we reported that the nominated individual (NI) did not have oversight of the work the registered manager had been tasked with doing. We saw no evidence that this situation had changed or improved, The NI had not reviewed any of the policies and procedures that had been updated since the previous inspection or directed the medical advisory committee to review them. The NI did not seem to understand the need for this to have been undertaken which would have provided assurance that the policies and procedures reflected the service, that they contained the latest national guidance and best practice information.

We reviewed the admission criteria, which was contained within the policy folder. This indicated that the board had corporate responsibility for the implementation of the policy and procedure and the registered manager had overall accountability. The policy went on to say the medical advisory committee (MAC) had principle

responsibility for maintaining the implementation of the policy and delegated responsibility to the governance and risk committee. The responsibilities of the governance and risk committee were outlined, including to monitor, 'THG compliance', and the committee reported to the MAC on a quarterly basis. We were concerned that this document had been copied from another providers policy, as it did not reflect the arrangements which were in place at the location. When we spoke with the nominated individual it was clear there were neither of these committees within the service, only the MAC.

Similarly, the clinical care and governance subgroup policy, which indicated it had been reviewed in June 2019, indicated meeting of this subgroup were held quarterly in each financial year and prior to board meeting. It described this team as having responsibility for reviewing and approving the internal clinical audit strategy and plan, of which the service did not have.

During the focused follow up inspection, we found that a medical advisory meeting had taken place in November 2019. We reviewed the agenda for this meeting and found that it was clear with items for discussion including; clinical audit, with an aspiration to introduce a calendar of clinical audits; infection control; surgical site infections and wound healing issues. Staffing issues and human resources, incidents, complaints and new staff were all listed. However, when we reviewed the minutes for this meeting, we did not see any discussion regarding complaints, incident management or risk identification. What was documented was a discussion relating to process and no action plan was identified from this. There were no dates in place at the time of the inspection for any further MAC meetings.

During the previous inspection we found there was no formal process in place for reviewing, updating and ratifying policies and procedures. The vast majority of the policies and procedures were reviewed during the inspection were past their review date by at least two years. We did not see any evidence they had been amended in line with latest changes to guidance.

In the focused follow up inspection, we found policies and procedures had been reviewed and their review by dates had been amended. We found areas of concern which are detailed within this report in the effective domain section entitled evidenced based care section.

At the previous inspection we found there were no processes for learning lessons from incidents, complaints and audits. Whilst the new manager at the time of that inspection who subsequently left the service following our inspection, told us they would ensure learning would be directed to the individual, we were not assured learning would be or was shared with other staff to improve quality and safety across the service.

This remained unchanged at the focused follow up inspection. We were not reasonably assured there was any learning from complaints or incidents. There was limited evidence of staff having feedback from complaints or incidents they had reported.

At the previous inspection we found that the service did not minute meetings that did take place between staff. Therefore, we were unable to gain assurance that both quality and safety were given coverage within such meetings, and if staff were engaged in improving quality and safety across the service.

During the focused follow up inspection, we reviewed the minutes of the heads of department meeting and the theatre staff meeting which took place in November 2019. Both these meetings had general discussion, but no special discussions were had about specific incidents or complaints.

During the previous inspection we found the mechanisms for reviewing and improving the quality of the service were limited. There was an audit schedule, but we did not see evidence of infection control audits or any quality and outcome audits.

We did not see any evidence that this had improved during the focused follow up inspection. When requested the service were unable to provide us with an evidence that any audits had been undertaken since the previous inspection.

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.

At the previous inspection we found the incidents management process had not been sufficiently developed

to enable effective incident management. Risk identification, mitigations and management systems had not been sufficiently developed to provide reasonable assurance of managerial oversight.

During our follow up inspection, we considered information which would expect to be part of the risk management system. This included protocols and arrangements for recognising and responding to risks. We noted there was an absence of some essential polices or protocols, including those for sepsis, management of haemorrhage, management of fat embolus following fat transfer, all if which are potential risks to patients.

We requested a copy of the service's risk register and the service could only provide a document entitled risk assessment list. This document was not a risk register and did not contain risks for the organisation. Following the inspection the service provided us with a copy of their risk register. The risk register had not been updated since February 2018 and did not have any reference to the risks that had been identified during our previous inspection in June and July 2019.

We spoke with the nominated individual about the arrangements for the supply of blood products for dealing with intraoperative or post-operative bleed. They said they had been in touch with another independent hospital and an NHS trust with a view to managing this going forward, but currently there was no protocol for managing such patient events if they occurred. Reliance would be on transfer by 999 ambulance. Our expert advisory for cosmetic/aesthetic standards indicated that surgery should not be carried out without access to blood product. We were concerned that the service did not have any protocol for managing haemorrhage or formal arrangements for the provision of blood and related products. The potential risks had not been fully considered or acted upon either and this matter was not on the risk register.

In our discussion with the nominated individual they told us the service only did minor or intermediate surgical procedures. We asked for clarification around gastric banding, as this was a listed procedure on the services website and signage at the front of the hospital. We were told gastric banding was not undertaken at the location, although it may be in the future. We asked if a procedure known as Brazilian butt lift (BBL) or fat transfer was carried out and were told they did not carry out this procedure. However, we noted this was also listed on the website and there had been one case listed on information provided to us about the number and type of surgical cases in the past year.

We were concerned the provider did not appreciate the significance of the risk facing both their patients and the staff. 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.

We spoke to one of the ward nurses about their understanding of risks and what would need to be escalated for consideration. Although they knew about patient risk assessment, they were only able to consider the context of other risks in relation to the abusive patients, if they were not happy with the outcome of their procedure. Although they said they would tell a manager about risks such as those related to oxygen stock, they could not articulate an understanding about risks or of there being any discussion of this area with the previous registered manager or otherwise.

There was still no formal process in place to demonstrate the service used patient feedback, feedback from complaints and incidents and audit results to help identify any necessary improvements needed to ensure they provided a high-quality, effective, safe service.

Managing information

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Engagement

This was not part of this inspection. Please see the previous inspection report for details on our findings.

Learning, continuous improvement and innovation

The service could still did not demonstrate it had a systematic approach to learning from when things went wrong and continuously improving.

During the previous inspection we found that the service did not have good systems for the reporting, monitoring, investigation of safeguarding, incidents, risks or complaints. The service did not have an adequate audit schedule in place. We did not see any examples of development or innovation.

Inadequate

Surgery

We did not find anything in the focused follow up inspection which demonstrated to us that improvement had taken place in these respective areas, or that the service had an action plan in place to ensure continuous improvement would be made in a timely manner.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure theatre equipment is correctly maintained, used in line with guidance and is in sufficient quantities for the procedures being undertaken.
- The provider must ensure safety checklists are completed on time and the content accurately reflects the process was followed.
- The provider must ensure equipment and medicines in resuscitation trolleys reflect national guidance and checklists on the content are accurately completed.
- The provider must ensure policies and procedures reflect the service, are up to date, and reflect current national guidance.
- The provider must ensure the incidents management process is further development to enable effective incident management.
- 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 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.

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 17 HSCA (RA) Regulations 2014 Good governance Policies and procedures were not always updated in line with national guidance and best practice. They did not always accurately reflect the service they had been written for. The service did not have all policies or procedures expected to cover all areas of the service. Regulation 17 (2)(a) The incidents management process was not sufficiently developed to enable effective incident management. Risk identification, mitigations and managements systems were not sufficiently developed to provide reasonable assurance of managerial oversight. Regulation 17 (2) (b) Regulation 16, (1) and (2) Receiving and acting on complaints Complaints systems were not sufficiently developed to provide assurance. Regulation 16, (1) and (2)