Nuffield Health The Grosvenor Hospital Chester

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health, The Grosvenor Hospital, Chester is an independent hospital, based in a semi-rural location in Chester and is part of Nuffield Health. The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning services
- Surgical procedures
- Treatment of disease, disorder or injury.

The hospital director is the registered manager, supported by a senior management team. The hospital director also managed another Nuffield Health hospital at the time of the inspection.

This inspection was carried out as part of our ongoing programme of comprehensive independent health care inspections. We inspected the hospital on 26 and 27 July 2016 as an announced visit. During the inspection there were scheduled surgical procedures and outpatient clinics taking place and also radiological investigations and physiotherapy clinical sessions. On 4 August 2016 we also carried out an unannounced inspection when there were surgical procedures, radiological investigations, physiotherapy clinical sessions and outpatient clinics taking place.

We inspected the core services of medicine, surgery and outpatients and diagnostics at the hospital.

Are services safe at this hospital

- There were good systems in place to prevent avoidable harm. These were being implemented appropriately at the time of the inspection.
- There was a culture of openness, reporting and investigation of incidents amongst staff. There were systems and processes in place to report incidents and to ensure learning from them. There was evidence of positive improvements and changes made as a result of incidents. Learning was disseminated to staff both within the various departments in the hospital and where relevant to other Nuffield hospitals to help prevent future occurrences.
- There were 261 clinical incidents in the reporting period (Apr 15 to Mar 16). Out of those, 49% (128 incidents) occurred in surgery or inpatients and 32% (83 incidents) in other services. The remaining 19% of all clinical incidents occurred in Outpatients and Diagnostics (50 incidents). The hospital reported no incidents as severe or death. For the time period April 15 to March 16, the assessed rate of clinical incidents in surgery, inpatients and other services was not high when compared to the average rates of other independent acute hospitals.
- The hospital provided a system to identify and safeguard the needs of vulnerable adults, children and young people. Staff were aware of their responsibilities and the correct procedures to follow if a patient was at risk. Safeguarding training formed part of the hospital's mandatory training programme and included information on Female Genital Mutilation and Child Sexual Exploitation. There was a lead nurse for safeguarding and there was evidence that safeguarding concerns had been raised appropriately.
- Systems were in place to protect people from the risk of healthcare related infections. There were no reported healthcare related infections at the hospital in the period April 2015 to March 2016 and there were no reported incidents of acquired venous thromboembolism or pulmonary embolism in the same period.
- Risk assessments were carried out for patients and stored in patient records. The hospitals reported that 100% of patients had been screened for venous thromboembolism (VTE) in the period April 2015 to March 2016.

Summary of findings

- The environment was generally visibly clean and tidy; w Action plans were in place, if necessary and were reviewed regularly.
- The hospital performed well in the Person-Led Assessment of the Care Environment (PLACE) audits. The results showed that the hospital performed better than the national average for cleanliness, and condition appearance and maintenance.
- Records were kept securely and contained all the relevant information required; they were generally comprehensive and legible.
- Medicines were stored securely and there were processes in place to ensure they remained suitable for use. There were pharmacy audits and controlled drugs audits completed.
- Staffing levels were planned and implemented to ensure that there was sufficient staff on duty to provide safe care. This included the resident medical officer (RMO) cover. There was very low use of agency staff.
- During the inspection, we found that the 'duty of candour' regulations were being implemented appropriately following patient harm. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw examples of this process and were satisfied that the process was in line with organisational policy and national guidance. Records showed that patients were involved and updated about investigations, invited to discuss the circumstances with senior staff and received an appropriate apology for the harm caused.
- However, the presence of carpet flooring in some clinical and ward areas were contrary to infection control best practice.
- There were some areas of low compliance with mandatory training in the hospital, including Mental Capacity Act, Consent, Deprivation of Liberties, and basic and immediate life support.

Are services effective at this hospital

- There were local policies and procedures in place and we saw evidence that departments followed relevant guidelines. The hospital kept their practices up to date and current by ensuring they were consistent with latest guidance such as those from the National Institute of Health and Care Excellence (NICE) and the relevant Royal Colleges'.
- Patients were prescribed analgesia to relieve pain and received the medication in a timely manner.
- Nutrition and hydration was assessed, information on fasting for surgery was available and there was dietician support and advice available for patients.
- There was a comprehensive induction programme in place for new staff.
- The hospital was generally performing similar to, or better than the England average, for outcomes in relation to knee and hip replacements.
- Staff were observed working in partnership with a range of staff from other teams and disciplines including allied health professional, consultants and administration staff. Staff told us there were very good working relationships and a culture of respect and collaboration. There was a good external working relationship with the local NHS acute hospital and staff were able to access necessary services. There were several service levels agreements in place.
- The hospital performed well in the Person-Led Assessment of the Care Environment (PLACE) audits. The results showed that the hospital performed better than the national average for food, organisational food and ward food.

Summary of findings

- Mandatory training subjects included the Mental Capacity Act (2005), the deprivation of liberty safeguards and consent. However, we found inconsistency amongst staff and uncertainty over who was responsible for determining patients' capacity to consent and how assessments were conducted in practice.
- Where patients had signed the consent form in advance of the day of surgery the confirmation of consent was not always completed on the day they were admitted to receive the surgery.
- Patients' undergoing cosmetic surgery were not always assessed psychologically before their surgery, there was no formal system in place to monitor the necessary cooling off period and the hospital did not have a cosmetic surgery specialist nurse.

Are services caring at this hospital

- Patients we spoke to were positive about staff and confirmed that staff were kind, considerate and treated them with dignity and respect.
- We observed staff being attentive and caring to patients during the inspection.
- The NHS friends and family test (FFT) is a survey, which asks NHS patients whether they would recommend the service they have used to their friends and family. From April 2015 to March 2016, hospital wide, 100% of NHS patients would recommend the service to their family or friends, the response rate was 49.9%.
- All patients were provided with a satisfaction survey following treatment. At May 2016 patient satisfaction was 96% which was better than the Nuffield hospitals as a whole and was better than the internal target of 95%.
- The hospital performed well in the Person-Led Assessment of the Care Environment (PLACE) audits. The results showed that the hospital performed better than the national average for privacy, dignity and wellbeing.

Are services responsive at this hospital

- The hospital had service level agreements in place with local NHS providers to meet the demands of the local population.
- Information provided regarding waiting times for treatment for NHS patients, also known as referral to treatment times (RTT) showed that from April 2015 to March 2016, on average 91% of patients referred to the Grosvenor Hospital were admitted for treatment within 18 weeks of referral.
- The hospital had introduced a health MOT for patients attending for pre-operative assessments. This was a comprehensive assessment of the patients holistic health and well-being including exercise, diet and lifestyle factors. A report and associate advice and guidance were provided to the patient in order to optimise their health for surgery but also for their future health and wellbeing.
- There were systems in place to support vulnerable patients and care was planned based on a patients individual needs.
- The hospital offered a professional face to face interpreter service for patients whose first language was not English. They were able to use the services of a telephone translation service where an interpreter was required at short notice.
- The hospital performed well in the Person-Led Assessment of the Care Environment (PLACE) audits. The results showed that the hospital performed better than the national average for dementia care.
- The hospital received 54 formal complaints between April 2015 and March 2016 for the whole hospital. The rate of complaints (per 100 day case and inpatient discharges) was not considered high when compared with other independent acute hospitals we hold this type of data for.

Summary of findings

- The overall responsibility for managing complaints was part of the hospital director's role. The hospital matron took the lead if complaints were in relation to clinical care but they were all signed off by the hospital director. We reviewed a sample of complaints and saw that in each case, the level of risk for each complaint was reviewed. Appropriate investigations were undertaken and lessons learnt were recorded. Most complainants were invited to meet a representative from the hospital. The final letter issued to complainants included details of how to further pursue the complaint if they were still not satisfied. Patients who had complained were invited to join the patient forum group to attend meetings and give feedback on patient care.
- Meeting minutes we reviewed indicated that complaints were discussed at the Senior Management Team (SMT) meeting. They were also discussed through the integrated governance and medical advisory committee (MAC) meetings, which were held regularly.

Are services well led at this hospital

- Staff were aware of the Nuffield Chester vision, values, and strategy.
- Nuffield health had values that they termed 'Everyday Epic' which were used to shape their decisions, and guided the way they behaved when treating patients and colleagues. The values were based on being enterprising, passionate, independent, and caring (EPIC).
- The leadership, governance and culture at the hospital promoted the delivery of high quality, person-centred care. There was a cohesive management team, which included the Medical Advisory Committee (MAC) Chair. Members of the leadership team were well respected amongst both staff and patients.
- An audit programme was in place to evaluate the hospitals compliance with key processes to promote safe, high quality care.
- There were integrated governance committee meetings held within the hospital. We reviewed the minutes of meetings from February 2016 and June 2016. The minutes were comprehensive. However, the structure meant it wasn't always clear who was presenting and discussing the items. In addition, actions, target dates for actions and the responsible person for completing them were not recorded consistently.
- There was a risk register in place at the time of the inspection. It contained details of risks and actions but the hospital was not using the Nuffield Health Group risk register template as set out in the Nuffield Corporate Risk Management Strategy. As a result, key information such as controls and gaps in controls for each risk were not included. We raised this with the Matron at the time of the inspection and the risk register was transposed onto the corporate template the next day. It was planned that this would be used as the risk register in future hospital governance meetings and heads of department meetings.
- Key risks to the hospital, such as the ageing theatres were known to leaders and they could describe the actions in place to mitigate risks to patients.
- The MAC monitored compliance with practicing privileges and there was evidence of action taken by the Hospital Director in consultation with the MAC Chair and corporate executive directors when competence issues arose.
- The leadership team at the hospital had taken the decision in May 2016 to suspend the paediatric service following the departure of the paediatric lead nurse. A new lead nurse had been appointed at the time of the inspection, but hadn't started. Leaders had conducted a gap analysis of service provision and planned a thorough review with the lead nurse before re-starting the service.
- The hospital engaged with a wide range of stakeholders, including patients, GP's, local NHS trusts and commissioners. Senior managers were active in promoting the services of the hospital. The hospital also engaged the community wherever possible. For example, we were told of an example where 15-17 year old students who were interested in healthcare were invited into the hospital for a question and answer session.

Summary of findings

- Leaders were keen to develop services further following the successful innovative programme of Health MOT's being provided at the hospital to actively promote a healthy lifestyle for patients.
- The hospital participated in a leadership MOT, which was a survey for staff to complete that could be compared against other Nuffield Hospitals in the group. We reviewed the results of the leadership MOT for October 2015. The overall results for the Nuffield Grosvenor Chester showed that the hospital performed better than the average in every question.
- The hospital participated in a Nuffield-wide consultant survey. The results from the 2015 survey were mixed, with some responses to questions better than other Nuffield hospitals and some worse. The hospital had developed a robust action plan in response and the majority of actions were complete at the time of the inspection. The main ones left open related to the paediatric service that had been suspended in May 2016 and was not in operation at the time of the inspection.
- There was evidence of an open culture. Senior managers held a monthly 360 feedback session with staff, which staff found positive.

We saw some areas of outstanding practice including:

- The Nuffield Grosvenor introduced a health MOT for patients attending for pre-operative assessments. This was a comprehensive assessment of the patients holistic health and well-being including exercise, diet and lifestyle factors. A report and associate advice and guidance were provided to the patient in order to optimise their health for surgery but also for their future health and wellbeing.

However, there were areas we feel the provider should make improvements;

In surgery

- Patients that sign the consent form in advance of the day of surgery should have confirmation of the consent documented on the day of surgery by a consultant or nurse.
- The hospital should ensure that the psychological aspects around cosmetic surgery are being considered during the consultation process, they should ensure a two week cooling off period is provided and establish a system of monitoring that these two practises are being achieved. They should consider the role of cosmetic surgery specialist nurse.
- The hospital should improve compliance with mandatory training in the areas where compliance is low, such as Mental Capacity Act, Consent, Deprivation of Liberties, and basic and immediate life support.
- All staff should adhere to the 'bare below the elbows' protocol.
- The Resident Medical Officer and ward staff should be trained and be aware of the process to perform a mental capacity assessment in the event that an assessment is required out of hours.
- The hospital should consider providing training for theatre staff in pain assessment for children and young people should the service recommence as planned.
- The hospital should record allergy status in all children and young people's records should the service recommence as planned.
- All paediatric early warning scores should be documented as per the hospital policy should the service for children and young people recommence as planned.
- A registered children's nurse should be available to document updates in the patient record should the service for children and young people recommence as planned.

Summary of findings

- All patient letters should be filed in the correct medical record.

In outpatients and diagnostic imaging

- The outpatients and diagnostics departments should reinforce the principles of the Mental Capacity Act 2005 in relation to the application of a test for capacity to consent to treatment. Further education regarding informal consent to treatment may be beneficial to eradicate any misconceptions about how consent may be gained.
- The outpatients and diagnostics departments should consider the replacement of carpets in clinical areas for infection control purposes.
- The department should ensure that the room used for laser procedures has the appropriate signage in place.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Not sufficient evidence to rate 	Emergency resuscitation equipment was in place in both the ward and surgical theatres. Endoscopy disinfection schedules were completed and tracking systems were in place. Two registered nurses from the inpatient ward provided 1:1 care to patients receiving chemotherapy and a breast care nurse was in post to support patients with a diagnosis of cancer. Care and treatment for patients receiving chemotherapy was delivered in line with evidence-based practice and the Nuffield chemotherapy pathway was in use. Staff followed chemotherapy protocols and guidelines from a local specialist NHS trust. Psychological support was provided to patients and family members by ward staff and staff met with patients prior to commencing chemotherapy treatment to get to know patients and develop a relationship with them. Prior to patients receiving chemotherapy treatment an assessment of social, emotional and spiritual needs was completed and chemotherapy regimes were adapted to allow treatment to be patient led. A one-stop breast clinic was provided so that, following consultation and examination, patients could undergo investigations such as mammogram and ultrasound and receive results within the same visit. Written information was provided to patients specific to their chemotherapy treatment regime and information leaflets were provided to patients attending for endoscopy both pre and post procedure. All patients were provided with a satisfaction survey following treatment.
Surgery	Good 	There was a culture of reporting investigating and learning from incidents. There were no surgical site infections

Summary of findings

reported for primary hip arthroplasty, primary knee arthroplasty, and spinal and breast surgery in the reporting period April 2015 to March 2016. Emergency resuscitation equipment was in place in both the ward and surgical theatres. Care and treatment for patients receiving surgical interventions was delivered in line with evidence-based practice.
Pre-operative assessments took place to identify any risks and to ensure patients could be treated at the hospital safely. Staff delivering services received training and were supported to learn and develop.
Patients felt involved in their care, with options about treatments available, and received information in a manner they understood. All patients were provided with a satisfaction survey following treatment.
However, patients' undergoing cosmetic surgery were not always assessed psychologically before their surgery, there was no formal system in place to monitor the necessary cooling off period and the hospital did not have a cosmetic surgery specialist nurse. Staff working in theatre were not achieving the target for compliance against Mental Capacity Act, Consent, and Deprivation of Liberties training.

Outpatients and diagnostic imaging

Good

There was a culture of reporting investigating and learning from incidents. The departments were visibly clean and there were low levels of healthcare related infections. There were effective procedures to stabilise and transfer patients who became unwell. Evidence-based guidance and best practice was followed. There were good reported outcomes for patients and evidence of peer review, external benchmarking. There was effective multidisciplinary working, where different disciplines worked well together to provide a more holistic service to patients.
Feedback from people was continuously positive, they said staff were

Summary of findings

compassionate and kind and were attentive to their needs. Patients were involved in decisions about their care and treatment. Care was planned and delivered in a pleasant and appropriate environment with the needs of patients and their relatives being taken into account. Complaints were dealt with appropriately. Leaders were visible, experienced, competent and enthusiastic. There were strategies and plans in place for the future for the hospital. There was effective governance, audits and internal measures of performance and quality. There was a positive staff culture. However; the presence of carpet flooring in some clinical areas were contrary to infection control best practice. There was some uncertainty over the application of the mental capacity act legislation, regarding the assessment of a person's capacity to consent.

Summary of findings

Contents

Good

Nuffield Health, The Grosvenor Hospital, Chester

Services we looked at
Medical care; Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Nuffield Health The Grosvenor Hospital Chester

Nuffield Health, The Grosvenor Hospital, Chester is an independent acute hospital, which opened in 1975 and is part of a group of 31 hospitals within Nuffield Health, which is a not for profit healthcare provider.

The hospital is located in Chester, in a semi-rural location, with good access by road and has free on site car parking. The hospital has a ward area with 29 inpatient and day-case beds.Start here...

Our inspection team

The team that inspected the service comprised an Inspection Manager, three CQC inspectors, a specialist pharmacy inspector, and specialist advisors including an operating theatres manager, a lead nurse with experience of working in a general medicine and outpatients departments, a manager with experience in governance and healthcare management and a lead nurse with experience in the care of children and young people.

How we carried out this inspection

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

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

The inspection was carried out as part of our ongoing programme of comprehensive independent health care inspections.

The hospital provided us with comprehensive information and data before the inspection and we also used information from patients and the public including patient survey data and feedback from patients who had received treatment at the hospital. We looked at information from Healthwatch and from the commissioners of the services. Some data was available nationally including friends and family data.

During the announced inspection on the 26, 27 July 2016 and the unannounced inspection on 4 August 2016 we spoke with a range of staff including senior managers, nurses, consultants, allied health professionals, administrators and health care assistants who worked at the hospital.

We spoke with patients and relatives who were attending the hospital at the time of our inspection. We gathered feedback from questionnaires and received comments from people who contacted us to tell us about their experiences. We also reviewed patient records.

We viewed policies and standard operating procedures. We observed care and treatment, reviewed performance and assessed information about the hospital and the different departments. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff. Following the inspection we requested additional information which was provided in a timely manner.

Information about Nuffield Health The Grosvenor Hospital Chester

- The services provided by the hospital included; orthopaedics, cosmetic surgery, plastic surgery dermatology, ear, nose and throat (ENT), audiology, general surgery, gynaecology, ophthalmology, gastroenterology, dental and maxillo-facial, pain management, physiotherapy, rheumatology, urology and endoscopy.

Summary of this inspection

- There were 29 inpatient beds with en-suite facilities which were used for both inpatients, day case and endoscopy day case patients.
- The theatre department comprised of two main operating theatres, one of which was equipped with laminar flow.
- There were 3,994 inpatient and day case episodes of care recorded at Nuffield Health Chester, The Grosvenor Hospital in the reporting period April 2015 to March 2016; the majority of patients (82%) were NHS funded patients and the remaining (18%) were funded by self-paying patients and through insurance funding.
- The outpatients department undertook 21,290 outpatient attendances between April 2015 and March 2016; the majority of these (83%) were funded by self-paying patients and through insurance funding and the remaining (17%) were NHS funded patients.
- The outpatient department comprised of 10 consulting rooms, a small ambulatory minor procedures room, a treatment room and a phlebotomy room.
- Radiology undertook 11,475 radiological investigations and procedures between April 2015 and March 2016.
- There were 11,658 physiotherapy outpatient appointments between August 2015 and August 2016.
- The radiology department had its own waiting and treatment areas. There was an magnetic resonance scanner (MRI) on site and a mobile computerised tomography scanner (CT) which visited each week, however these were operated by external providers through a service level agreement with Chester, the Grosvenor Hospital. The procedures carried out in the radiology department included plain x-ray, ultrasound, bone densitometry, mammography and interventional radiology procedures.
- The physiotherapy department was located on the ground floor having its own reception, waiting area and individual consultation and treatment rooms. A comprehensive rehabilitation area and gym was provided at the co-located Nuffield gym. The physiotherapy team also provided support for orthopaedic in-patients.
- The registered manager and accountable officer for controlled drugs was John Pickering.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We are will rate key questions where we have sufficient, robust information which answer the key lines of enquiry and reflect the prompts.

Not sufficient evidence to rate

Medical care

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

Information about the service

The Grosvenor Hospital provides endoscopy and chemotherapy services to patients as day-case procedures. The hospital also provides diagnostic procedures which include: endoscopy services for sinus or bladder, diagnostic gastroscopy, and colonoscopy.

Patients attending for chemotherapy and endoscopy procedures were cared for on the inpatient ward. Identified staff were allocated to provide care on a 1:1 basis for patients receiving chemotherapy.

Between April 2015 and March 2016, 156 oncology procedures and 13 haematology procedures were provided. In the same period, 952 diagnostic endoscopy procedures, 306 diagnostic gastroscopy procedures and 276 diagnostic colonoscopy procedures were performed.

We visited the Grosvenor Hospital between 26 and 27 July 2016 and performed an unannounced visit 4 August 2016. We inspected a range of day-case services including surgical theatres and the inpatient ward.

Due to limited numbers of patients we were unable to observe any endoscopy or oncology care and treatment during our inspection. The last patient to have attended for chemotherapy prior to our inspection was in April 2016.

This service has been inspected but not rated due to the low number of patients involved.

Summary of findings

This service has been inspected but not rated due to the low number of patients involved. Positively we saw that;

- Endoscopy disinfection schedules were completed and tracking systems in place to identify any failures.
- Emergency resuscitation equipment was in place in both the ward and surgical theatres.
- All patients receiving chemotherapy had a patient held treatment record in addition to a hospital medical record.
- Safeguarding flowcharts were displayed in clinical areas which included internal contacts for advice and support as well as external telephone numbers for local authority safeguarding services. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Procedures were in place for a patient who required transfer to an acute hospital if they became unwell.
- Two registered nurses from the inpatient ward provided 1:1 care to patients receiving chemotherapy and a breast care nurse was in post to support patients with a diagnosis of cancer.
- Care and treatment for patients receiving chemotherapy was delivered in line with evidence-based practice and the Nuffield chemotherapy pathway was in use. Staff followed chemotherapy protocols and guidelines from a local specialist trust.
- Staff delivering chemotherapy treatment to patients had completed competency assessments for the administration of chemotherapy and a placement at

Not sufficient evidence to rate

Medical care

a local acute specialist trust. A standard operating procedure (SOP) was in place for ensuring the competence of nursing staff administering cytotoxic chemotherapy.

- A one stop breast clinic was provided so that, following consultation and examination, patients could undergo investigations such as mammogram and ultrasound and receive results within the same visit.
- During chemotherapy administration and following endoscopic procedures patients were nursed in individual rooms.
- Chemotherapy regimes were adapted to allow treatment to be patient led.
- Psychological support was provided to patients and family members by ward staff and staff met with patients prior to commencing chemotherapy treatment to get to know patients and develop a relationship with them.
- A holistic needs assessment was completed for patients prior to commencement of chemotherapy and included social, emotional and spiritual needs as well as any multi-disciplinary intervention that maybe required.
- Written information was provided to patients specific to their chemotherapy treatment regime and information leaflets were provided to patients attending for endoscopy both pre and post procedure.
- We saw an effective governance framework to support the delivery of the strategy and good quality care. Staff were clear about their roles, responsibilities and level of accountability and integrated governance meetings were held quarterly to discuss issues including governance, risk and safeguarding.
- Staff described good leadership from the hospital director and senior management team, they said there was an open and honest leadership style and they were visible and approachable.
- All patients were provided with a satisfaction survey following treatment.

However;

- Nurses were not involved in multi-disciplinary team meetings for patients receiving chemotherapy but they did receive copies of outpatient consultations to ensure they were updated before the patient's next attendance.

Not sufficient evidence to rate

Medical care

Are medical care services safe?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. Positively we saw that;

- There were no never events or serious incidents in relation to chemotherapy or endoscopy services in the reporting period April 2015 to March 2016.
- Staff we spoke with on the ward and in theatres were aware of the term 'duty of candour'.
- Staff were aware of, and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy with the exception of one staff member in the theatre recovery area who was observed wearing a wrist watch.
- Decontamination of endoscopes took place on site. Endoscopy disinfection schedules were completed and tracking systems in place to identify any failures.
- Emergency resuscitation equipment was in place in both the ward and surgical theatres.
- All patients receiving chemotherapy had a patient held treatment record in addition to a hospital medical record. This was used when a cycle of chemotherapy was in progress and recorded details such as the regime being administered and when bloods were taken as well as contact numbers, appointments and information regarding treatment side effects.
- Safeguarding flowcharts were displayed in clinical areas which included internal contacts for advice and support as well as external telephone numbers for local authority safeguarding services. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Procedures were in place for patients' who required transfer to an acute hospital if they became unwell.
- Two registered nurses from the inpatient ward provided 1:1 care to patients receiving chemotherapy and a breast care nurse was in post to support patients with a diagnosis of cancer.

However;

- A message book was in use on the inpatient ward to record messages and actions from telephone calls from patients following discharge. Three messages related to patients who had received chemotherapy treatment. The book produced a duplicate copy for filing in patients records however all three messages had both copies present in the message book this may mean that the patients notes had no reference to the telephone contact or any advice given.

Incidents

- A standard operating procedure (SOP) for managing and reporting incidents was in place. Incidents were reported via an electronic system, and staff we spoke with at the time of our inspection knew how to access the system. There were no never events requiring investigation, (never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers), and no deaths reported during the reporting period April 2015 to March 2016.
- There were two incidents relating to endoscopy and chemotherapy between April 2015 to March 2016, both were classified as low harm. We saw evidence that incidents were reviewed and investigated, and learning was shared within the hospital and across other Nuffield locations if required.
- Staff we spoke with on the ward and in theatres were aware of the term 'duty of candour' (the duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).

Cleanliness, infection control and hygiene

- Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy with the exception of one staff member in the theatre recovery area who was observed wearing a wrist watch.
- Hand washing facilities, including hand gel were readily available in prominent positions in each clinical area.
- Records indicated that decontamination of endoscopes took place on site. Endoscopy disinfection schedules were completed and observed for the week prior to our inspection. There were tracking systems in place to identify any failures and monitoring systems included ensuring that equipment remained in the dryer for three days.

Not sufficient evidence to rate

Medical care

Environment and equipment

- Patients attending for chemotherapy treatment as a day-case were admitted to an inpatient room on the ward.
- Staff told us that chemotherapy was being administered as a bolus or infusion at the time of our inspection however managers told us specific pumps had been ordered for chemotherapy delivery.
- Patients attending for endoscopy were allocated a room prior to their procedure and returned to the room following a short period in recovery.
- Emergency resuscitation equipment was in place in both the ward and surgical theatres. At the time of our announced inspection we checked the adult resuscitation trolley in the recovery area in the theatre department. We found checklists were missing from January 2016 to July 2016 and the staff and theatre manager were not aware where they had been moved to. When we returned on the unannounced we saw that the checklists were in the file from January 2016 to July 2016

Medicines

- Chemotherapy prescriptions were prepared in advance and standard operating procedures (SOP) were in place for the chemotherapy prescription process and the handling and disposal of cytotoxic waste.
- Chemotherapy treatment was not stored on site and were delivered to the hospital pharmacy direct from the supplier as required.
- We found out of date Infacol in the endoscopy room at the time of our inspection. We informed staff and this was removed.

Records

- Staff told us all patients receiving chemotherapy had a patient held treatment record in addition to a hospital medical record. This was used when a cycle of chemotherapy was in progress and recorded details such as the regime being administered and when bloods were taken as well as contact numbers, appointments and information regarding treatment side effects.
- A message book was in use on the inpatient ward to record messages and actions from telephone calls from patients following discharge. We reviewed messages recorded between 19 November 2015 and 27 February 2016 and 6 March 2016 and 31 May 2016. Three of the messages related to patients who had received chemotherapy treatment and documented advice given and any follow up action required. The book, when complete, produced a duplicate copy for filing in patients records. However, all three messages had both copies present in the message book; this may mean that the patient's notes had no reference to the telephone contact or any advice given.

Safeguarding

- Safeguarding policies and procedures were in place in the hospital and these were available electronically for staff to refer to.
- Flowcharts were displayed in clinical areas which included internal contacts for advice and support as well as external telephone numbers for local authority safeguarding services.
- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- The matron was the identified lead for safeguarding children and adults and staff were aware of this.
- Data provided by the hospital at the time of our inspection showed completion rates for safeguarding vulnerable adults level 1 training was 82% of ward staff (18 out of 22 of the target group) and 82% of theatre staff (23 out of a target group of 28).
- Mental Capacity Act (MCA) training completion rates were 100% for ward staff (16 of the target group) and 74% of theatre staff (17 of a target group of 23).
- Not all theatre and ward staff would be involved in delivering care to endoscopy and chemotherapy patients but training completion rates could not be disaggregated specifically for staff providing endoscopy and chemotherapy services.

Mandatory training

- Training which was classed as mandatory were those subjects which were considered the most important such as basic life support, safeguarding patients and moving and handling.
- Mandatory training was kept updated by attendance on training courses or by training done remotely on a computer, however training completion rates could not be disaggregated specifically for staff providing endoscopy and chemotherapy services.

Not sufficient evidence to rate

Medical care

- Data provided by the hospital at the time of our inspection showed Basic Life Support training had been completed by 73% of ward staff (16 out of a target group of 22) and by 68% of theatre staff (19 out of a target group of 28).
- Immediate Life Support (ILS) training was completed by 7% of ward staff (1 staff member out of a target group of 14) and 26% of theatre staff (5 staff out of a target group of 19).
- Fire safety had been completed by 86% of theatre staff (24 out of a target group of 28) and by 91% of ward staff (20 out of a target group of 22).

Assessing and responding to patient risk

- The Nuffield Health oncology care record included a modified early warning score (MEWS) chart, which included observations of a patient including temperature and blood pressure. If a patient's condition deteriorated, the score for the observations increased and gave an indication that intervention maybe required. However, as there were no patients on the ward during our inspection we did not see this in use.
- Patients who became unwell while receiving treatment would be reviewed by the Resident Medical Officer (RMO) and following discussion with the consultant would arrange for transfer to the local acute or specialist trust if required.
- Procedures were in place for a patient who required transfer to an acute hospital following endoscopy.

Nursing staffing

- Nurse staffing for endoscopy and chemotherapy patients were considered as part of the ward complement.
- Staffing was prepared a week in advance once managers became aware of the number of admissions that were planned.
- Two registered nurses from the inpatient ward provided 1:1 care to patients receiving chemotherapy and a third nurse was due to undertake training in September 2016.
- One breast care nurse was in post to support patients with a diagnosis of cancer.

Medical staffing

- A resident medical officer (RMO) was on site for 24 hours a day, seven days a week.
- Consultants with practising privileges undertook endoscopy procedures at the hospital and maintained responsibility for their own patients.
- Two oncologists provided care at the hospital in addition to their NHS practise but one consultant was on long term sick leave at the time of our inspection.

Major incident awareness and training

- A standard operating procedure (SOP) was in place for management of cytotoxic spillage, waste and contamination.
- Training on fire procedures was updated as part of the hospital's mandatory training programme annually.
- Fire drills were undertaken periodically and evacuation procedures tested.
- There were business continuity plans in place which included contingency plans to be used in the event of staffing shortages and equipment failure.

Are medical care services effective?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. Positively we saw that;

- Care and treatment for patients receiving chemotherapy was delivered in line with evidence-based practice and the Nuffield chemotherapy pathway was in use. Staff followed chemotherapy protocols and guidelines from a local specialist trust.
- A nutritional assessment was undertaken as part of the pre-treatment assessment of patients who received chemotherapy. This included the impact of the side effects of treatment as well as any nutritional support or intervention required.
- A toxicity score was completed for all patients prior to delivery of treatment. This identified any adverse treatment effects and was documented in the oncology care record.
- Staff delivering chemotherapy treatment to patients had completed competency assessments for the administration of chemotherapy and a placement at a local acute specialist trust. A standard operating procedure (SOP) was in place for ensuring the competence of nursing staff administering cytotoxic chemotherapy.

Not sufficient evidence to rate

Medical care

- A one stop breast clinic was provided so that, following consultation and examination, patients could undergo investigations such as mammogram and ultrasound and receive results within the same visit.
- The Resident Medical Officer (RMO) provided medical support for all patients out of hours. Consultants were available on-call if required. Inpatient facilities were available 24 hours a day seven days a week.
- A standard operating procedure (SOP) was in place for pre-assessment and education of patients attending for chemotherapy and a SOP was in place for the administration of sedation for endoscopic procedures.

However;

- Nurses were not involved in multi-disciplinary team meetings for patients receiving chemotherapy however; they did receive copies of outpatient consultations to ensure they were updated before the patient's next attendance.

Evidence-based care and treatment

- Care and treatment for patients receiving chemotherapy was delivered in line with evidence-based practice, such as National Institute for Health and Care Excellence (NICE) guidance for the management of neutropenic sepsis in people with cancer.
- The Nuffield chemotherapy pathway was in use and staff told us they followed protocols and guidelines from a local specialist trust.
- A standard operating procedure (SOP) was in place for endoscopy.
- The hospital was working towards achieving the Joint Advisory Group (JAG) accreditation, which is a formal recognition that an endoscopy service has demonstrated that it has the competence to deliver endoscopy standards of best practice.

Pain relief

- The modified early warning score (MEWS) assessment included in the oncology care record included an assessment of pain however; as there were no patients on the ward during our inspection we did not see this in use.

Nutrition and hydration

- A nutritional assessment was undertaken as part of the pre-treatment assessment of patients who received chemotherapy. This included the impact of the side effects of treatment as well as any nutritional support or intervention required.

Patient outcomes

- Records indicated that a toxicity score was completed for all patients prior to delivery of treatment. This identified any adverse treatment effects and was documented in the oncology care record.
- A benchmarking report was completed monthly by the Matron which covered issues such as infection control, incidents and safeguarding.

Competent staff

- Staff delivering chemotherapy treatment to patients had completed competency assessments for the administration of chemotherapy and they had also been on a placement at a local acute specialist trust to obtain practical experience.
- Refresher training was planned for both nurses who were eligible to administer chemotherapy at the time of our inspection.
- A standard operating procedure (SOP) was in place for ensuring the competence of nursing staff administering cytotoxic chemotherapy.
- Plans were in place for two staff members to commence the Counselling in Cancer Care course in September 2016.
- All staff we spoke with told us they had received an appraisal in the 12 months prior to our inspection.

Multidisciplinary working

- A one-stop breast clinic was provided at the hospital. This meant that, following consultation and examination, patients could undergo investigations such as a mammogram or ultrasound and receive the results within the same visit. This ensured patients received prompt results which helped to reduce anxiety and also prevented the need for patients to return for further appointments.
- Staff told us the breast care nurse was present for outpatient consultations and multi-disciplinary meetings took place following clinics.

Not sufficient evidence to rate

Medical care

- Staff told us that nurses were not involved in multi-disciplinary team meetings for patients receiving chemotherapy however; they did receive copies of outpatient consultations to ensure they were updated before the patient's next attendance.
- Arrangements for the transfer of patients who became unwell while receiving treatment was arranged by the consultant as required.
- Staff reported a close working relationship with the local acute specialist trust who could be contacted for advice and support.

Seven-day services

- Inpatient facilities were available 24 hours a day seven days a week. The Resident Medical Officer (RMO) provided medical support for all patients out of hours. Consultants were available on-call if required.
- There was a system in place to contact a radiologist 24 hours a day, seven days a week to undertake time critical diagnostic tests. The radiologist was able to perform urgent scans and interpret reports urgently if required.
- A biomedical scientist was on call 24 hours a day to respond to urgent requests. There was an arrangement to obtain urgent tests with a local acute trust if this could not be accommodated within Nuffield Health laboratories themselves.

Access to information

- Records indicated that summary letters were sent to GPs following consultation or discharge.
- Staff were able to access information such as policies and procedures from the hospitals intranet.
- Staff could gain access to patient information such as laboratory results, appointment records, x-rays and medical records appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for procedures was obtained by the consultant.
- Information about side effects was discussed with patients before commencement of chemotherapy treatment and documented in the oncology care record.
- A standard operating procedure (SOP) was in place for pre-assessment and education of patients attending for chemotherapy.
- A SOP was in place for the administration of sedation for endoscopic procedures.

Are medical care services caring?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. Positively we saw that;

- Prior to patients receiving chemotherapy treatment an assessment of social, emotional and spiritual needs was completed and chemotherapy regimes were adapted to allow treatment to be patient led.
- Staff described how a patient's relative had been allowed to stay with the patient to alleviate their own anxiety regarding the treatment.
- Telephone numbers were provided to patients if contact was required between consultations or they had any concerns.
- Psychological support was provided to patients and family members by ward staff and staff gave specific examples.
- Staff met with patients prior to commencing chemotherapy treatment to get to know them and develop a rapport.

Compassionate care

- Prior to patients receiving chemotherapy treatment an assessment of social, emotional and spiritual needs was completed.
- During chemotherapy administration and following endoscopic procedures patients were nursed in individual rooms.
- We observed staff knocking before entering inpatient rooms to protect privacy and dignity.
- The Friends and Family Test, which assesses whether patients would recommend a service to their friends and family showed that between October 2015 and March 2016 the hospital consistently scored above 85% however response rates varied between 22% and 100% in this time period.

Understanding and involvement of patients and those close to them

- We were told that chemotherapy was arranged to accommodate the needs of the patients.

- Staff described how they had adapted the chemotherapy regime to allow treatment to be patient led by timing therapy to accommodate a patients work commitments.
- Staff described how a patient's relative had been allowed to stay with the patient to alleviate their own anxiety regarding the treatment.
- Telephone numbers were provided to patients if contact was required between consultations or they had any concerns.
- Discussion regarding treatment cost was incorporated into the consultation in breast clinic on receipt of investigation results so patients had relevant information to make informed decisions.

Emotional support

- Psychological support was provided to patients and family members by ward staff. Staff described how they had supported a patients' husband as well as the patient through diagnosis and treatment.
- Staff met with patients prior to commencing chemotherapy treatment to get to know them and develop a rapport and flexed their shifts to ensure continuity of care. Staff had also attended the funeral of a patient who had passed away.
- An end of treatment bell was used following completion of chemotherapy to mark the end of the intervention.

Are medical care services responsive?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. Positively we saw that;

- Facilities for refreshments were available for patients and visitors and arrangements could be made for family members to stay overnight.
- Chemotherapy was scheduled to accommodate patients' wishes, including work commitments.
- Blood tests were taken prior to each cycle of chemotherapy and staff told us blood results were available within an hour.
- A holistic needs assessment was completed for patients prior to commencement of chemotherapy and included social, emotional and spiritual needs as well as any multi-disciplinary intervention that maybe required.
- Written information was provided to patients specific to their chemotherapy treatment regime and information leaflets were provided to patients attending for endoscopy both pre and post procedure.
- One complaint was received relating to chemotherapy services in 2015 and documented lessons learned from this complaint included introduction of a ward led clinic to improve communication and a weekly chemotherapy planning meeting.

Service planning and delivery to meet the needs of local people

- Facilities for refreshments were available for patients and visitors. Arrangements could be made for family members to stay overnight if required.
- Sufficient car parking was available at the hospital site free of charge.

Access and flow

- Patients could be admitted for treatment through a number of routes and included referral from an NHS trust, referral from their own General Practitioner (GP) or self-referral.
- If a patient required a transfer to an acute hospital, the Resident Medical Officer (RMO) and consultant would review the patient in the first instance. The consultant would make the decision, speak with the accepting ward at the local acute hospital, and provide a verbal handover. Written information followed with the patient. Once a patient was transferred, the admitting consultant became responsible.

Meeting people's individual needs

- Chemotherapy was scheduled to accommodate patient's wishes, including work commitments.
- Blood tests were taken prior to each cycle of chemotherapy and staff told us blood results were available within an hour.
- Access to interpreting services could be arranged by telephone for those patients who did not speak English however we did not see this in use during our inspection as there were no patients who required this service.
- A holistic needs assessment was completed for patients prior to commencement of chemotherapy and included social, emotional and spiritual needs as well as any multi-disciplinary intervention that maybe required.

Not sufficient evidence to rate

Medical care

- Written information was provided to patients specific to their chemotherapy treatment regime.
- Information leaflets were available in a variety of languages for patients attending for endoscopy.

Learning from complaints and concerns

- Staff were aware of the complaints process and were able to advise patients regarding this.
- Learning from complaints was shared electronically by email, in team meetings, on notice boards and in departmental newsletters. They were also discussed in heads of department meeting and senior manager's team meetings.
- One complaint was received relating to chemotherapy services in 2015. Documented lessons learnt from this complaint included introduction of a ward led clinic to improve communication and a weekly chemotherapy planning meeting.

Are medical care services well-led?

Not sufficient evidence to rate

This service has been inspected but not rated due to the low number of patients involved. Positively;

- We saw an effective governance framework to support the delivery of the strategy and good quality care. Staff were clear about their roles, responsibilities and level of accountability and integrated governance meetings were held quarterly to discuss issues including governance, risk and safeguarding.
- We found that there were clear lines of management responsibility and accountability within theatre and on the ward and both areas were led by visible, experienced, enthusiastic and well respected leaders.
- Staff described good leadership from the hospital director and senior management team, they said there was an open and honest leadership style and they were visible and approachable.
- All patients were provided with a satisfaction survey following treatment.
- Patients were invited into a focus group to feedback on their experience.

Vision and strategy for this this core service

- Nuffield Health demonstrated a vision for the future of services. The corporate aim was 'To improve the health of the nation', using their expertise to enable people to be as healthy as possible.
- The values of the hospital were described using the term 'EPIC' which stood for Enterprising, Passionate, Independent and Caring.
- Staff were aware of the Nuffield Chester vision, values, and strategy, and we observed these demonstrated throughout their approach to care on the ward and in the theatre environment.
- The endoscopy service was working towards accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework in place to support the delivery of the strategy and good quality care. Staff at all levels were clear about their roles and responsibilities.
- Integrated governance meetings were held quarterly to discuss issues including governance, risk and safeguarding.
- There were assurance systems and service performance measures in place and the hospital used a quality and safety dashboard which included data such as never events, unplanned readmissions, transfers and friends and family results.

Leadership and culture of service

- We found that there were clear lines of management responsibility and accountability within theatre and on the ward.
- The theatre and ward were led by visible, experienced, enthusiastic and well respected leaders. They were passionate and knowledgeable about their departments and strived to improve quality and services to patients.
- All staff were very proud of their departments, the hospital and the care they delivered to their patients. They said that it was a good place to work and they enjoyed their job.
- Staff described good leadership from the hospital director and senior management team, they said there was an open and honest leadership style and they were visible and approachable
- Staff felt supported to learn and develop new skills.

Not sufficient evidence to rate

Medical care

Public and staff engagement

- Participation in monthly 360 degree meetings helped to facilitate effective communication between staff and managers.
- Regular departmental meetings ensured staff were updated on issues such as incidents and complaints, safety concerns and policy developments and the hospital closed for an annual away day to enable all staff to attend.
- All patients were provided with a satisfaction survey following treatment. At May 2016 patient satisfaction was 96% which was better than the Nuffield hospitals as a whole and was better than the internal target of 95%, however this could not be disaggregated for endoscopy and chemotherapy patients.
- Patients were invited into a focus group to feedback on their experience. The group were also involved in reviewing plans and changes for the hospital.

Innovation, improvement and sustainability

- The Nuffield Chester had a robust project plan to rebuild a new fit for purpose theatre department and endoscopy suite. These plans were signed off at the time of our inspection and work was due to commence later in the year.
- A third nurse was due to undertake training in September 2016 to deliver chemotherapy.

Good

Surgery

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

Information about the service

Nuffield Health The Grosvenor Hospital was opened in 1975. The hospital is part of a group of 31 hospitals. The hospital is located in Chester, is easily accessible, with free on site car parking.

There are two theatres and 29 individual patient bedrooms, each with en-suite facilities on the Eaton Ward. The hospital provides a range of elective surgical services for adults across different specialties including, orthopaedic, ophthalmology, and cosmetic surgery. Both theatres are available from 8.30am to 8pm, Monday to Friday, with the patient leaving the recovery area in these hours. At the weekend the theatre is in operation from 8.30am to 4pm. There is an on-call rota, for patients needing to return to theatre or for any emergencies which is available seven days a week outside of these operational hours. Theatre one is adapted to provide laser surgery.

The ten commonly performed surgical procedures include: diagnostic endoscopy of sinus or bladder, diagnostic gastroscopy, colonoscopy, prosthetic replacement of knee joint, lens eye surgery, and arthroscopic surgery. The provider also offers cosmetic surgery which includes; breast augmentation, varicose vein removal, abdominoplasty, rhinoplasty, and facelift surgery.

There were 3,994 inpatient and day-case episodes of care recorded at Nuffield Health Chester The Grosvenor Hospital in the reporting period April 2015 to March 2016; of these approximately 18% were NHS funded. During the same period, 47% of all NHS funded patients, and 32% of all other funded patients stayed overnight at the hospital.

Inpatient and day-case treatment had been offered for children and young people aged 0-16 years until May 2016 when the service was suspended due to the departure of the paediatric lead nurse. Plans were in place to resume these services but they were not in operation at the time of our inspection. Between April 2015 and March 2016, 18 children and young people received treatment as inpatients and 76 received treatment as day-case patients. Procedures included: adeno-tonsillectomy and circumcision.

As part of our inspection, we visited both theatres, the pre-operative and post-operative areas, and Eaton Ward. In total, we spoke with 5 patients and two patient's relatives. We observed care and treatment and looked at care records for 18 adult patients and 21 for children and young people. We also spoke to 18 members of staff from a range of different grades including surgeons, anaesthetists, doctor's nurses, theatre and ward managers, theatre staff, and the matron.

We received comments from patients receiving care at the time of our inspection, via CQCs "Tell us about your care" comment cards, and people who contacted us about their experiences. We reviewed performance information about the provider.

Good

Surgery

Summary of findings

We rated surgery at this hospital as 'Good' overall. This is because;

- There was a culture of reporting investigating and learning from incidents and there were improvements implemented to prevent similar occurrences in the future.
- There were no surgical site infections reported for primary hip arthroplasty, primary knee arthroplasty, and spinal and breast surgery in the reporting period April 2015 to March 2016 when a total of 316 procedures were performed.
- The hospital was generally performing similar to, or better than the England average, for outcomes in relation to knee and hip replacements.
- Patients were prescribed analgesia to relieve pain and received the medication in a timely manner. Patients said their pain was well controlled.
- Nutrition and hydration was assessed, information on fasting for surgery was available and there was dietician support and advice available for patients.
- Patients attending preoperative assessment were offered a health MOT which was an innovative approach to assessing and improving the health and well-being of patients.
- There was a comprehensive induction programme in place for new staff.
- Nuffield Health Chester had a vision and a set of values which was adopted by staff and embedded in their approach to patient care. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.
- Patients felt involved with options about treatments available, and received information in a manner they understood.
- Integrated governance meetings were held quarterly to discuss issues including, risk and safeguarding. There were systems in place to disseminate information to staff across the hospital.
- The surgical department was aware of risks held on the risk register. The theatre environment was on the hospital risk register due to requiring modernisation to improve services and maintain its fitness for purpose. At the time of our inspection we were made aware of the plans to modernise the theatres, we saw evidence of meetings held and we were told by the hospital director that finances had been approved for the rebuild and work was to commence at the end of the year.

However;

- Patients' undergoing cosmetic surgery were not always assessed psychologically before their surgery, there was no formal system in place to monitor the necessary cooling off period and the hospital did not have a cosmetic surgery specialist nurse.
- Staff working in theatre were not achieving the target for compliance against Mental Capacity Act, Consent, and Deprivation of Liberties training.
- We found two patient letters filed in the wrong patients record.
- We observed two members of theatre staff not adhering to the 'bare below the elbows' policy and may present an infection risk to patients.

Good

Surgery

Are surgery services safe?

Good

We rated surgery as 'Good' for Safe. This is because;

- There was a system in place to report and investigate incidents and there was evidence of lessons learnt from incidents.
- Adult and paediatric resuscitation equipment was in place and records indicated this was consistently checked.
- Staff received training in relation to hand hygiene and competencies were reviewed. A handwashing audit in July 2016 identified that the surgical services were achieving compliance with hand washing.
- We saw evidence that patients were screened for methicillin-resistant-staphylococcus aureus (MRSA) prior to receiving surgery in line with the hospital protocol.
- There were no surgical site infections reported for primary hip arthroplasty, primary knee arthroplasty, and spinal and breast surgery in the reporting period April 2015 to March 2016 when a total of 316 procedures performed.
- Risk assessments were completed and in ten records we reviewed, all included a venous thromboembolism (VTE) risk assessment.

However;

- We observed staff from theatre on the ward area wearing scrubs and theatre footwear which may present an infection control risk. We also observed two members of theatre staff not adhering to the 'bare below the elbows' protocol.
- We found two letters filed in a patient record that related to two different patients and not the patient whose record they were filed in.

Incidents

- The provider had a standard operational procedure for managing and reporting incidents. Incidents were reported via an electronic system, and staff we spoke with at the time of our inspection knew how to access the system. There were no never events requiring investigation, (never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers), and no deaths reported during the reporting period April 2015 to March 2016.
- There were 128 clinical incidents recorded within surgery and inpatients for the reporting period 1 April 2015 to 31 March 2016, of which none were graded as severe. The incidents that were reported included: medication errors, delayed discharges due to theatre over running, patients not being discharged as they had not met the discharge criteria, and lack of available equipment, causing cancellation of surgery.
- We saw evidence that incidents were reviewed and investigated, and learning was shared within the hospital and across other Nuffield locations if required.
- As part of our inspection we reviewed the root cause analysis (RCA) investigation reports for three incidents from June 2015 to September 2015. Two of these related to patients who developed a deep vein thromboembolism post-surgery and one patient who developed a pulmonary embolism post-surgery. We observed that lessons were learnt and plans were identified to disseminate findings. For example the provider had identified that a venous thromboembolism (VTE) risk assessment had not been completed post-surgery, identified plans to disseminate the findings, and at the time of our inspection all the patient's records we reviewed had documented VTE assessments pre and post-surgery.
- Staff we spoke with on the ward and in theatres were aware of the term 'duty of candour' (the duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).
- There had been no incidents of reported deaths at the hospital from April 2015 to March 2016.

Safety thermometer

- The trust completed assessments for venous thromboembolism (VTE). In the period April 2015 to March 2016, the hospital reported that 100% of patients were screened for VTE.

- At the time of our inspection we reviewed ten patient records for patients that had received surgical interventions and all ten records had a documented completed VTE assessment pre-surgery and within 24 hours post-surgery.
- Risk assessments formed part of the documentation and included: moving and handling, falls, pressure ulcers, and the malnutrition universal screening tool (MUST). Any falls or pressure ulcers that developed were recorded as an incident.

Cleanliness, infection control and hygiene

- The majority of areas we inspected were visibly clean and tidy. We saw 'I am clean' stickers' in place to inform colleagues at a glance that equipment had been cleaned after being used on a patient.
- In the patient-led assessment of the care environment (PLACE) for April 2015 to March 2016 the hospitals PLACE scores were the same or better than the England average for: cleanliness. The provider achieved 99% for cleanliness against a national average of 98%.
- We observed 13 competency records for staff in the theatre department and found all 13 staff had their competency in relation to hand washing procedures reassessed in the 12 months prior to our inspection.
- There were sufficient hand washing facilities and hand gels, we observed notices above sinks on the correct hand washing techniques. We observed staff using appropriate hand-washing techniques and personal protective equipment such as gloves, and aprons whilst delivering care.
- On the whole, staff were aware of, and adhered to, current infection prevention and control guidelines such as 'bare below the elbow' policy: however, at the time of our unannounced inspection we observed an anaesthetist in theatre department wearing a wrist watch whilst wearing scrubs.
- At the time of our announced inspection we observed a staff member enter the recovery area of theatre and walk through to the anaesthetic room without wearing any protective equipment or washing their hands on leaving the area. We asked staff what the policy was for people entering the area. We were informed that all staff wear work shoes that were only worn inside the hospital and that when ward staff bring patients to the anaesthetic room, they were not required to wear additional protective clothing. At the time of our unannounced inspection we observed two theatre staff wearing scrubs and theatre footwear on the ward which was a carpeted area, one of whom wore a rubber wristband whilst in scrubs and was not 'bare below the elbows'.
- In the theatre sluice area the hand basin did not have wrist or elbow action adaption and was not in accordance with HBN26 'facilities for surgical procedures' clinical hand wash basin. At the time of our unannounced inspection the sluice bowl was stained and appeared physically dirty.
- At the time of our unannounced inspection one patient, who was an inpatient on the ward, told us that the bathroom to their room was not cleaned for two days and that there were used urine bottles left in the room for two days.
- Patients awaiting surgery were screened for infections, such as methicillin-resistant-staphylococcus aureus (MRSA), during pre-operative assessment. We saw evidence of MRSA screening results in the patient records we reviewed at the time of our inspection.
- The provider reported that there were no episodes of MRSA, clostridium difficile (c.diff) or Escherichia coli (E.coli) recorded for the period 1 April 2015 to 31 March 2016.
- A range of cleanliness and infection control audits were undertaken across surgical services and included hand hygiene audits, surgical site infection, environmental audits. As at July 2016 the hospital was achieving compliance for hand washing.
- We observed the report for air slit sampling in theatres for August 2014 and February 2015 which requires completion every three years as minimum and all were within normal ranges.
- There were no surgical site infections reported for primary hip arthroplasty, primary knee arthroplasty, spinal surgery and breast surgery in the reporting period April 2015 to March 2016 when a total of 316 procedures performed.
- Both theatres were monitored for bacteria count, pathogens, and isolated fungal count, this had been a yearly event, however this policy had been changed to three yearly with the last one performed in February 2015 where no concerns were found.
- Both theatres had a high degree clinical deep clean every six months by a contractor and a certificate to evidence this was available for the last three cleans for the previous 18 months.

- We found the theatre storage room to be visibly dirty and dusty and there was a mix of sterile and non-sterile equipment stored in the cupboard. We observed syringe drivers on a dirty shelf next to barrier sterile drapes. We raised this with the theatre manager at the time of our unannounced element of our inspection.

Environment and equipment

- The hospital used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates.
- The service had arrangements for the sterilisation of reusable instruments, some on site and some contracted out.
- The ward areas we visited were generally well maintained, free from clutter and suitable for treating surgical patients. However, the layout of the ward did not allow patients that were returning from theatre to be observed from the nurse's station due to patients having their own individual rooms. This meant that if a patient had an acute episode where their condition deteriorated and they were unable to use the call bell there may be a delay in receiving emergency care. We raised this at the time of our inspection with the Hospital Director who advised that patients were not discharged from the theatre recovery area until they had met the discharge criteria as being stable and safe to discharge. We reviewed ten patient records and found the theatre discharge completed in all cases which identified patients stable at time of discharge back to the ward.
- Entry to the theatre area was via a controlled access system to manage access to the area.
- Systems were in place to maintain equipment. We observed in date safety tested stickers on equipment at the time of our inspection.
- At the time of our announced inspection we checked the adult resuscitation trolley in the recovery area in the theatre department. We reviewed checklists up to the time of our inspection and found them all completed appropriately and equipment was regularly checked. We checked the paediatric resuscitation equipment in the same area and all checks were documented appropriately to indicate the equipment had been regularly checked.
- Bariatric equipment, which was used for obese patients, was in place and readily available if required.
- In the patient-led assessment of the care environment (PLACE) for April 2015 to March 2016 the hospitals PLACE scores were the same or better than the England average for: condition, appearance, and maintenance.
- We observed the protective personal equipment store room and found gowns to be in good condition and appropriate hanging devices were in place.
- The control panel for the laminar airflow system in the theatre two did not illuminate when on full power which was required for orthopaedic surgery. The doors from the anaesthetic room to theatre did not close properly. We reviewed the ventilation verification report performed in February 2016 which had identified a number of tasks to ensure the system was compliant that had been completed on the action plan.
- The theatre environment was on the hospital risk register due to requiring modernisation to improve services and maintain its fitness for purpose. At the time of our inspection we were made aware of the plans to modernise the theatres, we saw evidence of meetings held and we were told by the hospital director that finances had been approved for the rebuild and work was to commence at the end of the year.

Medicines

- Medicines were stored securely and there were processes in place to ensure they remained suitable for use. Controlled drugs (CDs) medicines that require extra checks and special storage arrangements (because of their potential for misuse) were stored securely and records indicated they were checked regularly. Medicines for use in an emergency were available on the ward and records indicated they were checked regularly to ensure they were suitable for use.
- We saw patients were assessed to see if they were safe to manage their own medicines whilst in the hospital and were supported to safely do this where appropriate. All the medicines charts we reviewed had completed allergy statuses and Venous Thromboembolism (VTE) assessments. Pharmacist interventions were clearly documented on the medicines charts and in the patient notes.
- Audit data showed 100% patients had their medicines checked within 24 hours.
- We reviewed 11 prescription charts relating to paediatric inpatient care prior to the suspension of the service. Of

those reviewed, all prescriptions were signed, dated and recorded the age of the child, 10 were legible, nine had the weight of the child recorded however, only six had details of any known allergies documented.

Records

- Patients records were paper based and were stored in locked trolleys on the ward. We reviewed the care records for 10 patients on our announced inspection and found them to be structured, legible and up to date. All ten records had a completed VTE risk assessment.
- Patient records showed that nursing and clinical assessments were carried out before, during, and after surgery. Patient physiological observations were well recorded and the frequency of recordings was dependent on the level of the patient's individual need.
- We followed one surgical patient's pathway from admission to discharge at the time of our announced inspection and although when the patient was handed over from the ward to theatre staff the verbal handover advised that the patient had no pressure ulcers, we did not see this documented in the patient record.
- We reviewed 21 records of children and young people who had received care on the ward prior to the suspension of the service. All were legible, signed and dated and had documented consent and Paediatric Early Warning charts. However, only 15 of 21 records had Paediatric Early Warning scores recorded despite observations being documented.
- At the time of our inspection we found a child's case notes in the drawer of an unsecure cabinet, which had been there since the paediatric service had been suspended since May 2016. We raised this with the ward clerk and the ward sister who informed us they were unaware they were stored there and made arrangements for them to be stored as per policy. At the time of our unannounced inspection when reviewing a set of patient records we noticed there were two referral letters for two different patients secured in the records. We informed the ward manager at the time of our inspection who took the letters and asked the receptionist to report the issue as an incident. Neither of the two patients identified in the letters were on the ward or due on the ward that day.
- A message book was in use on the inpatient ward to record messages and actions from telephone calls from patients following discharge. We reviewed messages recorded between 19 November 2015 and 27 February 2016 and 6 March 2016 and 31 May 2016. Three messages related to children and young people we observed documented advice given and follow up action. The book produced a duplicate copy for filing in patient's records however, one message had not been duplicated on the copy underneath and one had both copies present in the message book meaning that the patient's notes may have no reference to the telephone contact or any advice given.

Safeguarding

- The provider had safeguarding policies and procedures in place and there was a safeguarding lead that could provide guidance and support in all areas. We observed the safeguarding referral pathway for adults and children on the notice board at the nurse's station on Eaton Ward. Staff we spoke with were aware of how to report a safeguarding issue and could give examples of safeguarding situations.
- Safeguarding training formed part of the trusts mandatory training programme and included information on Female Genital Mutilation and Child Sexual Exploitation.
- Two senior staff had completed Level 3 safeguarding training and could offer advice to other staff if required.
- Safeguarding children training level 2 had been completed by 13 ward staff (93% of the target group) and 16 theatre staff (84% of the target group).
- The Resident Medical Officer had completed level two safeguarding children training.
- A policy for the security arrangements to guard against the abduction of a child was in place at the time of our inspection but had not been ratified.

Mandatory training

- Training which was classed as mandatory were those subjects which were considered the most important such as basic life support, safeguarding patients and moving and handling.
- Mandatory training was kept updated by attendance on training courses or through e-learning.
- Paediatric Basic Life Support training (PBLS) was included within the mandatory training schedule.
- The provider had a mandatory training compliance of 85%. At May 2016 the hospital as a whole was achieving 85.3% which was better than their target.

- Data provided by the hospital at the time of our inspection showed Basic Life Support training had been completed by 73% of ward staff (16 out of a target group of 22) and by 68% of theatre staff (19 out of a target group of 28).
- Immediate Life Support training was completed by 7% of ward staff (1 staff member out of a target group of 14) and 26% of theatre staff (5 staff out of a target group of 19).
- All Resident Medical Officers completed mandatory training prior to attending the hospitals training courses.

Assessing and responding to patient risk

- The departments assessed and responded appropriately to patient risks; there were effective procedures in place to transfer patients to a local acute hospital if they became acutely unwell. In an emergency situation, emergency 'bleep holders' attended to treat deteriorating patients quickly. There was a transfer protocol in place if patients required to be transferred to the local NHS emergency hospital for urgent treatment either by 999 emergency transfer or if less urgent by routine ambulance transfer.
- If a child had a higher risk of complications or additional medical conditions that could not be safely managed at this hospital, they would be referred to an acute NHS hospital. An agreement was in place for those patients who required transfer to an acute NHS hospital for more intensive care or care which was not provided at this hospital. This ensured clear processes and clear lines of responsibility in order for the individual needs of the patient to be accommodated.
- If a patient required a transfer to an acute hospital for more intensive care or care which was not provided at this hospital the RMO and consultant would review them in the first instance. The patient's consultant would make arrangements with the accepting ward at the local acute hospital and provide a verbal handover. Upon transfer written information was provided with the patient and the admitting consultant took over responsibility for their care.
- There was a theatre duty manager available till 8pm. The service provided a call out team 24 hours a day should an emergency surgical procedure be required. The team were generally in place within 30 minutes of the need being identified. There was a team of on-call anaesthetists that could be called in for an emergency.
- The pre-operative assessment clinics highlighted potential risk for patients who were scheduled for surgical treatments. Patients were assessed to ensure they were suitable for the planned surgery and those at greater risk were referred to an anaesthetist for further assessment and advice and if appropriate sent for further tests.
- Training scenarios for paediatric resuscitation were completed with staff six times a year with the support of an external agency to promote practical resuscitation skills.
- The hospital was using the Modified Early Warning Score (MEWS) to assist to determine deterioration in a patient's condition. In ten patient records we reviewed all had a completed MEWS as part of the patients physiological monitoring. We saw evidence where a patient had an increased score this was escalated to the RMO and additional care was implemented. The provider had plans to replace the MEWS with the National Early Warning Score (NEWS) to improve the identification of patients at risk of deteriorating.
- We observed a flow chart pathway for the management of sepsis available on the ward. Sepsis is a potentially life-threatening complication of an infection. Two staff told us training in relation to sepsis was delivered as part of the alert training but they had completed the alert training over 12 months ago. Nursing staff were able to describe to us how they would identify potential sepsis and the actions they would take which followed policy.
- Staff used a pro-forma (RSKIN) to record findings from the 'comfort rounds' they performed which included an observation of the patient, a review of pressure areas if required, and any changes to the patient's position. At the time of our unannounced inspection we reviewed the RSKIN pro-forma for four patients and found all records had the pro-formas completed for periods of two to eight hourly, dependent on patient need for the previous 24 hours. We asked a member of staff what the policy was for completion and timeframes. We were told that it was based on clinical judgement how often to perform the system had only been in place a couple of weeks and there had been no formal training. One patient told us at the time of our inspection that they did not have a nurse check on them very often and definitely not hourly.
- The hospital used the World Health Organization (WHO) surgical safety checklist. In the ten patient records we

reviewed for patients that had been to theatre, the WHO checklist was completed in all cases. We observed two patients being taken into theatre and the WHO checklist was verbalised to all staff in theatre. The hospital did a documentation audit of ten records a month to determine compliance with the WHO checklist. In April 2016 the audit was 100% compliant. The theatre manager told us she did an observation audit of ten patients and found that seven of the ten observations identified that the sign out standard was not being documented at the time of sign out. An action plan was the outcome of the audit and actions had been completed.

Nursing staffing

- An acuity tool had not been used to calculate nursing staffing. Rotas were prepared a week in advance once managers became aware of the number of admissions and nature of admissions that were planned.
- Managers ensured there was an even mix of skills and competencies on duty and if necessary they could arrange agency staff with specific skills.
- We reviewed ward rotas for three weeks in June 2016, there was evidence of changes to the rota based on patient need and there was a nominated coordinator for the day who was responsible for ensuring safe staffing levels were in place on a daily basis based on the dependency of the patients and the theatre lists. Staffing in all of the departments was satisfactory at the time of the inspection.
- Staff rotas reviewed for the six weeks preceding the suspension of inpatient paediatric services in May 2016 indicated that paediatric nurses provided care on 11 shifts. Nuffield Health Hospitals Staffing Grid for Children's Services states children aged three to under 12 years of age who attend for inpatient/day case services should be cared for by a Registered Nurse Child (RN Child) at all times. Of the 21 inpatient records reviewed, entries showed that general nurses provided care on two occasions to patients ageing three and seven years.
- There was an average of 8% staff turnover for nurses working in theatre department in the reporting period April 2015 to March 2016).
- There was no staff turnover for health care assistants working in theatre departments in the reporting period April 2015 to March 2016.
- The theatre team had one nurse on maternity leave and one nurse on long term sick at the time of our inspection. Cover was being provided by agency staff who regularly worked at the department.
- The recovery area had two beds and two nursing staff worked in the area providing one to one care for patients post-surgery.
- Sickness rates for theatre healthcare assistants in the reporting period April 2015 to March 2016 were lower than the yearly average of 22 other independent acute hospitals except for June 2015 and March 2016.

Surgical staffing

- Theatre staffing was split into three teams which included: orthopaedic, general, and anaesthetics and recovery. All current posts were recruited to.
- When surgery took place there was a level of staffing that needed to be met: a surgeon, an operating department practitioner, an anaesthetist, two scrub nurses and a circulating nurse. We observed these staffing levels being in place at the time of our inspection and on the off duty that we reviewed at the time of our inspection.
- Theatre did not operate until the appropriate staffing was available.
- Following surgery, consultants undertook a ward round with the Resident Medical Officer (RMO) to ensure the RMO received all the appropriate information regarding the patients and the surgery undertaken. This also ensured that all team members were aware of who had overall responsibility for each individual's care.

Major incident awareness and training

- Mandatory training included updates on fire procedures and this was updated annually.
- Records indicated that fire drills were undertaken periodically and evacuation procedures were tested.
- There were business continuity plans in place which included contingency plans to be used in the event of staffing shortages and equipment failure.
- Managers had attended training for major incidents which included example scenarios and specific exercises.

Are surgery services effective?

Good

Surgery

Good

We rated surgery as 'Good' for Effective. This is because;

- There were local policies and procedures in place and we saw evidence that departments followed relevant guidelines including those from the National Institute for Health and Care Excellence (NICE).
- Patients were prescribed analgesia to relieve pain and received the medication in a timely manner.
- Nutrition and hydration was assessed, information on fasting for surgery was available and there was dietician support and advice available for patients.
- There was a comprehensive induction programme in place for new staff.
- The hospital was generally performing similar to, or better than the England average, for outcomes in relation to knee and hip replacements.
- Staff were qualified and had the skills they needed to carry out their roles effectively, in line with best practice. The learning needs of staff were identified and training was put in place to meet them.
- More than 75% of theatre and ward staff had received an appraisal.
- Staff could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made with the involvement of parents.

However;

- Staff working in theatre were not achieving the target for compliance against Mental Capacity Act, Consent, and Deprivation of Liberties training.
- Staff were unclear on the process for assessing a patient's capacity to consent to treatment.
- Where patients had signed the consent form in advance of the day of surgery the confirmation of consent was not always completed on the day they were admitted to receive the surgery.
- Patients' undergoing cosmetic surgery were not always assessed psychologically before their surgery, there was no formal system in place to monitor the necessary cooling off period and the hospital did not have a cosmetic surgery specialist nurse.

Evidence-based care and treatment

- The departments followed national guidance and evidence-based practice, including those from the National Institute for Health and Care Excellence (NICE) and the relevant Royal Colleges'.
- Staff followed local policies, procedures and established integrated care pathways for certain procedures that were evidence based.
- We observed one patient receiving intra-venous antibiotics prior to anaesthetic; their temperature was announced to all the team in adherence with normal thermia NICE guidelines. Skin preparation and sterile drapes were applied according to The Association of Perioperative Practice (AFPP) guidelines. Swabs, needles and other miscellaneous items were checked and recorded. Swabs were also recorded on the swab board during surgery to monitor how many were used.
- We observed the medical records for a patient having cosmetic surgery on the day of our unannounced visit. The patient had attended three clinic appointments prior to cosmetic surgery which had resulted in the patient having a cooling off period: however, when we discussed this with staff there was no formal process in place to ensure a cooling off period was offered and no monitoring or audit process to review.
- A cooling off period of two weeks is recommended to allow the patient to reflect upon their decision and to change their mind if they wished. Whilst we saw this two week period was observed, there was no policy or procedure available nor audits to ensure this was being implemented formally.
- Patients' undergoing cosmetic surgery were not always assessed psychologically before their surgery and the hospital did not have a cosmetic surgery specialist nurse to. The hospital's own audit in June 2016 showed that only 22% of patients had documentation confirming there had been consideration of psychological issues such as body image and appearance concerns. The hospital was conducting further investigations into this issue.
- The theatre department held a register of all cosmetic surgery implants used which we observed on site and this included: the patient's details, the procedure performed and the barcoded sticker. This information was then fed into a national register. This procedure also took place for any knee or hip prosthesis.

- Patients assessed to be at risk of Venous Thromboembolism (VTE) were offered VTE prophylaxis in accordance with NICE guidance. All the records we reviewed at the time of our inspection had a completed VTE assessment.
- An audit was performed in May 2016 to review the emergency transfer process for the two patients requiring transfer to other providers to ensure care was coordinated and all appropriate documentation was completed. The audit identified compliance against the standards.
- The service did not collect Q-PROMs for patients receiving cosmetic surgery. There was work ongoing with the Royal College of Surgeons to look at aligning the coding for cosmetic surgery to support a defined set of performance measures and to supply the data to the Private Healthcare Information Network (PHIN).

Pain relief

- There was a standard operating procedure for the use of pain relief in the departments which staff were aware of and followed.
- Patients told us their pain was controlled and they felt reassured nurses would bring them pain relief if this was needed.
- Patients told us they had been informed by staff which medicines from home they should continue to take before their operations. Patients and staff told us pharmacy staff spoke to patients about their medicines before they were discharged to explain any changes.
- Pain was assessed using a pain assessment tool and a pain scoring system to measure the severity of pain on the physiological recording charts which we observed in the patients records.
- All prescriptions were written prior to theatre nerve blocks being administered which demonstrated that medication was not administered until it had been prescribed.
- Staff in the theatre recovery area had not received training in assessing pain in children. There was no children's service in operation at the time of the inspection but was planned to commence again. The provider should consider introducing this before the service recommences.

Nutrition and hydration

- Records indicated that patients' nutrition and hydration needs were assessed during their pre-assessment and the Malnutrition Universal Screening Tool (MUST) was available to be used as part of the assessment. Food allergies were highlighted and kitchen staff and theatre staff were made aware.
- Pre-assessments included tailored nutrition and hydration guidance for patients and provided all elective patients with fasting instructions to follow on the day of their surgery.
- Patients using services had access to dietician services post-operatively if required, from the acute referring trust. Bariatric patients awaiting surgery had access to a dietician from the acute trust prior to any surgical procedure taking place at Nuffield Health Chester. Ongoing dietician involvement was by the GP and consultant. We spoke to one such patient following surgery who told us they had seen a dietician after undergoing surgery and had been given advice on their diet and a programme to follow for four weeks.
- Age appropriate menus and cutlery were available for children prior to the suspension of the children's' inpatient and day case service.
- There was a selection of food to choose from on the daily menus.

Patient outcomes

- On a monthly basis there was a report submitted to the corporate quality manager, this reviewed benchmarked data across the organisation.
- Hospital associated infections were uploaded onto a corporate clinical SharePoint site, and hip and knee arthroplasty surgical site infections reported to public health England. The hospital was working within the expected targets.
- The department assisted in the completion of the National Joint Registry (NJR) audits and the patient reported outcome measures (PROMS) in relation to knee and hip replacement procedures for NHS patients.
- The hospital's adjusted average health gain for Patient Related Outcome Measures (PROMs) for Primary Knee Replacement is within the estimated range of England average for the following measures: EQ-5D Index (Generic health status measure) out of 70 modelled records, 81.4% were reported as improved and 8.6% as worsened. The Oxford Knee Score; out of 75 modelled records 93.3% were reported as improved 6.7% as worsened for the period April 2014 to March 2015.
- The hospital's adjusted average health gain for PROMs for-Primary Knee Replacement was above (better) the

England average for the following measure: EQ-VAS (Visual Analogue Scale component of the EQ-5D) - Out of 67 modelled records, 65.7% were reported as improved and 22.4% as worsened during the period April 2014 to March 2015.

- The hospital's adjusted average health gain for PROMs -Primary Hip Replacement is within the estimated range of the England average for the following measures: EQ-5D Index (Generic health status measure), out of 62 modelled records, 98.4% were reported as improved and 1.6% as worsened, EQ-VAS (Visual Analogue Scale component of the EQ-5D), out of 59 modelled records 62.7% were reported as improved and 22.0% as worsened, Oxford Knee Score, out of 65 modelled records 100.0% were reported as improved.
- There have been nine cases of unplanned transfer of an inpatient to another hospital in the reporting period April 2015 to March 2016. Audits were completed for patients that were transferred out to an acute hospital to assess adherence to the hospital policy. We reviewed an audit that took place for a transfer in May 2016 and the audit concluded that the transfer had met the required standards.
- There was one case of unplanned readmission within 28 days of discharge in the reporting period April 2015 to March 2016.
- There were four cases of unplanned return to the operating theatre in the reporting period April 2015 to March 2016, with none reported since January 2016.
- All patients requiring a urinary catheter had it inserted in the theatre department. We observed an audit performed in April 2016 which identified that 99% (149 out of 150) were documented as following correct procedures.
- The service had a process in place to ensure the traceability of implants used in cosmetic procedures which we observed at the time of our inspection.

Competent Staff

- Staff were competent, experienced and were encouraged to further their professional development to improve their own performance and the service delivered.
- New staff completed a comprehensive induction programme before being able to work independently. This included corporate and clinical inductions and the delivery of organisations practices and principles as well as clinical mandatory training and job specific training.
- Three theatre staff had completed an external course relating to paediatric anaesthesia and recovery.
- Pharmacy staff told us they felt supported to develop, cost was never an issue for training courses, and they could pick anything they needed to support the role.
- Staff were supported by a central pharmacy team. There was an annual pharmacy conference where staff met pharmacy teams from other hospitals to share good practice.
- The revalidation and checking of doctors with practicing privileges were undertaken to ensure they had the qualifications, competence, skills and experience necessary for the work to be performed by them.
- The Medical Advisory Committee (MAC) met monthly to ensure clinical quality by providing oversight and guidance on clinical activity.
- Revalidation of nurses and operating department practitioners was supported by the ward and theatre managers. There was a resource package to assist nurses with the new revalidation programme and they received advice and assistance of how to maintain their portfolios and evidence.
- All staff we spoke with told us they had received an appraisal within the 12 months prior to our inspection. Data provided by the trust for the period April 2015 to March 2016 identified that 75% of nurses and 100% of other staff working on the wards had completed their appraisal and at least 85% of all theatre staff had completed an appraisal. This is above the hospital target of 75%.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patients care and treatment. We saw that care was well co-ordinated between pre-assessment, wards and theatre staff ensuring all teams were included in the process of care delivery.
- We observed a suitable ward handover which was recorded to enable the Resident Medical Officer (RMO) and staff transferring from other departments to have access to the necessary information to enable them to perform their role. This was deleted at the end of the day.
- The ward staff at Nuffield Health Chester liaised effectively with local trusts, local authorities and GP's, to ensure the arrangements for discharge were considered prior to elective surgery taking place.

- There was effective multidisciplinary working, where different disciplines worked well together to provide a more holistic service to patients.

Seven-day services

- The RMO provided medical support for all patients out of hours. Consultants were available on-call if required for surgical patients. Inpatient facilities were available 24 hours a day, seven days a week.
- Theatre was operational Monday to Saturday during the day. Outside of these hours there was daily 24 hour access to an emergency theatre team including nurses, anaesthetist and surgeon.
- There was a system in place to contact a radiologist 24 hours a day, seven days a week to undertake time critical diagnostic tests. The radiologist was able to perform and interpret urgent reports as required.
- A biomedical scientist was on call 24 hours a day to respond to urgent requests. There was an arrangement to obtain urgent tests with a local acute trust if this could not be accommodated within Nuffield Health laboratories themselves.

Access to information

- Staff had access to the organisations intranet to obtain information. They could access local and corporate Nuffield policies and procedures, and e-learning. They could also access external reference sources such as NICE guidelines and professional guidance.
- Staff could gain access to patient information such as laboratory results, appointment records, x-rays, medical records and physiotherapy records appropriately.
- Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the hospitals mandatory training programme.
- We found that at the 19 July 2016 100% of ward staff were compliant and had received training for consent, DoLS, and MCA. However, theatre staff had achieved 84% compliance with consent training, 74% with MCA compliance, and 70% with DoLS. The target for mandatory training was 85%.
- We spoke to the RMO on duty at the time of our inspection who informed us that any mental capacity assessments were performed in outpatients prior to the patient being admitted to the ward. However, when we spoke with staff in the outpatients department we found they were unable to describe the two-stage assessment of incapacity and there was some uncertainty over how this was applied in practice.
- A corporate Standard Operating Procedure (SOP) was in place for obtaining consent for the examination or treatment of children. We reviewed 21 children's medical records and found all had consent documented as obtained or confirmed on the day of the procedure.
- Staff could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made with the involvement of parents.
- We reviewed ten sets of medical records for adults that had received a surgical intervention and found that all ten patients had signed the consent: however, on three of the records the patient had signed the consent prior to the day of surgery. We found that on these three occasions the confirmation of consent was not completed on the day of surgery. The confirmation of consent should be signed by the consultant or a nurse when the patient is admitted for the procedure if the patient had signed the consent in advance.

Are surgery services caring?

Good

We rated surgery as 'Good' for Caring. This is because;

- Patients who had received surgical interventions and treatment at the hospital were positive about the care provided by staff.
- Patients felt involved with options about treatments available, and received information in a manner they understood.
- Staff treated patients and each other with dignity and respect.
- We observed staff delivering care and treatment in a compassionate manner.

Good

Surgery

- Feedback from patients was positive. The NHS friends and family test for April 2015 to March 2016 identified that 100% of respondents would recommend the service they had received at the hospital.

Compassionate care

- We observed compassionate care and positive interactions between staff and patients and their visitors on the ward and in the theatre area.
- In June 2016, the hospital scored 98% in the Patient Satisfaction Survey for treating patients with dignity and respect.
- Comments we received from patients were positive in relation to dignity, respect and compassionate care and comments included: 'I believe they treat patients with dignity and respect and listen to patients', 'I have received excellent care at this hospital both as an inpatient and outpatient, staff are friendly, courteous and professional', and ' the consultant treated me with dignity and respect'.
- The NHS friends and family test (FFT) is a survey, which asks NHS patients whether they would recommend the service they have used to their friends and family. From April 2015 to March 2016, hospital wide, 100% of NHS patients would recommend the service to their family or friends, the response rate was 49.9%.
- The hospital also undertook their own patient satisfaction survey, which included feedback from private patients, this was compiled and analysed monthly. From July 2015 to June 2016 the survey uncovered that between 94% and 98% of patients who responded were satisfied with their experience of care at the Grosvenor. This represented an average satisfaction rate of 96% across the year. The same survey identified that on average 90% of patients would recommend the hospital to friends or family if they needed similar care or treatment.
- We observed staff being polite with patients and other members of staff on duty.
- During our inspection, we observed a patient's journey through the surgery service, we saw that the patient was treated with compassion and respect. Staff were kind and friendly and all procedures were explained to the patient.

Understanding and involvement of patients and those close to them

- Patients told us that they received information and options about their care and treatment in a manner they understood. Comments received included: 'room was adequate, each step of procedures were explained', and 'consultant gave me options that were well explained and gave me time to talk to my husband about it'.
- Patients that were self-funding their treatment were given information on the fees and these were accessible on the organisations web site.
- Two patients that we asked told us that the physiotherapists were very good and had taught them exercises to perform throughout the day.
- One patient told us she was fully informed of the risks involved in their surgery and was advised on how she might expect to feel following surgery. This enabled her to manage her expectations and make plans for her recuperation.

Emotional support

- We observed staff providing reassurance and comfort to patients. Patients comments received included 'Consultant demonstrates excellent emotional intelligence, very reassuring'.
- We saw evidence at the time of our inspection that patients received comprehensive assessments.
- Patients told us that that staff were 'efficient, caring and kind' and 'nothing was too much trouble'. However, one patient told us the room was like a prison, they felt isolated and was concerned that staff could not see them.
- Another, patient told us that due to the nature of the surgery, they were provided with one to one nursing care for the two days following surgery. The patient found the nurse provided encouragement and excellent care, stated the pain control was excellent and the nurse was attentive to all their needs. However, when the one to one care was removed, the patient experienced delays in receiving pain relief and had to keep ringing the call bell for assistance.

Are surgery services responsive?

Good

We rated surgery as 'Good' for Responsive. This is because;

Good

Surgery

- Surgical services were available seven days a week. An out of hours on call rota was in operation in the event of any unforeseen urgent returns to theatre.
- As part of the preoperative assessment process patients were offered a health MOT which a proactive approach aimed at improving patient's health and wellbeing.
- The hospital had service level agreements in place with local NHS providers to meet the demands of the local population.
- 91% of patients started their inpatient treatment within 18 weeks of being referred to the hospital. The theatres department were achieving 67% theatre utilisation rates against their target of 60%.
- Patients were kept informed of any disruption or delays to their care and treatment.
- An agreement was in place for those patients who required transfer to an acute NHS hospital for more intensive care or care which was not provided at this hospital. This ensured clear processes and clear lines of responsibility in order for the individual needs of the patient to be accommodated.
- When patients were discharged following treatment a letter was generated to their GP on the same day to ensure all information was communicated in a timely manner. If the patients were receiving services in the community setting care and treatment was coordinated with the other services and providers prior to discharge.
- Patients living with dementia and learning difficulties were supported based on their individual needs.
- There were systems in place to support vulnerable patients and care was planned based on a patients individual needs.
- There was ongoing support to patients from physiotherapy services to assist patients to achieve optimum functional ability following surgery.

Service planning and delivery to meet the needs of local people

- The hospital had service level agreements in place with local NHS providers to meet the demands of the local population.
- The theatres were available from 8.30am to 8pm Monday to Friday, with the patient leaving the recovery area in these hours. At the weekend the theatre was in operation from 8:30am to 4pm. There was an on call rota, for patients needing to return to theatre or for any emergencies which was available seven days a week outside of these operational hours.
- One of the theatres provided laser treatment for which it had been specially adapted.
- A range of elective surgical procedures were available, some lower risk procedures were provided as day case procedures, which meant patients did not have to stay overnight in hospital.
- Patients who were booked for elective surgery had pre-operative assessments that took place in the outpatient department prior to the day of their surgery. These assessed the individual needs of the patient, determining if they were suitable for treatment at this facility and prepared them for their procedure.
- During the pre-operative assessment, health MOTs on patients coming to the hospital for procedures were undertaken. This was an individualised examination of a person's health and wellbeing and took into account their exercise levels, their diets and other lifestyle factors as well as physiological and clinical factors. The results were used to provide advice on improving health and wellbeing generally.
- Prior to the suspension of children's' surgery at the hospital, the service had flexible visiting policy for parents of children undergoing surgery. They were allowed to remain with their children on the wards and arrangements could be made for them to stay overnight on temporary beds in their child's room and meals were provided at no extra cost.
- Children attending for day case surgery could be accompanied by their parents into the anaesthetic room and parents could join their children in the recovery area however, there was no child friendly decoration observed in the recovery area.
- Facilities were available to support parents that were breastfeeding and a lift was available for parents with prams/buggies.
- The decoration in the ward areas we reviewed did not indicate any attempt to make the environment more appealing to children. However, at the time of our inspection day-case and overnight services were not being provided for children but they were planning to restart them in the future. Staff told us that appropriate bedding and a selection of toys were provided when children were admitted.

Access and flow

- Patients could be admitted for surgical treatment through a number of routes which depended on the

funding of their treatment. NHS patients were referred from their General Practitioner (GP) or NHS Trust, private insured patients required a GP referral and self-funding patients could refer themselves.

- Information provided regarding waiting times for treatment for NHS patients, also known as referral to treatment times (RTT) showed that from April 2015 to March 2016, on average 91% of patients referred to the Grosvenor Hospital were admitted for treatment within 18 weeks of referral.
- From April 2015 to March 2016, there were 3,994 inpatient and day-case episodes of care recorded at Nuffield Health the Grosvenor Hospital Chester; 82% of these were NHS funded and 18% were insurance funded and self- funded.
- From April 2015 and March 2016 47% of NHS funded patients and 32% of insurance funded and self-funded patients stayed overnight at the hospital.
- Theatre utilisation was monitored monthly. From July 2015 to June 2016 theatres were in use for 67% of the time it could be used. The department had a target to use the theatres for at least 60% of the available time as they considered this would be more efficient. The department benchmarked their activity against other Nuffield health hospitals and in particular a location that was a similar size to Chester. The theatre utilisation there for the same period was 37%.
- Between April 2015 and April 2016, eight scheduled operations were reported as being cancelled. Four were due to unavailability of equipment, two were due workloads and running out of time and two were due to the unavailability of a surgeon. Seven of the patients were offered another appointment within 28 days of the cancelled appointment.
- Prior to the suspension of inpatient services for children, it was not common practice to undertake child only theatre lists. However, staff told us when children were scheduled for an operation, they would be put first on the theatre list.
- The department followed the Nuffield Health paediatric admissions policy. Children who required surgery would be assessed pre-operatively to determine if they were suitable for treatment at this facility.
- Discharge was communicated to GPs by letter on the day of the patient discharge.

Meeting people's individual needs

- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. All were written in English. However, alternative languages and formats were available on request.
- The departments offered a professional face to face interpreter service for patients whose first language was not English. They were able to use the services of a telephone translation service where an interpreter was required at short notice.
- Patient-Led Assessment of the Care Environment (PLACE) assessments for provision of a dementia friendly environment at Nuffield Chester were 92%, which was better than the England average of 81%.
- Patients with mental health conditions could be referred to community mental health teams if it was deemed appropriate.
- Nervous and anxious patients and children were offered tours of the departments prior to their treatment being undertaken. They were given explanations as to what was going to happen and given reassurance in order to help reduce their anxiety.
- Staff told us if patients with learning disabilities or dementia attended the departments, they would treat each patient on an individual basis and try to best meet their specific needs. Patients living with dementia or learning disabilities were able to have their carer or family member accompany them to theatre and be there when they woke up. There were also picture cards used; for example, a picture of a toilet was placed on the bathroom door if a patient had dementia and required visual prompts.
- A room could be provided for prayer if patients requested this, though there was no established prayer room or chapel in the hospital.
- Receptionists had received training on dealing with vulnerable patients.
- Physiotherapists could offer bespoke rehabilitation and exercise plans for patients following their treatments.
- Patients with mental health concerns could be referred to community mental health teams if it was deemed appropriate.
- The pre-assessment team advised us that they shared information with theatres and the ward which highlighted any relevant individual needs they had identified from their assessment of the patient prior to admission. Such circumstances might be if a patient lived alone, needed a special mattress or had anxiety issues.

Good

Surgery

- We found that the service liaised with patients, families and carers when discussing discharge plans. Patients advised they were included in the planning process and staff ensured vulnerable patients when supported appropriately on their return home. They were supplied with aids and devices to assist with their individual requirements and circumstances.

Learning from complaints and concerns

- The hospital received 54 formal complaints between April 2015 and March 2016 for the whole hospital.
- When patients' complaints were received, the patients were offered the chance to meet managers to discuss their concerns. Patients who had complained were invited to join the patient forum group to attend meetings and give feedback on patient care.
- The overall responsibility for managing complaints was part of the hospital director's role. The hospital matron took the lead if complaints were in relation to clinical care.
- The MAC Chairman was involved to address any concerns in relation to complaints raised against consultants with practising privileges
- Staff were aware of the complaints processes and were able to advise patients how to go about complaining.
- Records indicated that learning from complaints was shared at team meetings, posted on notice boards and appeared in departmental newsletters and circulated by email. They were also discussed in heads of department meeting and senior manager's team meetings.
- Patients could submit complaints electronically through the clinical complaints portal online, through email and in writing.

Are surgery services well-led?

Good

We rated surgery as 'Good' for Well-led. This is because;

- Nuffield Health Chester had a vision and a set of values which were referred to as 'Everyday Epic' which were adopted by staff and embedded in their approach to patient care. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.
- Integrated governance meetings were held quarterly to discuss issues including, risk and safeguarding. There were systems in place to disseminate information to staff across the hospital.
- Quality and performance were monitored through a quality and safety dashboard and included data such as never events, unplanned readmissions, transfers, and friends and family results. Quality received sufficient coverage in board meetings, and other meetings below board level.
- A corporate paediatric and safeguarding lead was in post and staff knew how to make contact for advice and support.
- Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Staff felt supported, encouraged to develop skills, and were confident to raise concerns.
- There were systems in place for staff and public engagement to enable feedback to form part of future service development.
- Patient feedback was positive about services they received and feedback was used to identify any learning or improvements that could be made.
- Staff feedback from the hospital leadership performance MOT for 2015 was positive and better than the Nuffield hospital division with 98% of responses stating they would recommend services to friends and family.

Vision and strategy for this service

- Nuffield Health demonstrated a vision for the future of services; their broader plans involved expanding their services to encompass a wider involvement in health and wellbeing, using their expertise to enable people to be as healthy as possible.
- Nuffield health had values that they termed 'Everyday Epic' which were used to shape their decisions, and guided the way they behaved when treating patients and colleagues. The values were based on being enterprising, passionate, independent, and caring (EPIC).
- Staff were aware of the Nuffield Chester vision, values, and strategy, and we observed these demonstrated throughout their approach to care on the ward and in the theatre environment.

- The senior management team were aware of the challenges faced by the different departments and had action plans in place to address these challenges. Other strategies and challenges related to marketing, business growth, the provision of children's services, and the modernisation of the physical hospital environment including the theatres.
- Following the departure of the paediatric lead nurse earlier in the year, a review of paediatric service provision was completed in May 2016. This recommended that inpatient and day-case services for children and young people be suspended and that they be reconfigured to accommodate latest guidance and monitoring. An action plan was formulated and work was continuing on this at the time of our inspection.

Governance, risk management and quality measurement

- There was an effective governance framework in place to support the delivery of the strategy and good quality care. Staff at all levels were clear about their roles and responsibilities.
- The governance framework supported the risk management committees with clear evidence of dissemination of policy, national guidelines, and alerts, which were shared with heads of departments and cascaded at departmental level. This had been supplemented by the introduction of clinical newsletters.
- Prior to practising privileges being granted, surgeons must provide evidence that they hold an appropriate level of valid professional indemnity insurance. Records we reviewed showed these were in place.
- Integrated governance meetings were held quarterly to discuss issues including governance, risk and safeguarding.
- There were assurance systems and service performance measures in place and the hospital used a quality and safety dashboard which included data such as never events, unplanned readmissions, transfers and friends and family results.
- All hospital risks were held on one hospital-wide risk register at the time of our inspection. This was raised with senior managers and subsequently individual departments developed their own risk register. Risk assessments for individual risks were in place.
- Identified risk to services for children and young people related to the lack of a suitably qualified children's nurse to lead the service and to meet regulatory compliance for inpatient services. Managers were aware of this and could describe actions taken to address this issue.
- The provider held monthly heads of service meetings, we saw minutes from the meeting held in June 2016 which included updates from each clinical area, complaints and mandatory training. Outcomes from meetings were shared with staff via emails, or team meetings.
- The roles and responsibilities of the MAC were available. There was a clinical governance group responsible for reviewing performance and quality. Issues of clinical governance were discussed at the MAC meetings. This information was circulated to staff through meetings and newsletters. There was paediatric representation on the MAC.
- Nuffield Health gained assurance that medical practitioners involved in cosmetic surgery in the independent sector, informed their appraiser of this in their annual appraisal and maintained accurate information about their personal performance in line with national guidance on appraisal for doctors. Consultants requested a form completed by Nuffield Health, prior to appraisal, which stated specialist surgeries undertaken. This form was passed to the local trust appraiser. The appraisal was then shared with Nuffield Health.
- Theatre meeting minutes were available for staff to read in the theatre coffee room.

Leadership of service

- All staff we spoke with told us they had received an appraisal in the 12 months prior to our inspection. Staff felt supported to learn and develop new skills.
- A corporate paediatric and safeguarding lead was in post and staff knew how to make contact for advice and support.
- Managers told us the paediatric lead nurse post had been recruited to and a further paediatric nurse was also due to commence employment. Inpatient and day-case services for children and young people were to resume when new staff were in post and had attended induction and mandatory and role specific training.
- We found that there were clear lines of management responsibility and accountability within theatre and on the ward.

- The theatre and ward was led by visible, experienced, enthusiastic and well respected leaders. They were passionate and knowledgeable about their departments and strived to improve quality and services to patients.
- Staff said they felt very well supported and encouraged by their managers. They were encouraged to develop, take on extra skills and responsibility and were supported to achieve a good home and work life balance. They said managers were accommodating and flexible and in return staff were dedicated and responsible. Two staff working in the theatre department told us at the time of our inspection that they preferred not to provide care to paediatric patients due to their confidence and competence. This had been accommodated in the department by the theatre manager.
- Departmental managers told us they felt supported in their role and would not hesitate to escalate concerns to the senior management team. They said this was a simple and effective process and they were confident their concerns would be listened to and addressed.
- Staff described good leadership from the hospital director and senior management team, they said there was an open and honest leadership style and they were visible and approachable.

Culture within the service

- All staff were very proud of their departments and the hospital and the care they delivered to their patients. They said that it was a good place to work and they enjoyed their job.
- Staff told us they would be confident to raise a concern or highlight any issues with their managers and said there was a no blame culture in the hospital.
- Staff we spoke with stated they were respected and valued.
- Any behaviour and performance issues were addressed where required.
- We observed good team working between the ward and theatre department which included good communication in relation to staffing and transferring of patients between the two departments.
- We observed good working relationships between the nursing and medical staff and there was a level of respect for each other's skills and knowledge.
- Staff in theatres told us at the time of our inspection that if patients were not satisfied with any cosmetic surgery they had received they were brought back at no additional cost to try to rectify the issue via further surgery to ensure the patients were satisfied with the service they received.

Public engagement

- Feedback questionnaires were in use within the hospital. There was no specific satisfaction survey for children but the paediatric service was not in operation at the time of the inspection.
- The hospital engaged people that had used their services to form a patient focus group. The patients met regularly and were involved in reviewing plans and changes for the hospital and giving their feedback on their experience.
- The departments used patient satisfaction feedback in the form of the general hospital surveys. The feedback given from patients has been very positive. At May 2016 patient satisfaction was 96% which was better than the Nuffield hospitals as a whole and was better than the internal target of 95%.
- The hospital took part in the friends and family tests to gain feedback on their care and treatment and results for the period April 2016 to May 2016 were 90% or above which met the internal target and was better than the Nuffield hospitals as a whole.

Staff engagement

- The hospital had good opportunities for staff on the ground to engage with hospital executives. There was monthly 360 degree meetings which provided a two way process of communication and information sharing. Staff were encouraged to make suggestions and take ownership of projects.
- Staff were involved in planning care and treatment for patients. Staff had access to training and study days where required and were actively encouraged to develop their skills.
- The departments had monthly or bi-monthly staff meetings in which staff were updated on new developments, incidents and complaints, safety concerns, staffing, changes in policy as well as sharing other information of interest.
- The hospital used a Leadership MOT, which included a survey that went out to staff to gain their feedback. We observed results for April and October 2015. There were 49 positive responses in October 2015 in relation to staff recommending the hospital as a place to work which

was better than the response in April 2015 and better than the Nuffield hospital division where there were 25 positive responses There were 98% of responses in October 2015 that would recommend services to friends and family which was better than the Nuffield hospital division response of 91%.

Innovation, improvement and sustainability

- The Nuffield Grosvenor introduced a health MOT for patients attending for pre-operative assessments. This was a comprehensive assessment of the patients holistic health and well-being including exercise, diet and lifestyle factors. A report and associate advice and guidance were provided to the patient in order to optimise their health for surgery but also for their future health and wellbeing.
- The Nuffield Chester had a robust project plan to rebuild a new fit for purpose theatre department and endoscopy suite. These plans were signed off at the time of our inspection and work was due to commence later in the year.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Nuffield Health The Grosvenor Hospital Chester has a busy outpatient and radiology department hosting a number of different specialities including orthopaedics, plastic surgery, cosmetic surgery, oral surgery, dental and maxillofacial, ear, nose and throat, gastroenterology, gynaecology, urology, vascular surgery, general surgery, ophthalmology, dermatology, rheumatology and anaesthesia (pain).

Diagnostics undertaken at the Grosvenor include bone densitometry, mammography, X-ray and ultrasound. Nuffield patients can also have their magnetic resonance imaging (MRI) scan undertaken on site and one day a week have their computerised tomography (CT) scan completed on a mobile unit which is positioned on the car park. These were provided by an external provider through a service level agreement contract with Nuffield Health.

The outpatients department undertook 21,290 outpatient attendances between April 2015 and March 2016; of these, 17% were NHS funded patients and 83% were funded by self-paying patients and through insurance funding. Radiology undertook 11,475 radiological investigations and procedures between April 2015 and March 2016. There were 11,658 physiotherapy outpatient appointments between August 2015 and August 2016.

As part of the inspection, we inspected the outpatients' clinic areas, the physiotherapy outpatient areas, the ambulatory care area, the radiology department, the laboratory and the pre-operative assessment clinic.

We spoke with 22 patients and carers, and looked at 17 patient care records. We spoke with 17 staff of different grades including nurses, doctors, allied health professionals, support workers, managers and administrators. We gathered feedback from questionnaires and received comments from people who contacted us to tell us about their experiences. We observed care and treatment, reviewed performance and assessed information about the outpatients and diagnostic departments. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging as "Good" overall because;

- There was a good culture of reporting incidents and there was evidence of learning from them. Incidents were investigated and changes were implemented to prevent similar occurrences.
- The departments were visibly clean and there were low levels of healthcare related infections.
- There were effective systems to ensure equipment was serviced and maintained appropriately.
- The departments assessed and responded appropriately to patient risks; there were effective procedures in place to transfer patients if they became acutely unwell.
- The departments followed evidence-based guidance and best practice in the care and treatment of their patients. They kept their practices up to date and current by ensuring they were consistent with latest National Institute for Health and Care Excellence (NICE) guidelines and recognised recommendations.
- There were good reported outcomes for patients and there was evidence of peer review, external benchmarking and reviewing and improvements regarding their own performance.
- There was effective multidisciplinary working, where different disciplines worked well together to provide a more holistic service to patients.
- Feedback from people who used the service was continuously positive regarding the way they were treated by staff. They said that staff were compassionate and kind and were attentive to their needs.
- We saw that patients were involved in decisions about their care and treatment and that their views and wishes were listened to and acted upon.
- Care was planned and delivered in a pleasant and appropriate environment with the needs of patients and their relatives being taken into account when organising services.
- Departments took into account the individual needs of patients and accommodated individual requests.
- The departments had a good system for dealing with complaints and dealt with complaints in an effective and timeous manner. We saw positive changes as a result of complaints and learning from issues raised.
- The departments within outpatients and diagnostics were led by visible, experienced, competent and enthusiastic managers, who knew their own departments well and who strived for improvements in quality and performance.
- There were strategies and plans in place for the future for the hospital and each of the departments, the staff were familiar with the strategy and their role and expectations of them.
- The hospital had a set of values which were referred to as 'EPIC' which stood for enterprising, passionate, independent, and caring; these values were embraced by staff and embedded in their approach to patient care.
- The departments have effective governance, audits and internal measures of performance and quality in order to assess their performance and ensure continual improvement.
- Staff spoke of a positive working culture and spoke highly of their respective managers. They had good opportunities for development and took pride in the work they did.

However;

- The presence of carpet flooring in some clinical areas was contrary to infection control best practice.
- There was some uncertainty over the application of the mental capacity act legislation, particularly with regards to the process of assessing a person's capacity to consent.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging as 'Good' for Safe. This is because;

- There was a good culture of reporting incidents and there was evidence of learning from them. Incidents were investigated and changes were implemented to prevent similar occurrences.
- The radiology department had good practices and precautions relating to radiation safety, the latest Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 report was positive and showed compliance with regulations.
- The departments were familiar with and used the 'duty of candour' regulation appropriately when required.
- The departments were visibly clean with low levels of healthcare related infections.
- Records indicated that equipment was serviced and maintained appropriately.
- Our observations confirmed that medicines were stored, prescribed and dispensed in line with recommended practices.Records were maintained satisfactorily.
- The departments assessed and responded appropriately to patient risks; there were effective procedures in place to transfer patients if they became acutely unwell.
- Staffing in all of the departments was satisfactory.

However;

- The presence of carpet flooring in some clinical areas was contrary to infection control best practice.

Incidents

- There were no reported never events for outpatients and diagnostics from April 2015 to July 2016. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were also no reported serious incidents in outpatients or diagnostics from April 2015 to July 2016.
- The outpatients and diagnostics department reported 50 incidents from April 2015 to March 2016. These were mostly no and low harm incidents.
- As part of our inspection we examined a sample of incident reports and associated investigations and found that these were investigated appropriately, by suitably qualified and experienced staff, that contributing factors were highlighted and that action plans were put in place to help prevent any reoccurrence of these incidents.
- There was a good culture of openness, reporting and investigation of incidents. There was evidence of positive improvements and changes made as a result of incidents. Learning was identified from investigations and this was disseminated and shared with staff both within the outpatients department and diagnostics departments and to other departments in the hospital. Where relevant, this was also circulated to other Nuffield hospitals to help share learning and prevent future occurrences.
- The diagnostic imaging service reported radiation incidents under the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. These regulations place a duty on services to protect patients from harm. Only one incident was reported in the last year that concerned over exposure to radiation. This was reported via the incident reporting system and also reported to CQC as required. An IRMER compliance assessment report dated July 2016 was positive and showed the department was compliant with regulations.
- Morbidity and mortality issues were discussed during medial advisory committee meetings. Clinical incidents and issues including adverse incidents were discussed and analysed as part of the monitoring of clinical practice. There were representatives from the paediatric service on the committee.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff had received training on the duty of

candour and had a good understanding of what this involved along with a general understanding about openness and honesty policies. Senior staff were able to articulate the specifics of those incidents which fell under the duty of candour legislation.

- We found that the 'duty of candour' regulations were being implemented appropriately following patient harm. We saw examples of this process and were satisfied that the process was in line with organisational policy and national guidance. Records showed that patients were involved and updated about investigations, invited to discuss the circumstances with senior staff and received an appropriate apology for the harm caused.

Cleanliness, infection control and hygiene

- During our inspection we found that the outpatients, diagnostics, pathology and physiotherapy outpatient areas were visibly clean and tidy. We saw that cleaning rotas were in place and that these were audited regularly.
- Audits of the radiology department found that although cleaning regimes were being followed, the documentation was not always being completed fully. Following this, action plans were put in place, which included simplification of the documentation and raising it at team meetings. Subsequent audits showed improvements. Audits of the other areas found satisfactory compliance.
- There were no reported cases of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium difficile infection (CDI) or Escherichia coli (e coli) infections.
- We observed staff working in outpatient and radiology areas adhered to 'bare below the elbow' policies and were compliant with Nuffield Health uniform policy.
- There was adequate access to hand gels on entry to clinical areas and also at the point of care.
- We observed staff following infection control best practice in relation to waste management, disposal of sharps, contaminated waste and laundry.
- The departments had regular infection control audits and in the most recent audit of July 2016 were found to be 100% compliant with procedures.
- On each department there was a designated lead link nurse for infection prevention and control. These members of staff had attended additional infection prevention and control training and were responsible for advice, training and the promotion of infection control in their area.
- Patient-led assessments of the care environment (PLACE) is a system for assessing the quality of the patient environment, undertaken by patients and the public. Scores for the Grosvenor hospital as a whole were 99% for cleanliness, which was above the England average of 98%.
- Carpets were present in some clinical areas, which was not in line with infection control guidance due to difficulties in cleaning and sanitising carpets. The managers were aware of this issue and had plans to replace these carpets with more suitable flooring in the future. In the meantime they had a risk assessment in place and avoided using these rooms where possible.
- Cleaning checklists for toys were present in all outpatient areas however these were not consistently completed within the radiology department.

Environment and equipment

- There were systems in place for equipment servicing, testing and maintenance. The manager kept a record of when equipment required servicing and ensured these were up to date.
- We found that the clinical areas were well maintained, free from clutter and provided a suitable environment for dealing with patients.
- Waste and clinical specimens were handled and disposed of in a way that kept people safe. This included safe sorting, storage, labelling and handling.
- The hospital used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The service had arrangements for the sterilisation of reusable instruments, some on site and some contracted out. We saw that this process was efficient and effective.
- Records indicated that resuscitation equipment was checked in line with hospital policy; we saw that trolleys were locked, equipment was in date and records were kept of the unique seal reference numbers.
- Condition, appearance and maintenance of the environment in the PLACE assessments were 94% which was better than the England average of 92%.
- Designated rooms were used for outpatient consultations involving children and young people. The

decoration in the areas we reviewed did not indicate any attempt to make the environment more appealing to children. However staff told us that an appropriate selection of toys were provided when children attended.

- The specific imaging room used for x-raying children within the radiology department had colourful decorations and lead aprons and outpatient waiting areas had a range of toys for children to play with.
- Baby weighing scales observed in the Eaton Suite had a sticker indicating when they were last serviced. These were in date however, a set of stand on scales in the consultation room had been due for service in January 2016.
- Adult and paediatric resuscitation equipment was in place and records indicated this was consistently checked.

Medicines

- Medicines were stored securely and there were processes in place to ensure they remained suitable for use. Doors with keypad access were in place and had the codes changed periodically.
- We saw there had been a problem with room temperatures rising above recommended limits in two rooms where medicines were stored. This had been managed and escalated appropriately. We saw a new electronic room and fridge temperature monitoring system was being installed in the hospital at the time of our inspection.
- Medicines were available from the on-site pharmacy department, Monday to Friday. There were alternative arrangements for obtaining stock outside of these times. The RMO and nurse in charge had a key to access to stock outside normal opening hours in accordance with local policy.
- We checked the availability of emergency medicines for both adults and children on our inspection. These were stored appropriately, readily accessible and records indicated they were checked regularly.
- We saw accurate records were kept when medicines were administered and this included additional documentation for medicines used outside their product licence. All of the care records we looked at on our inspection included documentation of allergy status and details of the procedure with medicines administered.
- Patients were given prescriptions for medicines if necessary. These could be taken to the hospital pharmacy or a community pharmacy. Prescription pads were stored securely and records kept in accordance with national guidance. This was monitored by the pharmacy department.
- Staff told us details of prescriptions issued were written in the patients notes and communication was sent to the patient's GP. We looked at three sets of clinic notes and saw allergies, prescribing details and communication with the patient's GP were documented in all of these where needed.
- All medicines we checked were in date. We were advised that the pharmacy team check expiry dates and provide stock top ups. We also found all emergency medicines and equipment was in date.

Records

- Medical records were available for all patients attending for an appointment, these contained the referral letter and information about the patient's medical history. The consultant made entries in the patient's notes regarding the outpatient consultation.
- Medical records contained important information such as allergies, patient risk factors, past medical history and emergency contact details.
- As part of our inspection, we reviewed the records of 17 patients, 10 adults and 7 children; we found them to be accurate, complete and up to date. However three records did not have the designation of consulting professional on all entries.
- Consultants held their own outpatient records however the outpatient department kept records of children who underwent procedures such as hearing tests.
- We saw that patients' notes indicated that identified patient risks were highlighted and appropriate risk assessments were completed.
- We found the pre-operative documentation process to be comprehensive and complete.
- Documentation audits of outpatient records were undertaken monthly, we reviewed audits from February to July 2016 the results showed generally high compliance with good record keeping standards, any issues identified were circulated on notice boards and team meetings to highlight areas needing attention, these were then checked again the following month to monitor for improvement. Records for children and young people were included in in the main hospital notes audit.

- Staff told us Personal Child Health Records were completed by consultants if brought to an outpatient appointment.

Safeguarding

- All the staff we spoke with were aware of their responsibilities regarding safeguarding of patients and the correct procedures to follow if they felt a patient was at risk. They were able to describe the process, how to gain access the Nuffield policy and who to contact for advice.
- Safeguarding training formed part of the hospital's mandatory training programme and included information on Female Genital Mutilation and Child Sexual Exploitation.
- Information provided by the hospital showed that 94% of staff had completed training in safeguarding vulnerable adults at level 1 across the departments. In addition, 100% of staff had completed training in safeguarding children and young people at level 1 and 100% of the target group (six staff) had completed level 2. This exceeded their target of 85% compliance. Seven senior staff had completed training at level 3 for safeguarding children and young people.
- The department had a designated safeguarding nurse who was able to offer support and advise colleagues. The matron was the identified lead for safeguarding children and adults and staff were aware of this.
- Some staff had higher levels of adult and children and young people safeguarding training and who were used to give advice as required.
- A corporate chaperone policy was in place. Staff in the outpatients department could describe the policy and we observed documentation showing individual competency assessments completed by staff.

Mandatory training

- Training which was classed as mandatory was those subjects which were considered the most important such as basic life support, safeguarding patients and moving and handling.
- Mandatory training was kept updated by attendance on training courses or by training done remotely on a computer.
- Information provided by the hospital showed that 97.3% of staff in the outpatients department, 97.1% of staff in the physiotherapy department, 100% of staff in the radiology department and 96.9% of the staff in the pathology department were up to date with their mandatory training. This was against a target figure of 85%.

Assessing and responding to patient risk

- In an emergency situation, emergency 'bleep holders' attended to treat deteriorating patients quickly. A system was in place so that such patients could be transferred to the local NHS emergency hospital for urgent treatment either by 999 emergency transfer; or, if less urgent, by routine ambulance transfer.
- An early warning score system was in use for patients undergoing interventional radiology procedures to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score, which allowed nurses to monitor any deterioration and take appropriate action if a patient became unwell.
- Radiology had procedures in place for the rapid notification of 'red flag' findings for cancer and unexpected non-cancer findings, to ensure results were communicated quickly to the relevant team.
- The pre-operative assessment clinics highlighted potential risks for patients who were scheduled for surgical treatments. There was an assessment to establish whether the patient was suitable for the planned surgery and those deemed at greater risk were referred to an anaesthetist for further assessment and advice. If appropriate, further tests were requested. Where risks were identified, the patient was assessed to check if they could be treated safely at this hospital.
- Patients whose needs could not be safely managed at this hospital were referred to an alternative NHS organisation.
- Pre-assessment of children and young people prior to surgical procedures was completed by a paediatric nurse.
- The Resident Medical Officer was qualified in Advanced Life Support (ALS) and Advanced Paediatric Life Support (APLS) and was on duty 24 hours per day for a seven day period.
- All staff completed basic life support (BLS) and paediatric basic life support training (PBLS) as part of their mandatory training schedule. In addition some staff had completed intermediate life support (ILS) and paediatric intermediate life support (PILS).

Good

Outpatients and diagnostic imaging

- Any paediatric nurses employed on a bank or agency basis were required to have completed PILS training.
- Training scenarios for paediatric resuscitation were completed with staff six times a year with the support of an external agency to promote practical resuscitation skills.
- Risk assessments were completed in all areas that children attended.
- A risk assessment for paediatric imaging had been completed in radiology.
- Female patients from the age of 12 years were asked about their last menstrual period (LMP) in radiology as appropriate to the investigation prior to exposure to radiation and a signature was obtained to confirm this discussion.
- We observed a referral form demonstrating the referrer had considered LMP when initiating the referral and with parents' signature to confirm the discussion had taken place.

Nursing staffing

- An acuity tool had not been used to calculate nursing staffing. Rotas were prepared a week in advance following the manager's assessment of staffing requirements based on the number of clinics taking place, any minor procedures taking place and the numbers of patients expected.
- Changes were made if there was staff sickness or where additional clinics were added and additional staff or agency staff could be arranged. The use of agency registered nurses and healthcare assistants was low compared with information we have collected from similar independent health providers. The departments overall use of agency staff was very low for the previous 12 months.
- Managers ensured there was an even mix of skills and competencies amongst staff on duty. If necessary, they could arrange to use an agency nurse with specific skills, for example a paediatric nurse.
- Support for radiological procedures was provided by agency paediatric nurses. A radiology staffing grid was used to identify staff requirements and considered the age of the child or young person and the procedure to be undertaken.

Medical staffing

- A resident medical officer (RMO) was on site for 24 hours a day, seven days a week. If required the RMO could attend the outpatients and radiology departments to give advice and assistance.
- Consultants with practising privileges undertook outpatient clinics at the hospital. They maintained responsibility for their own patients for subsequent follow up appointments such as post-operative dressings and if not present at the time were available for advice and instructions by telephone.
- Consultants had good links with local NHS acute hospitals and could facilitate additional services and facilities for patients if required.
- Radiology staffing was based on the number, size and types of clinics being planned for the following week. Managers continually reviewed staffing to ensure there were enough staff to manage the clinics.
- There was a system in place to contact a radiologist 24 hours a day, seven days a week to deal with any out of hours and emergency tests should they be required.
- Consultants from a range of specialities saw children and young people within the outpatients department. Consultants also saw children and young people within their NHS practise.
- All radiographers undertook paediatric radiography and radiology staff remained on site until the last patient was seen in clinic.

Major incident awareness and training

- Major incident training, such as fire procedures were updated annually as part of the hospital's mandatory training programme.
- Records indicated that major incident drills, such as fire drills, were undertaken periodically and evacuation procedures tested.
- There were business continuity plans in place for each of the outpatient and radiology areas. These included contingency plans to be used in the event of staffing shortages and equipment failure.
- Managers had attended training for major incidents which included example scenarios and specific exercises.

Are outpatients and diagnostic imaging services effective?

Good

Outpatients and diagnostic imaging

Not sufficient evidence to rate

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging. Positively we saw that;

- The departments followed evidence based guidance and best practice in the care and treatment of their patients. They kept their practices up to date and current by ensuring they were consistent with latest National Institute of Health and Care Excellence (NICE) guidelines and recognised recommendations.
- The departments considered patients' experience of pain and planned their care accordingly.
- There were good reported outcomes for patients and there was evidence of peer review, external benchmarking and reviewing and improvements regarding their own performance.
- Staff were competent, experienced and were encouraged to further their professional development to improve their own performance and the service delivered.
- There was effective multidisciplinary working, where different disciplines worked well together to provide a more holistic service to patients.
- There was adequate access to out of hour's diagnostics and investigations, some clinics were provided during evenings and weekends.
- Staff had good access to the information they required to undertake their work effectively.

However,

- There was some uncertainty over the application of the mental capacity act legislation particularly with regards to the process of assessing a person's capacity to consent.

Evidence-based care and treatment

- The departments followed relevant National Institute for Health and Care Excellence (NICE) guidelines and evidence based practice guidance in their care and treatment of patients.
- The departments followed local policies and procedures and followed established integrated care pathways for certain procedures.
- The radiology department followed guidance in relation to the safe use of radiation as described in 'Ionising Radiation (Medical Exposure) Regulations' (2000) (IRMER) and recommendation from Radiology Protection Association (RPA).
- The outpatients department generally followed guidance in the safe use of lasers as described in the 'Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices (2015). However, the department had changed the room which was used for the laser but had not transferred the appropriate signage. They stated they were using a temporary sign which was not in keeping with the guidance.
- Physiotherapy outpatient sessions followed NICE guidance in relation to acupuncture and consultant led protocols regarding post-operative physiotherapy and rehabilitation.
- Ambulatory care minor procedures which were undertaken in outpatient clinics followed relevant NICE guidelines such as hysteroscopy, cystoscopy and dermatological procedures.
- Current paediatric policies and guidance were observed in the radiology department and staff were aware of how to access them.
- Standard operating procedures (SOP) were available for a range of procedures for example administering contrast to paediatric patients in radiology and pre-admission assessment for children attending as a day case or inpatient admission.
- A flowchart was in place for management of post-tonsillectomy bleed.
- The departments had a good system for identifying how new NICE guidance might impact their working procedures and practices. They undertook an impact assessment of new guidance and provided a summary for the use of team members. They shared this information and changes through team meetings, circulars and on noticeboards.
- The radiology department followed the guidance contained in 'Quality assurance guidelines for mammography: including radiographic quality control' compiled by the National Quality Assurance Coordinating Group for Radiography. We saw documentation of these processes during inspection.
- The department worked within the requirements of the National Breast Implant Registry for traceability of

implants linked to individual patients. We saw that implants unique reference numbers were recorded in patients' notes and a copy of this information was given to patients.
- The pathology and medical laboratories had achieved accreditation with Clinical Pathology Accreditation (CPA) for 'Quality management in the medical laboratory' and complied with annual audits to demonstrate continuing compliance. The latest audit was completed in January 2016 with no issues identified.

Pain relief

- Pain and pain relief was discussed during outpatient consultations.
- Patients stated and records showed that pain relief was administered in a timely way in interventional radiology and the ambulatory care unit during and after procedures.
- There was a standard operating procedure for the use of pain relief in the departments.
- Physiotherapists encouraged patients to take their pain relief prior to physiotherapy treatment for those who required it.
- Those patients with identified pain issues could be referred to an anaesthetist for their advice if required.
- Topical anaesthetic was available for children in the outpatient department who required a blood sample to be taken.

Patient outcomes

- The outpatients department undertook 21,268 appointments between April 2015 and March 2016; of these, 17% were NHS funded patients and 83% were funded through insurance or self-paying patients. Radiology undertook 11,475 radiological procedures between April 2015 and March 2016.
- The departments benchmarked themselves with other Nuffield Health hospitals on various measures such as infection rates, cancelled appointments, complaints, friends and family tests scores and patient safety events. Comparatively the department performed well in most areas however collectively the Grosvenor had a higher rate of complaints and greater numbers of patient safety events with harm than its fellow hospitals for the period Jan to March 2016.
- Private health insurance satisfaction surveys enabled the hospital to compare its results with other private providers for insured patients. This shows the hospital compares favourably with similar providers.
- Radiologists' completed peer reviews of other radiologists' reports to ensure adequate standards and share learning.
- Any discrepancies in radiological reporting were shared with colleagues and discussed at clinical and medical governance meetings to raise standards and help prevent future discrepancies.
- The department assisted in the completion of the National Joint Registry (NJR) audits and the patient reported outcome measures (PROMS) in relation to knee and hip replacement procedures and for inguinal hernia repairs and varicose vein surgery for NHS patients.
- The radiology department participated in the mammography peer review process to ensure standards of reporting and reduce discrepancies. Any professional disagreements were raised with the individual author and learning was circulated through clinical governance and radiology team meetings.
- Patient outcomes in physiotherapy were monitored on an individual patient level by well recognised outcome measures such as range of movement, pain scores and quality of life measures to establish effectiveness of treatment and to compare functionality pre and post treatment.
- All images were quality checked by radiographers before the patient left the department, so that if any invalid tests or images were identified they could be redone without having to recall the patient. Interpretation and reporting of images were undertaken within five days.
- Monthly audits of paediatric patient activity were completed in the outpatient department which included documentation and prescriptions review. Results were discussed at the departmental meeting and posted on the department noticeboard.
- A benchmarking report was completed monthly by the Matron which covered issues such as infection control, incidents and safeguarding.

Competent staff

Good

Outpatients and diagnostic imaging

- New staff completed a comprehensive induction programme before being able to work independently. This included corporate and clinical inductions and the delivery of organisations practices and principles as well as clinical mandatory training and job specific training.
- All outpatient, physiotherapy and radiology staff had received a personal development appraisal within the last 12 months at the time of the inspection.
- The radiology department belonged to the British Society of Paediatric Radiographers and three qualified staff had attended a 'good practice' study day in April 2016 with two further radiographers due to attend in September 2016.
- All radiographers had received training for paediatric radiography as part of their initial qualification.
- Local competencies had been devised for both permanent and bank paediatric radiographers and staff were in the process of undertaking peer audit at the time of our inspection.
- Outpatient staff had competency folders tailored to individual needs.
- Physiotherapy staff had completed a self- certified assessment regarding competencies for paediatrics.
- Revalidation of nurses, radiographers, laboratory staff and physiotherapists were supported by their departments. Outpatients had put together a package to assist nurses in the new revalidation programme and they received advice and assistance of how to maintain their portfolios and evidence.
- The revalidation and checking of doctors with practices privileges were undertaken to ensure they had the qualifications, competence, skills and experience necessary for the work to be performed by them.
- The Medical Advisory Committee (MAC) met monthly to ensure clinical quality by providing oversight and guidance on clinical activity. This included representatives from the various outpatients and diagnostics departments and children's services.
- Staff confirmed they were encouraged and supported to consider and undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. We saw all staff training and competency records were completed and retained safely and securely in staff training files.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and we saw that they all worked well together as a team.
- Staff were observed working in partnership with a range of staff from other teams and disciplines including allied health professional, consultants and administration staff. Staff told us there were very good working relationships and a culture of respect and collaboration.
- The Nuffield Grosvenor had a good external working relationship with the local NHS acute hospital and many of the staff also worked there. They were able to secure services and had various service levels agreements in place.

Seven-day services

- There was a system in place to contact a radiologist 24 hours a day, seven days a week to undertake time critical diagnostic tests. The radiologist was able to perform and interpret urgent reports as required.
- Laboratory cover was provided by an in house team, this was available from 8.30am to 6pm, Monday to Thursday, 8.30am to 5pm on Friday. A biomedical scientist was on call 24 hours a day to respond to urgent requests. There was an arrangement to obtain urgent tests with a local acute trust if this could not be accommodated within Nuffield Health laboratories themselves.
- Some outpatients clinics were undertaken on Saturdays and evenings on an ad-hoc basis, based on the consultants requirements.

Access to information

- Staff had access to the organisation's intranet to obtain information. They could access local and Nuffield policies and procedures and e-learning. They could also access external reference sources such as NICE guidelines and professional guidance.
- Staff could gain access to patient information, such as laboratory results, appointment records, x-rays, medical records and physiotherapy records appropriately.
- Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Outpatients and diagnostic imaging

- Records showed that 97% of staff had completed mandatory training on the Mental Capacity Act (2005) and the deprivation of liberty safeguards. However, when we spoke with staff there appeared some uncertainty over how this was applied in practice.
- The departments were involved in obtaining informal verbal consent for such things as taking blood, observations and examinations. We observed staff seeking verbal consent but were concerned that if a patient was unable to give consent themselves (due to dementia, a learning disability or mental incapacity) that some staff believed this could be gained from the patients' representatives or relatives, which is contrary to the Mental Capacity Act (2005).
- Two members of staff stated if the patient was unable to give their consent they would gain consent from the person accompanying the patient, another suggested they would undertake capacity screening. However none of the staff we spoke with were able to describe the two stage assessment of incapacity and they could not state who was responsible for this process i.e. the nursing or medical staff.
- The department was involved in gaining formal written consent from the patients in relation to their proposed surgical treatment or outpatient procedure and for radiological procedures. The 10 medical records we looked at showed it was done in each of the notes we checked and that this was legible and complete.
- The outpatient department and the radiology department undertook periodic consent audits and these found good compliance with formal consent procedures, in the June 2016 audit this was found to be 100%.
- A corporate Standard Operating Procedure (SOP) was in place for obtaining consent for the examination or treatment of children.
- Consent for procedures was obtained by the consultant using specific consent forms for children.
- Staff could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made with the involvement of parents.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging as 'Good' for caring. This is because;

- Feedback from people who used outpatients and diagnostic services was continuously positive. Patients said that staff were compassionate and kind and were attentive to their needs.
- During our inspection we witnessed professional and polite interactions between with patients from all the staff we observed.
- We saw that patients were involved in decisions about their care and treatment and that their views and wishes were listened to and acted upon.
- Staff protected the privacy and dignity of patients when providing care and treatment.
- We saw that emotional support was provided to patients and their psychological needs were taken into account.

Compassionate care

- During our inspection we observed staff interactions with patients and relatives and found these to be friendly, respectful, polite and professional.
- The patients and relatives we spoke with said that staff were very kind, caring, and they were treated with dignity and respect.
- Reception staff were friendly, helpful and directed patients' to the correct departments.
- We saw that consultation and clinic room doors were closed and curtains were pulled around during consultations or examinations to protect the privacy and dignity of patients; staff knocked and sought permission before entering such areas.
- Staff showed respect and regard to patients' personal, cultural and religious needs and gave choices regarding their care and treatment.
- Chaperones of the same sex were provided for patients who were being examined.

Good

Outpatients and diagnostic imaging

- Feedback from patients we spoke with was very positive. They told us staff were very friendly, approachable and gave them time to discuss any particular needs.
- The NHS friends and family test (FFT) is a survey, which asks NHS patients whether they would recommend the service they have used to their friends and family. From April 2015 to March 2016, hospital wide, 100% of patients would recommend the service to their family or friends, the response rate was 49.9%.
- The outpatients department undertook a patient feedback survey. The survey results from June 2016 found that 100% of patients felt involved in their care and treatment, 99% said their privacy and dignity was always maintained and 91% described their care as excellent with 7% saying it was very good and 1% saying it was satisfactory.
- Patient-led assessments of the care environment (PLACE) assessments for privacy and dignity at the Nuffield Grosvenor were 90% from February to June 2015 which was better than the England average of 87%.

Understanding and involvement of patients and those close to them

- The patients and relatives we spoke with said that they found all members of the Grosvenor outpatients' team respectful, inclusive and approachable. They reported that staff of all levels listened to what they had to say, acted upon their concerns and addressed any issues they may have had.
- Patients said they felt they had sufficient time to ask questions and to have their questions answered during consultations and clinic appointments.
- Patients said they received clear and comprehensive information about their care and treatment in a way they understood. They felt this assisted them to make informed choices about treatment options. This was supported by what we saw during our visit.
- The hospital provided clear and unambiguous information about prices and costs for medical treatment in order for patients to be clear about what to expect when being billed for services. There were folders and posters around the department highlighting the individual costs of treatments and tests.
- The parent we spoke with told us that the doctor had made their child "feel at ease" and had been "really good with him".
- Telephone numbers were provided to parents if contact was required between consultations or they had any concerns.

Emotional support

- Staff were able to give emotional support to relatives and carers and were seen to be compassionate and understanding to their needs.
- Staff were aware of the emotional impact of pain on patients' well-being and this was an integral part of quality of life measures used in physiotherapy to assess and evaluate clinical improvements and effectiveness of treatment and health and wellbeing for individual patients.
- Staff gave examples of when they had provided reassurance and comfort to anxious and nervous patients who were to undergo procedures or radiological tests. Patients who had had such tests confirmed that staff were very supportive and put them at ease.
- The preadmission assessment for children and young people included questions regarding anxieties about the proposed procedure. Of the 21 records reviewed,19 had documented this had been discussed.
- Children and young people attending radiology for procedures that required support of a paediatric nurse as identified by the radiology staffing grid would attend 30 minutes prior to the procedure to allow the nurse and child time to get to know each other.
- Children and young people attending radiology for lengthy procedures were given a "Nuffy" bear in the waiting room that they could keep and take with them on their journey through the department.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatients and diagnostic imaging was rated good for 'responsive' because:

Good

Outpatients and diagnostic imaging

- Care was planned and delivered in a pleasant and appropriate environment.
- The needs of patients and their relatives were taken into account when organising services.
- The numbers of cancelled appointments and tests were low and were only cancelled in unavoidable circumstances, such as machine failure or the absence of a consultant.
- The departments' offered a choice of appointment times to suit patients'. Evening and weekend appointments were provided.
- The departments met recommended referral to treatment times.
- Departments took into account the individual needs of patients and accommodated individual requests.
- There was access to leaflets and literature in different languages and an interpreter service was available for those patients whose first language was not English.
- The departments had a good system for dealing with complaints and dealt with complaints in an effective and timely manner. We saw positive changes as a result of complaints and learning from issues that had been raised.

Service planning and delivery to meet the needs of local people

- Physiotherapy, radiology, and outpatient departments offered evening and Saturday appointments to meet the needs of patients' working during the daytime and during the week.
- The environment provided for outpatients, physiotherapy outpatient and radiology was suitable and practical. There were facilities for patients and relatives to get hot drinks and cold water and there were vending machines for snacks. There were televisions and reading materials in the waiting areas and the environment was pleasant, arranged effectively and comfortable.
- The waiting areas for paediatric outpatients and radiology had a range of toys for children and young people. Colouring books were provided post procedure in the radiology department.
- The reception area provided privacy for the patients as it was not directly within earshot of seating and waiting areas.
- A child play area was provided in the waiting area; the toys used here were cleaned regularly as part of the cleaning and maintenance regimes.
- There was sufficient and free car parking facilities for outpatients to use and this was only a short walk away from the departments.
- Signage and directions were clear and helpful. Reception staff were attentive and helpful in showing patients where they needed to be.
- The pathology department offered a comprehensive service and provided access to an out of hour's service. Almost all tests and urgent requests could be accommodated by the laboratory and for those that could not; an arrangement was in place with a local acute hospital laboratory to process.
- Facilities were available to support parents that were breastfeeding and a lift was available for parents with prams/buggies.

Access and flow

- Patients were offered a choice of appointments at times and days to fit in with their personal circumstances. The parent of a paediatric patient told us that their initial outpatient appointment had been very prompt and arranged within two days of telephoning the hospital.
- The departments did not collect information about how long patients were waiting to be seen once they arrived for their appointment.
- During our visit we observed that patients were seen on time and patients told us that this was usually the case.
- The outpatients department arranged appointments within 18 weeks of referral for 94.4% of non-admitted patients and for 95% of patients waiting for treatment between April 2015 and March 2016.
- The total percentage of appointments that did not go ahead between April 2015 and April 2015 was 4.5%, this was due to; booking errors (0.7%), patients cancelling (0.2%), hospital cancelling (2.2%) and patients not showing up for appointments (1.4%).
- A total of 135 appointments for physiotherapy were cancelled; 19 were cancelled by patients and 115 (1.1%) did not attend for their appointments on the day, which is considered a low rate of people who did not attend.

Meeting people's individual needs

- Patient information leaflets were clear and available in different formats and languages.

Good

Outpatients and diagnostic imaging

- The departments offered a professional face to face interpreter service for patients whose first language was not English. They were able to utilise a telephone translation service in cases where an interpreter was required at short notice.
- Patient-led assessments of the care environment (PLACE) for February to June 2015 regarding provision of a dementia friendly environment at the Nuffield Grosvenor were 92% which was better than the England average of 81%.
- Children and patients who were nervous and anxious were offered tours of the departments prior to their treatment being undertaken. Such patients were invited to look around the room their treatment, test or procedure was to be undertaken in prior to being prepared and taken in for their procedure. They were given explanations as to what was going to happen and given reassurance in order to help reduce their anxiety.
- Letters were sent from radiology to advise on appropriate clothing for procedures so children and young people did not need to get changed.
- Staff told us that children and young people who attended for radiological procedures could bring toys or hand held games with them to help reduce anxiety and there were opportunities to attend the department prior to the procedure to allow patients to become familiar with the equipment and procedures.
- A distraction box was used in outpatient and radiology departments. This is a box of toys and games that was used to help distract patients while attending appointments or undergoing procedures such as the taking of a blood sample.
- Staff described how they managed children with challenging behaviour who may attend outpatient clinics.
- Staff told us if patients with learning disabilities or dementia attended the departments, they would treat each patient on an individual basis and try to best meet their specific needs. They would allow carers to remain with the patient if they wished to, or they would provide a quiet room if they thought it may be beneficial. Staff told us they would also ensure that patients were seen quickly to minimise the possibility of distress to them.
- A room could be provided for prayer if patients requested this, though there was no established prayer room or chapel in the hospital.
- Receptionists had received training on dealing with vulnerable patients.
- Physiotherapists could offer bespoke rehabilitation and exercise plans for patients following their treatments.
- The outpatients department undertook health MOTs on patients coming to the hospital for procedures. This was an individualised examination of a person's health and wellbeing and took into account their exercise levels, their diets and other lifestyle factors as well as physiological and clinical factors. The results were used to provide advice on improving health and wellbeing generally.
- Patients with mental health conditions could be referred to community mental health teams if it was deemed appropriate.

Learning from complaints and concerns

- The hospital received 54 formal complaints between April 2015 and March 2016.
- We reviewed five complaints that related to outpatients and diagnostics. We looked at their investigations and outcomes and were satisfied that they were investigated and dealt with in an appropriate and timely fashion.
- When patients complained, they were offered the chance to meet managers to discuss their concerns. Patients who had complained were invited to join the patient forum group to attend meetings and give feedback on patient care.
- Staff were aware of the complaints processes and were able to advise patients how to go about complaining.
- Learning from complaints were shared at team meetings, posted on notice boards and appeared in departmental newsletters and circulated by email. They were also discussed in heads of department meeting and senior managers' team meetings.
- We saw evidence of practical changes made in response to issues raised by patient complaints. For example some patients complained about charges, so the department produced posters, folders and leaflets which clearly outlined the charges and how they worked. They also ensured that patients were clear on charges before chargeable tests and procedures were carried out.
- Patients could submit complaints electronically through the clinical complaints portal online, through email and in writing.
- There were no child specific complaints or feedback forms available in areas that provided care to children but the service was not in operation at the time of the inspection.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Good

We rated outpatients and diagnostic imaging as 'Good' for Well-led. This is because;

- The departments within outpatients and diagnostics were led by visible, experienced, competent and enthusiastic managers, who knew their own departments well and who strived for improvements in quality and performance.
- There were strategies and plans in place for the future for the hospital and each of the departments; the staff were familiar with the strategies, their role and expectations of them.
- The hospital had a set of values which were referred to as 'EPIC' which stood for enterprising, passionate, independent, and caring; these values were embraced by staff and embedded in their approach to patient care.
- The senior management team were visible and approachable and there was effective two way communication between staff and the senior management team.
- The departments had effective governance, audits and internal measures of performance and quality in place.
- The departments had effective strategies to engage with prospective and current patients through focus groups and community events.
- Staff spoke of a positive working culture and spoke highly of their respective managers. They had good opportunities for development and took pride in the work they did.
- The outpatients department had started an innovative initiative of health MOTs for patients that attended for pre-operative assessment; this took a more holistic view of the patient and provided valuable insight into their health and wellbeing.

Vision and strategy for this this core service

- Nuffield Grosvenor demonstrated commitment to the Nuffield corporate vision for the future of services; which was to increase their services to cover a wider involvement in health and wellbeing and expansion of their health and wellbeing gymnasium provision. They saw clinical care being supported by more general health and wellbeing services.
- The senior management team were aware of the challenges faced by the different departments at Nuffield Grosvenor, and there were plans of action in place to tackle those challenges. Other strategies and challenges related to marketing, business growth, the provision of children's services and the modernisation of the physical hospital environment and the theatres block.
- Nuffield Grosvenor had established a set of shared values for the hospital entitled EPIC (enterprising, passionate, independent, and caring). These values were promoted throughout the hospital and used to convey initiatives such as 'Everyday EPIC' which was designed to incorporate these values into care delivery and staff engagement. These values were embraced and demonstrated by staff.
- Local staff were aware of the corporate Nuffield vision and strategy and those of the Nuffield Grosvenor and they demonstrated the values and behaviours of the organisation.
- The organisational, Nuffield Grosvenor and departmental strategies and plans were understood and supported by staff. Staff recognised their roles within the hospital strategy and were enthusiastic about changes and improvements.

Governance, risk management and quality measurement for this core service

- The heads of departments' attended monthly clinical governance meetings to discuss governance, quality reporting, incidents, complaints, audit results, key performance indicators and performance dashboard results. Any trends were monitored and action plans were produced as appropriate. For example, trends were identified regarding laboratory specimens, this led to a process review and a more robust procedure was put in place which led to a reduction in issues. Staff were provided with feedback and information about meetings in the form of minutes, emails, safety alerts, team meetings and newsletters.

Good

Outpatients and diagnostic imaging

- The overall hospital had a risk register in place and managers updated this accordingly. Heads of departments' did not have their own departmental risk registers, but were aware of the risks within their departments and were managing them appropriately using individual risk assessments for each identified risk. Following our initial visit on the unannounced visit, we found that plans were in place for each department to maintain their own departmental risk registers.
- The pathology and radiology managers described how there were audit systems in place to measure the quality and accuracy of their work and how this was peer reviewed to improve standards and quality of reports. Feedback from peer review was fed back to the originator of the report and any themes and interesting or unusual cases were shared at team meetings and the medical advisory and clinical governance meetings.
- Issues of clinical governance were discussed at the medical advisory committee meetings. This information was circulated to staff through team meetings and newsletters.

Leadership of service

- We found that there were clear lines of management responsibility and accountability within outpatients, radiology, pathology and physiotherapy departments.
- Each of the departments was led by a visible, experienced, enthusiastic and well respected leader. They were passionate and knowledgeable about their departments and strived to improve quality and service to patients.
- Staff said they felt very well supported and encouraged by their managers. They were encouraged to develop, take on extra skills and responsibility and were supported to achieve a good home / work life balance. They said managers were accommodating and flexible and in return staff were dedicated and responsible.
- Departmental managers told us they felt supported in their role and would not hesitate to escalate concerns to the senior management team. They said this was a simple and effective process and they were confident their concerns would be listened to and addressed.
- Staff described good leadership from the hospital director and senior management team, they said there was an open and honest leadership style and they were visible, approachable.

Culture within the service

- All staff were very proud of their departments and the hospital and the care they delivered to their patients. They said that it was a very good place to work and that the organisation was a good employer.
- Staff told us they would be confident to raise a concern or highlight any issues with their managers and said there was a no blame culture in the hospital.
- Staff described a supportive and inclusive team atmosphere and a team focus on working together for patients and improvements in service.

Public and staff engagement

- The hospital had good opportunities for staff on the ground to engage with hospital executives. There was monthly 360 degree meeting which provided a two was process of communication and information sharing. Staff were encouraged to make suggestions and take ownership of projects.
- The departments had monthly or bi-monthly staff meetings in which staff were updated on new developments, incidents and complaints, safety concerns, staffing, changes in policy as well as sharing other information of interest.
- The hospital engaged the services of Nuffield Grosvenor patients for their patient focus group. The patients met regularly and were involved in reviewing plans and changes for the hospital and giving their feedback on their experience.
- The departments sought patient satisfaction feedback in the form of the general hospital surveys but also the outpatients department had introduced its own outpatient survey to gain more specific feedback on their services. The feedback given from patient had been very positive. However, there was no specific satisfaction survey for children within the outpatients and diagnostics departments.
- The hospital took part in the NHS friends and family test to gain feedback on their care and treatment.

Good

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- The Nuffield Grosvenor introduced a health MOT for patients attending for pre-operative assessments. This was a comprehensive assessment of the patients holistic health and well-being including exercise, diet and lifestyle factors. A report and associate advice and guidance were provided to the patient in order to optimise their health for surgery but also for their future health and wellbeing.

Outstanding practice and areas for improvement

Outstanding practice

The Nuffield Grosvenor introduced a health MOT for patients attending for pre-operative assessments. This was a comprehensive assessment of the patients holistic health and well-being including exercise, diet and lifestyle factors. A report and associate advice and guidance were provided to the patient in order to optimise their health for surgery but also for their future health and wellbeing.

Areas for improvement

Action the provider SHOULD take to improve

In surgery

- Patients that sign the consent form in advance of the day of surgery should have confirmation of the consent documented on the day of surgery by a consultant or nurse.
- The hospital should ensure that the psychological aspects around cosmetic surgery are being considered during the consultation process, they should ensure a two week cooling off period is provided and establish a system of monitoring that these two practises are being achieved. They should consider the role of cosmetic surgery specialist nurse.
- The hospital should improve compliance with mandatory training in the areas where compliance is low, such as Mental Capacity Act, Consent, Deprivation of Liberties, and basic and immediate life support.
- All staff should adhere to the 'bare below the elbows' protocol.
- The Resident Medical Officer and ward staff should be trained and be aware of the process to perform a mental capacity assessment in the event that an assessment is required out of hours.
- The hospital should consider providing training for theatre staff in pain assessment for children and young people should the service recommence as planned.
- The hospital should record allergy status in all children and young people's records should the service recommence as planned.
- All paediatric early warning scores should be documented as per the hospital policy should the service for children and young people recommence as planned.
- A registered children's nurse should be available to document updates in the patient record should the service for children and young people recommence as planned.
- All patient letters should be filed in the correct medical record.

In outpatients and diagnostic imaging

- The outpatients and diagnostics departments should reinforce the principles of the Mental Capacity Act 2005 in relation to the application of a test for capacity to consent to treatment. Further education regarding informal consent to treatment may be beneficial to eradicate any misconceptions about how consent may be gained.
- The outpatients and diagnostics departments should consider the replacement of carpets in clinical areas for infection control purposes.
- The department should ensure that the room used for laser procedures has the appropriate signage in place.