Nuffield Health Cambridge Hospital

Quality Report

4 Trumpington Road
Cambridge,
Cambridgeshire
CB2 8AF
Tel:01223 303336
Website: www.nuffieldhealth.com/hospitals/cambridge

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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit on 11 July 2016 and an unannounced inspection on 26 July 2016.

Our key findings were as follows:

Overall the hospital was rated as outstanding.

Are services safe at this hospital

- There was a good incident reporting, investigation and feedback system and staff recognised how to respond to patient risk with arrangements to identify and care for deteriorating patients.
- Appropriate infection control procedures were in place and the environment was clean and utilised well. All areas were staffed appropriately by a skilled, supported and competent workforce.
- Staff recognised how to respond to patient risk and there were arrangements to identify and care for deteriorating patients.
- Venous thromboembolism, falls and urinary catheter care assessment audits were consistently undertaken to a good standard.
- Staff were aware of their responsibility to safeguard vulnerable adults and children from abuse. There were clear internal processes to support staff to raise concerns.
- Staffing levels were appropriate and planned in line with capacity. Agency staff were used when required with the same nurses used to maintain continuity for the service and the children.
- Staff received mandatory training and there was an excellent level of completion.

Are services effective at this hospital

- Policies and procedures were developed using relevant national best practice guidance.
- Patients had access to appropriate nutrition and hydration.
- The provision of pain relief was well managed with prescribing being done by the anaesthetist and/or the resident medical officer (RMO).
- The service had a high rate of consent to the National Joint Registry.
- The service performed above average in the Patient Reported Outcome Measures for hip and knee surgeries.
- Unplanned readmissions were low compared to other providers.
- Staff were supported with learning and development to ensure they were competent in their role.
- Staff appraisal rates were high between 96% and 100%.
- There was physiotherapy, radiology and pharmacy on call rotas to ensure that support was available to the ward seven days a week.
- Consent was consistently well recorded and audited.
- Staff were aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are services caring at this hospital

- Patient care was at the heart of the service and we saw several areas of outstanding practice. This included the emphasis on supporting people emotionally and socially with the on-site Maggie's Wallace charity.
- The feedback we received from people using the service was overwhelmingly positive with people describing the care they had received as, "Amazing" and, "First class."
- The service was scoring in the top 10 of all Nuffield Health hospitals for patient satisfaction and positive feedback.
- People had their privacy and dignity maintained at all times.
- Patients were listened to and actively involved in their care and treatment.
- People's emotional needs were highly valued by staff and we were given examples of how these needs would be met.

Summary of findings

- The emotional needs of the children were embedded in the care provided. Parents were able to accompany their child to theatre and be present in recovery to give extra emotional support.

Are services responsive at this hospital

- The service was planned and delivered to meet the needs of the patient groups it served.
- Access to the service was straightforward and timely. Patient flow was seamless and without delay.
- An average of 98% of patients were treated within 18 weeks of referral each month.
- Patients living with dementia received one to one care.
- Staff worked with families to support the needs of patients with learning disabilities.
- Systems and processes were in place to ensure patients' individual needs were met. This included the outstanding initiative to support patients following their treatment with a 12 week integrated cancer rehabilitation programme.
- We found an innovative approach to reduce anxiety in younger children with a small electric car used for the theatre transfer.
- The service had received eight complaints in the six months preceding our inspection but there were clear systems in place so that, should a complaint be received, learning could take place.

Are services well-led at this hospital

- The hospital had a clear vision and staff were aware of this.
- The leadership team were proactive and looked for opportunities to improve patient care.
- There was an open door culture at the hospital and staff were encouraged and felt empowered to raise concerns.
- There was an effective governance structure and learning and improvement was evident.
- The hospital was well supported by an active medical advisory committee.
- There was a robust and comprehensive competency scrutiny process in place through the medical advisory committee before practicing privileges were granted to medical staff.
- The hospital had a strategy to improve services for children and young people and the set objectives were being met.
- We saw that the hospital worked in close collaboration with the local NHS trust.

We saw several areas of outstanding practice including:

- The hospital leadership team were outstanding in how they led the service and continually strived to further improve the service for patients.
- We found an innovative approach to reduce anxiety in younger children with a small electric car used for the theatre transfer.
- Systems and processes were in place to ensure patients' individual needs were met. This included the outstanding initiative to support patients following their treatment with a 12 week integrated cancer rehabilitation programme.
- An average of 98% of patients were treated within 18 weeks of referral each month.
- Patient care was at the heart of the service and we saw several areas of outstanding practice. This included the emphasis on supporting people emotionally and socially with the on-site Maggie's Wallace charity.
- The feedback we received from people using the service was overwhelmingly positive with people describing the care they had received as, "Amazing" and, "First class."
- The service was scoring in the top 10 of all Nuffield Health hospitals for patient satisfaction and positive feedback.
- The service had a high rate of consent to the National Joint Registry.
- The service performed above average in the Patient Reported Outcome Measures for hip and knee surgeries.
- Staff achievements in completing mandatory training were excellent.The completion of training was seen as a priority for the service.

However, there were also areas of where the provider may wish to consider making improvements.

The provider should consider:

Summary of findings

- There was limited opportunity for the service to assess its effectiveness and make improvements because the 2016 audit plan only contained four audits.
- Not all staff were up to date with basic or intermediate life support training. Particularly bank staff.
- Auditing the effectiveness of pain relief did not take place.
- There was limited opportunity for the service to assess its effectiveness and make improvements because the 2016 audit plan only contained four audits.
- Oncology nurses did not work seven days a week, which meant patients being cared for on the ward during the weekend, did not have access to specialist nursing.
- There was no formal transition arrangements for patients moving through their cancer pathway to be transitioned back into NHS care for the end of their life.
- Consent forms had been signed by children and their parents but could not find documented evidence that "Gillick competence" had been considered or assessed formally if required.

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	**Outstanding** ☆	We rated medical care services at Nuffield Health Cambridge Hospital as outstanding. We rated safe, effective and responsive as good whilst we rated caring and well-led as outstanding. There was a good incident reporting, investigation and feedback system and staff recognised how to respond to patient risk with arrangements to identify and care for deteriorating patients. Appropriate infection control procedures were in place and the environment was clean and utilised well. All areas were staffed appropriately by a skilled, supported and competent workforce. Patient care was at the heart of the service and we saw several areas of outstanding practice. This included the emphasis on supporting people emotionally and socially with the on-site Maggie's Wallace charity. The feedback we received from people using the service was overwhelmingly positive with people describing the care they had received as, "Amazing" and, "First class." Policies and procedures were developed using relevant national best practice guidance and patients had access to appropriate nutrition and hydration including specialist advice and support. Patient access and flow was seamless and without delay and staff were aware of their responsibility to ensure patients' individual needs were met. This hospital provided an outstanding cancer rehabilitation programme. Patients were offered a 12-week programme as part of their treatment at a local Nuffield Gym, which was supported by fitness instructors who had received specialist oncology training. The purpose of the programme was to improve quality of life following cancer treatment by improving physical function and psychological and social wellbeing. The hospital had a clear vision and staff were aware of this. The leadership team were proactive and promoted an open door culture. The service was supported by a clear governance structure and an active medical advisory committee, which encouraged learning and improvement.

Summary of findings

Surgery

Outstanding 

Surgery services at Nuffield Health Cambridge were rated as outstanding overall. Safe, caring and responsive were rated as good with effective and well led rated as outstanding. Incidents were investigated and learning shared from heads of department meetings to team brief meetings. Infection control practice was in line with hospital policy and was regularly audited. Equipment required to provide safe care was regularly safety checked and serviced. Nurse staffing was managed so that there were enough staff to provide safe care. There was access to consultants both in working hours and out of hours in the event of a patient deteriorating, with the additional support of a resident medical officer if more urgent support was required. The service had a comprehensive audit plan in place to assess the provision of care. Outcomes on these audits were outstanding. Patients received pre-loading of pain relief where clinically appropriate. Patient feedback during our inspection was very positive and patients felt informed and involved in their own care. As a service the Nuffield Health Cambridge Hospital performed in the top 10 of all Nuffield hospitals for positive patient feedback and satisfaction. Patients were consistently treated within 18 weeks of referral. Patients living with dementia received one to one care. Staff worked with families to support the needs of patients with learning disabilities. Surgery related complaint numbers were low with no identifiable trends, and learning from complaints was a regular discussion at team briefs. There was a structured leadership in place that was well respected by staff. Staff felt the leadership was supportive, visible, and that they listened to staff. There was a well established and well run medical advisory committee (MAC) in the service, as well as senior meeting sand governance meetings to monitor quality. The leadership team locally as well as the senior management team were outstanding and demonstrated real passionate and committed leadership to delivering their service.

Services for children and young people

Outstanding 

We rated this service outstanding overall. Safe and effective were rated as good with caring, responsive and well-led rated as outstanding because the service had robust incident reporting systems and there was evidence of learning from incidents. We found assessments and procedures in place to safeguard

Summary of findings

children and young people from harm. There were measures in place to monitor and manage children and young people including signs of deteriorating health. Staffing was planned and continually monitored and agency staff were used when required with the same nurses used to maintain continuity to the service and patients. Children and their families reported that staff were kind and compassionate. Staff consistently included their patients and families in the care delivery and promoted their dignity. Young children had the option of driving a small electric car to theatre to reduce anxiety levels. The hospital had a service level agreement with the local NHS trust to give 24-hour consultant support and the transfer of an unwell child. The hospital had a strategy to improve services for children and young people and the set objectives were being met. There was a clear governance structure and this demonstrated a proactive approach to managing risk and quality improvement of services. The leadership team drove continuous improvement actively seeking feedback from staff and service users. We found there was strong leadership from the hospital director down to department managers. Staff were committed and cared about the services they provided and were supported by their managers.

Outpatients and diagnostic imaging

Outstanding ☆

Overall, we have rated the outpatients department as outstanding. Safety was rated as good, we do not have sufficient evidence to rate outpatient services effectiveness at this time. Caring, responsiveness and well-led were rated as outstanding.
Staff were clear on how to report an incident and had received training in this area. Incidents were discussed both locally and with senior management. Infection prevention measures were in place and we saw staff adhering to 'bare below the elbows' guidelines. Equipment within the department was regularly serviced and checked. Medical records were held securely, with a tracking tool in place to locate and prevent missing notes. Staff could access NHS notes and images through the NHS portal. Clear processes were in place to escalate concerns in the event of deteriorating health of a patient. Robust systems were in place with regard to the granting and renewal of practising privileges within the department. Patient feedback was extremely positive about the hospital

Summary of findings

premises and treatment from staff. Patients told us that staff were kind and caring. The outpatient and diagnostic imaging department met and exceeded its target for referral to treatment times (RTT) during April 2015 to March 2016. There were robust systems in place surrounding complaints and the management of complaints. The Nuffield Health Cambridge Hospital complaint rate was significantly lower than other acute independent hospitals. The hospital had a clear strategy and values, which were embedded with staff. There were clear governance structures in place within the outpatients and diagnostic imaging department, with effective information sharing between the senior management team.

Summary of findings

Contents

Outstanding ☆

Nuffield Health Cambridge Hospital

Services we looked at
Medical care; Surgery; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Cambridge Hospital

The original Nuffield Health Cambridge Hospital opened in 1921 as The Evelyn Nursing Home and is an established part of the local community. Nuffield Health Cambridge Hospital was acquired by the Nuffield Hospital Group in 2003 and in July 2015, opened its brand new £30 million state of the art hospital on its existing site and demolished the majority of the former building. Nuffield Health Cambridge Hospital offers a wide range of clinical services including: orthopaedics, oncology, urology, gynaecology and ear, nose and throat (ENT), general surgery and also offers a service for children and young people. It has four operating theatres, three of which are fully digital. It has an ambulatory care unit with capacity for five patients, a dedicated oncology ward with five bays and four beds, and 32 patient ward bedrooms all with ensuite facilities and a two bed bay with shared facilities. It has a diagnostic centre, offering CT, MRI, ultrasound, fluoroscopy, mammography and general X-Ray and a physiotherapy department. It also offers 19 consulting rooms in its outpatient department. The hospital is located approximately two miles from the nearest NHS hospital therefore convenient for consultants and patients to access. The hospital is on major bus routes into the centre and only 10 minute walk from Cambridge train station.

The hospital has on site pathology services. One pathology room located currently in the diagnostic imaging suite and relocated to a new build location in June 2016. This is a "spoke satellite" to a hub service provided by Nuffield Health pathology at another Nuffield Health Hospital.

- 34 inpatient or day case procedure beds.
- Five chair bays in oncology day unit.
- 19 Consulting rooms, one minor procedures room, one plaster / treatment room, one urology treatment room, one gynaecology treatment room, one ENT suite including audiology booth, one phlebotomy room, two pre-admission rooms.
- Four operating theatres
- The hospital is part of the Nuffield Health Group, which is a registered charity within England.
- For this inspection we looked at the core services of medical care, surgery, children and young people's services, and outpatient and diagnostic services.
- We have inspected this acute independent hospital as part of our scheduled commitment to inspect and rate all services of this type.

The Registered Manager for the hospital is Maxine Etsopp. The registered manager had been in post for five years and eight months at the time of our inspection.

Our inspection team

Our inspection team was led by:

Inspection Lead: Leanne Wilson, Inspection Manager, Care Quality Commission

The team of seven included CQC inspectors and a variety of specialists: theatre nurse, chemotherapy specialist and a governance specialist.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 11 July 2016 and an unannounced inspection on 26 July 2016. We spoke with a range of staff in the hospital, including nurses, allied health professionals, support staff and consultants. During our inspection, we reviewed services provided by Nuffield Health Cambridge Hospital in the ward areas, operating theatres, outpatients, pharmacy and imaging departments.

Summary of this inspection

During our inspection, we spoke with 22 patients, and their relatives, 33 staff, including consultants, who are not directly employed by the hospital. We observed how people were being cared for and reviewed personal care or treatment records of 21 patients.

To get to the heart of people who use services' experience 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?

Information about Nuffield Health Cambridge Hospital

The Nuffield Health Cambridge Hospital is registered for the following regulated activities. The service became registered for all activities on 26 November 2010.

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

General Activity

- There were 5,073 inpatient and day case episodes of care recorded at Nuffield Health Cambridge in the reporting period (April 2015 to March 2016); of these 14% were NHS funded and 86% other funded.
- 47% of all NHS funded patients and 22% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 12,016 outpatient total attendances in the reporting period (April 2015 to March 2016); of these 80% were other funded and 20% were NHS funded.

The following services are outsourced by Nuffield Health Cambridge Hospital:

- Catering - Sodexo
- Domestic waste disposal - Cambridgeshire City Council
- Facilities maintenance - CBRE
- Histopathology and blood transfusion services - Pathology Partnership in Cambridge University Hospital NHS Foundation Trust: Addenbrookes Hospital
- Intensive theatre suite cleaning - Imperial Cleaning Ltd
- Laundry services - Berensden
- Medical Devices Management - TBS
- Medical waste disposal - SRCL
- Theatres Suite cleaning general - Atkinson – Gregory Cleaners.

Controlled Drugs Accountable Officer (CD AO)

The Registered Manager, Maxine Etsopp, is the CD AO. They had been in post for five years and eight months at the time of our inspection.

Services accredited by a national body

BUPA Accreditation Breast Cancer, Colorectal Cancer and for Gynaecological Cancer. Cancer service has the Macmillan Quality Environmental Mark Accreditation Pathology service is fully CPA accredited and working towards UKAS ISO1589.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- There was a good incident reporting, investigation and feedback system and staff recognised how to respond to patient risk with arrangements to identify and care for deteriorating patients.
- Appropriate infection control procedures were in place and the environment was clean and utilised well. All areas were staffed appropriately by a skilled, supported and competent workforce.
- Staff recognised how to respond to patient risk and there were arrangements to identify and care for deteriorating patients.
- Venous thromboembolism, falls and urinary catheter care assessment audits were consistently undertaken to a good standard.
- Staff were aware of their responsibility to safeguard vulnerable adults and children from abuse. There were clear internal processes to support staff to raise concerns.
- Staffing levels were appropriate and planned in line with capacity. Agency staff were used when required with the same nurses used to maintain continuity for the service and the children.
- Staff received mandatory training and there was an excellent level of completion.

Are services effective?

Good

- Policies and procedures were developed using relevant national best practice guidance.
- Patients had access to appropriate nutrition and hydration.
- The provision of pain relief was well managed with prescribing being done by the anaesthetist and/or the resident medical officer (RMO).
- The service had a high rate of consent to the National Joint Registry.
- The service performed above average in the Patient Reported Outcome Measures for hip and knee surgeries.
- Unplanned readmissions were low compared to other providers.
- Staff were supported with learning and development to ensure they were competent in their role.
- Staff appraisal rates were high between 96% and 100%.
- There was physiotherapy, radiology and pharmacy on call rotas to ensure that support was available to the ward seven days a week.

Summary of this inspection

- Consent was consistently well recorded and audited.
- Staff were aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are services caring?

Outstanding ☆

- Patient care was at the heart of the service and we saw several areas of outstanding practice. This included the emphasis on supporting people emotionally and socially with the on-site Maggie's Wallace charity.
- The feedback we received from people using the service was overwhelmingly positive with people describing the care they had received as, "Amazing" and, "First class."
- The service was scoring in the top 10 of all Nuffield Health hospitals for patient satisfaction and positive feedback.
- People had their privacy and dignity maintained at all times.
- Patients were listened to and actively involved in their care and treatment.
- People's emotional needs were highly valued by staff and we were given examples of how these needs would be met.
- The emotional needs of the children were embedded in the care provided. Parents were able to accompany their child to theatre and be present in recovery to give extra emotional support.

Are services responsive?

Outstanding ☆

- The service was planned and delivered to meet the needs of the patient groups it served.
- Access to the service was straightforward and timely. Patient flow was seamless and without delay.
- An average of 98% of patients were treated within 18 weeks of referral each month.
- Patients living with dementia received one to one care.
- Staff worked with families to support the needs of patients with learning disabilities.
- Systems and processes were in place to ensure patients' individual needs were met. This included the outstanding initiative to support patients following their treatment with a 12 week integrated cancer rehabilitation programme.
- We found an innovative approach to reduce anxiety in younger children with a small electric car used for the theatre transfer.
- The service had received no complaints in the six months preceding our inspection but there were clear systems in place so that, should a complaint be received, learning could take place.

Summary of this inspection

Are services well-led?

Outstanding 

- The hospital had a clear vision and staff were aware of this.
- The leadership team were proactive and looked for opportunities to improve patient care.
- There was an open door culture at the hospital and staff were encouraged and felt empowered to raise concerns.
- There was an effective governance structure and learning and improvement was evident.
- The hospital was well supported by an active medical advisory committee.
- There was a robust and comprehensive competency scrutiny process in place through the medical advisory committee before practicing privileges were granted to medical staff.
- The hospital had a strategy to improve services for children and young people and the set objectives were being met.
- We saw that the hospital worked in close collaboration with the local NHS trust.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Surgery	Good	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding
Services for children and young people	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Notes

1. We are will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Outstanding ☆

Medical care

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Information about the service

The oncology service at the Nuffield Health Cambridge Hospital provided chemotherapy and supportive care for most adult solid tumours and malignant haematological disorders.

The oncology unit consisted of five chair bays with privacy screens and curtains, telephones and TVs. There was an isolation room, two individual treatment rooms and separate waiting areas together with an information booth. Two quiet rooms were also available, of which, one was designated for use by the cancer support charity Maggie's Wallace.

The service was available Monday to Friday between 8am and 6:30pm and in-patients were cared for by staff on Evelyn ward with the support of cancer nurses. Patients who had received oncology treatment could receive end of life care at the hospital, although there was no dedicated end of life service.

In 2015, there were 3382 oncology admissions to the hospital.

During this inspection, we spoke with seven members of staff, which included three nurses, the oncology unit manager, the oncology unit administration co-ordinator, the ward manager and the hospital matron. We spoke with four patients and reviewed documentation including six patient records and data provided by the hospital, prior, during and following our inspection.

Summary of findings

We rated medical care services at Nuffield Health Cambridge Hospital as outstanding. We rated safe, effective and responsive as good whilst we rated caring and well-led as outstanding.

This was because:

- There was a good incident reporting, investigation and feedback system and staff recognised how to respond to patient risk with arrangements to identify and care for deteriorating patients.
- Appropriate infection control procedures were in place and the environment was clean and utilised well. All areas were staffed appropriately by a skilled, supported and competent workforce.
- Patient care was at the heart of the service and we saw several areas of outstanding practice. This included the emphasis on supporting people emotionally and socially with the on-site Maggie's Wallace charity.
- The feedback we received from people using the service was overwhelmingly positive with people describing the care they had received as, "Amazing" and, "First class."
- Policies and procedures were developed using relevant national best practice guidance and patients had access to appropriate nutrition and hydration including specialist advice and support.

Outstanding ☆

Medical care

- The service was planned and delivered to meet the needs of the patient groups it served. Patient access and flow was seamless and without delay and staff were aware of their responsibility to ensure patients' individual needs were met.
- This hospital provided an outstanding cancer rehabilitation programme.
- The hospital had a clear vision and staff were aware of this. The leadership team were proactive and promoted an open door culture. The service was supported by a clear governance structure and an active medical advisory committee, which encouraged learning and improvement.

However:

- There was limited opportunity for the service to assess its effectiveness and make improvements because the 2016 audit plan only contained four audits. In addition, auditing the effectiveness of pain relief did not take place.
- Oncology nurses did not work seven days a week which meant patients being cared for on the wards over the weekend did not have access to specialist nursing.
- There was also no central point of reference to support oncology staff when they were assisting patients to manage social needs and end of life services were not fully developed.

Are medical care services safe?

Good

We rated medical care services as good for safe because:

- There was a good incident reporting, investigation and feedback system. Staff were aware of their responsibilities in relation to reporting incidents there was evidence that learning took place.
- Appropriate infection control procedures were in place and the environment was clean and utilised well.
- Staff recognised how to respond to patient risk and there were arrangements to identify and care for deteriorating patients.
- Staff were aware of their responsibility to safeguard vulnerable adults and children from abuse. There were clear internal processes to support staff to raise concerns.
- Staffing levels were appropriate and planned in line with capacity.
- Staff received mandatory training and there was an excellent level of completion.

However:

- Auditing the effectiveness of pain relief did not take place.
- There was limited opportunity for the service to assess its effectiveness and make improvements because the 2016 audit plan only contained four audits.
- Not all staff were up to date with basic or intermediate life support training.

Incidents

- We spoke with four members of staff who were aware of their responsibilities to report incidents through the hospital's electronic reporting system. Each member of staff gave appropriate examples of the types of incident which required reporting.
- The Nuffield Health Cambridge Hospital was a higher than average reporter of incidents. Between April 2015 and March 2016, the hospital reported 372 clinical incidents and 71 non-clinical incidents. Incident trends were reviewed and analysed as part of the hospital's governance framework.
- At a local level, we saw that incidents were discussed and reviewed at team meetings and regular reports

were sent to the governance committee and the medical advisory committee. We reviewed the medical advisory committee governance report from April to June 2016 and saw that information had been submitted in relation to oncology incidents. This meant that sufficient overview and scrutiny of these incidents was in place.

- We noted, from the governance report, an incident where a palliative patient had died and did not have a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR) in place. We saw that, following a root cause analysis (RCA) lessons had been identified and steps were taking place to ensure the discussion with patients with regards to DNACPR would be integrated into the patient pathway at an earlier time. We spoke with three members of staff in relation to learning from incidents, two were aware of this RCA and its outcomes and one was not.
- There had been no never events (wholly preventable serious incidents) or serious incidents within the oncology service between March 2015 and the time of our inspection.
- The hospital had regard to duty of candour. This is the duty on healthcare providers to act in an open and transparent way with patients when a notifiable safety incident occurs in relation to their care or treatment. We saw two letters, which demonstrated that patients were contacted when things went wrong and provided with appropriate information and support.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- Patient safety information was reported and measured through the hospital's own quality and safety dashboard. Outcomes were reported and compared nationally against other Nuffield hospitals on a quarterly basis.
- We reviewed the February 2016 dashboard and saw that out of the 17 dashboard outcomes, the hospital was meeting targets for 16. The one in which the hospital was not meeting was in relation to the Friends and Family Test for private patients. However, we would not expect the Friends and Family Test to be completed for non-NHS patients.
- We reviewed the dashboards for November 2015 and May 2016 and found that the service was consistently achieving their set targets and were comparable with outcomes in the top quartile of Nuffield hospitals in England.
- The dashboard was discussed routinely at the clinical governance meeting to identify any trends or areas of improvement. We reviewed the minutes of meetings held in January, February and March 2016 that supported the dashboard was shared and discussed in the service.

Cleanliness, infection control and hygiene

- The hospital's infection control manual was available to staff in hard copy form on the unit.
- All areas of the oncology unit were visibly clean.
- One-hundred per cent of oncology staff were up to date with their infection control and aseptic technique training.
- Regular cleaning audits were undertaken; we saw the completed audit for March 2016 which did not identify any concerns.
- All inpatients were cared for in individual private rooms with en-suite bathroom facilities. We saw that staff had access to personal protective equipment with dispensers available in all clinical areas and within patients' rooms.
- We saw hand gel dispensers located in all clinical areas and in patients' rooms. Sinks (compliant with the NHS standard HB09) were also available for use on the oncology unit.
- There had been no cases of MRSA or Methicillin-susceptible Staphylococcus Aureus (MSSA) reported between April 2015 and March 2016.
- All patients were screened for MRSA prior to admission to the hospital.
- Hand hygiene audits were in place to monitor compliance with the policy. We saw the hand hygiene audit results from February 2016, which showed good compliance with hand hygiene. Patients we spoke to reported that staff washed their hands before any care was given.
- As part of a recent hand hygiene audit, patients were given forms to record staff compliance with hand hygiene and gave positive feedback about being involved in the hospital's performance and monitoring.

Environment and equipment

- We reviewed the resuscitation trolley on the oncology unit and found that daily and weekly checks had been marked as complete on all days the unit was open during June and July 2016.
- Other equipment we checked such as patient monitoring equipment, computers, and infusion pumps were up to date to with servicing and portable appliance testing (PAT).
- The environment was well maintained; the building had recently opened and was well designed.
- Checks of the resuscitation trolleys were audited monthly and scrutinised quarterly by the resuscitation committee. The group resuscitation policy audit tool completed for the period July 2015 to December 2015 reflected that checks were not being completed 100% of the time, with the audit demonstrating compliance in 89% of cases.
- There were two adult resuscitation trolleys on Evelyn and one children's resuscitation trolley. The seal and cleaning schedule were scheduled for daily checks, and the whole trolley was scheduled for weekly checks. The log book for one trolley contained three months of checks and had omissions on one day. The log book for the other resuscitation trolley contained two months of checks. We reviewed this and found there were omissions for five days.
- During our unannounced inspection we examined the resuscitation trolley records for the period since our first inspection and found that the trolleys had been checked daily as required.
- There was a two-person check required to take blood from the bloods fridge on Evelyn ward. The blood audit and release system used in theatres had barcoded access to ensure that the correct blood product was released for the correct patient. This meant that blood products were securely stored and appropriately accessed.

Medicines

- Medicines on the oncology unit were stored securely. We saw that medicines were kept in a locked cupboard which only authorised staff had access to. The hospital used the NHS Protect medication security self-assessment to assure itself that all medicines were kept safely and securely.
- There were separate storage arrangements for both intravenous antibiotics and cytotoxic medicines. These again were kept in a locked cupboard which only authorised staff had access to.
- Room and fridge temperatures were monitored and recorded daily. We reviewed checks for June and July 2016 and saw these remained within acceptable levels. However, the fridge was not lockable but we saw from audits that a replacement fridge had been ordered.
- Controlled drugs were not kept on the oncology unit. Should controlled drugs be needed then these were accessed on the ward.
- We attended the ward to check the procedures for controlled drugs. We saw that storage arrangements were appropriate. These medicines were kept within a locked medicines cupboard within a locked room.
- We undertook checks for four controlled drugs and saw that the stock available matched that which was detailed in the controlled drugs book.
- The hospital policy stated that controlled drugs should be checked twice daily by two members of staff. During the two months prior to our inspection we found five occasions (3, 15, 27 and 30 June 2016 and 2 July 2016) where no checking of controlled drugs had taken place. This meant the hospital was not ensuring the safe management of controlled drugs in line with government legislation at the time of our inspection. However, during the unannounced inspection we checked the controlled drugs book and found that this was being checked twice daily as required by policy.
- The service had access to the hospital's pharmacy team who undertook audits on controlled drugs. We reviewed the most recent controlled drug audit for the ward dated May 2016 and saw that for the period of January to March 2016, there were no incidents where controlled drugs had not been checked.
- The hospital monitored medication safety through use of the Medication Safety Thermometer; a measurement tool for improvement that focuses on medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines.
- We reviewed data from January until April 2016. Early data, from January 2016, demonstrated that improvements to the medication processes were required. For example, we found that only 16.7% of patients had their medicines reconciled (checking of medicines on admission to ensure that the correct medicines are given during the patient's hospital stay)

and 14.3% of patients were not administered a critical medicine when this was needed. April 2016 data demonstrated improvements had been made with 100% of patients receiving critical medications and 72.7% had their medicine reconciled.

Records

- Records were easily accessible within lockable cupboards either behind reception or in the nursing office. We reviewed six sets of patient records on the oncology unit during the inspection.
- Specific oncology care bundles were in place (sets of interventions that, when used together, improve patient outcomes). We saw these complete in each record we reviewed.
- Nursing records, including risk assessments were completed in full as needed and plans of care were clearly documented. However, we noted on the ward, where one oncology patient was being cared for, that cannulation records were not always completed.
- Consultant notes were present and legible within the patient record.
- However, on one occasion we found that information relating to the prescribing of medicines was not present in the patient's record when it should have been. This was escalated to the management team during our inspection.

Safeguarding

- The hospital had appropriate procedures to deal with safeguarding concerns. We saw that a localised procedure had been developed which provided staff with relevant internal and external contact numbers.
- Staff received regular safeguarding training. As at May 2016 88% of staff had undertaken their annual safeguarding children level one training and 100% had undertaken level one adult safeguarding training. This was against a quarterly target of 85%. For safeguarding level two training for both adults and children the records showed that 100% of staff had completed this training.
- Senior management, such as the matron and hospital director, were trained to level three safeguarding as were the resident medical officers (RMOs).
- All staff we spoke with were aware of their responsibilities to raise safeguarding concerns and provided examples of situations in which this might occur.
- From January 2015 to April 2016, no safeguarding concerns had been raised.

Mandatory training

- There was an outstanding level of compliance with mandatory training across the service.
- Mandatory training included health, safety and welfare (100%), consent training (100%), fire safety (100%), record keeping (100%), manual handling (100%) and information governance (88%).
- The service was not meeting its target for the number of staff trained in basic life support (BLS) and intermediate life support (ILS) training. Overall 75% of staff were trained in BLS against a target of 85% and 71% of staff were trained in ILS against a target of 85%. All staff were booked on training sessions due to take place at local NHS trusts this year.

Assessing and responding to patient risk

- In order to assess a patient's risk factor and provide appropriate interventions during treatment we saw that the administration pathway included pre-treatment checks and risk assessments including the taking of recent medical history, venous thromboembolism (VTE) assessments and observations such as temperature, pain or discomfort and side effects during treatment.
- The service also used the UK Oncology Nursing Service (UKONS) 24 hour triage rapid assessment and access toolkit. This toolkit was designed to ensure that patient's received robust and reliable assessment every time they contacted the services helpline. This system was monitored on a monthly basis and outcomes were submitted to the clinical governance committee.
- The service also used a Modified Early Warning System (MEWS) whilst people were undergoing treatment. This is a scoring system based on a set of observations such as blood pressure, heart and respiratory rate and when combined produces a score, which indicates if a patient, is becoming seriously unwell.
- The service had an agreed transfer policy and pathway in place in the event of a patient medical emergency. Patients would be sent to one of two nearby hospitals in the Cambridge area. We reviewed the policy and agreement, which supported what we were told.
- The service has not had to transfer any patients out recently, but staff on the ward were able to clearly demonstrate the process should they need to commence an emergency transfer.

Outstanding ☆

Medical care

Nursing staffing

- Seven specialist cancer nurses were employed by the hospital, which met the service's planned establishment.
- Staffing was planned in advance depending on capacity with a minimum of three registered nurses on every shift.
- A handover took place daily at 7:30am. This was done from a handover sheet, which had been completed by the nursing team working the previous shift.
- There was no bank or agency staff use within this service.

Medical staffing

- At the time of our inspection, there were 255 doctors or dentists working at the hospital under practicing privileges.
- There was a resident medical officer (RMO) at the hospital 24 hours a day, seven days a week. The RMO's worked seven 24 hour shifts in a row, with facilities on site for them to sleep over night.
- Individual consultants responsible for patients were contactable whilst the patient was receiving treatment. The RMO was aware of how to contact consultants.

Major incident awareness and training

- There was an internal emergency incident and business continuity plan in place which described actions to be taken in the event of fire, flooding, loss of power or infection outbreaks.
- Table top training exercises were conducted at the hospital during team briefs to ensure staff could action the procedures detailed within the major incident plan.

Are medical care services effective?

Good

We rated medical care services as good for effective because:

- Policies and procedures were developed using relevant national best practice guidance.
- Suitable arrangements were in place to manage patients' pain.
- Patients had access to appropriate nutrition and hydration.
- Staff were supported with learning and development to ensure they were competent in their role.
- Staff were aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- Auditing the effectiveness of pain relief did not take place.
- There was limited opportunity for the service to assess its effectiveness and make improvements because the 2016 audit plan only contained four audits.
- Oncology nurses did not work seven days a week, which meant patients being cared for on the ward during the weekend, did not have access to specialist nursing.

Evidence-based care and treatment

- Hospital policies and procedures were developed nationally by Nuffield and took account of relevant best practice guidance including that issued by the National Institute for Clinical Excellence (NICE), the Department of Health and relevant royal colleges such as The Royal College of Nursing (RCN).
- Recently issued NICE Guidance was taken into account in the running of the service. This included 'NG36: Cancer of the upper digestive tract' and 'NG35 Meyloma diagnosis and management'. We noted that hospital policies were in the process of being reviewed by the oncology manager to determine if any change to practice was needed.
- The service had received Macmillan Accreditation in 2014 and was going forward for this accreditation again in 2016. This was due to the fact that the service had been relocated to a new building, and the service was confident of a higher level of achievement for the next award.

Pain relief

- All patients had their level of pain assessed prior to commencement of each cancer treatment. This was done using a five stage grading system.
- Should a patient's pain be graded high then nurses would take action to provide advice to the patient or refer them back to the consultant for a pain review.
- Auditing was not undertaken at this hospital to assess the effectiveness of pain relief.

Nutrition and hydration

- The waiting areas of the oncology unit had cold and hot drinks making facilities. Although at the time of our inspection, the hot drinks machine could not be utilised due to on-going building work.
- Patients were offered a choice of meals if their treatment was being administered during a mealtime.
- All patients receiving chemotherapy had regular screening for malnutrition and weight loss, the service recorded this using the Malnutrition Universal Screening Tool (MUST).
- Nutritional supplements, if required, were prescribed by the consultants and should further intervention be required then nutritional advice was available to patients through referral to a dietician.
- Specialist nutritional advice was also provided as part of the hospital's integrated cancer rehabilitation programme, which has been described in detail under the responsive section of this this report.

Patient outcomes

- We reviewed a copy of the hospital's 2016 audit plan and noted there were only four audits identified for the oncology service. This meant there was little opportunity for the service to assess its effectiveness and make improvements to benefit patients.
- However, the service had undertaken a full review of the service in relation to the national cancer strategy and an action plan had been put in place. This meant improvements were taking place to ensure patients received care in line with national best practice which would promote improved outcomes.
- Patient outcomes were also planned to be monitored as part of the integrated cancer rehabilitation programme (described in detail within the responsiveness section of this report). The Manchester Metropolitan University were due to undertake regular service evaluation to assess the long term health benefits of this initiative.
- The information, both qualitative and quantitative provided to us was very positive in terms of outcomes for patients. The rehabilitation programme which offered exercise and nutrition programmes to people with cancer had showed a correlation of improvement in the outcome of the patient when exercise and nutritional management is added into their rehabilitation.
- The service was not taking part in national audits in relation to oncology.

Competent staff

- The matron monitored nursing revalidation to ensure that staff renewed their professional registration every three years and demonstrated effective and safe practice.
- All staff received an induction prior to commencing work at the hospital.
- Staff had access to learning and development courses such as advance communication and clinical study days to support them in their roles. Nurses were also encouraged and supported to undertake academic qualifications. For example, one member of staff was undertaking a Bachelor of Science (BSc) qualification in haematology and another was undertaking their Master's (MSc) in cancer.
- We spoke with two members of staff who confirmed that they were regularly competency assessed in areas such as chemotherapy administration, equipment use and the insertion of cannulas.
- Clinical supervision was available to staff who requested this.
- Of the nurses working for the oncology service and the ward, 100% had been appraised within the last year.
- There was a robust procedure in place for the granting and monitoring of practising privileges for consultants. This was overseen by the medical advisory committee. All consultants practising at this hospital were required to submit a copy of their annual appraisal and evidence of General Medical Council (GMC) revalidation was required as part of ensuring they maintained practising privileges at the hospital.
- Over the last 12 months the hospital have removed 14 doctors practicing privileges and four had their practicing privileges (PPs) suspended. Of those, two had relinquished PPs, one doctor moved away from the area, two did not submit sufficient documentation to maintain PPs, one returned. The final eight were removed for not working at the hospital for two years or more.

Multidisciplinary working (in relation to this core service)

- Hospital staff engaged externally with three NHS trusts across Cambridgeshire and Peterborough as all patients were discussed at the disease specific multidisciplinary team (MDT) meetings held at these trusts.

Medical care

- The purpose of these meetings (attended by a group of health professionals with expert knowledge in specific types of cancer) were to regularly review patient's clinical conditions, assess the adequacy of treatment and discuss any further interventions which may benefit the patient.
- An internal MDT was held only in relation to breast cancers. Surgeons, oncologists and nursing staff attended these meetings to plan and co-ordinate the care of patients.
- The oncology nursing team provided support and guidance to staff on the ward so that they could care appropriately for oncology in-patients.

Seven-day services

- This service did not operate as a seven-day service. Treatment was usually provided Monday through to Friday 8am to 6:30pm. However, we were told that the service was flexible and opened outside of these hours depending on demand and individual treatment regimes. One patient confirmed this, and they told us, "Sometimes I have to stay late and I am never made to feel bad."
- At the time of our inspection, work was being undertaken to assess the need for a seven-day service whereby an oncology nurse could be present seven days a week to assist oncology patients who were being nursed as in-patients.
- High dose chemotherapy was administered on the in-patient ward by chemotherapy nurses seven days a week.
- The in-patient ward was supported by a resident medical officer (RMO) 24 hours a day.
- There was a 24-hour telephone service available to all current patients for advice and support.

Access to information

- Nursing and medical documentation was easily accessible within a secured room in the oncology unit. Staff we spoke with told us that when information was needed it was readily available.
- Records for the hospital patients overall were stored on site in a secure records storage room, which made them accessible for the staff at all times.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards

- Nursing staff we spoke with had a good understanding of consent and when consent was required. For example, implied or verbal consent was sought at the start of each treatment episode.
- We reviewed six patient records and saw, in each case, that consent forms were complete and legible. Risks and benefits were discussed with patients and clearly documented on the consent forms.
- MCA and Deprivation of Liberty Safeguards training was provided to staff. At the time of our inspection training compliance was at 100%.
- We spoke with two members of nursing staff who both demonstrated a good understanding of the requirements of the MCA. They were aware of the assessment criteria needed to assess if someone had capacity and understood the decision making processes for people lacking capacity to be in their best interests.

Are medical care services caring?

Outstanding ☆

We rated medical care services as outstanding for caring because:

- We heard directly from four patients who all reported positive experiences. Patients were extremely positive about the care they received and felt the service was "Amazing".
- Friends and Family Test data showed a high percentage of patients would recommend this service (between 91 and 100%).
- People had their privacy and dignity maintained at all times. Staff were polite, introduced themselves and made an honest effort to understand the needs of people.
- Patients were listened to and actively involved in their care and treatment. Comments from compliment cards included "I am so grateful and could not have got through my chemotherapy course without your kindness, understanding and professional advice."
- All patients we engaged with felt well informed and included in the entire decision making process in relation to their care and treatment. For example, one patient told us, "I have been involved in the decisions relating to my treatment".
- There was a best practice emotional, social and physical support service on site at the unit called Maggie's

Wallace (Maggie's). Maggie's is a free support service provided to people living with cancer and their families. It offers access to professional advice and support, meeting other people living with cancer and attendance at wellbeing courses such as managing stress, expressive art and creative writing.

- There were also courses specifically designed for family members, which included 'kids days', which offered the chance for young people whose parents had cancer to find support and answers, and a 6-week friends and family course for anyone caring for a person who has cancer.

Compassionate Care

- Throughout our inspection, we observed care being provided by nursing staff. We saw examples of staff being friendly, approachable and professional. We witnessed people being spoken to with respect at all times.
- We saw people's privacy and dignity was maintained at all times with the use of privacy curtains.
- We spoke with four patients during our inspection, reviewed 10 compliment cards and recent patient satisfaction survey results. Feedback was overwhelmingly positive.
- One patient told us that the staff were, "Amazing" and that they could not fault any aspect of their care. Another patient said, "I feel safe here, everyone is accessible".
- A third patient commented, "[Nurse] is brilliant – she knows just how to talk to me, when to be funny and when to back off".
- A patient who responded to the patient satisfaction survey in April 2016, stated, "I was regularly asked how I experienced individual treatments, my comfort, my meals and my pain control." Another patient commented, "The hospital is well run and welcoming. I always felt cared for and nothing ever seemed too much trouble for the staff. The staff are efficient and professional and the service provided is first class. I received excellent care from the nurses and other staff in the oncology unit and cannot praise them highly enough. A positive experience at a very difficult time".
- Comments from compliment cards included "I am so grateful and could not have got through my chemotherapy course without your kindness, understanding and professional advice." Another patient stated, "You [Staff] may think you are doing a job but for us patients you are literally a life line".
- Friends and Family Test (FFT) results for the period December 2015 to May 2016 demonstrated 100% of patients would recommend the hospital for every month with the exception of March 2016 when the result was 91%.

Understanding and involvement of patients and those close to them

- All patients we engaged with felt well informed and included in the entire decision making process in relation to their care and treatment. For example, one patient told us, "I have been involved in the decisions relating to my treatment" and another stated, "I have been very well informed – nothing has come as a surprise".
- We reviewed a patient satisfaction survey and again responses were overwhelmingly positive with patients confirming they had been provided with written and other information about different cancers, treatments and support that was available in the facility. We saw that a wide range of patient information leaflets were available to patients accessing this service.
- Comments from the survey included, "The Nuffield is a warm caring place. Staff are friendly from the reception staff up. People treat you with kindness and empathy always answering questions with honesty. The oncology team are an asset to the hospital" and, "I have received personal and individual attention".
- Patients were given written information about different ways to contact the facility and its staff, including consultants, during and outside of normal opening hours.

Emotional support

- Patients we engaged with told us staff were kind and considerate to them and their families during their visit to the hospital. For example, one patient stated, "[The nurse] helped me enormously by bringing my children to the unit and explaining to them why I have to have it [chemotherapy] and how it is given which took out all of the mystery [for them]". Another patient said, "I have been provided with information on where I may access support."

Medical care

- Staff we spoke with were aware of the emotional impact that having cancer could have on people. Staff gave us examples of how they would support patients, which included making time to sit, and talk with them and following up on their welfare the day after treatment.
- There was a best practice emotional, social and physical support service on site at the unit called Maggie's Wallace (Maggie's). Maggie's is a free support service provided to people living with cancer and their families. It offers access to professional advice and support, meeting other people living with cancer and attendance at wellbeing courses such as managing stress, expressive art and creative writing.
- There were also courses specifically designed for family members, which included 'kids days', which offered the chance for young people whose parents had cancer to find support and answers, and a 6-week friends and family course for anyone caring for a person who has cancer.
- There was a dedicated Maggie's room within the oncology unit, which offered patients a quiet place to sit and displayed information about the support offered. A dedicated Maggie's support worker was available on site two days per week.
- Counselling and mindfulness sessions were offered to patients, at cost, as part of their treatment options.

Are medical care services responsive?

Good

We rated medical care services as good for responsive because:

- The service was planned and delivered to meet the needs of the patient groups it served.
- Access to the service was straightforward and timely.
- Patient flow was seamless and without delay.
- Systems and processes were in place to ensure patients' individual needs were met. This included the outstanding initiative to support patients following their treatment with a 12 week integrated cancer rehabilitation programme.
- The service had received no complaints in the six months preceding our inspection but there were clear systems in place so that, should a complaint be received, learning could take place.

However:

- There was no formal transition arrangements for patients moving through their cancer pathway to be transitioned back into NHS care for the end of their life.

Service planning and delivery to meet the needs of local people

- The Nuffield Cambridge was a private hospital, which provided oncology to self-funding or medically insured patients. Due to the private business set up, the hospital could provide flexibility and choice to patients choosing to undergo their treatment at the hospital.
- The hospital provided only private oncology care to patients, and no NHS oncology care was provided by the service.

Access and flow

- Patients could access the service in a variety of ways, which included self-referral or GP referral following suspected or diagnosed cancer.
- Patients were seen in outpatient clinics by their consultant to discuss and agree on diagnostic and treatment options.
- Patients who had been diagnosed with cancer and wanted to be treated at the Nuffield Health Cambridge Hospital waited no longer than two weeks for their first appointment. Data provided by the service showed that the average wait for an appointment for oncology was 10 days. The wait was recorded as between one and 30 days in all cases. Where patients had to wait up to 30 days this was due to clinical recommendations that the patient waits to start their treatment after surgery.
- Data provided also showed that there was a rapid access system for people requiring chemotherapy. The timeframes provided showed that a patient could be seen at Nuffield Health Cambridge Hospital for chemotherapy within 48 to 72 hours after referral. This meant that the service was very responsive.
- Where surgery was decided as part of a patient's treatment plan surgeons and oncologists worked together to provide consistency in care. This meant that following surgery oncologists could act quickly to provide any further treatment.
- Where appropriate, there was access to diagnostic and imaging services and patients were offered these services in a timely manner in order for their treatment plan to be started.

- There were clear pre-admission systems for surgery and a nurse-led pre-treatment service.
- There was no delay in patients accessing chemotherapy and the service worked flexibly to ensure people's treatment regimens happened as planned.
- Discharge arrangements were in place, which included referral to NHS services or the patient's GP.

Meeting people's individual needs

- Holistic needs assessments were carried for all patients at regular intervals throughout their treatment pathway and care planning. This meant that their needs were continually reassessed so that signposting or referral for specialist input could be made.
- The hospital had developed a 'Recovery Plus Programme' and patients were benefiting from an integrated cancer rehabilitation programme as part of this initiative. Patients were offered a 12-week programme at a local Nuffield Gym, which was supported by fitness instructors who had received specialist oncology training. The purpose of the programme was to improve quality of life by improving physical function, psychological and social wellbeing. The aim was to alleviate side-effects from cancer and its treatments (chemotherapy, radiotherapy), such as fatigue, insomnia, breathlessness, depression, lymphoedema and to help prevent risk of disease reoccurrence or development of another cancer. This programme met the recommendations from the National Cancer Survivorship Initiative, which stated that people living with and beyond cancer should have access to physical activity interventions.
- The oncology unit was accessible. Lifts and ramps were available where appropriate to assist with people's physical disabilities.
- We spoke with three members of the nursing team who were aware of people's social needs and we were told that every effort was made to find services that could support patients in the community if that need was identified whilst the patient was using the service. However, we were told that the coordinating of these services could be problematic because there was no central point of contact, which meant nursing staff often had to spend time looking up information themselves.

Palliative Care

- At the time of our inspection, the hospital did not provide a dedicated end of life service. This was due to restrictions with insurance schemes for patients. However, should a patient who had received their care and treatment at the Nuffield express their preferred place of care to be the hospital, then this was catered for with the support of trained nursing staff.
- The hospital routinely spoke with patients about their expressed wishes following a terminal diagnosis, this included preferred place of care and death. We were provided examples of when a patient had preferred to die at the hospital and the service worked to ensure that this could be provided for the patient where possible. The service was able to demonstrate that they went above and beyond to try and accommodate patient wishes despite financial restrictions in place.
- There were links with the local Arthur Rank Hospice and the Macmillan At Home Team to support patients at the end of their lives. A member of the nursing team had been to the local hospice in order to learn and improve the way in which the hospital worked.
- The teams of nurses from the community and the hospice would routinely be invited in to meet the patients and be involved in their care in the lead up prior to the patient going back into NHS care. However, there was no formal transition plan, pathway or arrangement in place for this.
- However, we spoke with three members of staff who stated that the systems in place for transitioning people from this service to end of life services could be improved. This was recognised by the hospital management team. Whilst the hospital did not provide end of life care there was in formal service level agreement (SLA) in place for the transition of patients from private back to NHS, which could be improved.
- The hospital did not employ (through practicing privileges) a palliative care consultant. This meant that often patients at the end of their lives, who had built relationships with the medical team at the local NHS hospital, would be discharged to the NHS palliative care team and be cared for by nursing staff they did not know. Palliative care advice and support was however available from the local NHS Trust and the hospice if required for an inpatient.
- The service reported good links with the palliative care team at the NHS trust and with the hospice, and tried to

engage them at the earliest opportunity to support patients. However, it was reported that patients would benefit from more planned care as their terminal disease progressed.
- We discussed this with the manager of the oncology unit and saw that work was in progress to update the hospital's end of life policy to ensure it met national best practice guidance and consideration was being given to the initiation of a full end of life service.

Learning from complaints and concerns

- There was a complaints procedure in place at the hospital, accessible to both staff and patients.
- Complaints were thoroughly investigated and complainants were responded to by members of the senior management team within defined timescales. Complainants were offered face to face to meetings to discuss the outcome of complaint investigations.
- In order to identify learning opportunities complaints were reviewed and discussed on a monthly basis at the hospital board meeting and heads of department (HoDS) meetings and on a quarterly basis at the medical advisory committee and clinical governance meetings
- Consultant specific complaints were discussed at the medical advisory committee.
- There had been no oncology specific complaints in the six months preceding our inspection. However we noted from oncology team minutes from April, May and June 2016 that there was a specific agenda item to discuss any complaints that may be received by the service.

Are medical care services well-led?

Outstanding ☆

We rated medical care services as outstanding for well-led because:

- The hospital had a clear vision and staff were aware of this. The hospital's local vision was to become the, "Private Hospital of Choice".
- There was an effective and robust governance structure and learning and improvement was evident.
- The hospital was well supported by an active medical advisory committee. The Chair of the MAC was proactive and engaged with the service and had a good working relationship with the senior management team. The vision of all was to drive improvement in patient care through robust and effective processes.
- The local oncology leadership team were accessible and staff told us that they were approachable. We observed that the managers were very knowledgeable about the service, where their risks were and how they planned to improve their service.
- The hospital was managed by a dedicated and proactive senior leadership team. Staff told us how the hospital director and matron were routinely visible and approachable, willing to listen and open to ideas on how to improve the service.
- The leadership team of all levels were proactive and looked for opportunities to improve patient care.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.

Vision and strategy for this this core service

- The national Nuffield vision was to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner'.
- As a not for profit organisation in addition to this vision the hospital also worked to fulfil its charitable purpose which was "to advance, promote and maintain health and healthcare of all descriptions and to prevent, relieve and cure sickness and ill health of any kind, all for the public benefit."
- The hospital's local vision was to become the, "Private Hospital of Choice". The service was aiming to maintain its private hospital atmosphere while also making a contribution to NHS patient lists and leaders told us about increasing their work in conjunction with other local and community services.
- We spoke with two members of staff about the vision and strategy and there was an understanding of the goals and values of the hospital and how it had set out to achieve them.

Medical care

Governance, risk management and quality measurement for this core service

- The service had a robust structured process in place for the medical advisory committee (MAC). We reviewed the meeting minutes of meetings held in January and April 2016. These were detailed, comprehensive and covered all services within the hospital Topics discussed included risk, practicing privileges, quality dashboards and visions for the future.
- We spoke with the hospital director and MAC chair about the process of the committee and sign off. Both were articulate about the running of the service and MAC and had a clear understanding about the quality of service to be provided.
- Practicing privileges were routinely discussed as part of the MAC. Privileges are to be renewed and reviewed every three years as a minimum. There were 255 consultants on practicing privileges at the hospital and all privilege renewals would be discussed at MAC, as well as new appointments. Examples of where consultants had not adhered to requirements or fallen below the expected standards of behaviour were provided and practicing privileges were removed.
- We reviewed the risk register for the service dated April 2016. Four of these risks were rated as moderate and the remaining six were rated as low risks. Of the risks that were listed, three were related to medical services. There was clear detail recorded and plans for the service to mitigate risks. For example, contractual arrangements of oncology medicines and the cost of products. There were clear business parameters on this risk and what the impact would be, and how the service would manage the risk going forward with the price increase.
- We also reviewed risk registers completed in May and September 2015. We could see clear progression and monitoring of risks, with detailed updates and actions taken to mitigate risks where possible. This included clear reasons to downgraded and closed risks on the register. The risk register and risk management process for the service was outstanding.
- The risk register was a standard agenda item on the senior team meeting agenda, and risks were discussed at the clinical governance meeting and head of department meetings. We saw minutes of these meetings, which took place during 2016, which demonstrated that risk was a focal point for the leadership team.
- Locally, the service reported into the governance framework by completing monthly reports, which were submitted to the governance committee. We reviewed these reports from April, May and June 2016 and saw that relevant service information such as incidents, audit outcomes and health and safety information was reported for scrutiny.
- The medical advisory committee received a quarterly update on the performance of the oncology service. An oncologist was a member of the medical advisory committee, which meant there was good oversight of the service at senior level to ensure appropriate challenge and direction.

Leadership and culture of service

- The local oncology leadership team were accessible and staff told us that they were approachable. We observed that the managers were very knowledgeable about the service, where their risks were and how they planned to improve their service.
- The hospital was managed by a dedicated and proactive leadership team. Staff told us how the hospital director and matron were routinely visible and approachable.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.
- Locally the service was supported by a dedicated and proactive manager who worked to continually improve the service.

Public and staff engagement

- The service had developed a patient focus group where patients were invited to a meeting to discuss the running of the hospital. We reviewed minutes from the June 2016 patient focus group and noted patients had been engaged on areas such as discharge, waiting times and catering. This initiative was new to the hospital so we could not test how improvements following these meetings were implemented.

- The hospital matron and hospital director informed us about the variety of ways that they had worked to engage the public to attend or provide feedback, but were struggling to get engagement with this.
- However, there was evidence of actions taken from this patient engagement; for example, one patient explained how he attended the hospital on the same day every week and the hospital had the same weekly menu so he was always given the same lunchtime meal. Service leads told us how they had not considered how food could be a key, "motivating factor" for patients undergoing long-term treatment so changed the menu patterns to ensure variety of meal options available for patients.
- The service was actively trying to engage more staff in the investigation and root cause analysis process when incidents occurred to encourage shared learning from and responsibility for these actions. However, the service leaders told us that it had been challenging to encourage staff to become more involved.
- Heads of department had been involved in the design of the new site, which had recently been completed.

Innovation, improvement and sustainability

- The service was developing its staff, by allocating nurses to specific clinics and supporting learning, so that there could be more specialist knowledge and input into patient care.
- The oncology manager was developing ways in which to advertise the oncology unit better so that more patients could benefit from the services offered.
- Consideration was being given to expanding the integrated cancer rehabilitation programme to include surgical and outpatient specialities.

Outstanding ☆

Surgery

Safe	Good ●
Effective	Outstanding ☆
Caring	Good ●
Responsive	Good ●
Well-led	Outstanding ☆

Information about the service

A range of surgical services is provided by Nuffield Health Cambridge including orthopaedics and ear, nose and throat surgeries.

Surgical patients are admitted to the hospital's 34 bedded Evelyn ward, and operated on in one of the four operating theatres. For the period April 2015 to March 2016, 3,173 patients had received surgical treatment in the hospital. After endoscopic procedures, knee arthroscopic procedures were the most commonly performed surgeries at the hospital.

During our inspection we visited Evelyn ward, two anaesthetic rooms, theatres one and two, and theatres recovery. We spoke with 10 members of nursing staff including healthcare assistants, operating department practitioners, registered nurses and nurse managers. We spoke with two patients, and reviewed eight sets of medical records. Throughout our inspection we interviewed patients and staff, reviewed documentation, and observed the environment and the care provided.

Summary of findings

Surgery services at Nuffield Health Cambridge were rated as outstanding overall, with safe, caring and responsive rated as good. Effective and well led were rated as outstanding because:

- Staff knew how to report incidents. Incidents were investigated and learning shared from heads of department meetings to team brief meetings.
- Infection control practice was in line with hospital policy and was regularly audited. Audits showed the service to be compliant with infection control practices.
- Equipment required to provide safe care was regularly safety checked and serviced. However, omissions were noted in daily and weekly resuscitation trolley checks on Evelyn ward.
- Substantive staff were consistently compliant with mandatory training targets, although bank staff were failing to meet the mandatory training targets. However, the hospital was proactive in finding solutions and managing the risk to the service and its patients. The hospital managed nursing staffing so that there were enough staff to provide safe care.
- There was access to consultants both in working hours and out of hours in the event of a patient deteriorating, with the additional support of a resident medical officer if more urgent support was required.
- The service had a comprehensive audit plan in place to assess the provision of care.

Outstanding ☆

Surgery

- The audit plan included audits against the hospital's own policies and standard operating procedures as well as some national audit activity. Outcomes on these audits were outstanding.
- Patients received pre-loading of pain relief where clinically appropriate, and in cases where additional pain relief was required beyond what was expected, the resident medical officer was available to prescribe in the absence of the consultant.
- The service scored highly in the Friends and Family Test, and response rates to the survey were high. Patient feedback during our inspection was very positive and patients felt informed and involved in their own care.
- As a service the Nuffield Health Cambridge Hospital performed in the top 10 of all Nuffield hospitals for positive patient feedback and satisfaction.
- Patients were consistently treated within 18 weeks of referral. Discharge planning was commenced before patients were admitted to the hospital, and involved information sharing between the hospital, community care and primary care. Patients received health checks before their admission as part of their care package.
- Patients living with dementia received one to one care. Staff worked with families to support the needs of patients with learning disabilities.
- Surgery related complaint numbers were low with no identifiable trends, and learning from complaints was a regular discussion at team briefs.
- There was a structured leadership in place that was well respected by staff. Staff felt the leadership was supportive, visible, and that they listened to staff.
- There was a well established and well run medical advisory committee (MAC) in the service, as well as senior meetings and governance meetings to monitor quality.
- The leadership team locally as well as the senior management team were outstanding and demonstrated real passionate and committed leadership to delivering their service.

However:

- Bank staff were not achieving the hospital's mandatory training compliance target, although the senior management team were aware and had put plans in place to address this

Outstanding ☆

Surgery

Are surgery services safe?

Good

Safe was rated as good in surgery services because;

- All staff were fully committed to reporting incidents and near misses. The level and quality of incident reporting shows the levels of harm and near misses, which ensured a robust picture of quality. Incident reporting procedures were robust and staff understood how and when to report incidents. Staff received feedback and learning locally and hospital wide.
- A proactive approach to anticipating and managing risks to people who use services was embedded and is recognised as being the responsibility of all staff. Venous thromboembolism, falls and urinary catheter care assessment audits were consistently undertaken to a good standard.
- Infection control policies, practices and audits were robust. Audits showed that cleanliness and hygiene were being consistently maintained.
- Equipment was regularly serviced, safety checked and repaired.
- Medicines were stored and accessed securely. Audits showed compliance to the Controlled Drugs (Supervision and Management of Use) Regulations 2006.
- Substantive staff were exceeding the hospital's mandatory training target.
- Staff knew how to recognise and escalate deterioration in patients, and we saw evidence of staff preparing for potential deterioration of a patient in advance.
- Patients had access to their consultant every day that they were admitted to the hospital, including in the event of deterioration out of hours.
- Nurse staffing was planned to ensure that there were enough staff to provide safe care in both theatres and Evelyn ward.
- Evelyn ward was proactive in preparedness for emergency incidents with regular table top exercises.
- Checks of resuscitation trolleys on Evelyn ward were not consistently completed. However during our unannounced inspection we found that all required checks had been completed.
- Completion and escalation of early warning scores were low at 78% with no improvement seen in audit performance. Though the scores checked in records inspection demonstrated that scores were recorded appropriately.

However;

- Bank staff were not achieving the hospital's mandatory training compliance target, although the senior management team were aware and had put plans in place to address this.

Incidents

- All staff were open and transparent, and fully committed to reporting incidents and near misses. There was an electronic incident reporting system in use and staff understood how and when to report incidents onto this.
- The hospital reported a total of 349 incidents in the reporting period of April 2015 to March 2016, of which 177 related to the surgery service at the hospital.
- Investigations of incidents were completed by the nurse in charge and uploaded to the electronic reporting system, with learning being cascaded to staff in team brief meetings. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of quality.
- The theatre team briefs for March and April 2016 showed discussion of incidents and learning. However, the ward team brief for the same months did not show evidence of incident discussion.
- Incidents were discussed locally at ward and theatre level and at head of department meetings, MAC meetings and clinical governance meetings. Risks associated with incidents were seen as a priority and opportunities to learn and improve the service were consistently taken.
- One member of staff in theatre told us how practice had changed after a serious incident had occurred relating to a child in theatre. In July 2015, there had been one serious injury where a patient had experienced a scalp laceration from equipment used in theatre. A full root cause analysis had been conducted to identify the cause of the incident and any learning. The analysis included recommendations to prevent a reoccurrence and detail of how this learning was to be shared. The incident was also reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).

- The patient had received telephone, face to face and written communication regarding the incident. This meant that the service had investigated the serious incident thoroughly, informed the appropriate regulatory agency, developed learning to reduce the likelihood of this happening again, and had exercised its duty of candour to the patient.
- There had been no never events in the period April 2015 to March 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.
- The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. To date, the surgery department had no reported incidents which required the use of this legal duty.

Safety thermometer or equivalent

- Falls, venous thromboembolism (VTE) and urinary catheter care were assessed by the service. These assessments were regularly audited.
- VTE, falls, and urinary catheter care audit results for the period January to March 2016 showed that VTE and falls assessments were completed in 100% of cases. No patients had been catheterised in this time period so this was not audited.
- Initial VTE assessments were completed by nurses at the pre-assessment stage of care, and then each day in the VTE care plan once the patient was admitted. This meant that the risk of a VTE developing unnoticed was reduced by staff.
- Patient safety information was reported and measured through the hospital's own quality and safety dashboard. Outcomes were reported and compared nationally against other Nuffield hospitals on a quarterly basis.
- We reviewed the February 2016 dashboard and saw that out of the 17 dashboard outcomes, the hospital was meeting targets for 16. The one in which the hospital was not meeting was in relation to the Friends and Family Test for private patients. However, we would not expect the Friends and Family Test to be completed for non-NHS patients.
- We reviewed the dashboards for November 2015 and May 2016 and found that the service was consistently achieving their set targets and were comparable with outcomes in the top quartile of Nuffield hospitals in England.
- The dashboard was discussed routinely at the clinical governance meeting to identify any trends or areas of improvement. We reviewed the minutes of meetings held in January, February and March 2016 that supported the dashboard was shared and discussed in the service.

Cleanliness, infection control and hygiene

- All areas of the hospital that offered surgical services were visibly clean and well maintained.
- A daily cleaning rota and checklist was seen in the anaesthetic rooms and signatures were seen for all days that theatre lists took place on. A cleaning audit for Evelyn ward in March 2016 was also compliant.
- We saw that staff had access to personal protective equipment, such as gloves and aprons, and alcohol gel dispensers were available in all clinical areas and within patients' rooms. We observed them use it and staff were also noted to be bare below the elbows.
- All adults, except patients for upper and lower GI endoscopy and local injection procedures were screened for MRSA prior to admission to the hospital. There had been no cases of MRSA or Methicillin-susceptible Staphylococcus Aureus (MSSA) reported between April 2015 and March 2016.
- There was a policy in place for infection control including hand hygiene and MRSA screening. Hand hygiene audits were in place to monitor compliance with the policy.
- Hand hygiene audit results from February 2016 showed compliance with hand hygiene practices. Patients we spoke to reported that staff washed their hands before any care was given.
- As part of a recent hand hygiene audit, patients were given forms to record staff compliance with hand hygiene and gave positive feedback about being involved in the hospital's performance and monitoring.
- Sharps bins in theatres were all labelled. This meant that the storage and disposal of contaminated sharps was safe in accordance with the Royal College of Nursing Guidance to support the implementation of The Health and Safety (Sharp Instruments in Healthcare Regulations) 2013.

- All inpatients were cared for in individual private rooms with en-suite bathroom facilities. We saw that staff had access to personal protective equipment with dispensers available in all clinical areas and within patients' rooms.
- We saw hand gel dispensers located in all clinical areas and in patients' rooms. Sinks (compliant with the NHS standard HB09) were also available for use on the oncology unit.

Environment and equipment

- The environment was bright with most of the hospital receiving natural light. The corridors of Evelyn ward were carpeted although patient rooms were not.
- Equipment was in date and regularly safety checked. We checked 14 pieces of equipment were checked between the anaesthetic rooms and Evelyn ward. All equipment checked was within date for servicing and safety checks.
- The spinal, invasive, difficult intubation and airways trolleys in the theatres were checked weekly for stock check and cleaning schedule completeness. We reviewed 10 weeks of checks for all trolleys and found no omissions in the checks.
- The anaesthetic machines in theatres were checked daily if there was a theatre list and received annual servicing.
- Checks of the resuscitation trolleys were audited monthly and scrutinised quarterly by the resuscitation committee. The group resuscitation policy audit tool completed for the period July 2015 to December 2015 reflected that checks were not being completed 100% of the time, with the audit demonstrating compliance in 89% of cases.
- There were two adult resuscitation trolleys on Evelyn and one children's resuscitation trolley. The seal and cleaning schedule were scheduled for daily checks, and the whole trolley was scheduled for weekly checks. The log book for one trolley contained three months of checks and had omissions on one day. The log book for the other resuscitation trolley contained two months of checks. We reviewed this and found there were omissions for five days.
- During our unannounced inspection we examined the resuscitation trolley records for the period since our first inspection and found that the trolleys had been checked daily as required.
- There was a two-person check required to take blood from the bloods fridge on Evelyn ward. The blood audit and release system used in theatres had barcoded access to ensure that the correct blood product was released for the correct patient. This meant that blood products were securely stored and appropriately accessed.
- A service level agreement was set up for the provision of a medical engineering service. An engineer was on site twice weekly to service and safety check equipment, as well as respond to logged repair jobs. The ward kept the log of jobs for the engineer.
- The patients' lounge on Evelyn ward had oxygen and suction facilities should they be required.

Medicines

- Medicines were stored and accessed securely in theatres and on Evelyn ward.
- Controlled drugs were stored in a locked cupboard in theatres with one member of staff having the key to access the drugs. Controlled drugs were checked twice daily by staff in theatres. We reviewed checking books for theatres one and two with no omissions seen.
- Drugs fridges in the anaesthetic rooms were checked daily if there was a surgical list taking place in that theatre. The checking book for anaesthetic room one was reviewed and no omissions were seen.
- A pharmacist attended theatres weekly to perform medication audits. The controlled drug audits for theatres in February and May 2016 show compliance to the Controlled Drugs (Supervision and Management of Use) Regulations 2006, with the exception of cancellation, obliterations or alterations being recorded in the wrong format in the February audit. This is seen to be completed correctly in the May audit.
- Medicines security checklists for January and April 2016 in theatres showed compliance in all areas.
- We attended the ward to check the procedures for controlled drugs. We saw that storage arrangements were appropriate. These medicines were kept within a locked medicines cupboard within a locked room.
- We undertook checks for four controlled drugs and saw that the stock available matched that which was detailed in the controlled drugs book.
- The hospital policy stated that controlled drugs should be checked twice daily by two members of staff. During the two months prior to our inspection we found five occasions (3, 15, 27 and 30 June 2016 and 2 July 2016) where no checking of controlled drugs had taken place. This meant the hospital was not ensuring the safe

management of controlled drugs in line with government legislation at the time of our inspection. However, during the unannounced inspection we checked the controlled drugs book and found that this was being checked twice daily as required by policy.
- The service had access to the hospital's pharmacy team who undertook audits on controlled drugs. We reviewed the most recent controlled drug audit for the ward dated May 2016 and saw that for the period of January to March 2016, there were no incidents where controlled drugs had not been checked.
- The hospital monitored medication safety through use of the Medication Safety Thermometer; a measurement tool for improvement that focuses on medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines.
- We reviewed data from January until April 2016. Early data, from January 2016, demonstrated that improvements to the medication processes were required. For example, we found that only 16.7% of patients had their medicines reconciled (checking of medicines on admission to ensure that the correct medicines are given during the patient's hospital stay) and 14.3% of patients were not administered a critical medicine when this was needed. April 2016 data demonstrated improvements had been made with 100% of patients receiving critical medications and 72.7% had their medicine reconciled.

Records

- Records were stored securely on Evelyn ward in a locked office.
- Eight sets of records were reviewed on Evelyn ward. All records had appropriate documentation of consent and evidence of consultant review. Falls assessments were completed in all records. Observations were recorded clearly and we could see which nurse had taken the observation. One set of records was missing the designation of a doctor after their signature, and one set of records was missing a completed falls assessment.
- Patient records were audited as part of the service's local audit programme. We reviewed the records audit results for the period January 2016 to March 2016 and saw that out of 30 records audited, 94% of them were compliant with the 11 part audit. This was an improvement since a previous audit in the period April 2015 to June 2015 when the score was 91%.

Safeguarding

- Staff across the service knew how to respond to safeguarding concerns. Their first port of call was the theatre or ward manager and there was a process flowchart available in both theatres and on the ward for staff to follow. Flowcharts were also in place to guide staff in making a PREVENT, or counter terrorism, referral.
- The safeguarding vulnerable adults lead was the matron. Staff were able to identify the matron as the safeguarding lead.
- Mandatory safeguarding training included education on female genital mutilation (FGM). Safeguarding vulnerable adults level one was an e-learning module, with 86% of substantive staff being compliant to the hospital's target of 85% for completing safeguarding vulnerable adults level one training. Of the bank staff employed 81% had received safeguarding level one training. Compliance with safeguarding children and young adults level one and two was at 96% and 100% respectively for theatre staff. Out of ward staff, 94% and 100% of staff had received this training.

Mandatory training

- The hospital's target for mandatory training compliance was 85% and above.
- At the time of our inspection in July 2016, 91% of permanent staff were compliant to the hospital's mandatory training modules of incident reporting, fire safety, health, safety and welfare, managing stress and whistleblowing. Bank staff did not reach the target compliance for these modules, with 79% completing the training.
- Bank staff did not achieve compliance to the mandatory training modules of basic life support, infection prevention, information governance, and safeguarding children and young adults and vulnerable adults level one, with 67% completing training.
- The hospital had given bank staff access to an online portal to access mandatory training, as well as accepting proof of mandatory training compliance from bank staff's permanent employers. Work was being undertaken at the time of our inspection to strengthen the sharing of information between other providers and the hospital.
- On the ward we were told that two members of bank staff had been told that if they did not complete their mandatory training they would not be booked to come

back until they were compliant with mandatory training. A bank operating department practitioner (ODP) told us that they had to be compliant with mandatory training or they would be told to leave.

Assessing and responding to patient risk

- An early warning scoring system was in use across the service. This meant that staff had a process to monitor patients and recognise the early stages of deterioration. The use of the early warning scoring system was audited regularly as part of the hospital's local audit programme.
- We reviewed the audit results for the period January 2016 to March 2016, which showed that early warning scores were being appropriately recorded and escalated in 78% of cases. The audit included actions for improvement with a named lead for those actions. A previous audit for the period April 2015 to June 2015 showed a performance of 79%.
- Recent audit data from April 2016 to June 2016 revealed that early warning scores were appropriately recorded and escalated in 91% of cases showing improvement from the previous quarter.
- Of the eight records we examined, the early earning scores were appropriately calculated.
- Staff knew how to escalate concerns for deteriorating patients. Nursing staff had access to support from the ward manager and the matron. The consultant in charge of a patient's care would be contacted if they were not on site. The resident medical officer for the hospital was available to respond to deterioration in the absence of a consultant.
- Five steps to safer surgery checklists were completed and stored in patient records. Observational and documentation audits of the safer surgery checklists were completed regularly. Audits for the period January 2016 to March 2016 showed that checklists were completed 100% of the time for both documentation and observational audits. For the period March 2015 to June 2015 the observational audit showed performance of 100% and the documentation audit showed performance of 97%. This indicates audit improvement over the period March 2015 to March 2016.
- We observed the safer surgery checklist being undertaken in theatre and all safer surgery steps were being undertaken including a debrief stage.
- For the period April 2015 to March 2016 there were 11 cases of unplanned transfer of an inpatient to another provider. This was not an outlier in comparison to other independent healthcare acute providers, and was a known risk with the types of surgery procedures being undertaken.
- Wound healing problems identified in the tissue viability clinic were reported to the consultant by telephone call or via calling their secretary. This meant that there was a process for the escalation of deteriorating healing and wounds in discharged patients.
- Blood audit and release system scenarios were practiced weekly to ensure that staff could access and use the system properly in times of patients requiring urgent blood products.
- On the day of our inspection, the different life support competencies of each member of staff working in the operating theatre had been written on the theatre display board in anticipation of a child due for surgery. This meant that the staff were prepared in the event of deterioration requiring life support.

Nursing staffing

- On 1 April 2016, the staffing absolute numbers for theatres were 13 operating department practitioners (ODP's) and healthcare assistants (HCA's) and 10 theatre nurses.
- For the period April 2015 to March 2016, the use of bank and agency registered nursing staff was below the independent healthcare acute provider average for 10 out of the 12 months. For the same period the use of bank and agency ODP and HCA's was below the average for 11 out of the 12 months reported. This was reflected by two HCA's in theatre telling us they felt there was enough HCA's to provide good, safe care.
- Staffing levels were reviewed twice daily and a monthly departmental staffing review took place with the senior management team.
- On the day of our inspection there were 13 patients admitted to the hospital. There were three staff nurses and one healthcare assistant staffing the ward along with a ward manager. This meant the ward was working to approximately one nurse to every four patients, which was in line with the Royal College of Nursing Mandatory Nurse Staffing Levels policy briefing of March 2012.
- A safer staffing tool was being piloted at the time of our inspection; however we were unable to assess the effectiveness of the tool.

Surgery

- The turnover rate for nursing staff on Evelyn ward was average compared to other independent healthcare providers for the period April 2015 to March 2016.
- For the same period in theatres, the turnover of nursing staff was 33% which was higher than other independent healthcare providers. However, there had been no agency staff usage in theatres the year prior to our inspection. The small numbers of nursing staff in theatres meant that even if one staff member left, the percentage of staff leaving would appear high.
- Inpatient vacancies for nursing staff were 15% which equated to 4.5 full time equivalent (FTE) posts. The matron told us that the vacancies were two FTE at the time of our inspection, meaning that the equivalent of 2.5 FTE had been recruited to since we received that data. A business case to fill the remaining vacancies was in development, with the aim to have one regular agency nurse on Evelyn ward until the post was recruited to.
- There was a vacancy rate of 9% for nursing staff and 7% for ODP's and HCA's respectively in theatres. This equated to one full time staff member in each group.
- For the period April 2015 to March 2016, sickness rates for inpatient nurses were variable. Sickness rates were either the same as or better than other independent acute healthcare providers for the months April, May, October, and November 2015. Sickness rates were worse than other providers for all other months in the reporting period.
- For the same period, sickness rates for healthcare assistants were variable in comparison to other providers. Sickness rates were the same as or better than other providers for seven out of the 12 months in the reporting period, and worse than other providers for five out of the 12 months with a large peak in February 2016.
- Sickness was managed and monitored by having a rolling tracker of sick leave, and the use of return to work interviews.
- Sickness rates for theatres were the same as or better than other acute independent healthcare providers for nursing staff. ODP and HCA sickness rates were similar to or better than other acute independent healthcare providers for the same period for 10 out of the 12 reporting months.
- There were no unfilled shifts between January 2016 and March 2016 for both inpatient areas and theatres.

Surgical staffing

- The hospital did not directly employ surgeons. Surgeons were licenced to undertake surgery at the hospital and were granted practising privileges in accordance to the hospital's practicing privileges policy. The hospital had 255 doctors on practicing privileges at the time of our inspection.
- Consultants were present on the ward every day that their patients were admitted.
- There were mobile and landline telephone numbers for the consultant surgeons held on the ward. This meant that consultants were available in the event of their patients requiring their support.
- A resident medical officer (RMO) was available 24 hours a day seven days a week by a week on week off rota. The RMO liaised with consultants and was available to prescribe medications that had not been anticipated by the consultant and anaesthetist, and to review patients in their absence if required. This meant that patients had access to a doctor or surgeon the whole time of their admission.

Major incident awareness and training

- There was an emergency incident plan in place for the hospital for staff to access, as well as a fire evacuation process and policy, incident controller training and a process flowchart.
- A table top exercise took place with plastic brick toys at every team brief on Evelyn ward in preparedness for major incidents.

Are surgery services effective?

Outstanding ☆

Effective was rated as outstanding in surgery services because;

- The service followed a comprehensive audit programme and monitored the care provided against its own policies and standard operating procedures.
- The provision of pain relief was well managed with prescribing being done by the anaesthetist and/or the resident medical officer (RMO).

- The service had a high rate of consent to the National Joint Registry. This was voluntary by the patient but demonstrated effective communication and care from the team to achieve such high consent rates.
- The service performed well above average in the Patient Reported Outcome Measures for hip and knee surgeries when compared to other hospitals of a similar size.
- Unplanned readmissions were low compared to other providers.
- Surgical staff competence was scrutinised by the medical advisory committee before practicing privileges were granted.
- Staff appraisal rates were high at 96% for the ward and 100% in theatres, and included regular formal catch ups throughout the year.
- There was physiotherapy, radiology and pharmacy on call rotas to ensure that support was available to the ward seven days a week.
- Consent was consistently well recorded and audited.

Evidence-based care and treatment

- Policies and procedures used within surgery and theatres followed evidence based practice. For example, the surgical site infection monitoring in orthopaedics was followed in accordance with guidance from The National Institute for Health and Care Excellence for prevention and treatment of surgical site infection (SSI) clinical guideline number 74 (CG74).
- Venous thromboembolism in orthopaedic surgery guidelines were in accordance with (NICE) clinical guideline number 92 (CG92).
- The hospital had a comprehensive audit programme in place. The programme included the 'Gov 14' audit which covered a range of clinical governance elements such as venous thromboembolism (VTE) assessment and management, trips, slips and falls risk assessment, consent and information, surgical checklists, infection prevention and control, monitoring or urinary catheters, monitoring of peripheral lines and cannula, medicines administration audits, and records audits.
- Other audits in the programme included the 'being open' audit, resuscitation audit, safeguarding children audit, standard operating procedure (SOP) compliance audit, and decontamination audit.
- Many of the audits in the programme were set up to assess the service's compliance to their own policies and SOP's.
- Pressure ulcer guidelines were set up by the tissue viability nurse and made accessible on Evelyn ward.

Pain relief

- Pre-loaded pain relief was prescribed by the anaesthetist and was available for surgical patients as clinically appropriate. This meant that surgical patients had pain relief prescribed and ready for administration when they awoke from their surgery.
- The resident medical officer (RMO) was available to prescribe additional pain relief in the event that the anaesthetist was not available.
- One patient on Evelyn ward told us that they had not experienced any pain since their surgery, and had received enough pain relief.

Nutrition and hydration

- There was a clear policy in place for patients who were having procedures and when they could eat and drink prior to the procedures. This information was provided to the patients prior to admission. The idea of this was to avoid patients fasting or going without fluids for excessive periods of time. In the case of theatre lists over running, staff checked with anaesthetists if patients could receive food or water.
- The options for food for patients was extensive and patients could order from a menu or order specific food dependent on what they wanted to eat. The two patients we spoke to stated that they were happy with the quality of the food they were given.
- Food options were available for people with dietary needs such as gluten free, low salt, low fat, no dairy, vegan, vegetarian or halal.

Equipment

- The technology and equipment used in the hospital was mostly new and was very advanced. One staff member stated that one of the best things about working at the hospital was access to modern and advanced technology. The use of such modern technology enabled the service to work more efficiently.

- For example, the anaesthetic machines, were the latest technology and the staff as well as our specialist advisors were very impressed with the latest equipment available. All staff had received training in how to use this equipment. All equipment had service and maintenance contracts in place.

Patient outcomes

- There were five cases of unplanned readmissions within 29 days of discharge for the period April 2015 to March 2016. This is not high according to how other IHC acute providers perform.
- The hospital matron told us that all cases of readmissions were reviewed for learning. One case of readmission was in relation to a pre-existing cardiac condition that was not known by staff. Learning gained resulted in a change of language and terminology when speaking to patients at the pre-assessment stage of care. This was to ensure that patients understood what past medical history they were being asked for. More emphasis had also been put on medicines reconciliation on admission to the ward, to further understand patients' pre-existing conditions. Staff were also encouraged to highlight any issues showing on electrocardiographs (ECG's) at pre-assessment, regardless of how small the issue may seem.
- The service participated in the national Patient Reported Outcome Measures (PROMS) for primary hip replacement in NHS Funded patients. The most recent results for the EQ-5D index (generic health status measure) showed that out of 20 records 95% reported as improved and 0% as worsened; for the EQ-VAS (visual analogue scale component of EQ-5D), out of 19 records, 89.5% improved, 5.3% worsened; and for the Oxford Hip Score, out of 23 records 100% improved and 0% worsened. These outcomes were outstanding.
- The service also participated in the national PROMS for primary knee replacement (NHS funded patients). The hospital's adjusted average health gain is above the England average for the measures of EQ-5D (generic health status measure). Out of 37 records 94.6% reported as improved, and 0% worsened. For EQ-VAS (visual analogue scale component of EQ-5D), out of 38 records 86.8% reported improvement and 10.5% as worsened; and for the Oxford Knee Score, out of 39 records 100% improved and 0% worsened. These outcomes were outstanding.
- The service submitted data to the National Joint Registry. The 2015 audit report showed a consent rate to the register of 98%, which was excellent.
- The hospital was due to start submitting to the National Breast Implant Register. However, this audit's results were not yet available at the time of our inspection.
- For the period April 2015 to March 2016, there were no cases of surgical site infections for the surgical specialities of primary knee arthroplasty, spinal, breast, gynaecology, upper gastro-intestinal and colorectal, urological, cranial and vascular surgeries.

Competent staff

- The medical advisory committee (MAC) provided scrutiny of all applications by consultants to receive practicing privileges at the hospital. This meant that the hospital had assurance of the competency of the surgeons and anaesthetists practicing there.
- Over the last 12 months the hospital have removed 14 doctors practicing privileges and four had their practicing privileges (PPs) suspended. Of those two had relinquished PPs, one doctor moved away from the area, two did not submit sufficient documentation to maintain PPs, one returned. The final eight were removed for not working at the hospital for two years or more.
- For the period March 2015 to February 2016, the percentage of staff with a complete appraisal averaged at 96% across nursing staff, healthcare assistant (HCA's) and 'other staff' for the inpatient areas, and 100% of nursing and operating department practitioner (ODP) staff in theatres. Staff had appraisal catch ups at three and six months post appraisal.
- For theatre staff there was a process for completing competency checks. This process was started on induction. For the ward staff, competency files for registered nurses and a Nuffield academy project for healthcare assistant competency checks were in place.
- The hospital had medical devices champions who monitored equipment competencies through a tracker.

- The hospital's tissue viability nurse had a master's degree in tissue viability. The nurse provided tissue viability and pressure ulcer training on a quarterly basis for all staff across the service.
- Wound management and pressure ulcer prevention training was provided by an e-learning module.
- Individual staff files were kept in the ward office. We reviewed a competency folder that demonstrated competencies for medical devices, HCA competencies for catheter bag emptying, theatre preparation, mouth care and modified early warning scores.
- The service accepted student nurses and had two substantive registered nurses with mentorship competencies. One more nurse had been appointed with the mentorship competence but was not yet in post at the time of our inspection.

Multidisciplinary working

- Patients on Evelyn ward were supported by consultant surgeons and anaesthetists, a radiology team, physiotherapists, oncology nurse specialists, pharmacists, the local hospice, a contact line with the local NHS provider's stoma team, and dietician support from a local NHS provider if required.
- Evelyn ward had a physiotherapy station where patients could receive physiotherapy support. One patient told us that "the physios are great, I've seen them daily".
- There were no boards in patient rooms to state who their named nurse and consultant were. This was not in line with The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients.
- There was an out of hours on call system in place to provide pharmacy support to the ward.

Seven-day services

- Consultants were available out of hours for their patients still admitted to the hospital, with the support of the resident medical officer.
- There was an on call radiology team available to the ward if required.
- An on call physiotherapy service was available out of hours. The physiotherapists were on site seven days a week.
- Pharmacy support was available to the ward by an on call rota.
- Surgery routinely was offered Monday to Friday; however options for weekend surgeries were available if demand required it.

Access to information

- Staff had access to the information they needed to provide effective care. There was access to past medical histories and past admissions for NHS patients using the hospital. For private patients staff had access to GP referrals, the consultant's assessment, health questionnaires from the pre-assessment stage of care and the anaesthetist assessment.
- Information boards in theatres displayed the location of the invasive and difficult intubation trolleys to all staff. This was up to date at the time of our inspection and the information matched the location of the trolleys.
- The information board in theatres listed which surgeon and teams were working in which theatres each day.
- A mounted and laminated guide was on display to staff in the corridor outside the theatres. The guide contained information for staff such as a process flowchart for sharps injuries, biomedical scientist guidance for major haemorrhage, a blood transfusion guide, and handwashing processes. All documents in the guide with review dates marked were in date. Some of the documents did not have review dates and were marked with 'see Q pulse'. We asked a member of staff what this was and they did not know.
- One patient told us that the ward staff and consultant had given his GP practice relevant information about treatment in advance of his discharge and had arranged for follow up blood tests upon discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had consent forms specific for patients living with dementia available. This form highlighted the need for consideration for the needs of a person with dementia and the levels of consent possible for their condition.
- Consent was gained by consultants when they reviewed their patients on the ward before the theatre list started.

- We reviewed consent forms in eight sets of medical records. Consent forms were all completed with the proposed surgery, intended benefits, risks, consultant signatures, patient information given and patient signatures.
- Consent was audited by the hospital. The audit for the period January 2016 to March 2016 showed that the hospital scored 98% for the gaining of consent and the provision of information to patients.
- Deprivation of Liberty Safeguards training was provided as an e-learning module. Deprivation of Liberty Safeguards assessments and application forms were completed by consultants. Data for May 2016 showed that 97% of staff on Evelyn ward and 96% of theatre staff were compliant with Deprivation of Liberty Safeguards mandatory training.

Are surgery services caring?

Good

Caring was rated as good for surgery services because;

- Performance in the Friends and Family Test was good with mostly high response rates.
- The service was scoring in the top 10 of all Nuffield Health hospitals for patient satisfaction and positive feedback.
- Two patients we spoke to were happy with the care they received from staff.
- Patients felt informed about their care and what to expect once they were discharged.
- There was a good range of emotional support options available to patients including specialist nurses, and oncology teams if required. Access to counselling services was also available.

Compassionate care

- The hospital provides services to the NHS at 20% of their overall patient flow through the hospital. Friends and Family Test (FFT) results for the period December 2015 to May 2016 were mostly good. 100 per cent of patients said they would recommend the hospital for every month with the exception of March 2016 when the result was 91%.
- For the same period, response rates for the hospital were mostly good. Response rates were above the England average for four out of the six months. In March 2016 the response rate was 18% compared to the England average of 24.1%, and in February 2016 the response rate was similar to the England average.
- The hospital scored between 94% and 96% for patient satisfaction in monthly survey results. This was consistently above the Nuffield Health group average of 92%.
- We were able to speak with two surgical patients during this inspection. One patient told us that staff were, “So friendly, the nurses are helpful and polite. They get on with their job, if you ask for something it gets done. It’s been quite a pleasant experience. The atmosphere and treatment is wonderful, I feel quite content”.
- Another patient told us that, “The consultant and anaesthetist are fantastic. And the staff are attentive”.
- We observed the receptionist on Evelyn ward taking phone calls, answering politely and talking with respect to the callers.
- Patient satisfaction surveys were undertaken across the Nuffield Health group. The satisfaction results showed that at 96% The Nuffield Health Cambridge Hospital was performing in the top 10 of the 250 services in the group.

Understanding and involvement of patients and those close to them

- Patients felt informed and involved in their care. One patient told us that they were informed of their discharge plans and the arrangements made for follow up with their GP.
- One patient’s family, who we spoke with, had been made aware of their recovery needs once they were at home and requested to be present to assist in the patient’s recovery.
- Patients and their families are greeted by the inpatient team on arrival, met by the team once in their room, and then met again prior to discharge. During these meetings with staff the process and what to expect is fully explained to the patient and their family and there is opportunity for them to ask any questions that they may have.
- A patient we spoke with about the discharge process confirmed that they were well informed about the processes and what to expect.

Emotional support

- One patient told us that they felt well supported by the staff throughout their inpatient journey.
- The surgery service and the ward had access to the specialist nurses and staff internally should support be required. For example the service had a range of specialist nurses including breast nurses, and tissue viability nurses who would attend to the patient and provide support or advice where required.
- For emotional support and counselling the service could access or offer the patient a range of options with regards to seeking emotional support where required.
- Through the oncology service there were strong links with the local Macmillan teams who can support patients through their inpatient journeys with a diagnosis of cancer, and visit them during their recovery.
- The service could refer all NHS patients back through the system to access chaplaincy, specialist nursing or other counselling support if it was felt that this was required.

Are surgery services responsive?

Good

Responsive was rated as good for surgery services because;

- An average of 98% of patients were treated within 18 weeks of referral each month.
- Discharge planning started at the pre-assessment stage of care, and involved information sharing between the hospital, community care and primary care.
- Patients received health checks before their admission as part of their care package.
- Patients were admitted to private rooms with their own bathroom facilities and facilities to access the internet.
- One patient told us how staff responded promptly to their request to go outside and took the time to fulfil that request.
- Patients living with dementia received one to one care.
- Staff worked with families to support the needs of patients with learning disabilities.
- The service pre-ordered supplies for patients requiring supportive garments post-operatively, so that there was no wait for the garments required.
- Surgery related complaint numbers were low with no identifiable trends, and learning from complaints was a regular discussion at team briefs.

Service planning and delivery to meet the needs of local people

- The service provided mostly inpatient care for private insured or self paying patients. However, 20% of patients who attended the hospital were NHS funded patients who would attend on contract through the local commissioning groups.
- Surgery was provided in one of four theatres, with patients being admitted to Evelyn ward before their surgery and when they were fit to leave theatre recovery.
- Staffing was proactively planned in advance of theatre lists that were known to overrun. This meant that the ward was more likely to manage the change in demand on the ward well.

Access and flow

- Patients could access surgery services in a timely manner. For the period April 2015 to March 2016, an average of 98% of patients each month were treated within 18 weeks of referral, with a range of between 92% and 100%.
- For the period April 2015 to March 2016, six patients had their operations cancelled and four were offered an alternative date within 28 days.
- One recovery nurse told us that patients could sometimes wait up to an hour for the ward to be ready to receive them after they were ready to leave recovery.
- Admissions to Evelyn ward were staggered according to each patient's position on the morning or afternoon theatre list. This meant that patients were not admitted to the ward for excessive periods of time before their surgeries.
- Discharge planning for larger procedures started at the pre-assessment stage of care. Potential help at home requirements were assessed and if necessary contact was made with families and/or external agencies. Once home support was set up, the physiotherapists advised on any equipment required by working with the community occupational therapy teams.
- Once patients were fit for discharge, their GPs were sent a discharge summary of their admission. Patients were either referred to their practice nurse for wound care in the community or were invited back to the hospital tissue viability clinic. Plastic surgery patients received wound care at the hospital.

Meeting people's individual needs

Surgery

- Theatre one had its own anaesthetic room, was lead lined and fully digital with conference facility for surgeons to live stream for educational purposes. Most surgical specialties were performed in this theatre, and it was also suitable for emergency cases.
- Theatres two and three were also fully digital and had their own anaesthetic rooms. The theatres were also suitable for the majority of surgical specialties and emergency cases. Scoliosis surgery and surgery on children and young people were carried out in theatre two due to the proximity to additional resources and emergency equipment.
- Theatre four was a separate day case theatre. Minor surgeries performed under sedation and/or local anaesthetic were carried out in this theatre such as cataract surgeries and endoscopies. The theatre had its own two bay recovery area and was linked directly to the processing suite for endoscopy equipment.
- Evelyn ward was logistically designed so that 16 beds were located to one side of the nurses' station which were for patients who may be more dependent, and 18 beds were located to the other side of the nurses' station for day-case patients and patients with lower dependency.
- There was a two bedded bay adjacent to the nurses' station for nurses to monitor the most dependent patients.
- Tissue viability clinics were held twice weekly for patients requiring wound care after their surgeries.
- At the pre-assessment stage of care, patients were offered health checks and information leaflets regarding their treatment.
- Inpatients were cared for in individual private rooms with private bathroom facilities. The private bathrooms all had wet rooms for ease of access when showering. This reduced the risk of falls from climbing in and out of showers or baths.
- Evelyn ward had a patients' lounge with a television and hot drink making facilities.
- Each private room had a smart television which allowed patients access to their emails, the internet and online entertainment subscriptions.
- One patient told us that the food offered was suited to their soft diet. The food was also reduced in salt at their request.
- Another patient told us that the nursing staff responded quickly to the call bell being pressed. The same patient also stated that when they had requested to go outside for some fresh air, a member of staff took them immediately.
- A recovery nurse told us of a time when care was planned in advance for a patient with learning disabilities. The patient's family members went to the anaesthetic room with the patient and waited in recovery whilst the patient received surgery. The family members were supported by the recovery nurses as much as clinically appropriate to support the patient's recovery. This helped to ease any anxieties the patient had upon waking from anaesthetic.
- In recovery, patients living with dementia were nursed in beds furthest away from noisy machines to cause as little distress as possible.
- On Evelyn ward, patients living with dementia received one to one care. Carers could stay on Evelyn ward. Evelyn ward had a wander management system in place that sounded alarms when patients living with dementia wandered away from the location they were supposed to be in. However ward staff used this system cautiously as the alarms were noted to upset patients when they went off.
- The hospital had a dementia lead in post to offer specialist support to patients and staff. There was also a dignity awareness lead for the hospital who linked with the dementia lead.
- There were staff within theatres and on the ward who were dementia and learning disability champions. There were no champions for preventing domestic violence. However, the service were going to look into this.
- A telephone translation service was available to staff if they were treating a patient who could not understand nor speak English.
- Patients undergoing cosmetic surgery had their supportive garments ordered by the ward in advance of their admission, as informed by the consultant's secretary. This meant that the garments were ready for the patients immediately after their surgery.
- The hospital gave access to a fitness programme for orthopaedic and women's health patients to aid them in their recovery after treatment.
- Discharge booklets were given to patients with advice on post-operative care, venous thromboembolism, care of the skin post cannula removal, and ward contact information. Patients who had undergone larger

procedures received a telephone follow up call the day after discharge. Patients who had undergone hip and knee surgeries were followed up 30 days post procedure.

Learning from complaints and concerns

- Out of nine complaints received by the hospital in the period November 2015 to April 2016, three were clearly defined as surgery related. The complaints related to a cancelled operation, a delayed procedure and post-operative pain. Therefore there were no apparent trends in the surgical complaints for this period.
- Complaints were thoroughly investigated and complainants were appropriately responded to by the matron and sometimes the sales and service manager in a timely manner.
- Learning from complaints was fed back to staff in their staff meetings or team briefs. The theatre team briefs in March and April 2016 demonstrated discussion around complaints and learning. The ward team brief showed complaints discussion in April but not March 2016.
- Complaints were also shared and discussed at clinical governance meetings, heads of department meetings and senior managers meetings for discussion and learning.

Are surgery services well-led?

Outstanding ☆

Well-led was rated as outstanding for surgery services because;

- The hospital had a clear vision and staff were aware of this. The hospital's local vision was to become the, "Private Hospital of Choice".
- Evelyn ward had its own vision to treat every patient as if they were their only patient.
- There was a structured leadership in place for the ward and for theatres. Managers engaged the staff, created an open culture ad wanted to continually drive improvements in the service. Staff reported to us that they felt supported by the leadership team.
- The hospital was managed by a dedicated and proactive senior leadership team. Staff told us how the hospital director and matron were routinely visible and approachable, willing to listen and open to ideas on how to improve the service.
- There was an effective and robust governance structure and learning and improvement was evident.
- The hospital was well supported by an active medical advisory committee. The Chair of the MAC was proactive and engaged with the service and had a good working relationship with the senior management team. The vision of all was to drive improvement in patient care through robust and effective processes.
- The leadership team of all levels were proactive and looked for opportunities to improve patient care.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- Staff we spoke with were complimentary about the leads for theatres and for the leads of the ward. There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.

Vision and strategy for this this core service

- The hospital was part of the wider Nuffield health organisation, and shared in the organisation's four values. These values were to be enterprising, passionate, independent and caring. All staff we spoke with during the inspection were aware of these.
- Evelyn ward had its own goal 'to treat every patient as if they are our only patient'.
- The corporate vision and objectives for the Nuffield Health Cambridge Hospital were identified as goals and categorised by each of the key CQC questions. These included improving outcomes for patients, increasing staff knowledge and education, and improving patient satisfaction.

Governance, risk management and quality measurement for this core service

- The service had a robust structured process in place for the medical advisory committee (MAC). We reviewed the meeting minutes of meetings held in January and April 2016. These were detailed, comprehensive and covered all services within the hospital. Topics discussed included risk, practicing privileges, quality dashboards and visions for the future.

- We spoke with the hospital director and MAC chair about the process of the committee and sign off. Both were articulate about the running of the service and MAC and had a clear understanding about the quality of service to be provided.
- Practicing privileges were routinely discussed as part of the MAC. Privileges are to be renewed and reviewed every three years as a minimum. There were 255 consultants on practicing privileges at the hospital and all privilege renewals would be discussed at MAC, as well as new appointments. Examples of where consultants had not adhered to requirements or fallen below the expected standards of behaviour were provided and practicing privileges were removed.
- The MAC and hospital director had clear criteria for the issuing of practicing privileges for plastic and cosmetic surgery. Whilst there is no set criteria from the Royal College of Surgeons, the service had implemented a process to assess and determine competency for the surgeons wishing to undertake plastics procedures. This list was extensive and comprehensive and included operating hours, observation reports and refers to support clinical practice. We were provided with examples of where surgeons had been denied practicing privileges for plastic surgery where this criteria had not been met.
- We reviewed the risk register for the service dated April 2016. Four of these risks were rated as moderate and the remaining six were rated as low risks. Of the risks that were listed, one was dated back to 2009, was graded as a low risk and related to cancelled surgery. However, on discussion with the senior management team this was to maintain board focus on the importance of not cancelling surgery.
- We also reviewed risk registers completed in May and September 2015. We could see clear progression and monitoring of risks, with detailed updates and actions taken to mitigate risks where possible. This included clear reasons to downgrade and close risks on the register.
- The risk register was a standard agenda item on the senior team meeting agenda, and risks were discussed at the clinical governance meeting and head of department meetings. We saw minutes of these meetings, which took place during 2016, which demonstrated that risk was a focal point for the leadership team.

Leadership / culture of service

- An established senior management team (SMT) was in place at the hospital which included the hospital director, the matron, the finance manager and the sales and service manager. Evelyn ward and the theatres had managers in post who received support directly from the SMT.
- The hospital was managed by a dedicated and proactive leadership team. Staff told us how the hospital director and matron were routinely visible and approachable.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.
- Two healthcare assistants in theatres told us that they worked in a “lovely team, everyone gets on well”.
- Three staff members said they felt proud to work at the hospital. One staff member said they liked working at the hospital and that the team was good.
- Three staff members said they felt they had good relationships with the consultants, and one staff member said that one consultant was disrespectful to hospital staff. We escalated this to the senior management team who told us that this had been investigated and managed at a senior level.
- One staff member in theatre told us that the theatre manager was visible every day and gave them timely information relating to the service. The staff member also said that the matron was visible at least once a week and knew everybody by name, as did the hospital manager.
- One staff member said they felt the senior management team had an open door policy. Another said the senior management team were supportive and provided good leadership.
- One staff member on Evelyn ward told us that they saw the matron every single day, and that she “rolled her sleeves up” if she was needed.
- One staff member on Evelyn ward told us that they felt the SMT were open, they listened, and that they felt supported by them.
- Four members of staff stated that the one thing they would change would be the length of their working day.

The staff members stated that theatre lists often over ran, and that they felt the reasons were that surgeons arrived late or had too many patients on their lists. Staff stated they had raised this with the hospital manager and one staff member said they did not feel the senior management team dealt with this issue. Two staff members felt they were supported to have days off as time taken in lieu for hours worked over their contract of employment.

- The Nuffield Health Group have a whistleblowing policy in place, which staff were aware of when asked. Staff felt happy and open to raising concerns and speaking up to their local leaders or senior leaders for things that they were not happy with.

Public and staff engagement

- Mindfulness training, healthy eating support and gym memberships were offered to staff as part of a staff wellbeing programme.
- The service was actively trying to engage more staff in the investigation and root cause analysis process when incidents occurred to encourage shared learning from and responsibility for these actions. However, the service leaders told us that it had been challenging to encourage staff to become more involved.
- There were patient forums but it had been difficult to encourage patients to take part and so far only one meeting had been held. The hospital matron and hospital director informed us about the variety of ways that they had worked to engage the public to attend or provide feedback, but were struggling to get engagement with this.
- Staff and service users were involved in improvement and development. For example, the service had received feedback from patients about the length of time they had to go without food and water prior to surgery and not being kept up-to-date on this. As a result, service leaders had recently had discussions with the consultant body about staggering patient admissions for surgery.
- Heads of department had been involved in the design of the new site which had recently been completed.

Innovation, improvement and sustainability

- Jelly mattresses, which are soft and ventilated mattresses, had been introduced for orthopaedic patients.
- A red hat had been introduced for the leader in theatre to wear so staff knew who was in charge in the operating theatre when all staff present were wearing theatre hats, face masks and scrubs.

Outstanding ☆

Services for children and young people

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Information about the service

Nuffield Hospital Cambridge offered services for children and young people aged between three and 17 years for elective inpatient surgery. The inpatient areas included 34 single rooms with en-suite bathrooms on the general ward, theatres and a paediatric recovery area. Children and young people were cared for in one area of the ward which had additional security and larger rooms to facilitate parents to stay overnight if required. There were 191 day case surgeries and 90 surgeries that required an overnight stay between April 2015 and March 2016. Specialities included orthopaedic, ear, nose and throat (ENT) and general surgery. Surgical procedures for children and young people were booked for the second and third weeks every month.

Outpatient consultations and limited imaging services were offered for children and young people between 0 and 17 years of age. There were 615 children and young people were seen in the outpatient department between April 2015 and March 2016. Of those 47 of these attendances were for children aged 0 to 2 years. There was a small children's waiting area in the outpatient department.

The service for children and young people was led by a paediatric consultant and a lead registered nurse, (child branch). There were a further two registered nurses (child branch) who provided care and treatments for children.

We visited all areas where children and young people were cared for within the hospital. This included the ward, theatres, recovery, diagnostic imaging and the outpatient department. We reviewed four patient records and observed the care provided to children and young people and analysed data supplied by the hospital. We spoke to two registered nurses (child branch), two theatre practitioners, one registered nurse, three department managers and two children with their parents.

Outstanding ☆

Services for children and young people

Summary of findings

We rated this service outstanding overall. Safe and effective were rated as good with caring, responsive and well-led rated as outstanding because:

- The service had robust incident reporting systems and there was evidence of learning form incidents. We found assessments and procedures in place to safeguard children and young people from harm. There were measures in place to monitor and manage children and young people including signs of deteriorating health. Systems were in place that reflected national, professional guidance and legislation to keep people safe.
- Staffing was planned and continually monitored in accordance of the needs of the service. Agency staff were used when required with the same nurses used to maintain continuity to the service and patients.
- Care and treatment was planned and delivered in line with current evidence-based guidance and standards with a holistic approach to care. We saw that relevant audits were used to assess compliance with best practice.
- Staff were qualified and had the relevant skills for their role and were encouraged to undertake specialist training in their field of expertise. Staff had received an annual appraisal and were supported in the revalidation process.
- Children and young people received care from a range of staff and services, which worked in collaboration to achieve the best outcomes for their patients.
- Children and their families reported that staff were kind and compassionate Staff consistently included their patients and families in the care delivery and promoted their dignity. The emotional needs of the patients were embedded in the care provided. Parents were able to accompany their child to theatre and be present in recovery to give extra emotional support. Young children had the option of driving a small electric car to theatre to reduce anxiety levels.
- Services for children and young people were planned in accordance of the needs of the patients at a time that suited them. The hospital had a service level agreement with the local NHS trust to give 24-hour consultant support and the transfer of an unwell child. We saw that the hospital worked in close collaboration with the local NHS trust.
- The hospital had a robust complaints procedure and produced evidence to support the management and improvements made as a result of complaints. There were mechanisms in place to maintain staff and service user engagement.
- The hospital had a strategy to improve services for children and young people and the set objectives were being met.
- There was a clear governance structure and this demonstrated a proactive approach to managing risk and quality improvement of services. The leadership team drove continuous improvement actively seeking feedback from staff and service users. We found there was strong leadership from the hospital director down to department managers. Staff were committed and cared about the services they provided and were supported by their managers.

However:

- Consent forms had been signed by children and their parents but we could not find documented evidence that “Gillick competence” had been assessed or considered.

Outstanding ☆

Services for children and young people

Are services for children and young people safe?

Good

We have rated this service as good for safety because:

- The service had robust incident reporting systems and there was evidence of learning from incidents.
- There were risk assessments and procedures to safeguard children and young people from harm.
- There were systems in place to monitor and manage signs of deteriorating health in children and young.
- We found systems in place that reflected national, professional guidance and legislation to keep people safe.
- Staffing was planned and continually monitored in accordance with the needs of the service.
- Agency staff were used when required with the same nurses used to maintain continuity for the service and the children.

Incidents

- There was one never event involving children and young people (August 2015). A swab had been retained following an ear, nose and throat surgery and was later coughed out by the child resulting in no harm. We reviewed the investigation documentation and found there had been learning from the incident. All equipment counts are double checked by the theatre staff to ensure all equipment is accounted for at the end of the surgical procedure.
- There had been no other serious incidents involving children and young people between April 2015 and March 2016.
- There was an electronic incident reporting system in place. We spoke to four members of staff about incident reporting and all of them reported that they had access to the reporting system and knew how to report incidents. The staff were able to give examples of incidents they had raised. Managers were able to demonstrate learning from incidents took place following investigation and this was shared with staff.

Cleanliness, infection control and hygiene

- All areas of the hospital that offered services to children and young people were visibly clean and well maintained.
- Regular cleaning audits were undertaken, we saw the completed audit for March 2016 and we had no concerns.
- All inpatients were cared for in individual private rooms with en-suite bathroom facilities.
- We saw that staff had access to personal protective equipment with dispensers available in all clinical areas and within patients' rooms.
- We saw hand gel dispensers located in all clinical areas and in patients' rooms.
- There had been no cases of MRSA or Methicillin-sensitive Staphylococcus Aureus (MSSA) reported between April 2015 and March 2016.
- Children and young people were only screened for MRSA when having orthopaedic surgeries. However all adults were screened for MRSA prior to admission to the hospital. This was in line with recommendations from the Department of Health for MRSA screening.
- There was a policy in place for infection control including hand hygiene and MRSA screening. Hand hygiene audits were in place to monitor compliance with the policy.
- We saw the hand hygiene audit results from February 2016 which showed that six members of staff were observed, four clinical staff members and two non-clinical members of staff.
- All clinical staff maintained good hand hygiene. However, the two non-clinical staff members missed an opportunity to decontaminate their hands. We spoke to two children and their parents who reported that staff washed their hands before any care was given.

Environment and equipment

- The environment was bright with most of the hospital receiving natural light.
- Paediatric resuscitation trolleys were located in theatres, the ward area and in the outpatient areas of the hospital. We saw that equipment was checked daily and there were no gaps in the records.
- There was a small designated children's waiting area in the outpatients' department with age appropriate toys. The toys were cleaned weekly by one of the cleaners, this was supported by cleaning records and staff also shared with us how often the toys were cleaned.

Services for children and young people

- Children and young people were admitted to the general ward for day case surgery and overnight stays. The rooms used for children and young people were en-suite and were in an area of the ward that could be locked with swipe card access only. This area was usually locked at 7pm every day and parents were made aware of this at the point of admission. The area could be locked at an early time at staff request.
- Children and young people had access to a small selection of games, toys and colouring activities while in hospital. All rooms had flat screen televisions and telephones provided for the patients to use.
- Equipment was in date and regularly safety checked. We checked 14 pieces of equipment between the anaesthetic rooms and Evelyn ward. All equipment checked was within date for servicing and safety checks.
- The spinal, invasive, difficult intubation and airways trolleys in the theatres were checked weekly for stock check and cleaning schedule completeness. We reviewed 10 weeks of checks for all trolleys and found no omissions in the checks.
- The anaesthetic machines in theatres were checked daily if there was a theatre list and received annual servicing.
- Checks of the resuscitation trolleys were audited monthly and scrutinised quarterly by the resuscitation committee. The group resuscitation policy audit tool completed for the period July 2015 to December 2015 reflected that checks were not being completed 100% of the time, with the audit demonstrating compliance in 89% of cases. However, the actions identified related to adult resuscitation trolleys.
- During our unannounced inspection, we inspected two children's resuscitation trolleys and found that the required checks had been carried out.
- There was a two-person check required to take blood from the bloods fridge on Evelyn ward. The blood audit and release system used in theatres had barcoded access to ensure that the correct blood product was released for the correct patient. This meant that blood products were securely stored and appropriately accessed.
- A service level agreement was set up for the provision of a medical engineering service. An engineer was on site twice weekly to service and safety check equipment, as well as respond to logged repair jobs. The ward kept the log of jobs for the engineer

Medicines

- We reviewed four medicine charts for children and found these were completed with allergies, weight and height of the patient clearly recorded.
- All medications were prescribed appropriately for the age and weight of the patients.
- We saw that there was an up-to-date children's British National Formulary (BNF) available to staff for reference regarding medication.
- We saw that all medications had been administered as prescribed without omissions recorded on the medication prescription chart. This gave us assurance that patients had received their medications as they had been prescribed.
- Medication was stored securely in a locked drug room to which only permanent authorised staff had access. Codes to access the room were changed every six months.
- Room and fridge temperatures were monitored and recorded daily. We reviewed checks for June and July 2016 and saw these remained within acceptable levels.
- We checked 12 medicines and saw that these were within their expiry dates.
- The service had access to the hospital's pharmacy team who undertook audits. Audits from February and March showed good compliance with medicines checks.
- We checked the procedures for managing controlled drugs within the hospital. We saw that storage arrangements were appropriate. These medicines were kept within a locked medicines cupboard within a locked room.
- We undertook checks for four controlled drugs and saw that the stock available matched that which was detailed in the controlled drugs book.
- However, the hospital policy stated that controlled drugs should be checked twice daily by two members of staff. During the two months prior to our inspection we found five occasions (3, 15, 27 and 30 June 2016 and 2 July 2016) where no checking of controlled drugs had taken place. This meant the hospital was not ensuring the safe management of controlled drugs in line with government legislation. Though these medicines were predominantly used in the care of adults and not children.
- However, during the unannounced inspection we checked the controlled drugs book and found that this was being checked twice daily as required by policy.

Services for children and young people

Records

- We reviewed four complete records for children and young people and found that the documentation was accurate clear and legible.
- Risk assessments were included in the children's pathway for example moving and handling, pain and nutritional assessments.
- Patient records were kept in the staff office and could be accessed by staff at all times. The office entrance was behind a manned reception desk.
- All documentation completed during the patient admission was in paper format. However, discharge letters were typed and posted to the patient's GPs with a copy sent to the patient, parent or guardian.

Safeguarding

- The hospital used the Nuffield policy for the safeguarding of children. In addition, we saw that the hospital had a local flow chart for staff to use when raising children's safeguarding concerns.
- There was a dedicated children's safeguarding lead for the hospital that attended safeguarding meetings locally and liaised with the local NHS trust. This member of staff had completed safeguarding children level three training.
- Of the staff who cared for children 70 (68%) had completed safeguarding children level two and seven staff members had completed safeguarding children level three.
- There was always someone on duty to care for children who were admitted, who was safeguarding level three trained. There was always a safeguarding level three trained staff member in outpatients working when children had their appointments. The resident medical officer (RMO) were also safeguarding level three trained. We reviewed training records and rotas, which supported what we were told.
- We spoke to four staff members about safeguarding and all of them were able to give examples of when they would raise a safeguarding concern. They also demonstrated the process of how to raise a safeguarding concern using a flow chart
- The hospital had security arrangements in place which meant that all visitors had to sign in at reception. The area of the ward where children were cared for had a lock down process at 7pm after which time access was by swipe card. However, staff told us that lock down could be actioned at any time if required.
- Staff told us that parents were usually present for the duration of a child's admission. However, children were given one to one care if the parent was not present.

Mandatory training

- Information received from the hospital prior to our inspection showed that the target of 85% of staff completing mandatory training had been met in eight of the 10 modules. However, the taught session in infection prevention had a completion rate of 83%.
- Mandatory training included incident reporting, fire safety, safeguarding children and young adults level one, safeguarding adults level one, information governance, Infection prevention, basic life support, managing stress and whistleblowing.

Assessing and responding to patient risk

- The hospital had strict criteria to accept well children without pre-existing medical conditions. No emergency cases were admitted to the hospital. This was set out in the "CYP services provision statement".
- All patients were health screened prior to admission by the admitting consultant and the lead registered nurse (child branch).
- A Paediatric Early Warning Score (PEWS) tool was used for all children and young people admitted for surgery. PEWS is a nationally standardised assessment of illness severity in children and determines the need for escalation based on a range of patient observations such as heart rate. All of the records we reviewed showed that the scores had been completed and escalated appropriately.
- We saw that a service level agreement was in place with the local NHS trust that had a paediatric intensive therapy unit to transfer a seriously unwell child. We spoke to six staff members and all of them were aware of the agreement and when to escalate an unwell child.
- Two members of staff had undertaken advanced paediatric life support training. A registered nurse (child branch) was due to complete the training in October 2016. There was a resident medical officer on duty 24 hours a day with advanced paediatric life support training.

- The hospital reported that 60 staff members had undertaken paediatric basic life support training. Nine members of staff had untaken paediatric intermediate life support training and two had undertaken advanced paediatric life support (APLS) or equivalent.
- The "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" tool was used. This tool is used to reduce the risk of preventable errors and adverse events during surgery. We saw this had been completed in all four patient records that were reviewed, with all completed steps undertaken and recorded.
- We witnessed the initial stage of WHO check list being completed in the anaesthetic area, which was completed correctly.

Nursing staffing

- There were three registered nurses (child branch) employed at the time of the inspection. Surgeries for children and young people were planned every second and third week of the month. Staffing was planned to ensure that a registered nurse (child branch) was on duty during this time.
- Three staff members reported that surgical procedures were cancelled if there was no registered nurse (child branch) on duty for example due to staff sickness. We were given three examples of cancellation between January 2016 and July 2016.
- The ward manager and lead registered nurse (child branch) (RCN) reported that agency registered nurses (child branch) were used. However, they used the same agency staff on a regular basis when required to maintain continuity.
- The lead registered nurse (child branch) told us that there were plans to employ a further nurses to enable surgeries to be offered throughout the whole month rather than being restricted to two weeks every month.
- In recovery children and young people were cared for by an adult registered nurse that had access to a registered nurse (child branch) for advice and support.
- The outpatient department was staffed by adult registered nurses who were supported by the registered nurse (child branch). Staff told us that no procedures were undertaken unless a registered nurse (child branch) was present.

Medical staffing

- There was a medical lead for children and young people's services at the hospital. This was a consultant paediatrician and was the named consultant to support the registered nurses (child branch). This consultant also attended the medical advisory committee (MAC) meetings held quarterly.
- There were three consultant paediatricians with practicing privileges within the hospital. All of these consultants had substantive posts within the local NHS.
- There were two resident medical officers (RMO). The RMO work pattern was 24 hour cover for seven days with seven days' rest. However, the RMOs were not employed directly by the hospital and were sourced through an agency. The RMOs had to complete a hospital induction programme. The MAC ensured that RMOs had completed necessary training and had experience prior to the induction period.
- There was a service level agreement (SLA) in place with the local NHS trust for 24-hour access to a paediatric anaesthetist and consultants. Staff reported that they felt able to contact consultants if advice was required.

Major incident awareness and training

- The hospital did not receive emergency patients following a major incident. The hospital had an emergency incident and business continuity plan in place if there was a power cut or loss of communications.
- The hospital ran exercises such as fire drills throughout the year to ensure staff were trained in the requirements of emergency incidents.

Are services for children and young people effective?

Good

We rated this service good for effective because:

- Care and treatment was planned and delivered with current evidence based guidance and standards with a holistic approach to care.
- Relevant audits were used to assess compliance with best practice.
- Staff were qualified and had the relevant skills for their role and were encouraged to undertake specialist training in their field of expertise.

- We saw that staff had received an annual appraisal and were supported in the revalidation process.
- We saw that children and young people received care from a range of staff and services, which worked in collaboration to achieve the best outcomes for their patients.

However we also found:

- Consent forms had been signed by children and their parents but we could not find documented evidence that "Gillick competence" had been considered or assessed formally if required.

Evidence-based care and treatment

- Policies could be accessed by all staff through the hospital's intranet. Staff reported that they had access to these. One member of staff told us that copies of new policies or updated policies were printed off and left in the rest room for staff to read.
- The hospital based their policies around national guidance and this was reflected in the policies we reviewed. For example, we found the "consent to examination and treatment" and "children's services" policies were up-to-date and ratified.
- The paediatric admission pathway reflected evidenced based practice with PEWS and relevant risk assessments embedded in the pathway.
- We saw that the "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" tool was used. This reflected evidence-based practice to ensure safety for surgical procedures.
- We saw a schedule of audits conducted to ensure staff were compliant with policies for example hand hygiene audits and the patient record documentation audits.
- Staff reported that they were audited for hand hygiene, aseptic technique and audits were completed around medical devices.

Pain relief

- We reviewed four patient records and found that pain assessment was undertaken hourly following surgery.
- We spoke to two parents who reported that pain assessments had been carried out regularly and pain relief had been given in a timely way.
- Child friendly pain charts were embedded into the PEWS tool aiding younger children to express their pain.

Nutrition and hydration

- We saw four patient records that showed children's dietary needs were assessed and recorded on admission.
- The records we reviewed reflected that food and fluid charts had been completed accurately.
- We saw that patients had access to a water jug at the bed side.
- Children and their parents/carers were offered food at meal times. The two children and parents we spoke with reported that the food was good and there was a selection of choices on the menu.
- We saw that parent/carers had access to tea and coffee facilities on the ward and in the outpatients department.

Patient outcomes

- There were no national audits undertaken by the hospital involving children and young people.
- The hospital had no unplanned transfers to local NHS trust in the last 12 months for children and young people. However, we were told about a case where a child became unwell and the paediatric anaesthetist stayed overnight to oversee their care.
- Children and young people had a dedicated pathway for day surgery and overnight stays. However, this pathway was not used for scoliosis corrective surgery as the duration of stay was longer and the children's pathway did not allow for this. However, the adult pathway was used for these patients with the addition of the appropriate age related risk assessment and the use of the Paediatric Early Warning Score (PEWS) tool.

Competent staff

- Staff reported that they had access to education and training courses relevant to their area of specialism. Evidence of this was seen in theatres and the ward areas.
- All staff we spoke to reported that they had completed a yearly appraisal. The ward manager reported that the appraisal rate was 100% and this was demonstrated on a display board in the manager's office and in the records provided by the service.
- Staff we spoke to reported that they were supported to complete the Nursing and Midwifery Council (NMC) revalidation process.
- The hospital medical advisory committee (MAC) liaised with the responsible officer for the local NHS trust

regarding consultants with practicing privileges. The information shared with the responsible officer was taken into account during the revalidation and appraisal process.

Multidisciplinary working (in relation to this core service)

- There was an SLA in place for access to consultants including paediatric consultants within the local NHS trust. Six members of staff told us that there was a good working relationship with the local NHS and were able to contact consultants for advice at any time of day.
- We did not witness a multidisciplinary team meeting taking place. However, three members of staff told us that the physiotherapists reviewed the children and young people following orthopaedic surgery. They also reported that there was good working relationship with the physiotherapists and discussed patients progress daily.
- Staff reported that the pharmacist reviewed all patients daily Monday to Friday and would give advice regarding medications to the medical and nursing staff.

Seven-day services

- There was access to consultants 24 hours a day, seven days a week from the local NHS trust through an SLA. The resident medical officer (RMO) was present on site 24 hours a day, seven days a week.
- There was 24 hour access to imaging services with an on call system in place out of hours and at weekends. Staff reported that the system worked well and had no problems with access to imaging.
- There was an in house pharmacy, which was open from 8am to 6pm Monday to Friday and 8am to midday on Saturday. There was access to a pharmacist out of hours and at weekends. Three members of staff reported that the RMO and nurse in charge had access to the pharmacy if specialist medications were required. We saw that a standard operating procedure was in place for staff accessing pharmacy out of hours.
- Physiotherapists worked during the week and at weekends and would review orthopaedic patients. The scoliosis patients had physiotherapy at weekends following surgery. Some physiotherapists are employed on staff and some are bank, others have practice privileges and do not have set working hours. All groups however work flexible hours to support the service.

Access to information

- Patient records were kept in the staff office behind a manned reception desk and were available at all time to staff.
- Discharge letters were typed and sent via the post to GPs and a copy sent to the patient or parent/guardian following discharge.
- Staff reported that parents were given a telephone number to get advice 24 hours a day following discharge.

Consent

- We found that consent forms had been completed in all four records reviewed. In three cases we saw that the child had signed the form as well as the parent. However, we did not find any documentation to support that a 'Gillick competence' assessment had been considered to determine if an assessment was required. Gillick competence was assessed in children and young people to ensure they understand the risk and benefits to treatment in order to make an informed decision. One member of staff told us they did not formally document this.
- Children and their parents told us that staff gained consent before undertaking any care or procedures.

Are services for children and young people caring?

Outstanding ☆

We have rated this service as outstanding for caring because:

- We felt that caring was outstanding because there was a strong person centred culture and care was tailored to individual needs. Children and their parents were partners in the care with their preferences reflected in the care provided. Parents praised the staff without exception for the care and supportive way it was delivered.
- Friends and Family Test data showed a high percentage of patients would recommend this service was regularly 100%.

- Staff consistently included their patients and families in the care delivery and promoted their dignity. Staff spoke to children in ways which were appropriate for their age and addressed them as individuals. Staff also spoke to parents separately in an appropriate way.
- Children and their families were greeted by the inpatient team on arrival, met by the team once in their room, and then met again prior to discharge. During these meetings with staff the process and what to expect was fully explained to the patient and their family and there was opportunity for them to ask any questions that they may have.
- The emotional needs of the children were embedded in the care provided. Parents were able to accompany their child to theatre and be present in recovery to give extra emotional support.
- The service had considered the emotional needs of children and young people with the use of distraction therapy.
- Staff had thought of an innovative way to provide distraction therapy for children pre-surgery in the aim to reduce anxiety.Children had access to the use of a toy car to drive to theatre.Staff reported significantly reduced anxiety levels in children who used this car.
- Emotional support and care to the parents of children was equally outstanding. There was a true emphasis on ensuring that parents were the focus as well as the child to ensure a smooth process in the child's pathway.

Compassionate care

- We saw that staff consistently acted in a friendly and compassionate manner towards children and their families. Staff used appropriate language for the child's age, gaining their trust.
- We saw that privacy and dignity was maintained, staff knocked before entering the patient rooms.
- Staff responded promptly to any needs the children had. Parents reported that the staff were kind and nothing was too much trouble. One parent told us that they had been "impressed with the care". The parent explained that their child had not been anxious about surgery and attributed this to kind attentive staff.
- The Friends and Family Test data was not subdivided in to service specific information for children and young people's services. However, the Friends and Family Test (FFT) results for the period December 2015 to May 2016 demonstrated 100% of patients would recommend the hospital for every month with the exception of March 2016 when the result was 91%.
- We felt that caring was outstanding because there was a strong person centred culture and care was tailored to individual needs. Children and their parents were partners in the care with their preferences reflected in the care provided. Parents praised the staff without exception for the care and supportive way it was delivered.

Understanding and involvement of patients and those close to them

- Children and their families were greeted by the inpatient team on arrival, met by the team once in their room, and then met again prior to discharge. During these meetings with staff the process and what to expect was fully explained to the patient and their family and there was opportunity for them to ask any questions that they may have.
- Parents were able to stay with their child 24 hours a day for the duration of their admission. This allowed them to support their child emotionally throughout their stay.
- Parents of two children told us that they had been kept informed of their child's progress and been involved in their care.
- We saw that all children had a named nurse on admission and was responsible for the delivering and overseeing the care throughout their stay.

Emotional support

- The children's service and the ward had access to the specialist nurses and registered children's nurses internally should support be required. For example children's nurses were always present during appointments or on theatre days for the child to keep them calm.
- For emotional support and counselling the service could access or offer the patient a range of options with regards to seeking emotional support where required.
- Emotional support was provided by the staff to the parents during appointments and surgery. We observed staff supporting the parents during their time at the hospital as well as the child to maintain their emotional wellbeing as well.

- Parents were able to accompany their child to theatre and support the child in the anaesthetic room. They were escorted to the recovery room by an RCN when the child had been transferred from theatre.

Are services for children and young people responsive?

Outstanding ☆

We rated this service as outstanding for responsive because:

- A specialist paediatric clinic was held on the third Thursday of every month with paediatric consultant present. This ensured that the service was planned with appropriate staff and set up to meet the needs of the child.
- All children were prioritised for theatre to be first on the list either on the morning or afternoon list. This ensured that there were staff and equipment set up and readily available to meet the needs of the child.
- All admissions for children and young people were agreed with admitting consultant and the lead registered nurse (child branch).
- The hospital had a service level agreement with the local NHS trust to give 24 hour consultant support and the transfer of an unwell child.
- An electronic car was available for younger children to drive to theatre. The car was purchased to reduce the anxieties of the child and the parents before surgery. It was found to have significantly reduced the anxiety of the child going to theatre. The child was able to drive themselves to theatre and were not distressed.
- All children were offered a teddy bear to take home and bravery certificates were available in recovery, the ward and in the outpatients department.
- There were leaflets available and booklets for them to help them understand the surgery process. This included 'Detective Dave' who was a character in a leaflet who explained the process of an anaesthetic and what this meant.
- The hospital had a robust complaints procedure and produced evidence to support the management and improvements made as a result of complaints.

Service planning and delivery to meet the needs of local people

- The services available to children and young people were mainly privately funded. However some of the scoliosis surgeries were NHS funded. Privately funded patients had access to treatment by GP or self-referral for treatment. NHS patients were referred by their consultant for treatment.
- The hospital provided a ratio of private or insured paying 80% and 20% NHS care. The NHS care patients were agreed patients through a contract established with local commissioning groups.
- The service provision for children and young people was planned according to the need of patients. All surgeries were planned and took place on the second and third week of every month.

Access and flow

- A specialist paediatric clinic was held on the third Thursday of every month with paediatric consultant present. This ensured that the service was planned with appropriate staff and set up to meet the needs of the child.
- All children were prioritised for theatre to be first on the list either on the morning or afternoon list. This ensured that there were staff and equipment set up and readily available to meet the needs of the child.
- Only well children without pre-existing medical conditions over the age of three were admitted for surgery. The provision of children's and young people's services were set out in in the hospital's "CYP services provision statement". This meant that all children were low risk on admission.
- All admissions for children and young people were agreed with admitting consultant and the lead registered nurse (child branch). All children had a pre-admission assessment with a registered nurse (child branch) by telephone for minor procedures and face-to-face for more complex procedures.
- All surgical procedures were planned in advance and three members of staff reported they had never had any problems with bed occupancy.
- The lead registered nurse (child branch) reported that three surgeries had been cancelled in the last six months. All cancellation had been due to a registered nurse (child branch) not being available at the time of the planned surgeries. Although there is not a requirement for this level of registered nurse to be present, the hospital's policy is for a registered nurse (child branch) to be on duty.

Outstanding ☆

Services for children and young people

Meeting people's individual needs

- All children and young people using the service were low risk on admission and did not have complex needs. However, staff told us that they did occasionally admit children with mild learning difficulties. In these cases staff would prepare for the admission by discussing daily routines with parents and try to emulate the routine during the admission where possible.
- Three members of staff we spoke to reported they had access to a translation service and sign language service if this was needed.
- All rooms had a flat screen television with a variety of different channels. Staff informed us that they had a small selection of toys, games and colouring activities available for children and young people on the ward. There were TV channels specific for children and many options to keep them occupied whilst waiting for surgery.
- We were told that most children and parents brought tablets or electronic gaming devices with them on admission, which were allowed.
- An electronic car was available for younger children to drive to theatre. The car had a hand held remote control so that staff could take over if required. The child was introduced to the car on arrival and was able to drive it around the ward prior to their theatre slot. The car was purchased to reduce the anxieties of the child and the parents before surgery. It was found to have significantly reduced the anxiety of the child going to theatre. The child was able to drive themselves to theatre and were not distressed. The service was looking at purchasing a further car which was larger for children up to the age of 10.
- We saw the car in use for a theatre case. The child was excited about using the car and was driving it around the ward when we arrived. We observed the car be driven to theatre by the child who had no anxiety about their surgery and was happy to have driven the care. This resulted in reduced anxiety for the parents as well and was an outstanding example of responsiveness.
- Staff wore uniforms and photo ID badges so that parents and children could easily identify them. One patient reported that staff had always introduced themselves.
- There was a small waiting area for children in the outpatients department with a selection of age appropriate toys available.
- Children and young people were cared for in one area of the general ward. The rooms were larger and had an extra bed to enable parents to stay overnight. This area of the ward was able to be locked and separated from the rest of the ward area.
- All children were offered a teddy bear to take home and bravery certificates were available in recovery, the ward and in the outpatients department.
- There were leaflets available and booklets for them to help them understand the surgery process. This included 'Detective Dave' who was a character in a leaflet who explained the process of an anaesthetic and what this meant.
- There service had a lead nurse for dementia and learning disabilities. Any child with a suspected learning disability would be supported through outpatients, preadmission, admission and discharge in relation to their needs. This nurse was also available for the parents to speak to should they have any questions.

Learning from complaints and concerns

- Data from the provider showed that there had been one complaint about the children's and young people's services between October 2015 and March 2016. Three members of staff we spoke to confirmed this and reported that the complaint related to a cancellation of surgery. The surgery was cancelled due to there being no registered nurse (child branch) available for the surgery. The service chose to cancel on the grounds of safety and spoke with the family about why the surgery was cancelled. Whilst a complaint was made the surgery was rebooked quickly and went ahead without incident. The family were reportedly happy with the care received.
- Five members of staff we spoke to told us that they felt able to manage concerns raised by a patient or parents but would escalate any concerns that they could not manage to a senior member of staff.
- We reviewed the hospital complaints procedure and were assured by the process in place for responding to complaints and learning from them.
- There were information leaflets available to patients about the complaints process. Patients or parents were able to raise concerns on the patient satisfaction survey questionnaire which had a dedicated section for this purpose.

Outstanding ☆

Services for children and young people

Are services for children and young people well-led?

Outstanding ☆

We rated this service as outstanding for well-led because:

- The hospital had a clear vision and staff were aware of this. The hospital's local vision was to become the, "Private Hospital of Choice".
- Locally there were parents choosing to travel to the hospital with their children's due to the reputation of the service and the support provided to children.
- The hospital had a strategy to improve services for children and young people and the set objectives were being met. The services to children and young people had a clear vision for the future.
- There was an effective and robust governance structure and learning and improvement was evident.
- The hospital was well supported by an active medical advisory committee. The Chair of the MAC was proactive and engaged with the service and had a good working relationship with the senior management team. The vision of all was to drive improvement in patient care through robust and effective processes.
- The local children's leadership team were accessible and staff told us that they were approachable. We observed that the lead for the children's and young people's service was very knowledgeable about the service, where their risks were and how they planned to improve their service. They were very proactive in driving improvements.
- The hospital was managed by a dedicated and proactive senior leadership team. Staff told us how the hospital director and matron were routinely visible and approachable, willing to listen and open to ideas on how to improve the service.
- The leadership team of all levels were proactive and looked for opportunities to improve patient care.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.
- We saw that the hospital worked in close collaboration with the local NHS trust.
- There were mechanisms in place to maintain staff and service user engagement.

Vision and strategy for this this core service

- We saw the hospital's vision and strategy for 2016, with clear goals for children's and young people's services. The goals included increasing the number of full time registered nurses (child branch) posts. On inspection we saw that one member of staff was newly appointed with a further appointments planned.
- The lead registered nurse (child branch) told us that there were plans to increase the days surgeries offered for children and young people dependent following recruitment.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place for children and young people's service, with a pathway of escalation to paediatric lead consultant.
- There were quarterly children's and young people's meetings held chaired by the Matron and facilitated by the lead registered nurse (child branch). The reports from this meeting were submitted to the senior management team (SMT) meeting and the medical advisory committee (MAC).
- We saw the risk register for the hospital and this accurately reflected their identified risks, including the risk associated with the safe delivery of children and young people's service due to reduced resources.
- The two nurses we spoke with knew the identified risks for the service; their biggest concern was cancelation of surgeries because of low registered nurses (child branch) numbers. However, one nurse had recently been recruited with plans to recruit a further registered nurses (child branch).
- The service had a robust structured process in place for the medical advisory committee (MAC). We reviewed the meeting minutes of meetings held in January and April 2016. These were detailed, comprehensive and covered all services within the hospital. Topics discussed included risk, practicing privileges, quality dashboards and visions for the future.

- We spoke with the hospital director and MAC chair about the process of the committee and sign off. Both were articulate about the running of the service and MAC and had a clear understanding about the quality of service to be provided.
- Practicing privileges were routinely discussed as part of the MAC. Privileges are to be renewed and reviewed every three years as a minimum. There were 255 consultants on practicing privileges at the hospital and all privilege renewals would be discussed at MAC, as well as new appointments. Examples of where consultants had not adhered to requirements or fallen below the expected standards of behaviour were provided and practicing privileges were removed.
- The MAC and hospital director had clear criteria for the issuing of practicing privileges for children's surgery. The requirements to demonstrate they were suitable for practice was extensive and comprehensive and included operating hours, observation reports and refers to support clinical practice.
- We reviewed the risk register for the service dated April 2016. Four of these risks were rated as moderate and the remaining six were rated as low risks. Of the risks that were listed, one related to children's services. This was part of the service's vision to expand children's services and their challenges in recruiting full time children's staff when the work was not yet available.
- We also reviewed risk registers completed in May and September 2015. We could see clear progression and monitoring of risks, with detailed updates and actions taken to mitigate risks where possible. This included clear reasons to downgrade and close risks on the register.
- The risk register was a standard agenda item on the senior team meeting agenda, and risks were discussed at the clinical governance meeting and head of department meetings. We saw minutes of these meetings, which took place during 2016, which demonstrated that risk was a focal point for the leadership team.

Leadership / culture of service

- An established senior management team (SMT) was in place at the hospital, which included the hospital director, the matron, the finance manager and the sales and service manager. Evelyn ward and the theatres had managers in post who received support directly from the SMT.
- The hospital was managed by a dedicated and proactive leadership team. Staff told us how the hospital director and matron were routinely visible and approachable.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.
- The children's and young people's services had an identified lead registered nurses (child branch) and lead paediatric consultant. The lead nurse was new in post at the time of inspection and had identified future service developments such as increasing nurse establishment to increase services offered.
- The lead nurse was supported by the senior management team and the ward manager, all of whom demonstrated competent leadership skills.
- Staff values were based around the acronym "EPIC" - Enterprising, Passionate, Independent and Caring. These values were demonstrated by the staff during the inspection, they were committed and cared about the services they provided.
- Eight members we asked about job satisfaction all of staff told us that they enjoyed their jobs and were well supported by their managers.
- The Nuffield Health Group have a whistleblowing policy in place, which staff were aware of when asked. Staff felt happy and open to raising concerns and speaking up to their local leaders or senior leaders for things that they were not happy with.

Public and staff engagement

- There were regular staff meetings to share information with staff and we saw minutes from these meetings reflected this process.
- The hospital reported that they had regular engagement with service users by means of a patient satisfaction survey. All feedback was dealt with by the matron and discussed at head of department meetings. Four members of staff we spoke with reported that there was strong family and service user involvement who gave feedback on care and services provided.
- The service was actively trying to engage more staff in the investigation and root cause analysis process when

incidents occurred to encourage shared learning from and responsibility for these actions. However, the service leaders told us that it had been challenging to encourage staff to become more involved.
- There were patient forums but it had been difficult to encourage patients to take part and so far only one meeting had been held. The hospital matron and hospital director informed us about the variety of ways that they had worked to engage the public to attend or provide feedback, but were struggling to get engagement with this.
- Heads of department had been involved in the design of the new site, which had recently been completed.

Innovation, improvement and sustainability

- There were plans to increase the number of surgical admissions for children and young people, as the hospital was one of the limited number of private providers which offered a service to children and young people in the local area.
- Younger children were given the option to drive a small electric car to theatre to help reduce their anxiety levels. All children were offered a Nuffield teddy bear to take home and bravery certificates were available in all clinical areas.

Outstanding ☆

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department at Nuffield Health Cambridge Hospital consists of a diagnostic centre offering magnetic resonance imaging (MRI), computerised tomography (CT), ultrasound, fluoroscopy, mammography and general x-rays. In addition, the service has a physiotherapy department. There are 19 consulting rooms in the outpatient department. Speciality consultations are available in numerous fields, including cardiology, gynaecology, breast cancer and general surgery. Patients have access to a minor procedures room and an ear, nose and throat suite. The hospital provides consultations and treatment for children up to 17 years of age and adults.

The Nuffield Health Cambridge Hospital outpatients department operates between the hours of 8am and 9pm Monday to Friday, with appointments also offered on Saturdays between 8am and 2pm, depending on the demand for clinics. Patients attending the outpatient department have access to an on-site pharmacy during clinic opening hours.

We gathered information from a number of sources, including data provided by the hospital prior to our inspection. During our inspection we visited all areas of the department and we spoke with three healthcare assistants, three nurses and one consultant. We also spoke with four patients and three relatives. In addition, we spoke with the patient booking team who managed the appointments system and we reviewed case notes of three adult patients.

Between April 2015 and March 2016, the outpatients department saw 12,016 patients, 615 were children under 18 years and 11,401 were adults. Data provided by the hospital showed that 80% of patients were either self-funding or insurance funded, the remaining 20% of patients were funded by the NHS.

Percentage breakdown of outpatient department specialties:

- Breast 4%
- Colo-rectal 5%
- ENT 12%
- Gynaecology 3%
- Neurosurgery 3%
- Oncology 15%
- Orthopaedics 26%
- Other 15%
- Radiology 9%
- Rheumatology 2%
- Urology 6%

Diagnostic services provided:

- CT
- Fluoroscopy
- General x-ray
- Mammography
- MRI
- Ultrasound

Outstanding ☆

Outpatients and diagnostic imaging

Summary of findings

Overall, we have rated the outpatients department as outstanding overall. Safety was rated as good, we do not have sufficient evidence to rate outpatient services effectiveness at this time. Caring, responsiveness and well-led were rated as outstanding.

- The outpatients and diagnostic imaging department had clear processes in place with regard to incident reporting. Staff were clear on how to report an incident and had received training in this area. Incidents were discussed both locally and with senior management.
- Infection prevention measures were in place and we saw staff adhering to 'bare below the elbows' guidelines. All areas we inspected were visibly clean and regular hand hygiene audits were carried out in the department by the infection prevention lead.
- Equipment within the department was regularly serviced and checked.
- Medical records were held securely, with a tracking tool in place to locate and prevent missing notes. Staff could access NHS notes and images via the NHS portal. This information technology system allowed access and sharing of patient images and information. If necessary, the hospital could share new findings with the local NHS Trust.
- Clear processes were in place to escalate concerns in the event of deteriorating health of a patient. The hospital had medical cover from a resident medical officer (RMO) 24 hours a day. In addition, staff within the diagnostic and imaging department had access to on-call radiographers and radiologists out-of-hours.
- Robust systems were in place with regard to the granting and renewal of practising privileges within the department. We saw evidence that these were reviewed regularly at senior management level.
- Patient feedback was extremely positive about the hospital premises and treatment from staff. Patients told us that staff were kind and caring. We witnessed staff interactions with patients during our inspection and noted that relatives were involved during consultations where appropriate.
- The department had a dignity representative. Chaperones were offered to all patients. A chaperone is a person who acts as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure.
- The outpatient and diagnostic imaging department met and exceeded its target for referral to treatment times (RTT) during April 2015 to March 2016.
- There were robust screening processes in place to assess the suitability of NHS patients for treatment prior to appointments being allocated, thus preventing unnecessary attendances.
- There were robust systems in place surrounding complaints and the management of complaints. The Nuffield Health Cambridge Hospital complaint rate was significantly lower than other acute independent hospitals.
- The hospital had a clear strategy and values, which were embedded with staff.
- There were clear governance structures in place within the outpatients and diagnostic imaging department, with effective information sharing between the senior management team.
- Medicines, whilst securely stored, were not subject to stock checking by staff within the department. However, during our unannounced inspection, the service had improved on this and medicines were being checked appropriately.

However:

- Staff within the outpatients and diagnostic imaging department fell short of the hospital's 85% target for completing safeguarding of vulnerable adults; level one training, achieving only 79%.

Outstanding ☆

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated the safety of the outpatients department as good because:

- Patient records were completed to the required standards and all medical notes were held securely, with procedures to track notes in place.
- Equipment was well maintained and regularly checked.
- Staff were adhering to infection prevention techniques and the environment was visibly clean.
- There had been no never events within the department within the last 12 months. There was a robust and clear incident reporting culture found. Staff were clear on incident reporting and could describe feedback and learning that had been shared with them in relation to incidents.
- Staff were aware of duty of candour, and the requirements of being open to patients.
- Medicines, whilst securely stored, were not subject to stock checking by staff within the department. However, during our unannounced inspection, the service had improved on this and medicines were being checked appropriately.
- Staff were aware of emergency procedures including fire evacuations, training had been provided on this and exercises had taken place in outpatients.
- Room temperature checks were missing over a number of months in the radiology and diagnostic imaging department medicines rooms. However, during our unannounced we found that these were now mostly being recorded in line with hospital policy.

However, we also found that:

- Staff within the outpatients and diagnostic imaging department fell short of the hospital's 85% target for completing safeguarding of vulnerable adults; level one training, achieving only 79%.
- Further improvements were needed and for improvements to be sustained in ensuring that notes for patients were available in outpatients.

Incidents

- There had been no reported 'never events' between August 2015 and June 2016 recorded in the outpatient or diagnostic department. 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 had been four incidents reported for the outpatients department during the last 12 months. Incidents were reported using an electronic reporting system. Staff we spoke with were clear on how to report incidents and told us immediate line managers were available for support if required.
- We spoke with two nurses who were able to share an example of feedback provided to them about an incident that happened elsewhere in the hospital. These were discussed during team briefs.
- Staff training was provided on incident reporting and what constitutes an incident. The outpatient team had all been trained and compliance for incident reporting training was 100% however radiology were falling short of the target of 85% compliance, with only 75% of staff having received training in incident reporting.
- All staff we spoke with were clear on the meaning of duty of candour. We were given an example of when the wrong blood containers were used for a test. The staff member responsible called the patient immediately, apologised and explained that the patient would need to re-attend. The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. To date, the surgery department had no reported incidents which required the use of this legal duty.
- There were no reporting of injuries, diseases and dangerous occurrences (RIDDOR) incidents reported in 2015/2016.

Cleanliness, infection control and hygiene

- Staff in the outpatients department were observed adhering to 'bare below the elbow' guidelines.
- The hospital had achieved a 93% completion rate for infection prevention training and offered both practical and theoretical training in this subject.

Outpatients and diagnostic imaging

- Mandatory training for the department included guidance on aseptic technique (goals of aseptic technique are to protect the patient from infection and to prevent the spread of infection) when carrying out blood tests and other invasive procedures.
- Aprons and gloves were readily accessible in consulting rooms. Hand gel was available at regular intervals in the department.
- All clinical and non-clinical areas were visibly clean. Containers we saw for the disposal of sharps (needles) were clearly labelled and were filled to appropriate levels.
- The outpatients waiting area had a specific children's play area. This area was clean and stocked with wipe clean surfaces and toys to allow effective cleaning.
- We observed good hand hygiene from both nurses and doctors during our inspection. Staff were seen to wash hands and apply hand gel at regular intervals. Upon entering the hospital, all visitors were politely requested to make use of hand sanitising gel.
- There were clear processes in place to decontaminate areas within the diagnostic imaging department after treating a patient with an infectious disease, if required. If a patient had MRSA, for example, they would perform a deep clean prior to continuing with clinic lists.
- The main corridors to the consulting rooms were noted to be carpeted though no clinical procedures took place in these areas. All clinical areas were hard floored to enable effective cleaning and decontamination.
- The hospital had an infection prevention lead, who carried out regular infection prevention and control audits on a hospital wide basis. Information from this lead was fed in to regular clinical governance meetings. No issues were reported for outpatients or diagnostics within the last 12 months.

Environment and equipment

- The outpatients department was adjacent to the main entrance of the hospital. We were told by a consultant within the outpatients department that staff were involved with the design of consulting rooms during the planning of the new hospital to ensure all rooms were fit for purpose.
- Members of the public had unrestricted access to the nurse's station and consulting rooms within this area. However, main reception and nursing staff had a good oversight of this area.
- Access to the diagnostic imaging department was protected by swipe card access in all areas. Clear warning signs were in place to warn of the danger of being exposed to radiation. Information on risks was displayed in a number of different languages.
- Staff had access to lead aprons and other personal protective equipment should the need arise.
- Patients and relatives had access to a spacious waiting area and comfortable seating in two locations, one for consulting room appointments and the other for diagnostic imaging. All areas were visibly clean and well maintained.
- Consultation rooms were visibly clean with a curtain separating the examination area and bed. Clinical waste and sharps containers were clearly segregated within these areas.
- The department had two resuscitation trolleys, one of which was specifically for the provision of care to paediatrics. When viewing this equipment, we noted that they were well stocked with the appropriate equipment, oxygen cylinders were full and within use by dates. All resuscitation drugs were locked securely. The department checked resuscitation equipment on a daily basis when open to patients.
- Observations of the dirty utility room within the department revealed this area was secure and limited access to staff members only. A urinalysis testing machine was overdue a service by three years. We highlighted this to a member of nursing staff who reported they would escalate this to the maintenance team. When we returned this item of equipment had been serviced.
- Whilst the commode and other equipment in this area appeared clean, there was no 'I am clean' sticker attached so staff could not ensure cleanliness prior to the next use.
- The cupboard for theControl of Substances Hazardous to Health Regulations (COSHH) was locked securely.
- The specimen fridge temperature had been checked on all relevant days except for two in the previous month, therefore ensuring the integrity of contents within this area awaiting analysis.
- The clean utility room stocked consumables such as dressings. This area was well stocked and organised by each speciality, therefore allowing the prompt identification of stock when required.

- Information from the hospital health and safety committee and medical devices and equipment department regularly fed in to the clinical governance meetings.
- The radiology department had access to a diagnostic centre, offering magnetic resonance imaging scans (MRI), computerised tomography scans (CT), ultrasound, fluoroscopy, mammography and general X-ray and a physiotherapy department.
- The contrast oven was within its service period and was checked by staff on a daily basis.

Medicines

- There was an on-site pharmacy open Monday to Friday 8am to 6.30pm and 8am to midday on Saturdays. The department was covered on an on-call basis outside of opening hours. Pharmacy staff told us that on rare occasions, if a particular medicine was not in stock, they could order this in to the hospital within six hours.
- Prescription pads within the outpatients department were locked in a secure cupboard and monitored by a signing in and out checklist. On the day of our inspection, the checklist and corresponding prescription pads were in order and tallied correctly.
- We noted in both the clean utility area and recovery room, prescription drugs were securely stored and accessible by key only. However, the department had no record of how many of each specific medication was available within each area. We were told by nursing staff that the pharmacy kept records of stock levels for both of these drug cabinets. When we returned for the unannounced inspection, we found that the service was now recording the stock numbers of medicines.
- The clean utility room in the radiology department was secured with swipe card access. Within this area we noted that drugs were in date and secure. However, there was no record keeping process in place of the actual stock numbers of each specific medication. When we returned for the unannounced inspection, we found that the service was now recording the stock numbers of medicines.
- Checks on room temperature within the radiology clean utility room should have been carried out daily. However, records revealed that there were 15 days in the previous month where no checks had taken place. This could affect the integrity of medicines stored within this area. We highlighted this to the staff in charge of this area. When we returned for our unannounced inspection we again checked this area and found that two days had not been recorded.

Records

- We reviewed three sets of adult outpatient notes during our inspection. All notes had the appropriate fields completed, were legible and signed by a consultant. Allergies were recorded and risk assessment for venous thromboembolism (VTE) carried out.
- We spoke with the booking and medical records department. The hospital utilised a note tracker to help prevent and find missing notes. All cases of missing notes were raised as a Datix (electronic incident form). The hospital would contact the consultant's secretary and request a copy of notes if the need arose. However, staff reported that the tracker system worked well.
- We visited the medical records department and noted this area had restricted access. The code to this area was available to senior management only and changed on a regular basis. All notes going out and coming in to the medical records room were recorded to ensure up to date information on the location of notes. On arrival at clinics, the relevant department signed to confirm they had received the notes.
- We were assured that no patient was seen in the outpatients department without a valid referral letter. Staff checked that all patients had a referral letter prior to new appointments and notes if applicable for patients re-attending. If this was not the case, secretaries would make contact with the patient's GP or referrer to request a referral letter in advance of the appointment, detailing the patient's condition and previous medical history.
- Data provided by the hospital prior to our inspection reported that 80% of patients were seen in the department without full medical records being available. However, there were clinic notes available.
- The hospital was ensuring that copies of notes were taken following the patient's appointment. At the time of our inspection the service was able to provide audit evidence from July 2016, which showed that of the patients who were to have a second appointment 100% had records available for this appointment.

- Where consultants did not comply this would be addressed through performance under their practice privileges. We were assured by the improvement plan in place for records availability.
- For NHS patients, there was a central electronic referral submission process for referrals to be electronically accessed and forwarded for prior approval to the clinical commissioning group (CCG) before the patient was listed on to a clinic appointment. Once confirmed on a database, the referral was used as the basis of a set of Nuffield Medical records, prepared the day before the clinic. Local NHS patients were not listed for appointment until medical records were received from the trust.
- The hospital was working towards an electronic system to scan all clinic notes prior to consultants removing them from the hospital. This had been trialled in two other specialities with success and Nuffield Health was striving towards implementation of this on a national basis.

Safeguarding

- Nuffield Health Cambridge Hospital had reported no safeguarding incidents between April 2015 and March 2016.
- The hospital had a named lead for safeguarding for both adults and children. Staff had access to safeguarding policies online.
- Staff within the outpatients department had access to staff who had received level three safeguarding training, including the registered nurses (child branch), senior management team and resident medical officer, who was available 24 hour per day. Staff we spoke with knew who these individuals were and how to contact them.
- The outpatients department had achieved 100% for safeguarding adults, level one and two which exceeded the hospital target of 85%.
- The diagnostic imaging department had achieved 100% compliance with safeguarding children and young adults, level one. However, only 63% of staff had received training on safeguarding vulnerable adults, level one.
- FGM safeguarding training included education and awareness of female genital mutilation (FGM).
- Staff were clear on how to raise safeguarding concerns for both adults and children, stating they had guidance within the department on how to raise concerns. In addition, any concerns were reported to the ward manager who in turn would escalate to the local authority.

Mandatory training

- Staff within in the outpatients department were required to complete mandatory training in a range of subjects. Out of 25 subjects, the hospital was achieving its target of 85% to 100% compliance for all but three of these areas. Manual handling, paediatric basic life support and safeguarding adults level one fell short of the 85% hospital target at 71%, 79% and 79% compliance respectively.
- Staff within the radiology department were also required to undertake mandatory training in a variety of subjects. Out of 24 subjects, the hospital was achieving it's target of 85% to 100% compliance in 17 areas. Incident reporting, fire safety, health, safety and welfare, infection prevention, paediatric basic life support and safeguarding vulnerable adults level one fell short of the hospital's 85% target at 75%, 63%, 75%, 75%, 50%, 75% and 63 % respectively.

Assessing and responding to patient risk

- The diagnostic imaging department used the World Health Organisation (WHO) safer surgery checklist specifically for radiology interventions. This tool is used by the clinical teams to improve the safety of surgery and procedures by reducing deaths and complications.
- Audits on safer surgery were undertaken on five sets of notes on a monthly basis in radiology. For the period April 2016 to July 2016 showed that checklists were completed 100% of the time for both documentation and observational audits on all but the July 2016 audit where 80% was scored.
- Staff described their response should a patient become acutely unwell patient within the outpatients department. Staff would immediately escalate their concerns to the resident medical officer (RMO) to assess and treat the patient whilst making them as comfortable as possible.
- In 2016, the service had introduced additional on-site training for clinical staff in recognition and management of the deteriorating patient. Training records provided evidenced that al clinical staff in outpatients had received this training.

Outpatients and diagnostic imaging

- The hospital carried out cardiac arrest scenarios in various departments to ensure staff were responding correctly and in a timely manner. One member of staff said 'you never know when they are going to happen; it is really good as it keeps you up-to-date with basic life support'. We were told these scenarios occurred approximately once every two months.
- The radiology department had a specific room for patients should they feel unwell during or after a procedure. As with the main outpatients department, they would seek attendance of the RMO to assess and treat the patient if necessary.
- The diagnostic imaging department had access to a specific medication box to treat anaphylaxis (a rare life threatening allergic reaction) to contrast agents used during scanning. This box contained adrenaline, steroids and anti-histamines to enable prompt treatment should this situation arise.

Nursing and diagnostic staffing

- As of April 2016, seven whole time equivalent (WTE) nurses and two WTE healthcare assistants staffed the outpatient department. For the outpatient department there was a ratio of one nurse to 0.3 whole time equivalent (WTE) healthcare assistants. The staffing ratios were sufficient to meet the demand of the service.
- Within the diagnostic imaging department there were 5.8 WTE radiographers and two HCA/Admin staff, which was sufficient to meet the needs of the service.
- Use of bank and agency staff for healthcare assistants working in the department was higher than the yearly average for other independent acute hospitals for the period of April 2015 to March 2016.
- Staffing levels were adjusted in advance depending on clinic attendances and speciality to ensure adequate staffing levels at all times.
- The outpatients department would forward plan clinics to ensure a registered nurses (child branch) was available when paediatrics attended for invasive procedures.
- For the period of April 2015 to March 2016, the sickness rate for outpatient nurses and healthcare assistants was varied when compared to the yearly average of other independent hospitals. During two months in this period levels of sickness amongst nursing staff rose to 10% and 15% which was five to 10% above the level compared to other independent acute hospitals that we hold data for.
- For the period of April 2015 to March 2016, the rate of sickness amongst healthcare assistants was also variable rising to 18% in one month out of this period.
- Staff vacancies in relation to the healthcare assistant role were considerably higher as of April 2016 at 25%.

Medical staffing

- The hospital had 255 doctors on practicing privileges at the time of our inspection.
- The hospital had two resident medical officers (RMO's) providing an alternate week long block of cover, 24 hours a day. Whilst not employed directly by the hospital, they had an agency handbook and hospital induction programme prior to commencing work.
- The hospital had access to agency RMO's should there be a need, therefore ensuring cover at all times. This was in place to provide cover if the RMO had worked excessive hours during the night, to aid necessary rest periods.
- Patients were provided with a point of contact should they have concerns about their treatment or condition in between appointments. Staff reported all consultants were easily accessible when not at the hospital to give advice and to book emergency clinics should this be required.

Major incident awareness and training

- There was an internal emergency incident and business continuity plan in place which described actions to be taken in the event of fire, flooding, loss of power or infection outbreaks.
- Table top training exercises were conducted at the hospital during team briefs to ensure staff could action the procedures detailed within the major incident plan.
- Equipment within the diagnostic and imaging department had mechanisms in place to safely abort scanning and procedures should the electricity fail. The hospital was equipped with oil generators in the event of a loss of power supply.

Outstanding ☆

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

At present we do not rate the effectiveness for outpatient and diagnostic imaging services in acute independent hospitals but during our inspection we noted the following good practice:

- Hospital policies and procedures were developed nationally by Nuffield and took account of relevant best practice guidance including that issued by the National Institute for Clinical Excellence (NICE), the Department of Health and relevant royal colleges such as The Royal College of Nursing (RCN).
- Appraisals were being carried out on a regular basis within the outpatient and diagnostic imaging department.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007).
- The hospital took part in a variety of audits, including hand hygiene and completion of patient care records.
- The hospital participated in various national audits, including the National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMS).
- Consent in notes was clearly documented prior to treatment or procedures.
- Robust systems and processes were in place with regard to consultants' practising privileges.

Evidence-based care and treatment

- Hospital policies and procedures were developed nationally by Nuffield and took account of relevant best practice guidance including that issued by the National Institute for Clinical Excellence (NICE), the Department of Health and relevant royal colleges such as The Royal College of Nursing (RCN).
- We reviewed policies and procedures on outpatients appointments times and the need to see patients within 18 weeks. Staff were aware of the contents of this policy, it was monitored locally and at hospital level. This policy was being adhered to in line with best practice.
- The hospital took part in a variety of audits, including hand hygiene and completion of patient care records.
- The hospital participated in various national audits, including the National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMS). We saw evidence in patient notes that consent was gained prior to the use of patient data in relation to National Joint Registry (NJR).
- The diagnostic imaging department had clear processes in place to report incidents. This process was structured and began with electronic incident reporting, notification to the radiation protection advisor and then notification to IR(ME)R if appropriate. We were told by a radiographer that there had been no exposures greater than intended within the diagnostic imaging department within the last 12 months. IR(ME)R reports provided by the service supported this.

Pain relief

- The medicines management forum discussed pain management with information being fed in to the clinical governance committee.
- Out of the three patients' notes we viewed, pain relief was not required for the outpatient appointment. However if pain relief was required this could be accessed for the patient.
- Within the diagnostic service pain relief was offered for patients undergoing interventional radiology procedures. The pain relief offered was dependent upon the patient and the procedure. The doctor undertaking the procedure would assess the need for pain relief.

Nutrition and hydration

- Patients and relatives had access to both hot and cold drinks in all outpatient waiting areas. During our inspection we saw staff signposting patients to these areas.

Patient outcomes

- The diagnostic imaging department carried out weekly audits in relation to the completeness of paperwork, fridge checks and documentation around the risk of pregnancy. Staff told us that patients were questioned regarding the risk of pregnancy during consultations and prior to diagnostic imaging being carried out. In addition, signage was in place in the radiology department relating to pregnancy. If any doubts were in place, patients were tested for pregnancy prior to the exposure of radiation.

Outpatients and diagnostic imaging

- The radiology service undertook annual audits on radiation exposure limits and local diagnostic reference levels (DRLs). The most recent audit from February 2016 did not identify any concerns regarding patient exposures.
- The annual radiation protection audit (October 2015) provided an outcome 'fully compliant with no improvements required'.
- Blood transfusion sample audits were undertaken in outpatients. We reviewed the audits and results for April and May 2016, which showed that the service achieved 100% compliance with the requirements of blood transfusions.
- We reviewed the chaperone policy audit completed by the service for March, May and July 2016. This audit was undertaken by observation of the outpatient sessions and through speaking with patients. The audit results showed that 100% of patient were offered or used a chaperone where appropriate. There was also evidence that suitable signage was displayed throughout the service.

Competent staff

- Data provided by the hospital prior to our inspection revealed that from March 2015 to February 2016, 87% of nurses and 100% of healthcare assistants within the outpatient and diagnostic imaging department had received an appraisal against a target of 85%.
- Data provided by the hospital relevant to the outpatients department showed that staff were achieving the hospital training compliance rate of 85% in all but three of 25 training areas. Manual handling, paediatric basic life support and safeguarding vulnerable adults level one were falling short of the 85% target at 71%, 79% and 79% compliance respectively.
- Nursing staff in post longer than six months had their validation rechecked in 100% of cases.
- The hospital medical advisory committee (MAC) had primary oversight of the clinicians practicing privileges (PP's). The registered manager (hospital director) and chair of the medical advisory committee (MAC) was responsible for the granting of PP's. There was a robust checking system in place prior to employment to ensure consultants met the required standard.
- The majority of consultants employed at the hospital were employed elsewhere within the NHS. All medical staff working at the hospital were required to provide proof of appraisal to be able to work at the Nuffield Health Cambridge Hospital.
- Over the last 12 months the hospital have removed 14 doctors practicing privileges and four had their practicing privileges (PPs) suspended. Of those two had relinquished PPs, one doctor moved away from the area, two did not submit sufficient documentation to maintain PPs, one returned. The final eight were removed for not working at the hospital for two years or more.

Multidisciplinary working

- There were robust working arrangements in place between the local three NHS trusts and the Nuffield Health Cambridge Hospital. There were agreed service level agreements (SLA's) between the NHS trusts and the hospital to provide outpatient services to NHS patients at the hospital. There were also agreements in place for the use of the diagnostic service.
- There was good working relationships and MDT working with regards to oncology services. Whilst patients who received oncology treatment at the hospital were entirely private the hospital ensured that the NHS service was aware of patients receiving outpatient appointments at the service.
- Throughout the inspection we observed a good working relationship between outpatients, the ward, the domestic and housekeeping services and the hospital management team. There was a good relationship between the outpatient and diagnostic service who also worked together.

Seven-day services

- The Nuffield Health Cambridge Hospital outpatients department operated between the hours of 8am and 9pm Monday to Friday, with appointments also offered on Saturdays between 8am and 2pm, depending on the demand for clinics. Patients attending the outpatient department had access to an on-site pharmacy during clinic opening hours.
- A resident medical officer (RMO) was available 24 hours a day, seven days a week, with processes in place via an agency for cover to ensure safe working, for example when the on-site RMO had been working excessively during night-time hours.

Outstanding ☆

Outpatients and diagnostic imaging

Access to information

- Access to NHS patients' records and previous medical records was via the NHS portal. Referrals for NHS patients were triaged for suitability prior to being booked.
- Secretaries to the consultants sent electronic clinic lists that were security encrypted to protect patient confidentiality.
- Images from the diagnostic imaging department were shared electronically with the local NHS trust in Cambridgeshire.
- The matron was the Caldicott lead for the hospital. Formal requests for information access were sent through matron for approval to ensure that the hospital policy was followed and to ensure that data protection principles were followed.
- The radiology department had the ability to securely transfer images to the local NHS trust, therefore enabling continuity of care for patients receiving care at different locations.
- For NHS patients, there was a central electronic referral submission process for referrals to be electronically accessed and forwarded for prior approval to the clinical commissioning group (CCG) before the patient was listed on to a clinic appointment. Once confirmed on a database, the referral was used as the basis of a set of Nuffield Medical records, prepared the day before the clinic. Local NHS patients were not listed for appointment until medical records were received from the trust.
- Off-site private medical records were brought in secure packaging (data bags) to and from the hospital by either the consultant or their secretary. There was a robust signing in and out process in place to allow tracking of notes in a timely manner.
- All information, for example clinic lists, were sent securely and encrypted by secretaries when sent to the consultants.
- Patients had access to leaflets within the diagnostic imaging area, giving information on computerised tomography (CT) scanning and mammograms.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (2007). Training figures provided by the hospital revealed good compliance in this training with 86% of outpatient staff having received Deprivation of Liberty Safeguards training and 93% of staff had received training in the Mental Capacity Act (MCA) against a target of 85%.
- Consent was sought prior to any procedure taking place within the outpatients and diagnostic imaging department. Staff had access to this policy online. We reviewed this policy and noted that it was in date.
- Within radiology an audit we reviewed on safer surgery for May, June and July 2016 which covered the need to take consent from the patient. We observed that for two of the three months the service achieved 100% on the question for 'sign in all checks complete', which includes consent being taken. On the other month 8% was achieved with one set of notes not having all the required elements checked.
- The National Joint Registry (NJR) is a record in which hospitals submit information about patients who have received joint replacement. This is to improve and maintain the quality of care of individuals receiving joint replacement surgery across the NHS and the independent healthcare sectors. In one set of notes we viewed for an orthopaedic patient, consent had been gained prior to the entering of patient details on the NJR.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

We rated outpatients and diagnostic imaging services as outstanding for care because:

- Friends and Family Test (FFT) results demonstrated 100% of patients would recommend the hospital for every month with the exception of March 2016 when the result was 91%.
- Patient satisfaction data collected by the hospital showed that the hospital received, on average, positive feedback scores of 96%. This was consistently above the Nuffield Health group average of 92%
- Patients we spoke with were complimentary about the care they had received. We received unanimously positive comments from patients and their relatives who could not speak highly enough about the service.

Outpatients and diagnostic imaging

- A chaperone service was planned in advance and offered to all patients. The hospital could provide male or female chaperones depending on the procedure to be carried out and took into account religious beliefs of patients.
- Relatives were welcomed to accompany patients in to consultation areas for support
- People we spoke with said 'the staff are so kind and caring, nothing is too much trouble'. Another patient said 'I have been coming to the Nuffield in Cambridge for over 20 years, everyone is lovely and friendly, we get seen on time'.
- The department had a dignity representative. The service had access to specialist nurses and support services to support a patients emotional and wellbeing needs.

Compassionate care

- Friends and Family Test (FFT) results for the period December 2015 to May 2016 demonstrated 100% of patients would recommend the hospital for every month with the exception of March 2016 when the result was 91%.
- Patient satisfaction data collected by the hospital showed that from January 2016 to June 2016, the hospital received, on average, positive feedback scores of 96%. This was consistently above the Nuffield Health group average of 92%.
- The department offered chaperones for all intimate procedures and patients could request this service at any time. The use of a chaperone was clearly documented in patient notes. In addition, staff told us that they could provide male or female chaperones depending on the procedure to be carried out and took into account religious beliefs of patients.
- We saw episodes of patient care during our inspection where staff were courteous to patients. Staff spoke with patients in a kind and polite manner and introduced themselves by name prior to consultation.
- We spoke with four patients and their relatives during the inspection. People we spoke with said 'the staff are so kind and caring, nothing is too much trouble'. Another patient said 'I have been coming to the Nuffield in Cambridge for over 20 years, everyone is lovely and friendly, we get seen on time'.
- We spoke with a dignity representative who was passionate about their role within the department. One member of staff said 'everything we do is for the patients, to give them the best care possible'.
- Each consultation room door clearly displayed whether or not the room was actively in use. Staff made use of this signage when showing patients in rooms, therefore protecting privacy and dignity of patients during consultations or procedures.

Understanding and involvement of patients and those close to them

- Patient feedback cards were available in the hospital reception area, enabling patients to submit compliments or concerns in relation to their experiences. We asked to see a selection of responses however reception staff reported that they regularly get sent to the administration department to be actioned, if necessary, hence none were available.
- Relatives were welcomed to accompany patients in to consultation areas for support.
- Staff within the diagnostic and imaging department had designed a card for paediatrics due to attend the department. This was sent prior to the appointment and explained what to expect when visiting this area of the hospital. In addition, prior to scans being carried out, children had access to sit on equipment and familiarise themselves with the environment prior to procedures being carried out.
- The costs of appointments were very clearly provided to the patient prior to and at the time of booking their outpatient appointment. When a further treatment, procedure or surgery was required the full costs were provided to the patient and broken down by individual cost such as anaesthesia, surgery, equipment etc.
- The service had information on leaflets and on the hospital website regarding costs, options for payment and the processes to follow.
- The service had not received any complaints regarding fees, costs or arrangements for outpatient payment at the service. No concerns were raised to us about this during our inspection and we were assured that patients and their relatives understood their treatment and payment arrangements.

Emotional support

Outstanding ☆

Outpatients and diagnostic imaging

- In 2015, the Nuffield launched a pilot scheme, in collaboration with 'The Maggie's', an organisation that provides support and advice to those undergoing cancer treatments. Patients within the outpatients department had access to this service. Support included referral to workshops and a clinical psychologist at the local NHS Trust.
- The hospital had access to a specialised breast care nurse within Nuffield Health Cambridge Hospital. This specialist nurse was available to attend outpatient appointments to provide emotional support to patients.
- The service had access to counselling services through the local NHS trust. This was specific to end of life or palliative care. Though the service could provide support information for other organisations if the diagnosis required emotional or counselling support that was not cancer related.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

We rated outpatients and diagnostic imaging for responsiveness as outstanding because:

- The outpatients department exceeded its target of 92% for referral to treatment times in less than 18 weeks, achieving 100% for 11 months straight.
- The outpatient service for oncology ran a 'one stop' clinic for patients with breast cancer, which could be accessed within one week should the patient require it. This was well utilised and responded to individual needs for emotional support and to avoid inpatient admissions.
- The hospital had a rapid access process for outpatient appointments. This meant that in the event of urgent referrals the service would aim to get the patient an appointment within three to five days where suitable.
- The outpatients and diagnostic imaging department had robust systems in place to handle complaints. The hospital complaint rate was significantly lower than other independent acute hospitals.
- Patients had access to translation services should their first language not be English.
- The hospital monitored how long the patient spent in the hospital prior to their appointment, and found that the patients often waited no more than 15 minutes for their outpatient appointment.
- The hospital provided data in relation to NHS funded patients and diagnostic waiting times. Between April 2015 and March 2016, no NHS patient waited longer than six weeks for MRI, barium enema, colonoscopy, flexi sigmoidoscopy, cystoscopy and gastroscopy.
- The costs of appointments were very clearly provided to the patient prior to and at the time of booking their outpatient appointment. The service had information on leaflets and on the hospital website regarding costs, options for payment and the processes to follow.

Service planning and delivery to meet the needs of local people

- Hospital objectives for 2016 were noted to include improvement of access to products and services to meet people's needs. This was primarily focused on the private patient and included a review of pricing to ensure competitiveness.
- We saw notes from a clinical governance meeting from March 2016 which detailed two new proposals for service development. This included weight loss management and bariatric surgery and the addition of lung function clinics. These proposals were due to be taken to the medical advisory committee for review and proposal (unable to find in data of this has actually happened).
- The outpatient service was supporting local NHS services by providing 20% of their service capacity to NHS patients. The service leaders were clear that they wanted to focus on providing the best outpatient care and would not go above a 20% provision for outpatients.
- The hospital was going through a major refurbishment and landscaping programme at the time of our inspection. This meant that for a short period of time there had been some challenges with reduced car parking facilities. However, this was temporary whilst the new car park was being laid and the grounds being landscaped.
- With the new building it had been noted that some mobile phones had limited reception and this had been

feedback by patients. However, the service was going through a review process with engineers to rectify the problems with mobile phone reception and were confident it would be resolved.

Access and flow

- The outpatients department exceeded its target of 92% for referral to treatment (RTT) waiting times in less than 18 weeks for the period of April 2015 to March 2016 for incomplete patients. These figures were pertaining to NHS funded patients only.
- Targets for non-admitted patients' treatment beginning within 18 weeks were abolished in June 2015. It is however positive to note that for the period of April 2015 to March 2016, the outpatients department exceeded its target of 95% on a consistent basis, reaching 100% in 11 months during this period.
- The hospital provided data in relation to NHS funded patients and diagnostic waiting times. Between April 2015 and March 2016, no NHS patient waited longer than six weeks for MRI, barium enema, colonoscopy, flexi sigmoidoscopy, echocardiography, cystoscopy and gastroscopy.
- Within the period of April 2015 to March 2016, 50% of patients waited more than six weeks for a CT scan. However, it is to be noted that this was a sample size of two patients.
- The hospital had five NHS patients waiting longer than six weeks for non-obstetric ultrasound and in the same reporting period. This was low which was positive, and this was monitored by the service to ensure patients were seen in a timely way.
- For all private patients, the booking department told us that once a referral had been received from a GP, they would contact the patient, offering them a choice of consultant and date of appointment.
- NHS patients would all be screened for suitability for treatment and then access the NHS choose and book system for an outpatient appointment.
- The length of appointments was tailored according to speciality and treatment required. We were told that the majority of consultants requested an initial appointment time of 30 minutes and 15 minutes for a standard follow-up-appointment.
- Staff we spoke with reported the clinics flowed on time and patients were not subjected to extended waits within the department. On the day of our inspections, all patients were seen in a timely manner. No concerns were raised to us about the waiting times within the clinics held during our inspection.
- The hospital director shared with us that they were continually monitoring outpatient waiting times to ensure that patients did not have to wait too long for appointments. They shared with us that there were approximately 200 patients waiting for dermatology outpatients and additional clinics had been scheduled to reduce the wait list from three weeks to under two weeks.

Meeting people's individual needs

- The outpatients department had access to translation services via the telephone for people whose first language was not English. Staff told us that patients requiring translation services were planned for in advance, ensuring a cordless phone was available to facilitate with this service in the privacy of a consultation room.
- There was a specialist nurse named to provide support for patients with dementia or learning disabilities. When these patients were booked arrangements were made for the specialist staff to attend and support the patient's needs.
- The outpatient rooms, treatment rooms and diagnostic rooms had couches, tables and chairs, which were suitable for bariatric patients.
- Where a patient had a fear of needles or treatments, arrangements were made to provide support for the patient as part of the appointment. This included going into the scanning machines in radiology.
- The outpatient service for oncology ran a 'one stop' clinic for patients with breast cancer, which could be accessed within one week should the patient require it.
- The hospital had a rapid access process for outpatient appointments. This meant that in the event of urgent referrals the service would aim to get the patient an appointment within three to five days where suitable.

Learning from complaints and concerns

- Patients and relatives had access to information on how to complain, we saw comments cards in the outpatient department during our inspection. Patients could also complain by going to a link on the hospital website.

Outstanding ☆

Outpatients and diagnostic imaging

- The Nuffield Health Cambridge Hospital reported 20 complaints in the period April 2015 to March 2016. The number of complaints received was for the hospital as a whole, none of which pertained to the outpatient and diagnostic imaging department.
- The number of complaints received by the hospital was significantly lower than other independent acute hospitals (based on 20 other hospitals we hold data for).
- None of the complaints received had been referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and were dealt with at a hospital level.
- The hospital had a policy in place for dealing with complaints; overall responsibility for complaint management lay with the hospital director. If a complaint was in relation to clinical care, a clinical member of staff would lead the investigation. The hospital aimed to acknowledge receipt of all concerns and complaints within two working days.
- Complaints were discussed at monthly clinical governance meetings and where applicable, information was cascaded to hospital staff to ensure that learning took place.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated the outpatients and diagnostic imaging department as outstanding for being well-led because:

- The hospital had a clear vision and staff were aware of this. The hospital's local vision was to become the, "Private Hospital of Choice".
- The hospital had four values; enterprising, passionate, independent and caring, known as 'EPIC'. We saw adherence to these values in the work carried out by staff with their caring nature to patients and passion to provide high quality care to patients.
- There was an effective and robust governance structure and learning and improvement was evident.
- The hospital was well supported by an active medical advisory committee. The Chair of the MAC was proactive and engaged with the service and had a good working relationship with the senior management team. The vision of all was to drive improvement in patient care through robust and effective processes.
- The local outpatient and diagnostic leadership team were accessible and staff told us that they were approachable. Staff told us how their managers were 'Outstanding'.
- The hospital was managed by a dedicated and proactive senior leadership team. Staff told us how the hospital director and matron were routinely visible and approachable, willing to listen and open to ideas on how to improve the service.
- The leadership team of all levels were proactive and looked for opportunities to improve patient care.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.
- We saw that the hospital worked in close collaboration with the local NHS trust.
- There were mechanisms in place to maintain staff and service user engagement.

Vision and strategy for this this core service

- The national Nuffield vision was to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner'.
- As a not for profit organisation in addition to this vision the hospital also worked to fulfil its charitable purpose which was "to advance, promote and maintain health and healthcare of all descriptions and to prevent, relieve and cure sickness and ill health of any kind, all for the public benefit."
- The hospital's local vision was to become the, "Private Hospital of Choice". The service was aiming to maintain its private hospital atmosphere while also making a contribution to NHS patient lists and leaders told us about increasing their work in conjunction with other local and community services.

- We spoke with two members of staff about the vision and strategy and there was an understanding of the goals and values of the hospital and how it had set out to achieve them.
- The strategy for Nuffield Health Cambridge was; 'to help individuals achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner'. The strategy was underpinned by four values; enterprising, passionate, independent and caring, known as 'EPIC'.
- We saw adherence to these values in the work carried out by staff with their caring nature to patients and passion to provide high quality care to patients.

Governance, risk management and quality measurement for this core service

- The service had a robust structured process in place for the medical advisory committee (MAC). We reviewed the meeting minutes of meetings held in January and April 2016. These were detailed, comprehensive and covered all services within the hospital. Topics discussed included risk, practicing privileges, quality dashboards and visions for the future.
- We spoke with the hospital director and MAC chair about the process of the committee and sign off. Both were articulate about the running of the service and MAC and had a clear understanding about the quality of service to be provided.
- Practicing privileges were routinely discussed as part of the MAC. Privileges are to be renewed and reviewed every three years as a minimum. There were 255 consultants on practicing privileges at the hospital and all privilege renewals would be discussed at MAC, as well as new appointments. Examples of where consultants had not adhered to requirements or fallen below the expected standards of behaviour were provided and practicing privileges were removed.
- We reviewed the risk register for the service dated April 2016. Of the risks that were listed, no risks were identified related to the outpatient or diagnostic service. No concerns were identified by the inspectors that warranted inclusion on the risk register for these services.
- It was evident through speaking with hospital leaders and local leaders that they were fully aware of the risks and challenges of the department, and when they would include items on the risk register.
- We also reviewed risk registers completed in May and September 2015. We could see clear progression and monitoring of risks for the hospital, with detailed updates and actions taken to mitigate risks to services where possible. This included clear reasons to downgraded and closed risks on the register. The risk register and risk management process for the service was outstanding.
- The risk register was a standard agenda item on the senior team meeting agenda, and risks were discussed at the clinical governance meetings and head of department meetings. We saw minutes of these meetings, which took place during 2016, which demonstrated that risk was a focal point for the leadership team.
- Locally, the service reported into the governance framework by completing monthly reports, which were submitted to the governance committee. We reviewed these reports from April, May and June 2016 and saw that relevant service information such as incidents, audit outcomes and health and safety information was reported for scrutiny.
- The medical advisory committee received a quarterly update on the performance of the outpatient and radiology service, including the monitoring of RTT. This meant there was good oversight of the service at senior level to ensure appropriate challenge and direction.

Leadership / culture of service

- The consultants described a good working relationship with nursing staff.
- Staff within the department said 'I feel valued, my manager is a great support, you can ask her anything'. No worries were reported by staff within the department. However, we were told they would feel able to speak to managers if concerns arose.
- The hospital was managed by a dedicated and proactive leadership team. Staff told us how the hospital director and matron were routinely visible and approachable.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.

- Locally the service was supported by a dedicated and proactive manager who worked to continually improve the service.

Public and staff engagement

- The service had developed a patient focus group where patients were invited to a meeting to discuss the running of the hospital. We reviewed minutes from the June 2016 patient focus group and noted patients had been engaged on areas such as discharge, waiting times and catering. This initiative was new to the hospital so we could not test how improvements following these meetings were implemented.
- The hospital matron and hospital director informed us about the variety of ways that they had worked to engage the public to attend or provide feedback, but were struggling to get engagement with this.
- The service was actively trying to engage more staff in the investigation and root cause analysis process when incidents occurred to encourage shared learning from and responsibility for these actions. However, the service leaders told us that it had been challenging to encourage staff to become more involved.
- Heads of department had been involved in the design of the new site, which had recently been completed.

Innovation, improvement and sustainability

- When speaking with a professor within the outpatients department, we were told of systems in place to offer breast care patients a one-stop-shop for consultation, treatment and scanning. The aim of which was to see patients in a timely manner and reduce unnecessary stress of multiple hospital attendances.
- Consideration was being given to expanding the integrated cancer rehabilitation programme to include surgical and outpatient specialities.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital leadership team were outstanding in how they led the service and continually strived to further improve the service for patients.
- We found an innovative approach to reduce anxiety in younger children with a small electric car used for the theatre transfer.
- Systems and processes were in place to ensure patients' individual needs were met. This included the outstanding initiative to support patients following their treatment with a 12 week integrated cancer rehabilitation programme.
- An average of 98% of patients were treated within 18 weeks of referral each month.
- Patient care was at the heart of the service and we saw several areas of outstanding practice. This included the emphasis on supporting people emotionally and socially with the on-site Maggie's Wallace charity.
- The feedback we received from people using the service was overwhelmingly positive with people describing the care they had received as, "Amazing" and, "First class."
- The service was scoring in the top 10 of all Nuffield Health hospitals for patient satisfaction and positive feedback.
- The service had a high rate of consent to the National Joint Registry.
- The service performed above average in the Patient Reported Outcome Measures for hip and knee surgeries.
- Staff achievements in completing mandatory training were excellent.The completion of training was seen as a priority for the service.

Areas for improvement

Action the provider SHOULD take to improve

- Consider auditing the effectiveness of pain relief, which was not taking place at the time of our inspection.
- Ensure that bank staff and service staff are all up to date with basic or intermediate life support training.
- Ensure that there is a formal transition arrangement for patients who required an end of life or palliative care pathway to be transitioned back into NHS care.
- Ensure that "Gillick competence" is considered or assessed formally if required.