Hassan Shaaban Limited

ASET 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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated this service as requires improvement because:

- Staff had not always completed training in key skills and safeguarding training completion rates were low. Staff had a basic understanding of how to protect patients from abuse. Staff did not always manage medicines well. Staff did not always record key information in care records. The service mostly controlled infection risk although one treatment room had visible damp on the wall.
- The service did not always take account of patients' individual needs and arrangements for patients who required interpreter or communication support were limited. There was a lack of information provided for patients about how to raise a concern or a complaint to the service.
- Staff did not always understand the service's vision and values, and how to apply them in their work. The service did not always promote equality and diversity in daily work. Leaders did not always operate effective governance processes throughout the service or manage risks in the service. There was limited engagement with patients and the community.

However:

- The service had enough staff to care for patients and keep them safe and had systems to manage safety. Staff assessed risks to patients, acted on them. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders used information systems to run the service and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to providing a quality experience for patients.

We rated this service as requires improvement because it was effective, caring and responsive, although safe and leadership requires improvement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	We rated this service as requires improvement. See further details in the main summary above.
Outpatients	Requires Improvement 	Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. The service had two consultation rooms. One of these was also described as theatre room 2, but was used flexibly as a clinical treatment room and for consultations. We rated this service as requires improvement because it was caring although safe, responsive and well led requires improvement. We inspected but do not rate the domain for effective. We spoke with nine patients who had received outpatient care in the service.

Summary of findings

Contents

Summary of this inspection

Background to ASET Hospital

ASET Hospital is a registered location of Hasaan Shaaban Limited. The provider has been registered since 2019 to provide the regulated activities Treatment of Disease Disorder or Injury, and Surgery. The service provides a range of surgical and non-surgical cosmetic procedures for private patients. The service also had arrangements with several third-party providers for provision of different services, these being mainly theatre services and related staffing support. The service did not treat any patients under 18 years old.

This was the first inspection since the provider's registration in August 2019.

How we carried out this inspection

We inspected the provider's hospital location which provides facilities for surgical procedures, inpatient care and clinic consultation appointments. We carried out a comprehensive inspection to assess the provider's compliance with fundamental standards of safety and quality. We looked at key questions of the safe, effective, caring, responsive and well-led domains. We reviewed specific documentation, interviewed key members of staff including the medical director; registered manager, nursing, clinical, operating theatre and administrative staff. We interviewed the senior management team who were responsible for leadership and oversight of the service, and we spoke with nine patients about their experience of care in the service.

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

Outstanding practice

We found the following outstanding practice:

- The service had a designated emotional wellbeing practitioner who was closely involved in providing tailored support for individual patients, working together with nursing and consultant staff in the service. This support available included psychological assessment, stress management techniques if required on the day of surgery and a wellbeing follow up appointment. This staff member was also the patient co-ordinator and chaperone; patients we spoke with spoke highly of their very positive experience of patient care in receiving this service.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure the proper and safe management of medicines. Regulation 12 (2)(g)
- The service must ensure that staff complete safeguarding training to ensure that all staff can identify and report abuse of service users. Regulation 13 (1)(2)

Summary of this inspection

- The service must ensure that it establishes and operates effective systems and processes to assess monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities Regulation 17(1)(2) (a)
- The service must ensure that it establishes and operates effective systems and processes to assess monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk from the carrying on of the regulated activity. Regulation 17(1)(2)(b)
- The service must ensure that persons employed by the service provider receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a).

Action the service SHOULD take to improve:

- The service should ensure that substances that are hazardous to health are locked away appropriately to ensure safe practice.
- The service should ensure that information is clearly displayed and available for patients regarding how to raise a concern or a complaint.
- The service should review its approach for promoting equality and diversity in daily work.
- The service should review their strategy and identify a relevant action plan.
- The service should review its arrangements for supporting patients and family members who may require information in alternative language formats, or support from an interpreter.
- The service should review its provision for any patients who have sensory disabilities, including visual and hearing loss.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Surgery

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

Are Surgery safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

Staff did not keep up to date with their mandatory training.

The service had a mandatory training policy which indicated minimum training requirements for staff. Compliance rates for training was variable. Staff (not including new starters) had a high completion rate for health and safety training (92%), fire safety training (100%), manual handling (100%) and basic life support (100%). Some of the mandatory training compliance rates were less, including infection prevention control (78%) and controlling substances hazardous to health (42%).

Mandatory training for clinical staff were low in areas such as sepsis awareness training (50%), medicine management (50%) and early warning scores (a tool that is used to identify patients at risk of clinical deterioration and to help establish rapid and timely management) (17%).

Managers did not always monitor mandatory training and alert staff when they needed to update their training.

Safeguarding

Not all staff had completed training on how to recognise and report abuse and compliance with safeguarding training was low. Staff had an understanding of how to protect patients from abuse and a basic awareness of safeguarding procedures in the service.

Staff had access to separate mandatory training modules to complete for safeguarding adults and safeguarding children. Doctors could access level three training, nurses and operating department practitioners' level two training and health care assistants' and administrative staff level one training.

Clinical staff (not including new staff) had poor compliance rates for safeguarding training, with 60% completing safeguarding adults training and 70% completing safeguarding children training. Some members of staff had completed the safeguarding children training and not the safeguarding adults training, despite the service predominantly coming in to contact with adults.

Requires Improvement

Surgery

The service provided a separate, "one off" module for clinical staff to complete for Female Genital Mutilation (FGM). Clinical staff (not including new staff) had 10% compliance levels for the electronic learning course. However, theatre staff had a good knowledge of Female Genital Mutilation (FGM) and what the process would be to escalate concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They explained they would discuss the case with the registered manager who was also the designated safeguarding lead for the service. The registered manager had completed level three safeguarding training.

The registered manager told us that no safeguarding referrals had been made since the service opened in 2019.

Safeguarding information was not displayed in the waiting room, nor the patient toilets.

Not all staff wore name badges. All staff should wear name badges to ensure that patients know who they are.

Ten staff files were reviewed. One member of staff did not have their Disclosure and Barring Service (DBS) evidence and another consultant did not have a copy of their contract in their file.

We reviewed the hospital's safeguarding adults and safeguarding children policies which were in date. The policies detailed individual responsibilities and processes for reporting and escalating concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm.

Cleanliness, infection control and hygiene

The service mainly controlled infection risk well, however the air filter in one of the theatres was visibly dusty. The service used systems to identify and prevent surgical site infections. Staff mainly used equipment and control measures to protect patients, themselves and others from infection. They kept the premises visibly clean.

The medical director was the named infection control lead. The service had a comprehensive policy for infection prevention and control which had been issued earlier this year. It provided information on hand hygiene, personal protective equipment and waste management. The service also had a policy for the decontamination of equipment and environment which provided specific guidance on decontamination tasks that staff completed.

The non-clinical areas in the service were clean and had suitable furnishings. For example, the flooring was vinyl throughout, and the chairs were wipeable. We observed the housekeeper carrying out various cleaning duties in a thorough way on the day of inspection.

The ward areas were mainly clean and had suitable furnishings. There was a continuous return between the floor and the wall which allowed for easy cleaning. However, the extraction grill in one of the theatre rooms was visibly dusty which was an infection risk. The registered manager told us that an external company were booked to complete the clean that month.

Requires Improvement

Surgery

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing uniform that was 'bare below the elbow' and they adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting wards. We witnessed staff using PPE effectively.

We inspected a sample of patient rooms and en-suite bathrooms and found them to be visibly clean. Patients we spoke with were satisfied with the level of cleanliness of their patient rooms.

Hand sanitising gel was available for staff and patients throughout the service. The hand sanitiser bottles in the reception area were passed their expiry date. We observed bottles of hand sanitiser being used by theatre staff, instead of individual sachets which increased the chances of cross contamination between staff.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Theatre staff had a clinical cleaning checklist which included daily tasks such as ensuring the theatre was clean and ready for next use and emptying all bins and weekly tasks such as cleaning the anaesthetic machine. All clinical instruments were collected twice a day and sterilised at the local NHS hospital before being returned.

Staff and patients had access to hand washing facilities in all clinical rooms and in the bedrooms for overnight stay. Sinks on medical wards had elbow closing taps.

There had been no instances meticillin-resistant Staphylococcus aureus (MRSA), Escherichia coli or Clostridium difficile in the service, within the last twelve months.

We did not see the World Health Organisation (WHO) Five Moments of Handwashing above some of the sinks in the theatre areas.

We saw evidence of legionella testing being completed which was valid until August 2023.

We entered an unlocked cleaning cupboard which contained substances that were hazardous to health and should have been controlled. The service had a responsibility to ensure that such substances were locked away for safe practice.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mainly kept people safe, however one of the clinical rooms had damp on the wall. Staff mainly managed clinical waste well. Staff were trained to use equipment.

Surgical patients were cared for on the first floor of the building. Patients were cared for in private single rooms with en suite facilities. All patients had a call bell next to their bed and emergency buzzers. We observed that patients could reach call bells and staff responded quickly when called. The patient rooms were next to each other, and the doors closed to ensure privacy and dignity.

The service had two operating theatres which were based on the lower ground floor.

There was a patient lift which transferred patients from theatres to the wards.

The service had fire extinguishers that had been serviced, an evacuation sledge for the stair well and fire exits located on both levels.

Requires Improvement

Surgery

Staff carried out daily safety checks of specialist equipment. We saw evidence of theatre staff completing equipment checklists and fridge temperature checks for the theatres. We saw evidence of completed portable appliance testing checks, as well as copies of current equipment maintenance and servicing records which were all complete.

Staff had specialist training from representatives from external companies when they were provided with new equipment.

The service had enough suitable equipment to help them to safely care for patients. For example, the surgical beds were in good condition, staff told us that they had enough PPE, and we observed the two main theatres had piped oxygen.

The service had a designated resuscitation trolley and a difficult airway trolley. We saw evidence of daily checks that were completed. The trolleys had a seal in place and contained the appropriate equipment. This ensured that staff had access to the right equipment, in the event of a significant patient emergency.

We checked consumable equipment cupboards and found that all items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care.

The service had suitable facilities to meet the needs of patients' families. The service had a large waiting area and chairs were situated in the patient's bedrooms for visitors.

The service had appropriate service level contracts and agreements in place with third parties including gas engineers and clinical waste management services.

The service had damp in one of their theatre rooms which if used could cause a risk of infection for patients. Leaders told us that the damp treatment had been cancelled due to the inspection. They explained that the clinical room had not been used since the damp had been identified.

Staff did not always dispose of clinical waste safely. In one of the theatre rooms one of the syringe bins was above the fill line and temporary closure was not in place which could have resulted in injury.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Patients had a pre – operative assessment prior to their procedure. Third party patients who were having their procedure at ASET Hospital would initially have their pre – operative assessment with the third-party provider and then a review would be completed by the senior nurse from ASET Hospital.

The pre – operative assessment considered factors such as age, substance misuse, allergies and medical problems including psychological difficulties before deciding whether the surgery was appropriate. The patient admission criteria outlined actions that would be taken if a patient presented with such conditions.

The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative tests. The service risk assessed patients against their own preadmission criteria as they were a non-acute facility managing a low risk category of patient (categorised as ASA 1 which is a health patient and ASA 2 which is a patient with mild systemic disease).

Requires Improvement

Surgery

The lead anaesthetist or the registered manager would decide on whether a patient would be appropriate for surgery if concerns were identified at the pre – operative assessment.

The service had a policy for reducing the risk of Venous Thromboembolism (VTE) which is a term which refers to blood clots in the veins, which undiagnosed can lead to complications. Flowtron therapy was used for patients having over two-hour surgery to prevent VTE. We saw evidence in patients notes that risk assessments for VTE had been completed. The VTE policy stated that nursing staff should undertake VTE training, however we did not see evidence of this on the training matrix.

Staff used the national early warning scores (NEWS2) to assess for deteriorating patients. We checked patients' NEWS2 charts and found them to be filled in correctly.

Staff were aware of escalation protocols for deteriorating patients. Staff explained how they would support a patient whose condition deteriorated. Nursing staff would escalate for support from the resident medical officer who was on site and an on-call anaesthetist and surgeon if required. Consultants were always required to be available to attend to their patient in the event of an emergency. Staff explained that the provider would call the emergency services to arrange for transfer to the local NHS hospital, this was also outlined in the patient transfer policy.

The service had a policy for the management of sepsis which included an inpatient sepsis screening and action tool, as well as the sepsis six pathway which was also on posters in some of the consultation rooms.

The service's hospital policy stated that they did not perform major liposuction under tumescent local anaesthesia.

The use of the World Health Organisation (WHO) five steps to safer surgery checklist was embedded in practice and we saw that staff used this in theatres.

The operating department practitioner was trained in level two advanced life support, level two resuscitation of an adult and level two basic life support training. All other clinical staff had level two basic life support training. Staff told us no patients had required resuscitation in the last 12 months.

Staff were aware of the process if a patient had to return to theatre overnight. A resident medical officer provided 24-hour cover for the service. Patients who required an unplanned return to theatre for further surgery within 30 days of their initial surgery were prioritised.

The emotional wellbeing practitioner completed, psychosocial assessments and risk assessments for patients thought to be at higher risk of mental health issues. Staff told us that were a patient to present at consultation for cosmetic surgery and they made disclosures about their certain reasons for elective surgery, the patient could be referred to a psychologist to help ensure informed consent.

Patient discharge letters included information such as symptoms to look out for and a 24 – hour telephone number if they had concerns or needed advice post discharge. Patients we spoke with who had accessed this support were seen the same day or following day if they had any post-operative concerns.

Nurse and support staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Leaders regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction.

Requires Improvement

Surgery

The service had enough nursing, theatre and support staff to keep patients safe. Staff told us there were no issues with staffing and they always felt well supported.

The theatre manager (ODP) and deputy hospital manager accurately calculated and reviewed the number of nurses and health care assistants needed on each shift in accordance with national guidance. They could adjust staffing levels daily according to the needs of the patients. The number of nurses and healthcare assistants matched the planned numbers.

The service had low sickness rates for the last three months. We requested information for staff vacancies and staff turnover rates for the last six months but did not receive this.

Managers requested bank staff that were familiar with the service. From 1 October to the 1 December bank staff had collectively completed 683 hours, which approximately equated to 56 hours per week. The service used regular agency staff to ensure continuity of care.

Managers made sure all bank staff had an induction when they started the service

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Leaders regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. In total, there were 12 active surgeons (not including the commercial director) and nine anaesthetists who worked at the hospital under practicing privileges.

Medical staff who had their practicing privileges approved, were provided with a welcome pack and an induction session which provided instructions on online systems, policies, reporting systems and more. We were informed that medical staff with practicing privileges had formal reviews every two years with the medical director to renew or end their contract, however we did not see any evidence of reviews that had been completed.

The medical staff matched the planned number. The service ensured RMO cover was available for out of hours response whenever needed.

The service ensured that medical staff had annual appraisals, 91% of medical staff had completed them.

Medical staff were responsible for their patients throughout their stay in the hospital. Consultant surgeons were required to be contactable by telephone and be able to attend to their patient within 30 minutes or ensure that there was suitable cover to attend to patients in the event of an emergency.

The service had a consultant on call during evenings and weekends.

Records

Records were clear, up to date, stored securely and easily available to all staff providing care. Staff kept detailed records of patients' care and treatment; however, they did not always document patient's allergies.

Patient records were stored securely in a locked room in secured metal cabinets that required keys to access them.

Patient notes were comprehensive, and all staff could access them easily.

Requires Improvement

Surgery

We reviewed five sets of patient records and found they were comprehensive and detailed. We saw in patient records that fluid balance charts, the modified early warning score assessment (MEWS) and venous thromboembolism (VTE) risk assessments had all been completed. Operation notes were mainly legible, comprehensive and explained the procedure that was undertaken with postoperative plans included. Medicines used in patients' procedures were clearly listed in the patient records. However, in four of five patient records we reviewed we saw that staff did not always document the patient's allergies.

The service had a mixture of paper and electronic records. Patient records were in the process of being updated to electronic systems. Staff told us that daily notes and observations that they took could not easily be recorded on the electronic record and so these would be scanned on to the electronic system by administrative staff. Some of the surgeons completed their documentation using a tablet which then uploaded on to the electronic system.

Patients told us they received a discharge information letter when they were discharged from hospital.

The deputy manager said that documentation of medical records was audited on a monthly basis. In November 2022 the service scored 100%.

The service ensured that professional guidance was followed in respect of recording and management of medical device implants, for example inclusion in the Breast and Cosmetic Implant Register (BCIR). The theatre manager completed the BCIR electronically following insertion. Serial numbers were documented on the implant register and in the patients notes.

Medicines

Medicines were not always stored safely. The service used systems and processes to safely prescribe, administer and record medicines.

Medicines were not always stored away safely. We saw boxes of anaesthetics were stacked in a disorderly way on the floor of a store cupboard instead of on racking. However, the medicines in the theatres were stored in lockable cupboards and fridges. The controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act' (2001) were stored securely in a lockable metal cabinet in a store room.

Most medicine fridge temperatures were checked and recorded consistently. However, one of the medicine fridges in a store cupboard contained medical glue and we saw no evidence of fridge temperature checks.

We completed a sample of medicines and found that some medicines were out of date and so were not safe to use.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the CD log which had been completed accurately and countersigned.

The service ensured that they had medicines in stock which were effective in treating central nervous toxicity.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines.

Staff mostly completed medicines records accurately and kept them up to date.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Requires Improvement

Surgery

Oxygen cylinders were stored securely and were in date.

Incidents

Staff knew what to do if an incident occurred. Staff understood the duty of candour.

Staff knew what incidents to report and how to report them. Staff were aware that they would raise incidents with the hospital manager or medical director, as outlined in their significant events, adverse events and near misses policy. Staff, with support of the hospital manager or medical director would complete an incident form. Staff had access to paper copies of the form or could report incidents using an application on their work phones that was linked to the hospital.

In the last year there was one incident that was reported. This was an accident that had occurred. We reviewed the investigation and found it to be detailed. We saw evidence that the manager had debriefed and supported the staff member involved following the incident.

The service had no never events.

Managers did not have the opportunity to share learning about incidents due to there being so few in the last 12 months.

Staff had a good understanding of the duty of candour.

Are Surgery effective?

Good

We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance. Policies were available on the hospital internal computer systems and on an application that staff had access to on their work phones.

We reviewed a sample of hospital policies including policies for safeguarding adults, the mandatory training policy, incident policy, recruitment policy, medicines management policy, whistleblowing policy, consent policy, business continuity policy and IPC policy. All were in date and appropriately referenced best practice such as that recommended by the National Institute for Health and Care Excellence and the Royal College of Physicians. Policies were reviewed and authorised by the clinical director. Leaders would inform staff of changes to policy by sending them email alerts.

The service used evidence based 'care bundles.' A care bundle is a set of evidence-based interventions that, when used together, can improve patient outcomes. For example, we saw that staff used the intravenous cannula insertion care bundle which consists of essential elements that are completed during cannula care.

Requires Improvement

Surgery

The service had a monthly audit register which consisted of audits for fire safety, the environment, sharps, fridge temperatures, ward drugs, hand hygiene and waste. The audits we reviewed from November 2022, showed that staff were fully compliant. However, records we saw during inspection showed that fridge temperature checks were not always completed consistently.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

There were appropriate processes in place to ensure patients nutrition and hydration needs were met. One patient explained how they had only come out of surgery late, but that staff accommodated their nutrition and hydration needs regardless.

The catering staff provided a menu to inpatients which catered for different patient groups, including those with specific dietary requirements such as allergies and intolerances. All the items on the menu were designed to aid recovery.

Fasting instructions were provided to patients at the pre – operative assessment stage and patients told us that staff checked their understanding before concluding the appointment.

We reviewed fully completed fluid charts which were used to monitor patients particularly after a surgical procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

The service did not have a specific pain assessment chart, but it was documented on the MEWS chart.

Patients were reminded upon discharge they could call the ward at any time if they were experiencing pain or had any questions following their procedure.

Staff prescribed, administered and recorded pain relief, such as analgesia on discharge, accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The provider was able to demonstrate they were engaged with the Private Healthcare Information Network (PHIN) and were collecting and submitting data in accordance with legal requirements. We reviewed five consultants' profiles from PHIN and found that all had been rated over 95% for satisfaction and over 95% for experience by patients.

The service participated in some local surgical outcome audits. These showed zero surgical site infections, zero never events, zero transfers to another hospital, zero incidents, zero re admissions to the hospital and one return to theatre in the last twelve months.

Requires Improvement

Surgery

The emotional wellbeing practitioner completed outcome measures with some patients for their psychological wellbeing. The patient health questionnaire (PHQ9) and generalized anxiety disorder scale (GAD7) were completed. The body dysmorphia scale was also referred to but not completed as an outcome measure.

Managers did not always make sure that staff understood information from the audits as there was limited opportunity due to the lack of team meetings that have occurred in the last year.

The service did not participate in relevant quality improvement initiatives, such as national clinical audits, benchmarking, research or trials.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw evidence of four completed appraisals for administrative and nursing staff. All had agreed action plans and were thorough. Records confirmed that 91% of medical staff had completed their appraisals.

The service had a staff recruitment (fit and proper persons employed) policy which outlined a list of criteria that staff must have before being considered to become an employee. These include a Disclosure and Barring Service Check (DBS), evidence of relevant qualifications for the role applied for and references.

Medical staff were granted practicing privileges by the medical director who had operational responsibility for all the activities within the service. For medical staff to be granted practicing privileges, they were required to hold a GMC licence to practice, relevant insurance, a DBS certificate and proof of qualifications and identification. Following this, medical staff under practicing privileges were interviewed by the medical director and if successful formally reviewed every two years.

We reviewed eight staff files, all staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Some staff had years of experience working in the NHS and had worked together previously.

We received information which provided evidence that training needs for staff were met and that managers supported development. For example, we saw evidence of ward-based competency assessments, as well as specific competency assessments for the safe removal of intravenous cannulas.

New starters told us that they had an induction which consisted of shadowing established members of staff. The induction was not always comprehensive.

Four link roles had been identified for specialist areas of the service, to act as a source of local expertise and advice. These were completed by the medical director, registered manager and deputy manager. However, none of the nurse and healthcare assistant staff had link roles.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held multidisciplinary meetings to discuss patients and improve their care.

Requires Improvement

Surgery

We saw evidence of the staff working together to benefit patients. For example, the emotional wellbeing practitioner, with the consent of the patient, would attend their pre-operative assessment and work closely with the medical staff to identify any psychological needs or barriers to surgery.

The service had a referral pathway for patients who required mental health assessments when they showed signs of mental ill health such as depression. They also had links to a clinical psychologist who would offer sessions with the patient if they required psychological support.

The provider had service level agreements with three independent healthcare providers to transfer patients for surgery at their location.

The service had supported the NHS during the height of the pandemic and had close links with the local hospital for emergencies.

Seven-day services

The service was available seven days a week to support timely patient care.

The service was available seven days a week. The service was flexible to meet the demands of its patients. Staff could contact the on-call resident medical officer for support if needed.

Patients that were discharged were given a telephone number to call at any time of the day if they had concerns or questions. Patients were also provided with details of the consultant whom they could call if they had questions prior to their post-surgery follow up appointment.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

The service had a consent to care and treatment policy which staff knew how to access. The policy outlined the importance of gaining consent, providing patients with all the information for them to make an informed decision and how to assess for capacity to consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. The service provided clear explanations of treatment and sought written or non-written consent prior to their procedure.

Requires Improvement

Surgery

Staff gained consent from patients for their care and treatment in line with legislation and guidance involving a two-stage process with a cooling off period of 14 days where they could change their mind about their decision to undergo cosmetic surgery.

Staff clearly recorded consent in the patients' records. We also observed consent being confirmed with patients in theatre prior to anaesthetic.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was embedded within the safeguarding modules, however staff had poor completion rates for these modules.

Are Surgery caring?

Good

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients told us that staff took time to interact with them and spoke to them in a respectful and considerate way. All the patients we spoke with said their privacy and dignity was considered.

Patients said staff treated them well and with kindness. One patient told us that it was their second visit to the service for a different procedure and they felt valued as staff had remembered them from their first visit. Another patient said that they felt "part of the ASET family" when they had been an inpatient and said that staff could not do enough for them.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. One patient explained how one of the drains had disconnected and had leaked on to their bed and how this was quickly resolved by staff.

Most patients said they were not hungry due to the side effects of the anaesthesia, but that staff would provide them with food or snacks when they felt ready.

Patients told us that staff ensured that their treatment was confidential.

Staff we spoke with understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Requires Improvement

Surgery

ASET patients were all offered access to an emotional wellbeing practitioner. If patients wanted further support from the emotional wellbeing practitioner, sessions were offered. In the sessions the practitioner would assess for symptoms associated with depression, anxiety and more specifically body dysmorphia disorder (BDD). They would also review the reasons the individual was having the treatment. If the patient was deemed to present with mental health difficulties or may be having the procedure for alternative reasons such as being pressured, the practitioner would refer them to a psychologist and inform the general practitioner.

One patient explained they chose the service over others due to the psychological support available. They explained how the assessments completed by the emotional wellbeing practitioner provided they with reassurance to help them make the correct choice.

On the day of the procedure the emotional wellbeing practitioner offered distraction techniques to patients who may be feeling anxious.

Patients told us that staff provided emotional support prior to, during and following their procedure. The emotional wellbeing practitioner completed follow up calls with all patients who had attended as an ASET patient.

Staff understood the emotional impact that a person's care, treatment or condition had on their wellbeing and on those close to them. One patient explained to us that the consultants helped to make decisions about their treatment that was in their best interests.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. One patient's relative explained how the service had kept them updated during and after the treatment.

Patients told us that staff talked to patients and families in a way that they could understand.

Staff supported patients to make advanced decisions about their care. Patients told us there had been many appointments and correspondence from the service prior to the procedure. Patients explained how they were well informed about their treatment.

Staff supported patients to make informed decisions about their care. The emotional wellbeing practitioner was present at all initial consultations with patients to support them in making appropriate decisions.

Patients told us they all had the two weeks "cooling off period" following the initial consultation to make sure they wanted to go ahead with the treatment.

Patients gave positive feedback about the service.

Requires Improvement

Surgery

Are Surgery responsive?

Requires Improvement

We rated responsive as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in local organisations to plan care.

Managers planned and organised services to provide cosmetic surgery services for fee- paying private patients. The cosmetic surgery services offered by the different consultants working in the hospital offered a patient choice for the local population.

The service worked in response to patient preference and staff availability to minimise the number of times patients needed to attend the hospital and where possible, ensuring patients had access to the required staff and tests on one occasion.

The hospital had previously delivered patient care services in ENT on behalf of the NHS, as part of mutual aid support working during COVID-19. Service leaders continued to engage with NHS commissioning services for similar future contract opportunities.

Facilities and premises were appropriate for the services being delivered.

The service had a positive working relationship with the local NHS trust and referral systems to direct patients who may be in need of additional support or specialist intervention.

The service responded to patients on an individual basis and offered flexible arrangements to suit patients' preferences. Managers ensured that patients who did not attend appointments were contacted and offered an alternative appointment.

Meeting people's individual needs

The service mostly took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services, although there were limited arrangements for patients who required support from an interpreter or for communication needs. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Referrals to the service indicated whether patients had any additional needs or support requirements. Most patients presented as self-referrals to the service and the hospital manager and their deputy carried out initial triage of these to assess any specific individual needs. Following this, the service's emotional health and wellbeing lead would contact all patients who were having cosmetic surgery, prior to their clinical consultation.

All patients would go through a thorough consultation process which included seeing the consultant surgeon face-to-face, with support from nursing staff as needed. All patients were offered a second, or more, consultations to discuss the procedure again and answer any questions

Requires Improvement

Surgery

All appointments were offered a chaperone for support. The service routinely provided emotional wellbeing advice and support throughout the patient's journey, with individual calls and appointments provided where needed to support the clinical consultations. Full support was offered to ensure patients had clear understanding of their treatment options, and to manage their expectations. The emotional health and wellbeing lead worked closely with consultants and wherever this was identified, would refer patients for psychological support if this was needed.

The service had a policy for interpreter and translation. However, there was low awareness of this and staff we spoke with could not describe the arrangements for arranging services or describe any examples of when this had been implemented. The service did not provide information leaflets available in different languages.

Staff were unaware of any access to communication aids to help patients become partners in their care and treatment. The premises did not have a hearing loop available to support any patients with hearing loss who used hearing aids. There was no information in the waiting room for individuals with visual difficulties.

Patients were given a choice of food and drink.

Car parking was available with ground level entrance. The premises were fully accessible for wheelchair users. The service had installed a lift to the first floor which could accommodate a patient on a stretcher. The ward had an accessible private room which included accessible en-suite bathroom facilities for wheelchair users. The service confirmed this facility had been used three times in the past 12 months for wheelchair using patients or patients with mobility difficulties. At the time of inspection, the room was being used as a storage area.

The service did not see any patients who had complex disabilities or health needs, including dementia, mental health illness or learning disabilities.

Access and flow

People could access the service when they needed it and received the right care.

All patients were seen within two weeks of applying to the service, at a mutually convenient appointment time. Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.

Managers monitored any cancelled appointments to keep these to a minimum. Patients would be contacted to rearrange their appointments in case of any cancellations. Cancellation rates in the service for appointments and treatments were at a low level. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers and staff planned each patient's discharge as early as possible. Consultants provided follow up care for patients when they were discharged and were available for advice where this was needed, and in case patients had any concerns. This included medical cover provided for any concerns in the immediate post-operative period following surgery. The service worked well with the individual consultants working with practicing privileges in the service to ensure there was appropriate cover available in a timely way for responding to patient needs.

Staff supported patients if they needed to be referred to other services.

Requires Improvement

Surgery

Learning from complaints and concerns

It was not always easy for people to raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers did not always know how to complain or raise concerns.

The service did not clearly display information about how to raise a concern in patient areas We did not see any complaint poster or information on how to complain in the reception. The service's website did not provide details of how to raise any complaints.

Staff completed an eLearning module regarding complaints management and the service had a. complaints policy. Staff told us that complaints were discussed in team meetings and that they would be updated of any complaints by email. They felt that complaints were learned from. The most recent staff meeting minutes we reviewed indicated there had been no complaints since February 2022.

Managers investigated complaints. Managers shared feedback from complaints with staff and learning was used to improve the service. Following the inspection, the service provided details of a complaint which had arisen since the last staff meeting. We saw this had been followed up and changes made with staff advised to ensure followed up any patients who may appear upset when leaving the service.

Staff could give examples of how they used patient feedback to improve daily practice, reflecting an issue which had been raised by a third-party provider, regarding linen storage in a patient's private room. Systems were changed to ensure items were not stored in patients' rooms, thereby limiting interruptions to patients' privacy.

Are Surgery well-led?

Requires Improvement

We rated well-led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They mostly understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The director of the company, who was also the medical director for the service, was based at the location for most of their working week. The medical director had a close day to day working relationship with staff in the service and met regularly with the registered manager to discuss the service. The medical director was a consultant surgeon with many years' clinical experience in plastic surgery. The medical director continued to have a limited number of hours practicing in the NHS as a consultant in head and neck surgery.

The service had a senior leadership team which included the registered manager, the deputy hospital manager and the theatre manager. The registered manager had been in post since the service was established; the deputy hospital manager and theatre manager both had clinical backgrounds in the specialism, with original professional experience in

the NHS. In addition, the service had a finance manager and a lead anaesthetist. The ward staff, administrative and housekeeping staff were managed under one service line, with the theatre manager overseeing the operating theatre department. There was regular day-to-day contact between the senior leaders regarding any operational issues in the service. Human resources services were provided by an independent external consultative service.

Whilst we saw there was a good level of informal communication between leaders and staff in the service, when we spoke with leaders during the inspection, they told us they did not always formally document meetings.

Staff in the service described leaders as being visible and approachable, having an 'open door' approach for staff to be able to raise any issues as and when they needed to. Staff described leaders as being fair in their approach; leaders encouraged staff to reflect the service values and work in accordance with these principles. Leaders were motivated to provide a quality service for patients and were keen to identify where improvements could be made.

At the time of inspection, the service was pursuing different opportunities for service contracts, including from NHS clinical commissioning groups. There had been some expansion in the service and staff recruitment particularly over the past six months and there were continuing ambitions to increase the service offer for the future.

It was acknowledged there were some challenges with the current location and hospital premises, with reference to the limitations of the environment and particularly in having enough available storage space. There was a general plan to increase staffing to meet the needs of the future service development, although these were not formally documented and were in early development. There was a general acknowledgement of the challenges to sustainability, although there were no specific actions identified to respond to or address these potential challenges.

The service did not have any formal leadership development programme for staff, however, we noted that staff were supported in different ways to progress their skills. One staff member was continuing to develop their specialist interest in plastic surgery. We were told during inspection that the deputy hospital manager was being supported for developing more formally into a senior role, including possibility of becoming a registered manager in the future.

Vision and Strategy

The service had key objectives for what it wanted to achieve. However, there was limited development of a strategy to turn this into action. The vision and strategy were not always focused on sustainability of services and staff did not always have a clear understanding of future plans for the services.

The service identified its key objectives as 'to provide the highest standard of independent healthcare and surgical healthcare services in a safe healthcare environment; and to spend time answering patients' questions in a clear and understandable way, so that fully informed choices can be made.'

Staff we spoke with had a general awareness of providing a patient-centred approach to care as the service's key aim. Not all staff were aware or sure of the vision of the service and they were unable to articulate specific organisational values, but some staff said they had been updated about potential structural developments. Staff had not been directly engaged in developing service objectives and did not always have an understanding of their role in achieving the strategy.

The service provided a simple document which summarised the main phases of development in the service to date and plans for future development. Since original registration in October 2019 services had been provided from the ground

floor only of the current premises. These services included cosmetic surgery and general plastic surgery. In February 2022, ASET hospital secured a business loan to fund phase 2 development which included erection of a hospital lift, creation of patients' ward upstairs and an extra 2 theatres on the ground floor. The new general anaesthetic theatre had opened in September 2022.

During the COVID-19 pandemic the hospital had been able to expand its services into other surgical specialities, such as ear nose and throat (ENT) and general surgery, as part of mutual aid support for NHS trusts. At the time of inspection, this additional provision was not continuing, although the service was exploring further opportunities to develop this area of work in the future.

In response to the growth of service and business, the hospital had secured more funding to complete the final phase of its planned development. This phase identified more consultation rooms, a staff room and more storage space. We were told the building work was due to start in early 2023.

We saw that the strategy documents provided by the service were mainly in the form of plans for building work and redesign of the current premises, in relation to expansion of the business. During the inspection well led interviews, leaders told us of the general aim to expand the services offered, with an aspiration to be a leader in the field of cosmetic surgery. However, there were no documented action plans of how this would be achieved. We heard of general plans to expand staffing in the future, but the exact numbers of staff required, or the types of procedure or operational activities in relation to capacity and demand were not identified as part of the business development or strategic plans.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service did not always promote equality and diversity in daily work although staff had opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with felt proud to work for the service. In particular, there were several staff in the service who had joined the team more recently over the past six months who described their employee experience as very positive. Staff in general were positive about the service and happy, there was an open culture where staff were confident to raise any concerns if these arose. There was a patient centred focus in the service which was to provide for the needs and best experience of each individual patient.

The service had a Freedom to Speak up policy which identified freedom to speak up ambassadors and a senior lead with responsibilities to respond to any concerns. During the inspection we did not hear of any freedom to speak up issues raised by staff. The culture encouraged openness and honesty at all levels, with a recognition of the need to be transparent in communicating and responding to any patient or staff concerns. We saw that staff worked well together and there were cooperative and appreciative relationships between staff across different parts of the service.

The service was open in its communications with patients and had a system to provide patients with clear information regarding terms and conditions, including the amount and method of payment of fees.

The service provided for the safety of staff at work. Staff we spoke with told us there was not any particular emphasis on staff wellbeing compared to any other clinical settings they had worked in. However, staff could access to wellbeing support through the service's mobile phone Human Resources application.

All staff were required to completed e-learning modules for Equality and Diversity. However, data provided by the service following inspection showed low compliance for this, with only 23% of temporary staff and 28% of established staff having completed this training. Staff we spoke with had a generalised basic awareness of equality and diversity, however we did not see a strong focus in this area overall.

Governance

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had some opportunities to meet, discuss and learn from the performance of the service.

We saw that although the service had identified a strategy, this was largely aspirational in its content and was not always supported by effective structures, processes and systems of accountability to be able to achieve delivery of the strategy. The service had been through, and was continuing to experience rapid growth, through which leaders did not always have the mechanisms in place for assuring the quality and sustainability of the service.

During inspection we heard that routinely the service held a limited number of meetings, with the service relying on day to day communications between staff for sharing any operational information. Also, different staff members provided different responses about the frequency and type of meetings that were held. Service leaders told us about the different types of meetings and the general arrangements for those held in the service, stating that the senior leaders had a weekly meeting although this was not formally documented. Following the inspection, we requested details of the governance structure and process; the service provided an organisational chart which indicated the departments and roles of staff but did not clarify the systems used for monitoring performance or escalating any potential issues.

Following the inspection, we requested details of the formal meetings held in the service and any minutes for these meetings. The service informed us that the hospital's Medical Advisory Committee (MAC) meeting and staff meeting were held together due to the small nature of business and number of staff involved. We were told this joint meeting was held every alternate month with attendance of staff in person, withformal minutes noted. On the alternate meeting's months, the hospital's management team held a series of face-to-face separate meetings with each department within the hospital structure, including for example, the theatre, ward, administrative, marketing and finance teams. These meetings were not formally noted in meeting minutes.

The service informed us there had been no meetings between February and September 2022 due to the building expansion and expected growth of clinical services. The service advised us that during this time the hospital management set up a few different action groups to plan, monitor and action such development. There were no further details available for these meetings.

The medical director was strongly motivated to engage with individual consultants under practising privileges arrangements only when they had strong confidence in the consultant's clinical professional practice. We were told this was usually only when the medical director had personal working experience or a long-term knowledge of the individual consultant's working practice. Consultants in the service were employed under practicing privileges. The medical director stated they maintained oversight of these through formal review in a Medical Advisory Committee (MAC) in the service. However, the records we reviewed during inspection did not confirm any completed consultant appraisals or how the medical director maintained oversight of consultant competencies and patient outcomes.

We reviewed meeting minutes provided by the service for one of the joint MAC and staff meetings, entitled 'ASET hospital review meeting'. Items discussed included clinical governance, staff, training, and any other business. The notes recorded details of updates to the Covid testing policy, potential development of new contracts, incidents of return to theatre,

training in intermediate life support skills. There was reference to all staff continuing to work to support the service development. The meeting included discussion of patient safety outcomes since February 2022, which indicated zero% mortality, readmissions to hospital and transfers to another hospital, no never events, no surgical site infections and no incidents.

Whilst we saw the minutes noted that three new consultants were joining the hospital team, there was no other reference to oversight of quality and performance regarding patient outcomes for the different consultants practicing under privileges with the hospital. We also saw there was reference to sourcing of equipment for possible contracts the service may be successful in achieving. There was no related reference to any required training or upskilling of staff that may be needed in this regard.

Staff we spoke with during the inspection said they were clear about their roles and knew who to report to, although most staff said that formal meetings were not frequently held as there was regular daily communication in the service.

The service had arrangements with several different third-party providers for use of their surgical theatres for various cosmetic procedures. These arrangements were detailed in a service level agreement (SLA) with the hospital. We reviewed details of the SLAs following inspection and saw these identified that ASET hospital may refuse provision of clinical services if: it deems that the patient is unfit for such treatment; the patient is unsuitable for the hospital facility, or that the patient's behaviour is unacceptable for ASET's patients and its staff.

The registered manager and the hospital manager would review any patients referred through the Service Level Agreements (SLAs) to ensure this criterion was met. The service also had different arrangements within each of the SLAs with regards to pre-operative assessment arrangements and follow up care. However, each of the SLAs identified that ASET hospital staff would be responsible for clinical care during the patient's admission and in the first 24 hours after surgery, including in case of any emergency. We saw there was an informal monitoring of the SLAs, in terms of noting which service was using or planning to use theatre space. During the inspection we raised a query with the service regarding how it would be possible to identify any potential issues in line with the service's policies and procedures, for example if there had been a safeguarding concern, where the patient was seen for their initial assessment outside the service in the first instance. Whilst we had not identified a specific issue at the time of inspection, the provider recognised they could review this aspect of their systems for oversight of SLAs.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. Not all relevant risks had been identified or actions identified to reduce their impact. They had plans to cope with unexpected events.

Leaders did not have clear systems and processes to enable clear oversight of any potential or actual risks in the service. There was a lack of comprehensive assurance systems for managing performance effectively and to ensure any issues were escalated in a timely way.

Following the inspection, the service provided details of their risk register, which was in the form of a document of completed risk assessments. The risk assessments covered a range of potential hazards, including both clinical and non-clinical, such as 'storage of medical gases' and 'general admin'. However, the service risk register itself identified only one risk, which was detailed as 'Lack of storage space after opening phase 2'.

Requires Improvement

Surgery

We saw during the inspection there were issues with storage in the hospital and observed different areas cluttered with equipment. The mitigating actions identified to manage this risk included to 'change the pattern of deliveries for smaller quantities over frequent deliveries' and to 'free the files room'. Whilst we were told there was some activity to scan all old notes for storage off site, it was evident that the one identified risk was not being managed in an effective way. The medical director informed us during the inspection that phase 3 in the expansion will resolve these issues.

We noted during inspection the service had been through a period of expansion over the past 12 months. Also, there had been several new staff recruited to replace staff who had left the service in the past six months The medical director told us that staffing was a risk, however this was not recorded in risk registers or any actions identified to mitigate any risks regarding staffing . During the inspection we raised this potential concern with service leaders, with regard to the future plans for expansion and the stability of the workforce during periods of rapid growth.

We also saw during the inspection there were several key risks which had not been identified by the service. For example, environmental and infection risks associated with damp seen in a clinical treatment room, and dust observed on a theatre extraction fan. There was no record of any risks associated with equipment breakdown, or wider risks which may affect the service for example financial or reputational risks.

The service had a business continuity policy which identified key responsibilities in the event of a business continuity incident. We noted much of the policy content was generic and sections with information specific to the service were incomplete.

There was a limited approach for monitoring service outcomes in cosmetic surgery, or a process for reviewing overall service performance. The service completed some audits, including such as for surgical site infections, hand hygiene and medicines. However, the service was unable to demonstrate how they delivered continuous improvement, or whether there were any plans for developing accountable leadership in specific service areas.

Information Management

The service did not always collect reliable data and analyse it. Staff could find the data they needed, to understand performance and make decisions. The information systems were integrated and secure.

The service used electronic patient systems which staff could access through computer terminals in different parts of the service. These were password protected. Staff had access to the service's electronic system for access to policies, procedures, incident management and complaints logs. Leaders had access to some service data which they used to monitor referrals and treatments; however, this was not extensive and limited data was used to monitor quality performance in the service.

Staff used encrypted email addresses to ensure confidentiality when sharing information with NHS.

Engagement

Leaders and staff engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service provided some patient information through their website and social media platforms about the types of treatments available. Service leaders engaged with other NHS and private healthcare organisations regarding possible service provision and contract arrangements.

Requires Improvement

Surgery

There was limited engagement with patients and the community. The service did not consult or engage with staff in any formal process; however, we saw from staff meetings that staff were involved in general discussions about the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff were committed to improving services and were motivated to provide a high-quality experience for patients. Service leaders informed us that all surgical and clinical services performed at ASET Hospital were standard cosmetic and plastic surgery procedures and since opening in October 2019, the hospital had not been involved in any new innovation or research. Information on the service's website appeared to contradict this however, which stated 'We are constantly researching and implementing the latest advances in innovation across both our procedures and our overall patient service'.

We were told during inspection that the hospital management view was to concentrate all effort to establish a solid base of successful clinical practice before extending its involvement in new innovative procedures or technology.

Requires Improvement

Outpatients

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Are Outpatients safe?

Requires Improvement

We rated safe as requires improvement.

For our detailed findings on mandatory training, safeguarding, cleanliness, infection control and hygiene, environment and equipment, assessing and responding to patient risk, staffing, medical staffing, medicines and incidents, please see under these subheadings in the surgery report.

Mandatory training

The service provided mandatory training in key skills but staff did not always keep up to date with this.

For our detailed findings on mandatory training please see under this subheading in cosmetic surgery report.

Staff received but did not always keep up to date with their mandatory training. Compliance rates for the courses offered differed and did not always meet the providers target for completion.

Managers did not always monitor mandatory training and alert staff when they needed to update their training.

Safeguarding

Not all staff had completed training on how to recognise and report abuse and compliance with safeguarding training was low. Staff had an understanding of how to protect patients from abuse and a basic awareness of safeguarding procedures in the service.

For our detailed findings on safeguardiing please see under this subheading in cosmetic surgery report.

Staff compliance with safeguarding training was low overall and in some areas this was poor. Safeguarding information was not displayed in waiting areas or toilet facilities. However, staff knew who to inform if they had concerns.

For our detailed findings on safeguarding please see under this subheading in the cosmetic surgery report.

Requires Improvement

Outpatients

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

For our detailed findings on cleanliness, infection control and hygiene please see under this subheading in the cosmetic surgery report.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

During inspection we saw an unlocked cleaning cupboard which contained substances that were hazardous to health and should have been controlled.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mainly kept people safe, however one of the clinical rooms had damp on the wall. Staff mainly managed clinical waste well. Staff were trained to use equipment.

For our detailed findings on environment and equipment please see under this subheading in the cosmetic surgery report.

There were two consultation rooms available for patient appointments, which were used flexibly in the service. The clinic rooms were mostly appropriate however in one room used as a consultation room we saw there was visible damp on the wall. This could present a risk of infection.

Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff identified if patients at higher risk of mental health issues.

For our detailed findings on assessing and responding to patient risk please see under this subheading in the cosmetic surgery report.

Requires Improvement

Outpatients

Service leaders carried out initial triage of referrals to the service in accordance with their admission and exclusion criteria. Consultants working under practising privileges in the service would carry out individual assessments for patients, proceeding to treatment, based on their clinical judgement. Staff completed risk assessments at pre-operative assessment for all patients who were proceeding for surgery.

Staff knew about and dealt with any specific risk issues.

The service had access to an emotional well-being practitioner employed in the service for additional support. The emotional wellbeing practitioner completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at a higher risk of mental health issues.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

For our detailed findings on staffing please see under this subheading in the cosmetic surgery report.

The service had enough nursing and support staff to keep patients safe. Staff worked flexibly across different parts of the service on a day-to-day basis in response to demand. There were sufficient numbers of staff for managers to adjust staffing levels daily, according to the varying needs of patients.

Managers made sure all bank staff had a basic induction and understood the different areas of the service. The induction was mostly completed by shadowing a shift.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

For our detailed findings on medical staffing please see under this subheading in the cosmetic surgery report.

There were 12 consultants working under practising privileges in the service. Each consultant worked flexibly according to their individual agreement and based on this; the service planned for the overall clinical activities at the hospital. The service had enough medical staff to keep patients safe.

The service always had a consultant on call during evenings and weekends in case of any emergency or advice for patients that was needed.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

For our detailed findings on records please see under this subheading in the cosmetic surgery report.

Patient notes were comprehensive, and all staff could access them easily. However, staff did not always document patient allergies. Records were stored securely.

Requires Improvement

Outpatients

Medicines

The service used systems and processes to prescribe, administer, and record medicines.

For our detailed findings on medicines please see under this subheading in the cosmetic surgery report.

Staff followed systems and processes to prescribe and administer medicines.

Staff completed medicines records accurately and kept them up-to-date.

Incidents

Staff knew what to do if an incident occurred. Staff understood the duty of candour.

For our detailed findings on incidents please see under this subheading in the cosmetic surgery report.

Staff knew what incidents to report and how to report them. There had only been one incident reported over the past 12 months.

Are Outpatients effective?

Inspected but not rated

We inspected but do not rate the domain for effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

For our detailed findings on evidence-based care and treatment please see under this subheading in the cosmetic surgery report.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were available to all staff through internal computer systems. Care and treatment was based on recognised guidance and standards.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

For our detailed findings on patient outcomes please see under this subheading in the cosmetic surgery report.

Regular audits were completed in the service overall, staff worked flexibly across different areas of the service in response to demand. Results from local audits demonstrated staff were fully compliant, including for example, in hand hygiene and records audits.

Requires Improvement

Outpatients

Due to limited opportunity for staff meetings managers had not always shared and made sure staff understood information from the audits.

Improvement was checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support and development.

For our detailed findings on competent staff please see under this subheading in the cosmetic surgery report.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

For our detailed findings on competent staff please see under this subheading in the cosmetic surgery report.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

For our detailed findings on multidisciplinary working please see under this subheading in the cosmetic surgery report.

Staff held multidisciplinary meetings to discuss patients and improve their care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The service also had links to a clinical psychologist who would offer sessions with the patient if they required psychological support.

For our detailed findings on multidisciplinary working please see under this subheading in the cosmetic surgery report.

Seven-day services

Key services were available seven days a week to support timely patient care.

For our detailed findings on seven day services please see under this subheading in the cosmetic surgery report.

Requires Improvement

Outpatients

Consultation appointments were mainly held during Monday to Friday, although these could be offered at weekends to meet patients' preferences. Medical staff were available in an on-call rota to respond to patients in case of any emergencies.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

For our detailed findings on health promotion please see under this subheading in the cosmetic surgery report.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards please see under this subheading in the cosmetic surgery report.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff followed the service's consent policy in providing patients with all the information patients needed to make an informed decision about their treatment and care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance involving a two-stage process with a cooling off period of 14 days where they could change their mind about their decision to undergo cosmetic surgery.

Staff clearly recorded consent in the patients' records.

For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards please see under this subheading in the cosmetic surgery report.

Are Outpatients caring?

Good

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Requires Improvement

Outpatients

For our detailed findings on compassionate care please see under this subheading in the cosmetic surgery report.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

For our detailed findings on compassionate care please see under this subheading in the cosmetic surgery report.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

For our detailed findings on emotional support please see under this subheading in the cosmetic surgery report.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

For our detailed findings on emotional support please see under this subheading in the cosmetic surgery report.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

For our detailed findings on understanding and involvement of patients and those close to them please see under this subheading in the cosmetic surgery report.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients and families in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service.

For our detailed findings on understanding and involvement of patients and those close to them please see under this subheading in the cosmetic surgery report.

Requires Improvement

Outpatients

Are Outpatients responsive?

Requires Improvement

We rated responsive as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

For our detailed findings on service delivery to meet the needs of local people please see under this subheading in the cosmetic surgery report.

Managers planned and organised services so they met the changing needs of the local population.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were mostly appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers ensured that patients who did not attend appointments were contacted.

For our detailed findings on service delivery to meet the needs of local people please see under this subheading in the cosmetic surgery report.

Meeting people's individual needs

The service mostly took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services, although there were limited arrangements for patients who required interpreter or communication support. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

For our detailed findings on meeting people's individual needs please see under this subheading in the cosmetic surgery report.

Staff assessed patients individually to identify any support needs. The service's emotional health and wellbeing lead was routinely involved in supporting patients who were having cosmetic surgery and supported clinical staff during consultation appointments.

All appointments were offered a chaperone for support.

The service did not provide information leaflets available in different languages. Staff had limited awareness of translation and interpreter services and did not provide any examples of where these had been used.

Requires Improvement

Outpatients

Staff were unaware of any access to communication aids to help patients become partners in their care and treatment. The premises did not have a hearing loop available to support any patients with hearing loss who used hearing aids. There was no information in the waiting room for individuals with visual difficulties.

For our detailed findings on meeting people's individual needs please see under this subheading in the cosmetic surgery report.

Access and flow

People could access the service when they needed it and received the right care.

For our detailed findings on access and flow please see under this subheading in the cosmetic surgery report.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers worked to keep the number of cancelled appointments to a minimum.

For our detailed findings on access and flow please see under this subheading in the cosmetic surgery report.

Learning from complaints and concerns

It was not always easy for people to raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

For our detailed findings on learning from complaints and concerns please see under this subheading in the cosmetic surgery report.

Patients, relatives and carers did not always know how to complain or raise concerns.

The service did not clearly display information about how to raise a concern in patient areas We did not see any complaint poster or information on how to complain in the reception or consultation areas. The service's website did not provide details of how to raise any complaints.

Staff understood the policy on complaints.

Managers investigated complaints.

Are Outpatients well-led?

Requires Improvement

We rated well-led as requires improvement.

Requires Improvement

Outpatients

For our detailed findings on leadership, vision and strategy, culture, governance, management of risk, issues and performance, information management, engagement and on learning, continuous improvement and innovation please see under these sub-headings in the surgery report.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not ensure that staff completed safeguarding training to ensure that all staff can identify and report abuse of service users.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure that it establishes and operates effective systems and processes to assess monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. The service did not ensure that it establishes and operates effective systems and processes to assess monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk from the carrying on of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service did not ensure that persons employed by the service provider receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

Diagnostic and screening procedures

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The service did not ensure the proper and safe management of medicines.