Bodmin Treatment Centre

Quality Report

Boundary Road
Bodmin
Cornwall
PL31 2QT
Tel:01208 262520
Website:www.ramsayhealth.co.uk/hospitals/bodmin-treatment-centre

Date of inspection visit: 12 & 13 October 2016
Date of publication: 15/02/2017

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Bodmin Treatment Centre is an independent treatment centre operated by Ramsay Health Care UK Operations Limited. We carried out a comprehensive inspection as part of our national programme to inspect and rate all independent hospitals. We carried out the announced inspection on 12 and 13 October 2016.

The treatment centre provides surgery and outpatients to NHS patients and privately funded patients, including self-funded and medical insured. The day surgery unit offers procedures in orthopaedic, general surgery, ears nose and throat (ENT), gynaecology, maxillofacial / oral, ophthalmic and urology. The day surgery unit has two theatres and one recovery area. The recovery area is located at the end of corridor close to both theatres and can accommodate up to five patients. The treatment centre does not operate on children only adults (18 and above) and has no overnight beds. The outpatient department has five consulting rooms and a minor procedure room.

We rated the service overall as requires improvement. We rated surgery and outpatients as requires improvement. This was because we had concerns about aspects of safety and leadership in surgery and outpatients services. We found the management of incidents and governance processes were inadequate. However, we found the service provided good care for its patients and those close to them, and services were planned and delivered in a way that met the needs of the local people.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated this hospital as requires improvement overall.

We found areas of practice that require improvement in surgery services and outpatients:

- Not all incidents were being reported via the providers reporting system. Therefore, incidents were not properly investigated and actions taken to minimise any risks and analysis of trends to prevent reoccurrence were not in place.
- There was no guidance on quality standards for sepsis screening and management pertinent to Bodmin Treatment Centre.
- The procedure for emergency calls for collapsed patients was not specific enough and staff were not identified as to whom would attended.
- Staff did not have a clear understanding of risks, as there was no departmental or detailed local risk register to allow risks to be recorded, escalated and managed locally.
- A corporate audit programme was in place but actions to improve results and performance were not implemented effectively and rarely followed through.
- Governance arrangements did not always identify areas of concern or risk.
- Some senior management were not always visible and/or accessible to staff.
- There was formal engagement with staff but they felt unable to give their views on the service provided due to time constraints.

Summary of findings

- Staff had not received specific training on caring for patients living with dementia.

In surgery:

- The endoscopy unit in theatre two did not meet the requirements for Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal validation that an endoscopy service has demonstrated it delivers against a range of quality improvement and assessment measures. The unit was not validated because the recovery area did not meet the requirements for privacy. Plans had been submitted to address this and they were awaiting a response at the time of our inspection.
- Staff were not following all National Institute for Health and Care Excellence (NICE) guidance as required, especially relating to recording of patients temperature pre, during and post operations. There was no documented evidence to demonstrate if all staff were following NICE guidance.

In outpatients:

- Out of date medication found in the outpatient department.
- Medical equipment inside the resuscitation trolley on the outpatient department was outside its use by date.
- Infection and prevention controls were not adhered to by all staff.
- Guidance on the cleaning of specialist equipment was not always adhered to.
- Leak testing of nasopharyngeal endoscopes was not performed between each patient use, which was a requirement in line with guidance for decontamination, Health Technical Memorandum 01/06 part E testing.
- Staff were not always following medication management policy.
- Resuscitation procedures were not formalised and scenarios within the outpatient department were not practiced. There was no evidence that results from audits were being used to highlight areas for improvement within the department.
- There was a lack of communication between senior management and the outpatient department as incidents and learning outcomes were not always shared internally.

However,

We found outstanding practice in relation to patient care in surgery services:

- They exceeded the England average scores in the Patient Led assessments of care environment (PLACE).
- Patient Reported Outcome Measures (PROMs) data for groin hernia repairs also exceeded the England average.

We found good practice in relation to surgery services and outpatients:

- There were no hospital-acquired infections from July 2015 to June 2016.
- All staff that we spoke with understood the principles of duty of candour.
- Patient records were stored securely and completed in full.
- All staff were up to date with their mandatory training.
- All care and treatment was consultant led and delivered.
- The compliance rate for yearly staff appraisals was high.
- Staff had access to all information needed to meet the needs of patients during their treatment.

Summary of findings

- Patients were treated with kindness, dignity and respect.
- The vast majority of comments from patients were very positive and they had good results from the NHS Friends and Family Test (NHS FFT).
- Patients were encouraged to be actively involved in the decision making process regarding their care and proposed operation/procedure.
- Information about their condition, treatment and operation/procedure was shared with the patient so they were aware of the benefits and any potential risks.
- Staff demonstrated good communication to patients.
- Information about the needs of the local population was used to inform how services were planned and delivered and they worked in partnership with the local commissioners.
- Complaints were reviewed and investigated in line with policy and shared at relevant committee meetings and lessons learnt disseminated.
- Staff were highly positive about their department manager and the some of the hospital management team.
- Senior local leadership within the hospital were visible, approachable and supportive.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected surgery and outpatient services. Details are at the end of the report.

Name of signatory

Ted Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Contents

Requires improvement

Bodmin Treatment Centre

Services we looked at
Surgery, outpatients and diagnostic imaging services.

Summary of this inspection

Background to Bodmin Treatment Centre

Bodmin Treatment Centre opened in December 2005 and is one of 8 centres across the UK where Ramsay Health Care Operations UK Limited is working in partnership with the NHS. The treatment centre primarily serves the communities of the Cornwall and the Isles of Scilly. It also accepts patient referrals from outside this area.

The registered manager is Christopher Sealey who has been registered with us since 1 March 2016. The accountable officer for controlled drugs is Jacqueline Preston, the matron who has been registered for this post for 10 of years.

Vivienne Heckford was the nominated Individual.

The treatment centre was last inspected in September 2013 and was found to be compliant.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Sharon Hayward-Wright, and other CQC inspectors. We had two specialist advisors, one with expertise in anaesthetic medicine and the other in leadership of surgery and outpatient departments. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Information about Bodmin Treatment Centre

The treatment centre is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning services (this was added in September 2013).
- Surgical procedures
- Treatment of disease, disorder or injury

We carried out an announced visit to the hospital on 12 and 13 October 2016. We met and spoke with 11 patients and their relatives or those close to them during the inspection. We spoke with a range of staff including the registered/general manager, matron, heads of departments, nursing and administration staff and surgeons and anaesthetists working under practising privileges. We also held two focus groups for all members of staff to attend.

We inspected surgery and the outpatients department. We observed care in the operating theatre, pre surgery area, recovery and the outpatients department. We reviewed various files including complaints received by the hospital, incident reports, patient care records, hospital policies and staff training records.

There were no special reviews or investigations of the treatment centre ongoing by the CQC at any time during the 12 months before this inspection. The treatment centre was last inspected in September 2013 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Between July 2015 and June 2016 there were 4,109 episodes of day case surgeries recorded at Bodmin Treatment Centre, of these 99.7% were NHS funded and 0.3% were private funded. The most commonly performed surgical procedures were phacoemulsification cataract extraction with 1346, excision of lesion of skin or subcutaneous tissue 282 and primary excision of malignant lesion 198.

Summary of this inspection

There were 8,092 outpatient total attendances between July 2015 and June 2016; of these 98% were NHS funded and 2% were other funded (private). The largest clinics were ophthalmology and dermatology, making up 32% and 17% respectfully of the total number of attendances.

Patient care is consultant led and they come from local NHS trusts under service level agreements. Three other consultants are employed by Ramsay Health Care UK Operations Limited and work at Bodmin Treatment Centre.

Thirty-six surgeons and anaesthetists worked at the treatment centre under practising privileges. Bodmin treatment Centre employed 13 registered nurses (full time equivalent) and four care assistants/operating department practitioners (full time equivalent) and a range of administrative staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the hospital matron.

The sickness rates for nurses working in theatre was varied compared to the average of other independent acute hospitals we hold this type of data for in the reporting period (July 15 to June 16). There was no sickness for nurses working in outpatients during this same reporting period. The sickness rates for operating department practitioners and health care assistants working in theatre departments was also varied compared to the average of other independent acute hospitals we hold this type of data for in the reporting period (July 15 to June 16).

The rate of sickness for outpatient health care assistants was lower than the average of other independent acute providers that we hold this type of data for in the same reporting period, except for in March 2016 when the rate was higher than the average.

There were four complaints made to the treatment centre during the same time period and no complaints made to the CQC. The rate of complaints per 100 day case and inpatient attendances were lower when compared to other independent acute hospitals.

Track record on safety:

- No Never Events
- Clinical incidents were three and two were rated as no harm, one as moderate and took place between July 2015 and June 2016.
- There were 13 non clinical incidents reported in the same period.
- No incidences of hospital acquired MRSA
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli

Services accredited by a national body:

- None at the time of our inspection as the Joint Advisory Group on GI endoscopy (JAGS) accreditation had been removed but plans were ongoing to address the issues identified.

Services outsourced at Bodmin treatment Centre:

- Pathology
- Pharmacy
- Clinical imaging

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?

Requires improvement 

- Not all incidents were being reported via the providers reporting system. Therefore, incidents were not properly investigated and actions taken to minimise any risks and analysis of trends to prevent reoccurrence were not in place. This was a breach of a regulation. You can read more about all breaches or regulation at the end of this report.
- The endoscopy unit in theatre two did not meet the requirements for Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal validation that an endoscopy service has demonstrated it delivers against a range of quality improvement and assessment measures. The unit was not validated because the recovery area did not meet the requirements for privacy. Plans had been submitted to address this and they were awaiting a response at the time of our inspection.
- There was no guidance on quality standards for sepsis screening and management pertinent to Bodmin Treatment Centre.
- Staff did not have a clear understanding of risks, as there was no departmental or detailed local risk register to allow risks to be recorded, escalated and managed locally.
- A corporate audit programme was in place but actions to improve results and performance were not implemented effectively and rarely followed through.
- The procedure for emergency calls for collapsed patients was not specific enough and staff were not identified as to whom would attended. This was a breach of a regulation. You can read more about all breaches or regulation at the end of this report.
- Out of date medication found in the outpatient department. This was a breach of a regulation. You can read more about all breaches or regulation at the end of this report.
- Medical equipment inside the resuscitation trolley on the outpatient department was outside its use by date. This was a breach of a regulation. You can read more about all breaches or regulation at the end of this report.
- Guidance on the cleaning of specialist equipment was not always adhered to. This was a breach of a regulation. You can read more about all breaches or regulation at the end of this report.
- However,

Summary of this inspection

- Bodmin Treatment Centre was better than the England average for their Patient Led Assessments of the Care Environment (PLACE) assessments. The whole hospital appeared to be cleaned to high standards.
- There were no hospital-acquired infections from July 2015 to June 2016.
- All staff that we spoke with understood the principles of duty of candour.
- Patient records were stored securely and completed in full.
- All staff were up to date with their mandatory training.
- All care and treatment was consultant led and delivered.
- Medicines were secured safely.

Are services effective?

Good

- There were no planned/unplanned patient transfers to other hospitals or unplanned patient readmissions between July 2015 and June 2016.
- They performed significantly better in the Patient Reported Outcome Measures (PROMS) data for groin hernia repairs than the England average for NHS funded patients.
- The compliance rate for yearly staff appraisals was high.
- Staff had access to all information needed to meet the needs of patients during their treatment.

However,

- There was no adapted guidance on quality standards for sepsis screening and management.
- Staff were not following all (NICE) guidance as required, especially relating to recording of patients temperature pre, during and post operations. There was no documented evidence to demonstrate if all staff were following NICE guidance.

Are services caring?

Good

- Patients were treated with kindness, dignity and respect.
- The vast majority of comments from patients were very positive and they had good results from the NHS Friends and Family Test (NHS FFT).
- Patients were encouraged to be actively involved in the decision making process regarding their care and proposed operation/procedure.
- Information about their condition, treatment and operation/ procedure was shared with the patient so they were aware of the benefits and any potential risks.
- Staff demonstrated good communication to patients.

Summary of this inspection

Are services responsive?

Good

- Information about the needs of the local population was used to inform how services were planned and delivered and they worked in partnership with the local commissioners.
- Targets for referral to treatment times were exceeded for NHS patients between July 2015 and June 2016.
- Cancelled operations were re booked within the 28 day time scale for NHS funded patients.
- Complaints were reviewed and investigated in line with policy and shared at relevant committee meetings and lessons learnt disseminated.
- Patients' individual needs were identified using the outpatient medical questionnaire.

However,

- The day surgery unit did not have separate areas for male and female patients, but wooden screens were in place to provide privacy for patients.
- Staff had not received specific training on caring for patients living with dementia.

Are services well-led?

Inadequate

- There was no departmental risk registers to allow risks to be recorded, escalated and managed locally. Not all risks were identified and added to the risk register. You can read more about all breaches or regulation at the end of this report.
- There was a corporate audit programme, which was followed, but actions transferred from previous audits were not recorded or followed up.
- Governance arrangements did not always identify areas of concern or risk. This was a breach of a regulation. You can read more about all breaches or regulation at the end of this report.
- Some senior management were not always visible and/or accessible to staff.
- There was formal engagement with staff but they felt unable to give their views on the service provided due to time constraints.

However

- Staff were highly positive about their department manager and the some of the hospital management team.
- Senior local leadership within the hospital were visible, approachable and supportive.
- A number of staff within the theatre/day unit had been working at Bodmin Treatment Centre for many years and they spoke positively about working there.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Inadequate	Requires improvement
Overall	Requires improvement	Good	Good	Good	Inadequate	Requires improvement

Requires improvement

Surgery

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Inadequate

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

- **Incidents**
- Not all incidents were being reported via the provider's electronic incident reporting system.
- Staff we spoke with were aware of the processes for reporting incidents on the hospital's electronic incident reporting system. However, there were a low number of incidents reported so we were unable to confirm whether staff were using the system effectively to report incidents. We were told when an incident occurred they would inform their head of department and complete a report on the electronic risk management reporting system. Not all staff reported the incident themselves using the incident reporting system. For example, some employed consultants would report to the matron and they would report the incident.
- The general/registered manager told us the hospital had been identified as an outlier for incident reporting amongst other Ramsay Health Care UK Operations Limited locations. There was no evidence of an investigation to identify the reasons for under reporting of incidents. When interviewing the general/registered manager they were unaware that some of the issues discussed in committee meetings, which would be categorised as incidents, had not been recorded on the incident reporting electronic system. Therefore, trends and patterns were not being picked up by the hospital due to the under reporting.
- We identified a number of incidents prior to the inspection that had not been reported via the providers reporting system. For example, in the minutes of the heads of department meeting it was documented that a consultant had been late for the start of their theatre list which had affected patients. Another example was where patients had turned up for their operations but had eaten or drunk resulting in their operation being cancelled. During our meeting with the registered manager, they told us these incidents should have been reported on their incident reporting system.
- The provider sent us information prior to our inspection where they told us they had three clinical incidents and 13 non-clinical incidents in a year. However, during the time between us receiving the information and our inspection four more clinical incidents had been reported.
- We reviewed a reported incident where a diabetic patient was placed fourth on the theatre list and therefore had their surgery cancelled. There was no investigation documented on the incident report and the outcomes recorded were not appropriate for the case. There was a lack of acknowledgement that the patient's diabetic status was not identified during the patient's pre-assessment. However, a senior member of staff told us they planned to devise a standard operating procedure (SOP) for all staff to follow when a diabetic patient was admitted in future and this would be shared with outpatients. Nevertheless, this was not recorded on their incident form nor embedded in an action plan that was being monitored.
- There was no evidence of how learning was shared with staff in theatre; we were told the heads of department provided verbal feedback.

Surgery

- One member of staff explained how they had raised an incident on the electronic system and they received feedback from senior staff.
- **Duty of Candour**
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. All staff that we spoke with understood the principles of openness and transparency that were encompassed by the duty of candour.
- A corporate 'being open' policy was available to staff and provided guidance on the duty of candour. However, no training on the duty of candour was provided to staff. The 'being open' policy stated staff should receive training in being open and meeting the requirements of the duty of candour.
- We reviewed one incident, which was subject to the duty of candour. The matron told us they had been open and honest with the patients involved and provided them with an apology. However, there was no evidence of the duty of candour recorded on the incident report in line with the corporate 'being open' policy, as patients should be provided with a written notification.
- **Cleanliness, infection control and hygiene**
- The whole hospital appeared to be cleaned to a high standard.
- The housekeeping team, which included a team of six staff members, were responsible for cleaning the whole hospital. We observed completed cleaning schedules, which were checked by the housekeeping manager. Every six months an external company deep cleaned the hospital.
- All equipment we observed in theatre and recovery unit was also visibly clean. Cleaning schedules for pre-operative rooms and recovery area were all up to date.
- Protective equipment, which included gloves and aprons, was in place for staff to use. Alcohol hand gel dispensing machines were also located throughout the theatre and recovery unit.
- The hand hygiene audits (which varied in time scales from between two to four months) from July 2015 to April 2016 all documented issues with staff not being bare below the elbow in clinical areas. For example, wearing cardigans and rings with stones in them. There was no documented evidence of actions taken to address this issue. This was also documented in the infection control meeting minutes in June 2016. We spoke with a senior member of staff who told us this had since been addressed. During our inspection, all staff in theatres and recovery unit were all bare below the elbow, or in the recovery area wearing cardigans that were disposable. However, not all senior staff adhered to policy as we observed that some were not bare below the elbow when visiting clinical areas.
- Additional infection control audits took place which included checks on the hospital environment. In March 2016, the environmental audit scored 100% but in November 2015, a score of 99% was achieved due to identified damage to a chair, which was subsequently removed.
- The hospital did not routinely monitor surgical site infections and were reliant on being informed by patients or other healthcare providers if one had occurred.
- Root cause analysis (RCA) were undertaken if a patient developed an infection. We reviewed four RCA following infections and no cause or trends were identified.
- Staff working within endoscopy told us about how they cleaned the scopes once they had been used which involved the use of dirty and clean utility areas. Scopes, once used, were passed through a hatch area, in theatre two (where the procedures took place), into the dirty utility where the cleaning process took place. The member of staff was very knowledgeable about the process and made sure the scopes were protected from possible risk of cross-infection. When the equipment had been cleaned, a label was placed on it to indicate when it had been cleaned and it was hung in a special cabinet to dry out.

- The matron was the lead for infection control and had attended an external infection prevention and control training course. They identified how they were struggling at present to meet the demands of the infection control lead along with other commitments, for example the day to day running of Bodmin Treatment Centre. Another member of staff had recently been appointed as the infection control link nurse for the whole treatment centre. They had received corporate training for this role and attended corporate infection control meetings and fed this information back to the matron. The Ramsay Health Care UK Operations Limited infection prevention control lead was available for advice and would review all root cause analysis following identified infections.
- In the last year, two infection prevention and control meetings had been held. The matron said how there were difficulties to make these meetings quorate. We were not told what was being done to address this. The matron was the lead for infection control and had attended a corporate infection prevention and control training course. The senior management team identified how they were struggling at present to meet the demands of the infection control lead and were unable to evidence how they were promoting infection control to staff and patients. Although they had implemented change to promote infection control as part of their Commissioning for Quality and Innovation Payments framework (CQUIN) at the centre which included hand hygiene. To promote hand hygiene within the hospital, leaflets had been placed in staff areas and wash hand signs were visible when entering departments. The CQUIN framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.
- The water quality was regularly monitored and we saw evidence of a completed Legionella logbook. No records of any issues was found.
- Bodmin Treatment Centre had reported no cases of MRSA, Methicillin Sensitive Staphylococcus Aureus(MSSA) and Clostridium difficile (C.difficile) between July 2015 and June 2016. Patients were screened for MRSA in pre-assessment in line with Ramsay Health Care UK Operations Limited policy, which included patients who had been in contact with MRSA. The hospital aimed for MRSA screening to be completed within one month of admission. If a patient was identified as positive for MRSA they would receive treatment then be re screened, as soon as the result was negative, they would aim for admission within two weeks.
- Staff told us curtains around the trolley area in the recovery unit were changed every six months unless they were soiled. Staff told us this was documented when they were changed.
- There were safe systems for managing waste to prevent cross infection. In theatres, staff used a number of different bags to put in clinical and non-clinical waste before it was disposed of into the dirty utility area.
- The Department of Health and the NHS England recommend that all hospitals, hospices and independent treatment centres providing NHS funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. Patient-led assessments of the care environment (PLACE) took place between February and June 2016. Cleanliness scored 100% compared to the England average of 98%.
- **Environment and equipment**
- Bodmin Treatment Centre was a purpose built unit for day procedures/operations and outpatients.
- Lifts were available to help patients access the theatre, pre operation area and recovery unit. Toilets were clearly signposted with separate toilets for men and women. Toilets for patients with a disability were also available.
- Following a complaint, we were told by staff a moving and lifting aid was purchased but staff had not received training on how to use it safely and no plans for training were in place.
- A senior member of staff in theatres had devised an equipment spread sheet for theatre equipment to identify when equipment was last serviced and when it required servicing. This was red/amber/green rated, for example, green if serviced, amber if nearing service and red if the date for service had passed. This system had very recently been introduced and some equipment

servicing dates needed to be added. They told us Ramsay Health Care UK Operations Limited had corporate contracts with external companies to complete their servicing of equipment.

- We read in the minutes of a heads of department meeting that some equipment was nearly 10 years old and would be need to be replaced as spare parts were no longer available for them. We were told investment in new equipment was on hold until they had received confirmation that the contract from the local Clinical Commissioning Group to continue providing treatment to NHS patients had been secured. They were hoping the decision would be shared with them in the next few months.
- We saw that sharps bins were correctly filled, labelled and securely fastened.
- A number of incidents involving the blood fridge had been recorded as non-clinical incidents. A senior member of staff told us this was due to how it was set up to record the temperature. A service level agreement (SLA) was in place with local acute NHS trust for the provision of blood products. The SLA included sending in the weekly record sheet to demonstrate the fridge was operating between the required temperatures. The senior member of staff felt the issues with incorrect set up had been addressed as staff had received more training. The blood fridge was also connected to an alarm system which was monitored by an external company so if the temperature was outside the required temperature this would be identified and addressed especially as Bodmin Treatment Centre was closed at nights, weekends and public holidays.
- We were told there had been an issue with the temperature of one of the rooms where some medication (not controlled drugs) and the blood fridge was stored. A senior member of staff told us this had been addressed as an air conditioning unit had been fitted and temperatures were within the required safe limits.
- There were ongoing issues with the control of temperature in theatres as it was either too hot or too cold depending on the time of year. This issue had not been reported as an incident or documented on the hospital's risk register but was discussed at the senior management meetings. This was a potential issue for patients undergoing operations as they could become too cold or too hot and would be unable to tell staff if they were under general anaesthetic. We also identified that patients' temperatures were also not being documented on their records/pathway. This is discussed further later in the report.
- A hospital engineer was on site three days a week and was responsible for building maintenance which included preventative tests and reactive work should there be a fault.
- Portable appliance testing was last completed in September 2015 and we were informed the annual testing was in a programme of being completed at the time of inspection in October 2016.
- We saw evidence of completed records of regular checks of the hospital environment to include; monthly medical gas scavenging system checks, monthly vacuum plant changes, monthly theatre light checks and six monthly services, monthly changes of reverse osmosis machine filters and quarterly air handling unit checks.
- Staff told us about the daily checks they undertook on each of the two endoscope washer machines and the other checks they undertook on other machines used in the dirty utility room. Staff documented when they had completed these checks and we were shown where these were recorded.
- Bodmin Treatment Centre had their own Central Sterile Stores Department (CSSD) and had clear procedures in place for the management of dirty and clean equipment to make sure patients were not at risk of cross infection. The provider had undertaken an internal audit of this and staff told us they had some areas for improvement which were in the process of being addressed. The audit was shared with us after the inspection. Where areas had been highlighted as needing improvement an action plan had been devised and it was documented when they had been addressed.
- Resuscitation equipment was maintained and ready for use in an emergency. The trolley was checked daily on the top shelf and weekly for the rest of the trolley. Records demonstrated that checks had been completed. Security was maintained with tamper-evident seals.

- Patient-led assessments of the care environment (PLACE) took place between February and June 2016 for the condition, appearance and maintenance of the building and scored 99% compared to England average of 93%.
- There was a schedule for daily checks to be carried out on anaesthetic equipment in theatre before use. We reviewed the schedule and found these were up to date.
- **Medicines**
- Medicine practices we observed were mostly safe.
- The provider told us Bodmin Treatment Centre did not have a pharmacy on site. Medication was ordered from an external provider and there were only two senior staff members who ordered medication. Each department filled in an order form and this was given to one of the two staff to order medication on their behalf. There was one order per week and one delivery. The delivery was only accepted by one of the two allocated members of staff. There was service level agreement (SLA) with an external pharmacy company, who also provided eight hours of onsite support per month. The pharmacist role was to reconcile 'to take home medication' for patients, medicine management audits, review practice, expiry dates of medication and any other support required. The matron, who was the accountable officer, attended quarterly controlled drugs local intelligence networks (CD Lin) meetings. The purpose of these meetings was about the monitoring the effectiveness of controlled drug local intelligence networks and ensuring that local governance arrangements and provisions for incident panels are satisfactory.
- We examined a number of audits undertaken by the pharmacist which included required actions. For example, a prescribing audit undertaken in May 2016 identified that anaesthetic charts did not have the route of administration clearly recorded, due to limited space for recording it on the anaesthetic chart. The pharmacist also identified positive findings which included; oxygen prescriptions and medicines reconciliations on anaesthetic charts.
- We found that the management of controlled drugs was mostly safe. In the treatment centre's controlled drugs register there was a section where staff wrote the time it was supplied, administered and if any was destroyed. A staff member told us all controlled drugs were supplied out of the secure storage at the same time. Controlled drugs were then placed into trays for each patient and were taken into theatre to be administered by the anaesthetist, but were never left unobserved. However, we found that for one patient, morphine sulphate was supplied at 8am (which meant taken out of secure storage) and was not administered for another two hours and another patient had not been medicated until four hours later. We checked with Ramsay Health Care UK Operations Limited medicines management policy which stated 'controlled drugs may be drawn up in advance but must not be left unattended once prepared, or if unattended must be locked back in the controlled drugs cupboard'. Staff had been following the policy but there was a risk of drug errors occurring when medication was supplied a number of hours before administration. We spoke with a senior member of staff who told us they would stop this practice with immediate effect. However, in theatre two, we observed a colonoscopy list where controlled drugs were supplied and administered for each patient on an as required basis.
- We observed one incident where a consultant had prescribed medication but had not signed for its administration.
- **Records**
- Patient records were held securely and completed in full.
- During our inspection, we examined 12 sets of patients' records and all sections had been completed. Each patient had a pathway of care that was started at the pre-operative assessment and went through to discharge, so all information was in one place. It included their medication, past medical history, physical observations, any allergies, information from their GP, World Health Organisation (WHO) surgical safety checklist, risk assessments and a record of their operation/procedure. Out of the 12 sets of patients' records, we found one consent form where it was difficult to read the consultants hand writing in relation to the documented risks.

- All patients had completed a health questionnaire prior to their admission and staff told us they reviewed this prior to their admission. This was to ensure patients were suitable to attend Bodmin Treatment Centre, as they were a day-case facility.
- Following reprocessing/cleaning of endoscopes, records for tracking and traceability were produced. A copy was entered into the patient's notes and a copy entered against the patient's identifiable label in the unit's traceability register.
- We observed that track and traceability labels were placed in patient's notes for the lenses used in cataract surgery, so they could be traced if a problem arose in the future.
- An audit of records was undertaken locally and these included medical records, pre operation and discharge and care pathways. The timescale on these varied but the hospital had a compliance rate of above 90% on each. However, issues identified at previous audits were not always transferred to the next and actions and dates of completion were not always recorded.
- During cataract operations we observed patients pulse and oxygen saturation were being monitored, however no records of these observations were maintained.
- **Safeguarding**
- Staff were aware of their responsibilities to investigate and report any safeguarding concerns about children or adults.
- Staff completed level one safeguarding training for children as part of their mandatory training and we were told they were all up to date. Following the inspection we were sent data that showed that all but four (three of these were bank staff) staff were up to date with safeguarding of adults at level one and level two. At the time of this inspection Bodmin Treatment Centre did not take children.
- We spoke with one of the two safeguarding leads who said their role was to support and advise other staff on safeguarding and possible referrals to the local council. They had completed training to level 2 for but told us they planned to undertake safeguarding training in level 3. If they required further internal support they would contact the safeguarding lead for Ramsay Health Care UK Operations Limited who was trained to level five safeguarding.
- Prevent training was being delivered to staff by senior staff via a training presentation and three short films. Prevent is part of the Government's counter-terrorism strategy CONTEST and aims to stop people becoming terrorists or supporting terrorism; as such it is described as the only long term solution to the threat we face from terrorism. Prevent focuses on all forms of terrorism and operates in a pre-criminal space, providing support and re-direction to vulnerable individuals at risk of being groomed in to terrorist activity before any crimes are committed. Radicalisation is comparable to other forms of exploitation; it is therefore a safeguarding issue staff working in the health sector must be aware of.
- Staff told us they had received training on female genital mutilation, as it was part of their safeguarding training. Ramsay Health Care UK Operations Limited policy on safeguarding also contained information for staff about this subject.
- One safeguarding referral had been completed by the matron between July 2015 and June 2016, following identification by theatre staff. The referral was sent to the local county council who confirmed they were already involved in the case. Record of the safeguarding referral was held on the electronic reporting system and closed once a response from the council had been received.
- **Mandatory training**
- All staff were up to date with their mandatory training.
- Employed staff received mandatory training which included; work place diversity, manual handling patients, infection control, health and safety, fire and personal safety, basic life support, safeguarding adults, safeguarding children, customer service, information security, data protection, sharps and intravenous drugs. In the first two weeks of employment, staff were expected to complete their mandatory training.
- Staff said they had access to training and found the quality to be good.
- A new e-learning software programme was introduced in June 2016. The hospital were unable to pull data to

report training compliance as the old system had not transferred to the new system and the system was not recording correctly when staff had completed training. In future, it was hoped the new system would allow training reports to be run. We were informed mandatory training was 100% compliant in July 2015, and staff pay was dependent on their completion of all mandatory training. In the first two weeks of employment staff were expected to complete their mandatory training. The hospital personal assistant maintained their own spread sheet which recorded completion of training. They would email the head of department and highlight if there were gaps in training or if training for staff was due to expire. In order for staff to be alerted of their training status they needed to log in to the centre's computer system. Staff said they had access to training and found it to be of good quality.

- Consultants with practising privileges were required to complete mandatory training in immediate life support, manual handling, health and safety, fire, infection control, safeguarding, information security and consent. We were not shown evidence that this was up to date.

- **Assessing and responding to patient risk (theatres and post-operative care)**

- Not all risks to patients undergoing surgery or procedures had been assessed and had their safety monitored and maintained.

- Processes for responding to a medical emergency were not safe. A corporate adult resuscitation policy was in place and up to date. However, the local procedure on how the treatment centre responded to a medical emergency was not specific enough to indicate who from each department would be attending. Therefore, there could be a risk of no staff attending if they were not allocated.

- The emergency call system was tested weekly. This was not in line with the corporate policy, which states it is the responsibility of the registered manager to ensure the system was tested daily. There were no individual resuscitation bleep holders as there was not an allocated resuscitation team; staff said they would all respond to a cardiac arrest call. There was a potential risk the response to a cardiac arrest would not be safely co-ordinated if a dedicated team are not allocated. The treatment centre were not compliant with their own corporate policy which states a medical emergency team should be allocated and include at least one doctor and no fewer than three registered health care professionals. The team leader should hold Advanced Life Support training and all members should have at least Immediate Life Support training. The resuscitation lead was trained in advanced life support and all other staff in immediate life support.

- We saw no evidence resuscitation scenarios were completed between July 2015 and June 2016. The corporate policy states scenarios must be held bi-monthly in different areas of the treatment centre, and these may be full arrest scenarios but can include other emergencies as appropriate.

- A member of the theatre staff who was the critical care lead did not have protected time to perform their role which was not compliant with the corporate policy. We were not told why they were not allocated time. However, following the inspection the provider told us they were allocated protected time.

- Emergency resuscitation equipment was available and equipment checks were up-to-date. These trolleys were tamper evident.

- The operating theatres used the internationally recognised World Health Organisation (WHO) surgical safety checklist ('the checklist') in all operations and procedures. The checklist formed part of a process carried out to scrutinise all safety elements of a patient's operation/procedure before and after. This included, for example, checking it was the correct patient, the correct operating site, consent had been given, and all the staff were clear in their roles and responsibilities. The review checked all equipment was present and functioning, and all used instruments and swabs accounted for.

- A senior manager told us WHO audits were carried out monthly by a senior member of staff in theatres and fed back to staff in their unit meetings. However, we found the audit was not specific enough as it was not broken down to areas of the WHO checklist to clearly identify if any issues were found and where. We saw the results for May and June 2016 which were all compliant. However, another more detailed audit of the WHO was undertaken every three months which included all the individual areas of the WHO. We were sent copies of the audit completed in November 2015 which scored 95%

but did not include any details as to why this was or any planned actions. The audit completed in February 2016 scored 100% and in May 2016 the score was 97%, but again no reasons for this score or planned actions to address the non-compliance were recorded.

- During our observations in theatre, we observed all staff participating in the WHO safety checklist and records were maintained.
- Bodmin Treatment Centre used an early warning score system to respond to deteriorating patients. The hospital protocol followed the guidance of the National Early Warning Score (NEWS) system. All patients were monitored by the nursing staff for a number of clinical and physiological markers. This included for example, patients' blood pressure and respiratory measures. However, the vast majority of patients were not having their temperature monitored either in theatre or in recovery, which is one of the physiological markers for NEWS. This potentially meant that patients' NEWS may not be accurate. Staff told us they did not always monitor patients' temperatures as they are not in theatre very long, however we examined nine sets of patients' notes where at least four patients had operations of over one hour. We found all four had no documented evidence that their temperature was monitored during their operation. Three patients had evidence of one temperature check in recovery and the other patient had no evidence of a temperature check in recovery. This was not in line with NICE guidance Hypothermia: prevention and management in adults having surgery. This guidance is about the importance of maintaining a patient's body temperature above 36 degrees centigrade. However, in the two audits of deteriorating patients' records we were sent, they stated that temperature recordings were in place.
- Staff told us they would contact the patient's consultant in theatre if they were concerned about a patient's condition or another consultant who was present in the building.
- Audits were undertaken on NEWS scores in 10 patients' notes. The audits were six monthly and in September 2015 it stated one set of notes was missing a pathway for laparoscopic procedures and the action to be taken, they scored 99% compliance. In the March 2016 audit, it was not documented why they scored 99% for compliance.
- The hospital holds two units of O negative blood for use in the event of an emergency. We saw that as part of the service level agreement (SLA) with the local acute trust this was returned and replaced with new stock every two weeks. We saw records of delivery, expiry date, blood unit number and date of return back to the acute trust in line with the SLA.
- During our inspection, we did not see a procedure or policy for staff to follow for the identification or management of sepsis. The chairperson for the medical advisory committee (MAC) also confirmed they were not aware of these.
- Staff told us that if a patient was not well enough to go home at the end of the day they would inform the consultant to review the patient. If they felt the patient would be well to go home the next day they would be transferred to one of Ramsay Health Care UK Operations Limited other hospital locations nearby. If the patient was clinically unwell and needed medical input, they would be transferred to the local NHS acute hospital for treatment by an ambulance. Senior staff told us a service level agreement was in place with the local acute trust that covered all types of admissions to them, for example, if a patient required critical care. The protocol in place was to call for an ambulance, provide them with the details, and then inform the local acute trust about the patient. Following the inspection the provider told us that all patients were transferred directly to the local acute NHS hospital and all staff have be informed if this.
- **Nursing and support staffing**
- There were safe levels of nursing staffing on the theatre/ day unit.
- The provider told us staffing was planned on a weekly basis and then assessed on a daily basis. Daily nursing hours were calculated as per the Ramsay Health Care UK Operations Limited safe staffing guidance and were allocated accordingly. The theatre unit utilised The Association for Perioperative Practice (AfPP) guidelines in determining staffing levels whilst also taking into account the surgical speciality. Theatre staffing did not follow the guidelines fully for the number of staff as a senior manager told us the operations were minor rather than major operations. Therefore, they did not always have two scrub practitioners, a circulating

member of staff and anaesthetic member of staff. We observed during a list of patients having cataract surgery there was one scrub member of staff, a circulating member of staff and an anaesthetic member of staff. This appeared to be safe as the patients were awake. We were not shown individual risk assessments to demonstrate patients were safe with the lower number of staff in theatre.

- Ramsay Health Care UK Operations Limited also had a new rostering system in place. This enabled the heads of department to manage rotas, skill mix, staffing requirements, monitor staff sickness and annual leave absences.
- A senior member of staff told us they did not have many incidents of staff shortages as other staff would always cover or they would use staff from their own bank. Other staff we spoke with said they did have times of staff shortages but staff would stay on shift longer if needed. We were told staff shortages were not recorded as incidents using the provider incident reporting system so we were not able to follow this up.
- More bank staff were being recruited as senior staff told us they could not appoint permanent positions due to the uncertainty surrounding their contract with the local Clinical Commissioning Group (CCG).
- Each morning heads of department had a daily 'huddle', which highlighted any sickness that day and how the departments would manage or reallocate resources as required.
- The information sent to us prior to our inspection showed there had been use of bank staff among the qualified nurses between July 2015 and June 2016. In the theatre/day unit, this has risen to 20% in April to June 2016 (22 shifts in April, 15 shifts in May and 23 shifts in June). There was no bank staff use for operating department practitioners (ODP's) during the same period.
- There had been high levels of ODP sickness between July 2015 and June 2016, although this was because the full time equivalents numbers were low, so the level can appear abnormally high. For example, the sickness rate for ODP's sickness rate was 33% in April and May 2016. The sickness rate over the same period varied for qualified nurses but there was none throughout May and June 2016.
- Turnover of staff within the theatre and recovery unit was low between July 2015 and June 2016, which was around 18%.
- **Medical staffing**
- The service was led and delivered by a small team of consultants.
- Three consultants were employed directly by Ramsay Health Care UK Operations Limited with the remaining 33 were working under practising privileges.
- As the hospital was closed at nights and weekends and there was no out of hour's medical cover. Once patients were discharged, they were given the contact details of another local hospital managed by Ramsay Health Care UK Operations Limited to contact if they had any concerns. Staff told us they were able to contact consultants for advice if required.
- **Emergency awareness and training**
- Bodmin Treatment Centre was not part of a major incident plan with the local NHS acute trust.
- The hospital had a standby generator, which provided an eight hour supply of power. We saw evidence the fuel was checked weekly and the generator was tested monthly by running for an hour. Generator checks were recorded and a service was completed every six months.
- Arrangements were in place in the event of a fire. The fire alarm was tested weekly and full evacuation drills were completed six monthly, which was evidenced in the fire logbook for September and March 2016.
- Bodmin Treatment Centre had a business continuity plan, which was corporate based but individual details were added in for each location. For example, how to manage a power cut and with details of local companies to contact.

Are surgery services effective?

Good

We rated effective as good.

- **Evidence-based care and treatment**

- Ramsay Health Care UK Operations Limited policies and procedures were based on National Institute for Health and Care Excellent (NICE) and other guidance where appropriate.
- We also observed their corporate audits undertaken at Bodmin Treatment Centre referred, where applicable, to NICE guidelines.
- They were unable to provide an example of local policies and said these changes came from Ramsay Health Care UK Operations Limited.
- The matron told us that updated NICE guidelines were sent to them by Ramsay Health Care UK Operations Limited head office and then disseminated to the clinical governance committee and medical advisory committee (MAC) to be discussed. However we saw no evidence of this information then being cascaded to staff. The lead for the MAC told us NICE guidance was discussed at the MAC meetings but the method of cascading information was from each consultant who attended for their speciality. There was no system in place for monitoring if consultants were working to NICE guidelines.
- Clinical governance meeting minutes did not demonstrate how the hospital was following new or revised clinical guidance. In the three sets of minutes we reviewed, from May 2015, September 2015 and March 2016 it said to circulate guidelines to all consultants but did not detail what NICE guidelines it referred to.
- A consultant told us they received updated NICE guidelines and/or changes to policies via email and was required to sign that he had received and read the information. However, the hospital was unable to provide an example of local policies and said any changes came from Ramsay Health Care UK Operations Limited.
- We found theatres and the recovery unit were not meeting all the NICE guidance Hypothermia: prevention and management in adults having surgery. This guidance is about the importance of maintaining a patient's body temperature above 36 degrees centigrade. This guidance was not being followed, as there were no recorded temperatures for patients in theatre. The guidance states temperatures should be taken every 30 minutes during an operation. We examined records of patients who were in theatre for over 60 minutes and found no documented evidence of temperature recording even though issues had been identified with the temperature of theatres. Post operation, patients' temperature should be monitored and recorded every 15 minutes. In the patient records, we saw this was not being done. However, we did observe the use of patient warming devices.
- The Department of Health issues patient safety alerts via the central alerting system. The matron and heads of department were responsible for informing staff of these.
- The hospital participated in the programme of Patient Reported Outcome Measures (PROMs). PROMs was a programme established by NHS England to measure patients' health-gain following four common procedures. The hospital reported for one of these procedures it performed, namely groin hernia surgery.
- The endoscopy unit had not met the requirements for the Joint Advisory Group (JAG) accreditation for gastrointestinal endoscopy. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited. Staff told us this was due to the environment in the recovery area and plans were in place on how to proceed.
- Two members of staff were part of a Ramsay Health Care UK Operations Limited group looking at the NatSSIPs are intended to provide a skeleton for the production of Local Safety Standards for Invasive Procedures (LocSSIPs).
- Bodmin Treatment Centre had a programme of corporate audits they undertook which ranged from medical records to auditing the care and treatment patients received. However we did identify issues with the recording of some of the audits, implementing actions to address shortfalls and the monitoring of this.
- **Pain relief**
- Patients had their pain controlled.
- We saw a number of results from pain audits undertaken in endoscopy. There were no identified issues and each patient's pain had been assessed and controlled appropriately.

- We observed patients being administered pain relief during their operations/procedures. Staff told us if a patient was uncomfortable they would inform the anaesthetist who would respond promptly by carrying out a pain assessment and administer further pain relief if required.
- Patients who were part of the National Bowel Cancer Screening Programme had their pain assessed using the Gloucester scale (pain assessment tool) when undergoing their colonoscopy (camera into the bowel). The member of staff observing the patient had to ask them about their pain and it was scored from comfortable to severe.
- Patients told us they had no complaints of pain.
- Bodmin Treatment Centre did not have a dedicated pain team, as they were an elective day care unit. However, systems were in place to make sure pain was controlled.
- Some patients were discharged with pain relief and advice on pain management depending on the operation/procedure they had.
- **Nutrition and hydration**
- As Bodmin Treatment Centre is a day treatment centre patients were given hot drinks and biscuits following their procedure/operation before they were discharged home. There were no other catering facilities.
- Patients were provided with fasting details at their pre-assessment appointment in outpatients and patients were required to read and sign the information to confirm their understanding. This information was not reiterated to the patient following pre-assessment.
- Patients undergoing bowel procedures, for example colonoscopies, had to take bowel preparation prior to their procedure. We were told patients were given instruction on how to take and when to change their diet.
- **Patient outcomes**
- Bodmin Treatment Centre participated in corporate/ local audits and some national audits.
- Ramsay Health Care UK Operations Limited had a corporate template of audits that were undertaken at their locations. Data submitted by them demonstrated their audit programme which included patient care and treatment audits. For example, venous thromboembolism, hydration and nutrition and infection control. The results of which demonstrated the hospital had performed well between July 2015 and June 2016.
- The hospital participated in the Patient Reported Outcome Measures (PROMs) audits for NHS-funded patients undergoing groin hernia surgery. Results for these were significantly better than the England average for those in NHS hospitals. The results for the latest published period with ratified data (April 2014 to March 2015) were as follows:
- Groin hernia
- The European quality of life five dimensions questionnaire (EQ-5D) index measured responses in five broad areas of mobility, self-care, usual activities, pain/ discomfort, and anxiety/depression. In the EQ-5D index, out of 56 modelled records 69.6% were reported as improved and 5.4% as worsened.
- The European quality of life visual analogue scale (EQ-VAS) index measured how the patient would describe their general health on the day they completed their questionnaire. In the EQ-VAS index, out of 57 modelled records 52.6% were reported as improved and 26.3% as worsened.
- The hospital was using warming equipment to maintain patients' normal body temperatures (called normothermia). It has been recognised that maintaining body temperature and preventing hypothermia (caused sometimes by anaesthetics, anxiety, wet skin preparations and skin exposure) helps to reduce post-operative complications. We observed these being used on some patients in recovery.
- There were no reported cases of unplanned transfer of a day patient to another hospital in the reporting period July 2015 to June 2016. There were also no reported cases of unplanned readmission within 28 days of discharge for the same period.
- The Commissioning for Quality and Innovation (CQUIN) payment framework had set targets for the centre. The commissioning for quality and innovation payments framework encourages care providers to share and continually improve how care is delivered and to

achieve transparency and overall improvement in healthcare. Throughout 2015 and 2016, all national requirements were 100% achieved but they had only achieved a 50% compliance rate with local requirements. These included a national requirement for the implementation of a staff wellbeing initiative and local requirements for hand washing improvement and availability of hand wash gel initiatives.

- Information we received prior to our inspection stated that Bodmin Treatment Centre was waiting for guidance from Ramsay Health Care UK Operations Limited on how to provide The Private Health Care Information Network data from their location.
- **Competent staff**
- Each new staff member completed an induction. Induction involved a presentation and every new staff member was reviewed weekly, two weekly and monthly for six months by their head of department on their competencies, training and performance.
- Staff are encouraged and given opportunities to develop. Staff told us there were opportunities to further their learning through corporate training. For example, acute illness management and surgical first assistant course.
- Health care professional's registration was monitored to ensure staff were registered, the rostering system would not allow staff to be booked if their registration was not valid.
- Qualified nurses told us Ramsay Health Care UK Operations Limited had provided information and guidance for them on revalidation of their Nursing Midwifery Council (NMC) registration.
- All staff had received customer excellence training. This training focussed on providing good customer/patient service.
- Practicing privileges was specified in a Ramsay Health Care UK Operations Limited corporate policy, which set out rules on who can practice at the centre. Of the 33 consultants with practicing privileges at the centre, the medical advisory committee at the centre were responsible for the annual review of 11 of them, with the other 22 being reviewed by their sister hospital in Truro.
- As part of the process for approving a consultant for practicing privileges, a medical practitioner could only treat patients once they received accreditation to do so. Prior to offering accreditation, each practitioner had to obtain approval of a scope of practice within one or more categories specified in the rules. The medical practitioner had to attend a meeting with the general/registered manager to discuss credentials, any special requirements and the needs and strategic direction of the centre. They then had to submit a completed application to the general manager, which included two references.
- It was the responsibility of the general/registered manager to ensure that the medical practitioner held the appropriate registration with the relevant professional body, had the appropriate certification form, an enhanced disclosure and barring service certificate and a verbal reference if the applicant was not known to the general manager or medical advisory committee member. The applicant had to hold professional indemnity insurance, complete a conflict of interest form and have a satisfactory annual appraisal.
- Consultant appraisals were indicative of consultant competency. These were completed by the employing NHS trust or through Ramsay Health Care UK Operations Limited appraisers. The spread sheet of appraisal dates showed three expired appraisals, two were within three months and therefore acceptable and one had expired four months prior but the consultant in question was managed by another Ramsay Health Care UK Operations Limited provider. We reviewed consultant files for three consultants with practising privileges and one employed consultant. An appraisal was not on file for one consultant with practising privileges.
- Consultants with practising privileges were required to complete their scope of practice in their application form which included their annual volumes. This ensured each consultant was competent to carry out their practice.
- Examples were provided of staff suspension due to misconduct or investigation. This showed poor performance was identified and appropriate action taken to address the issues.

Requires improvement

Surgery

- A senior member of staff in the theatre department told us they had two appraisals left to complete and would meet the 100% target in the next few weeks. One member of staff from theatres told us they had not had an appraisal since 2014.
- **Multidisciplinary working**
- There were arrangements for multidisciplinary support between staff internally and external agencies.
- The hospital had service level agreements with other providers. This included emergency transfer arrangements with the local acute NHS hospital.
- This was a small independent treatment centre where many staff had worked together a long time and knew each other well. Staff were aware of each other's different strengths and experience they could draw upon throughout the hospital.
- Patients' records showed a good range of multidisciplinary input. Most patients had input from their consultant and nursing team.
- Some staff felt that the working relationship between the theatre and outpatient department needed to improve. Staff told us that they felt there was a 'them and us' attitude at the hospital, although this feeling was not shared unilaterally. Staff told us they documented all communication between departments in patient notes to avoid confusion and conflicting information. However, we observed teamwork between the two departments when a theatre staff member approached an outpatient staff member to request assistance with a patient who required additional assessments following surgery. The outpatient staff member was accommodating and assisted the theatre staff member promptly, and communicated when they would be able to help.
- **Seven-day services**
- Bodmin Treatment Centre was closed at night and on weekends and therefore does not provide seven-day services.
- On discharge, patients were given the contact details of another local Ramsay Health Care UK Operations Limited hospital to contact for advice and support. Staff told us they provided this hospital with details of patients who were discharged from them each day.
- There was a service level agreement with the local acute trust to cover all services the treatment centre may require. For example emergency transfers, blood products and microbiology. We were told the microbiologist was available if the hospital required advice.
- The following services were outsourced and not provided at Bodmin Treatment Centre: pathology services, clinical imaging and pharmacy.
- **Access to information**
- There was good access to patients' records.
- There was limited storage on site and medical records were held in paper format for a set period of time before being transferred to another location. These were held securely in a medical-records office in an organised and well-designed system. Records could therefore be accessed easily, and there were staff available in medical records to help.
- Patient records were in good condition. The patient paper-based records we saw throughout the hospital, were well organised and pages were secured. There were no loose pages in the files we looked at and they were set out in a logical order.
- Senior staff told us there were plans in place to introduce a computer based patient records system in the near future.
- Information about patients was sent from their GP's to the hospital in the form of a referral. This was to help staff assess if patients were suitable for treatment at this location. Patients also completed a medical questionnaire about their past medical history and present medical condition.
- Upon discharge, GPs were sent information about the care and treatment their patients received at the hospital.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- Patients were enabled to give valid informed consent.
- Patients assessed as having the mental capacity to make their own decisions were given time and information, helping them to give informed consent. Clinical staff taking consent from patients recognised

the legal and ethical principles around gaining valid informed consent. Patients we spoke with all said they had given consent for their procedure/operation. Advantages and any possible risks of the proposed operation/procedure had been explained to them. Patients said they had been able to ask any and all questions about their proposed treatment. Patients told us they were aware they could change their minds, even after signing their consent form. Staff were required to check on admission that patients were still happy to go ahead with their operation/procedure. Bodmin Treatment Centre only performed planned elective operations/procedures.

- Staff told us when a patient attended for their outpatient appointment their mental capacity would be assessed to determine their ability to consent to the proposed treatment. If staff felt the patient was unable to consent to their proposed treatment this would be discussed with the consultant and the patient's family/representatives to decide the best course of action.
- Four different consent forms were in place, one of which was for patients who were unable to consent to their treatment. Staff told us a best interest meeting would need to take place and involve all the relevant people before treatment happened and to make sure Bodmin Treatment Centre was the best place for meeting their needs.
- Four consent form audits had been undertaken between September 2015 and June 2016. Two of these audits did not record the issues of why they did not achieve 100% compliance but the other two recorded issues with staff not obtaining second stage consent when patients were admitted for their operation/procedure. This was when a patient signed their consent form at their pre-admission outpatient appointment and staff had not checked they still gave their consent on admission for their procedure/operation. We saw evidence of heads of department meeting minutes from June 2016, which highlighted four out of 10 sets of patients records reviewed did not have second stage consent documented. An audit carried out in March 2016 also found issues with risks not being documented on the consent form. We found previous audits did not carry across issues and they were not followed up during subsequent audits. Actions were not documented on how they planned to address the findings. A senior member of staff told us the issue with staff not obtaining secondary consent had been addressed. In 11 of the 12 patient records we examined we found evidence of secondary consent had been obtained.
- However, we reviewed 12 sets of patients' records all of whom had surgery within the last six weeks. We found one did not have second stage consent recorded as being obtained and one consent form had the risks on them but it was difficult to read.
- A senior member of staff told us had training in Deprivation of Liberty Safeguards but it was unlikely to apply in this treatment centre. A person can be deprived of their liberty if they do not have the capacity to make their own decisions, and need treatment, care or safety to protect them. An application to deprive a person of their liberty in order to receive care and treatment was unlikely to be required for a patient treated at Bodmin Treatment Centre. Staff told us this would be identified at pre-assessment and the appropriate actions taken.

Are surgery services caring?

Good

We rated caring as good.

- **Compassionate care**
- Patients were treated with compassion in a caring manner.
- We observed a number of interactions between staff and patients. All staff showed empathy, kindness and care towards their patients and their relatives/carers. When patients received treatment, we saw the staff treat them with dignity and respect.
- Staff spoke with patients and their relatives in a respectful manner, taking time to explain what they were doing and the treatment they were receiving.
- One patient told us the staff were "lovely" and the care was "excellent". Other comments from patients were "staff very helpful", "staff were very friendly" and "staff very great" However, one patient felt they did not always know who staff were or what their role was as not all staff introduced themselves.

Requires improvement

Surgery

- Comments made by patients and relatives in the comment books included 'put immediately at ease by very warm welcome from receptionist and very caring attitude from nurse' and 'first class service everyone is so very kind and helpful'.
- In the theatre waiting room, it was difficult to maintain privacy because of the layout, which meant patients were close to the reception desk. This meant conversations between patients and receptionist could be overheard.
- We identified an issue during our inspection regarding the privacy and dignity of patients in the waiting room. This was reported to a senior member of staff as it had also been reported by a patient. Wooden screens were provided in the recovery area of theatre to provide privacy for each patient.
- The friends and family test (FFT) is a feedback tool that gives people who use services the opportunity to provide feedback on their experience. Performance from 1 August to 30 August 2016 demonstrated 98% of patients recommended Bodmin Treatment Centre and 2% did not recommend. The response rate from patients was 16%. We were shown some of the comments patients had put on their friends and family test. All but one was very positive. The only negative comment was that the patient would not recommend Bodmin Treatment Centre as it was too far for their friends/family to travel.
- Patient-led assessments of the care environment (PLACE) took place between February and June 2016. Bodmin Treatment Centre scored 93% for privacy, dignity and wellbeing, compared to an England average of 83%.
- In the patients were asked if they 'given enough privacy to discuss condition or treatment to which 98.7% of patients responded yes.
- **Understanding and involvement of patients and those close to them**
- Patients undergoing procedures/operations were provided with information to enable them to make an informed decision about their treatment.
- Patients told us there had been sufficient time at their outpatient appointment for patients to discuss any concerns.
- We observed one member of staff taking their time explaining the physical observations (blood pressure etc.) they were doing and what to expect.
- Three patients told us the "staff explained everything very well".
- Staff spoke with patients so they understood their care and treatment options.
- In the patient satisfaction survey for Ramsay Health Care UK Operations Limited for the first three months of 2016
- Relatives/carers of patients were also involved in treatment and care as appropriate.
- Patients were able to bring a relative/carer with them if they needed support as waiting areas were provided downstairs.
- **Emotional support**
- As Bodmin Treatment Centre was a day care unit, clinical nurse specialists were not available at this site. However, patients were provided with information about their operation/procedure.
- In the patient satisfaction survey for Ramsey Health Care UK Operations Limited, patients were asked 'did you find someone on the hospital staff to talk about your worries and fears' and 92.9% of patients felt that they did.
- Staff provided patients with information prior to their discharge to include details of who to contact if they had any concerns.

Are surgery services responsive?

Good

We rated responsive as good.

- **Service planning and delivery to meet the needs of local people**
- The provider worked with commissioners to plan and meet the needs of local patients.

Requires improvement

Surgery

- Bodmin Treatment Centre was opened in January 2006 and is one of 10 centres across the UK where Ramsay Health Care UK Operations Limited was working in partnership with the NHS. They provided consultant led and delivered care.
- Patients from across Cornwall were able to use the NHS e-Referral to come to Bodmin Treatment Centre and they were treated well within the recognised treatment times for the NHS.
- Bodmin Treatment Centre had plans to work with the local Clinical Commissioning Group (CCG) to expand the services provided. However, at the time of our inspection, these plans were on hold to see if the NHS contract with the CCG was going to continue.
- The premises and facilities were appropriate for the services planned and delivered, although there were problems with car parking at various times of the day. The patient areas of Bodmin Treatment Centre were spread over two floors. The first floor was accessible by stairs or a lift and the lift was suitable for wheelchair access.
- The area surrounding the hospital had a lot of road works at the time of the inspection but patients had not been sent information about the road works and the best way to access the hospital. A staff member had identified this the week prior to our inspection and the business administration team said they would produce a map and directions to include with the patient letter.
- **Access and flow**
- Patients had timely access to care and treatment.
- Care and treatment was only cancelled or delayed when necessary. The provider told us they had cancelled 23 operations for non-clinical reason in the last 12 months and all were re-booked within the 28-day timescale. The hospital was treating NHS-funded patients within 18 weeks of their referral for treatment.
- The head of department meeting minutes recorded the number of cancelled operations each month. Senior staff were not able to tell us if these were operations were cancelled due to the patients not attending or for other reasons as they did not have the information.
- Following an outpatient appointment, the administration team would aim to book all patients on to the theatre list the same day, so patients left the hospital with an appointment date and time. Patients received a phone call 72 hours before their surgery to remind them of their appointment and ensure they understood pre-surgery advice.
- When booking operations/procedures a senior member of staff told us patients with complex needs such as diabetes or a latex allergy were placed first on the list. If special equipment was required, this was flagged and ordered/obtained ready for their planned operation/ procedure.
- The hospital had staggered admission times. Patients having a general anaesthetic were admitted 45 minutes before their surgery time and patients receiving local anaesthetic or sedation were admitted 30 minutes before their procedure/operation time. This meant patients were not waiting around for long periods of time.
- A senior member of staff said they were able to accommodate urgent appointments for surgery, which would be communicated from the consultant. Examples included how consultants would extend their list to ensure a patient was seen urgently.
- Weekly activity meetings were held and attended by the matron, theatre manager, outpatient's manager and business administration manager. These meetings were used to review the operation/procedure lists and identify any gaps. For example, patients could be brought forward should a gap be identified.
- One patient told us the process from arriving at Bodmin Treatment Centre to their operation was 'seamless'. They had not waited long for their initial appointment as they had waited approximately three weeks and then a further two weeks for their operation. They felt everything was 'well organised'.
- **Meeting people's individual needs**
- Services were planned to take account of the needs of different patients.
- If a patient required an interpreter, the interpreter's availability would be confirmed and then the patient would be booked accordingly. In the last year, the hospital had used approximately 12 interpreters for patients.

- When a patient booked through the NHS e-Referral electronic system they were automatically sent information which included information on booking patient transport should they have difficulties traveling to the hospital. This information was also supplied by the hospital if the patient needed transport services.
- There was only one recovery area so male and female patients were in the same room. However, wooden screens were provided for privacy.
- Patients were able to recover in their own time from their operation/procedure, for example they were not rushed to leave the recovery areas until they were ready.
- Staff told us they were able to care for patients living with dementia and a learning difficulty. However, a full assessment of their needs would be undertaken prior to admission to ensure the hospital could accommodate their needs. Staff had not received training in caring for patients living with dementia or a learning disability.
- Patients told us they had received leaflets about their treatment. We were shown one about cataract operation by a patient, which told them what to expect.
- Patient-led assessments of the care environment (PLACE) took place between February and June 2016. For patients living with dementia, Bodmin Treatment Centre environment scored 97%, and 98% for disability which were better than to the England average of 80% and 81% respectively.
- In the patient satisfaction report for quarter one 2016 (January to March), conducted by Ramsay Health Care UK Operations Limited, patients were asked 'did hospital staff tell you who to contact if you were worried about your condition or treatment after leaving hospital' and 94.8% of patients agreed. This figure had slightly reduced from the last survey findings for the end of 2015.
- **Learning from complaints and concerns**
- Complaints were responded to in a timely way and learning shared with staff.
- Patients were aware of how to make a complaint or raise concerns. Information on how to make a complaint was available within a leaflet, which set out how to make a complaint and what to expect. The leaflets were available in the waiting area at reception.
- There was a clear complaint process within the centre, which was followed when a complaint was received. The general manager/registered manager had overall responsibility for complaints at the centre but it was the matron who managed them on a day to day basis. Once a complaint was received, it was documented on a complaints form by the general manager's personal assistant. A holding letter was sent within two days of receipt, indicating the timeframe for completion and expressing regret that the patient had to make a complaint. The details were sent to all parties implicated in the complaint, with a request for investigation and statements within a set time. Once all statements were received, the general manager/ registered manager collated them and wrote to the complainant within 20 working days. If the investigation was ongoing they wrote to the complainant to explain why a response was not yet available.
- If patients were not satisfied with the response to their complaint, systems were in place to escalate them. Patients who were not satisfied with the response from the general manager/registered manager would write or call with regard to the response and in some cases may appoint independent representation, for example independent complaints advocacy service, to seek further clarification. This was made clear in the Ramsay Health Care UK Operations Limited complaints leaflet. Patients were always given the opportunity to call the general manager/registered manager directly if they wished to discuss the response further. If no feedback was received, they assumed that the complainant was satisfied with the response and the complaint was closed. However, a complaint could be reopened if requested.
- The number of complaints received was low, they received four between July 2015 and June 2016. The CQC did not receive any complaints during the same period. None of the complaints had been referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service. We reviewed three complaints and saw that timely responses were provided to complainant, which were in line with the time frames set out in the complaints procedure.
- One complaint received by the hospital allowed learning to be identified, and staff spoken with used this as an example of how they had learned from a complaint. A

patient had difficulties standing and the hospital was unable to support or meet their individual needs. Because of this complaint, standing aids and transfer boards were purchased and staff were awaiting training in their use. This outcome and learning was not evidenced on the reporting system.

- Complaints were discussed at a number of meetings to include heads of departments, risk management and medical advisory committee.

Are surgery services well-led?

Inadequate

We rated well-led as inadequate.

- **Vision and strategy for this this core service**
- Bodmin Treatment Centre had a vision and set of corporate values which some staff described to us as "The Ramsay Way" but not all were able to tell us what these were in detail. Their values included they were caring, progressive, enjoy their work and use a positive sprit to succeed and take pride in their achievements.
- Senior management were keen to expand the services provided at Bodmin Treatment Centre for both NHS and private patients. These plans were on hold until there was confirmation that the NHS contract with the local Clinical Commissioning Group (CCG) had been secured.
- The centre had recently lost their Joint Advisory Group (JAG) accreditation for endoscopic procedures due to the layout of the recovery environment. The planned improvements for the centre had been submitted but as the centre was only contracted to provide services to NHS patients on a rolling 12-month contract, investment in the premises was on hold until there was increased long-term certainty.
- **Governance, risk management and quality measurement**
- There was a governance framework in place but it was not cohesive and risks were not clearly identified or documented with actions taken.
- Senior staff told us that they tried to hold the Clinical Governance Committee every two to three months; however, the hospital had found challenges in achieving a quorate committee as they were a small location and the staff required were not always on duty. We were sent minutes of three meetings and these had taken place between four and six months. Between four to five senior staff attended these meetings which included some consultants.
- The medical advisory committee (MAC) was held quarterly with attendance of consultants from each speciality, with the remit attendees would disseminate the information to their colleagues. However, we were told they were not always well attended. We were sent minutes of two meeting which showed the same three members of staff did not attend. Nine members of senior staff attended these meetings and of these six were consultants. Senior staff told us that due to the consultants working for the acute NHS some of the meeting clashed with their other workloads so they were not able to attend. The MAC agenda included feedback from other meetings and plans, clinical incidents, administration, complaints and audits if relevant. During our inspection the MAC chair was not available for interview; however we spoke with them following the inspection. We therefore discussed the roles and responsibilities of the committee with a MAC representative at the inspection. This representative was aware of their responsibilities relevant to their own speciality but areas which were outside of their responsibility tended to be overlooked. We discussed areas for improvement identified in the consent audit about risks not being recorded on the consent forms; however, they did not any have knowledge of this.
- In the MAC meeting minutes they highlighted incidents that were not reported via the Ramsay Health Care UK Operations Limited reporting system. These included breakdown of equipment in theatre, which resulted in an operation list being cancelled. It was not picked up at these meetings that incidents had not been reported via the incident reporting system.
- The MAC minutes makes reference to NICE guidance but when we asked the MAC lead how they monitor that NICE guidance was being followed by the other consultants they were unable to demonstrate how this was monitored.
- There were a number of other meetings held on a frequent basis, where governance was discussed. For

example, heads of department, senior managers and clinical governance meetings. A round up of these meetings was also discussed at the MAC meetings. We were sent minutes of all of these meetings.

- We spoke with the clinical governance lead who told us their role was to supervise and help with governance arrangements to ensure staff gave the best care to patients. They were able to give us some examples where procedures had improved and changes made to practice. For example, specific equipment in theatres was replaced because it was old and may not have been safe. Therefore, the equipment was reviewed and the issues were presented to senior management and new equipment was purchased.
- We were told about the clinical audit programme and their responsibility for ensuring audits took place. Senior staff told us audits were discussed at the clinical governance meetings and at the MAC meetings. Senior staff also said that it was everyone's responsibility to monitor the actions from the audits and they were included on the clinical governance action plan. We asked to see a copy of this action plan but they could not produce it.
- The MAC lead also oversaw the practicing privileges of consultants with the general/registered manager. We asked what system they had in place to monitor consultants where issues or complaints had been raised about them or their work. Senior staff were not able to tell us about a documented system they had in place. We asked for evidence during our inspection and senior staff were not able to provide us with any evidence of a robust system. Therefore, patients were potentially being placed at risk of unsafe treatment and care.
- A corporate audit programme was followed at the treatment centre. The general/registered manager and matron acknowledged the gaps in the auditing process and identified this as an area for improvement. Audits were carried out but results were not reviewed in detail and actions from previous audits were not followed through or completed. There was no evidence of learning from audits being shared with staff. Audits were completed hospital wide and therefore departmental actions were not clearly identifiable.
- There were no robust arrangements for identifying, recording or managing risks. The hospital's risk register was a corporate risk register with only one local risk. This local risk was with regards to patients from a neighbouring mental health unit entering the premises and was added to the risk register following direction from an external provider. There were no risk registers for departments and not all heads of department were aware of the hospital risk register. When we spoke with the general/registered manager they were unable to tell us what was on the hospital's risk register and they were unaware that there were no local risks recorded. Over the course of the inspection areas were identified which would be suitable to be included on the risk register.
- There was no formal process for reviewing and monitoring incidents or complaints involving consultants. When an incident had taken place, there were no records to demonstrate their conduct was being monitored and actions put in place to make sure they were following safe policies and procedures. The MAC lead had not been involved in this process.
- Staff from theatre/ day unit said information was relayed to them however they did not feel information from them was relayed upwards.
- Two staff representatives attend the National Safety Standards for Invasive Procedures (NatSSIPs) Ramsay Health Care UK Operations Limited working group, this allows local safety standards to be developed. Two examples provided of changes made following attendance at the NatSSIPs working group were no late additions to theatre lists and for each theatre list to have a World Health Organisation surgical safety checklist champion.
- The administration team felt the local management team were very approachable but issues and concerns were not always actioned.
- We spoke with the general/registered manager regarding their corporate Statement of Purpose as it states Bodmin Treatment Centre performed cosmetic surgery. However, he confirmed this was not the case and said they would update their Statement of Purpose to reflect the services being delivered.
- **Leadership / culture of service related to this core service**

Requires improvement

Surgery

- Staff said local management had an open door policy and they were approachable so they could discuss any concerns they had with them.
- The leadership team was the general/registered manager, matron, theatre/day unit and outpatient department managers.
- Staff were extremely complimentary about the local management which included the matron, outpatient manager and theatre manager.
- The corporate management team did not visit regularly and some staff would not recognise them if they visited the hospital. Staff in theatre/day unit said they did not see the general/registered manager when he visited.
- The matron, theatre manager and outpatient manager, attended a daily operational huddle, this meeting discussed any issues from the previous day and any perceived risks for the upcoming day. We observed a daily huddle, which discussed staffing, use of bank staff and the appointment or theatre lists for the day. The staff present told us they would also discuss any incidents, complaints and/or staff issues as required. The heads of department would feedback information to staff if relevant.
- The general/registered manager informed us they were at the hospital site once a week and occasionally twice a week. They identified their role as ensuring governance was in place and the hospital was safe and to provide leadership and direction. The general/registered manager felt there was good communication when they were absent and they had daily discussions with the matron.
- The matron was the clinical lead; however in the absence of a full time registered manager their role was also the day-to-day operation of the hospital. They also had many other roles to undertake which meant they could not always meet them fully as well as being the clinical lead. All staff were very complimentary about the matron and their management style.
- Staff we spoke with told us they felt well supported by the immediate management team.
- There was no specific training for duty of candour regulations but the matron had put up posters informing staff of how to meet the regulation.
- Some staff raised differences between theatre/day unit and outpatients as there was a 'them and us' feel and they wanted a better working relationship between them.
- A large number of staff had worked at Bodmin Treatment Centre for a long time and all said they enjoyed working there and felt part of a team.
- One staff member was the well-being lead for the hospital. A well-being walk for staff was completed once a month, however, the theatre/day unit staff were unable to participate in this.
- The matron told us the staff at the hospital were excellent, they look after patients and ensure they have a good experience.
- **Equality and diversity**
- The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers and independent acute providers that deliver £200,000 or more of NHS-funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.
- We were sent the WRES data for Bodmin Treatment Centre. The matron had completed the WRES on their behalf as a provider of NHS health care. They had a duty to be compliant in line with its standard contract obligations. In the WRES report, they referred to the current Equality Duty Report by Ramsay Health Care UK Operations Limited that stated it included organisation wide actions. They also stated the report looked at workforce equality data, any significant gaps and commentary. Ramsay Health Care UK Operations Limited corporate human resources department was currently updating this report and therefore we did not see a copy of it. The WRES report stated they were no Black and Minority Ethic staff at Bodmin Treatment Centre. However, it was noted that due to the small numbers of staff working at independent hospitals/ treatment centres this might mean it is difficult to draw strong conclusions about the equality and diversity performance from these.
- **How people who use the service, the public and staff engaged and involved.**

Requires improvement

Surgery

- Patients were able to give their views on the services provided. However not all staff felt their views were asked for.
- The hospital had good results from the NHS Friends and Family Test (NHS FFT) for example. In August 2016 98% of patients recommended Bodmin Treatment Centre. However, the response rate was 16%, which was lower than the NHS average of 28%.
- Patients' views and experiences were gathered to improve the services provided. Ramsay Health Care UK operations Limited carried out patient surveys for all their locations. The survey asked patients about various aspects of their experience from their initial contact with the hospital prior to their appointment through to their discharge. We have used some of the scores from their latest survey results in this report which indicated that the hospital had performed very well.
- PLACE assessments had been undertaken at the hospital and they performed better than the England average for areas inspected.
- A senior member of staff in theatres showed us some feedback from patients they had received which was very positive.
- Comment books were in both reception areas. However, it was not clear when these comments were reviewed and there was not a sign off to confirm they had been read, shared and actioned where necessary.
- A survey had been sent to some patients who had undergone an endoscopy. The vast majority of feedback was very positive. One patient had written that they were given a copy of their endoscopy report but did not understand what it said. At the time of our inspection, no action plan had been devised to state how they planned to address this feedback.
- The hospital held a staff forum, however this forum was used to keep staff informed but did not allow staff to ask questions. Staff said they did not feel they could say anything because they needed to get back to work.
- Staff received a monthly newsletter.
- Ramsay engagement survey for staff dated 2016 showed Bodmin Treatment Centre scored 83% for engagement as a whole, which was rated as good.
- **Innovation, improvement and sustainability**
- Bodmin Treatment Centre had plans in place for developing their services for both NHS and private patients.
- This would involve extending their surgery services to deliver a wider range of procedures.
- The general/registered manager was proud of the cataract service provided at Bodmin Treatment Centre as patients travelled varied distances to the hospital to use their service.
- A senior member of staff told us they recently started a 'see and treat' system for ophthalmology patients. This was a one-stop assessment process where they had their outpatients' appointment in the morning and then they had their operation in the afternoon if they were assessed as being suitable. This was for patients having local anaesthetic and they were told this would happen prior to their appointment. This was to reduce the burden of patients coming to Bodmin Treatment Centre on more than one occasion for appointments.
- Another innovation they were planning was the use of one eye drop prior to eye surgery rather than the current system, which involved a number of eye drops at set intervals.

Requires improvement

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	
Caring	Good
Responsive	Good
Well-led	Inadequate

Are outpatients and diagnostic imaging services safe?

Requires improvement

Incidents

- It was not clear whether the safety performance of the outpatient department between July 2015 and June 2016 was good. The data submitted to the CCQ demonstrated that there had only been two incidents, which occurred in the outpatient department, one involving a cancellation of an appointment due to lack of appropriate equipment and the other involving staff conduct. We were not shown any evidence as to whether the low number of incidents was due to under reporting or whether incidents were avoided through mitigation of risk. There were no never events, deaths or serious incidents reported within the same period. Never events are serious incidents that are wholly preventable, however, the matron explained how learning from never events at other Ramsay Health Care UK Operations Limited sites were shared at the centre during clinical governance and head of department meetings.
- Staff understood their responsibilities to raise concerns, record safety incidents and to report them. An electronic risk management reporting system where all incidents were reported was in place. Staff told us they were aware of the processes for reporting incidents and were encouraged to report. We were told when an incident occurred they would inform their head of department and complete a report on the electronic risk management reporting system. However, there were a low number of incidents reported and they were unable to provide any evidence to confirm whether staff were using the system effectively to report incidents. Staff told us feedback was provided to staff following an investigation of the incident. However, staff told us of an incident, which occurred in the outpatient department, but they were unclear on the outcome and what actions were put in place to prevent it occurring again. When we questioned this further we were provided with conflicting information on the actions implemented.
- Bodmin Treatment Centre did not provide us with any evidence that showed safety goals had been set or performance was monitored effectively. Safety goals are created by a provider to encourage improvement of safety outcomes in an attempt to reduce incidents. For example, the general/registered manager told us the hospital had been identified as an outlier for incident reporting amongst the Ramsay Health Care UK Operations Limited providers on their 'funnel chart data'. However, there was no evidence investigations had been made to identify why there appeared to be an under reporting of incidents. The general/registered manager was unaware that some of the issues discussed in committee meetings, which would be classed as incidents, had not been recorded on the incident reporting electronic system. Therefore, trends and patterns were not being picked up by the centre due to under reporting. For example, cancellation of surgery due to patients not fasting appropriately had not been reported as an incident, which meant the cause had not been investigated.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the provider to be open and transparent with a patient when things

go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff could not demonstrate whether patients using outpatient services were told when they were affected by something that goes wrong. A corporate 'being open' policy was available to staff at the centre and provided staff with guidance on the duty of candour. However, no specific training on the duty of candour was provided to staff. The corporate 'being open' policy states staff should receive training in being open and meeting the requirements of the duty of candour. Staff within the outpatient department were able to explain what their responsibilities were under the duty of candour but could not give any examples of when it had been applied.

- Reviews and investigations were carried out when things went wrong but documentation completed was not detailed and actions taken were not fully implemented. We saw evidence of an incident involving inappropriate staff conduct within the outpatient department. An investigation was carried out but it lacked formal documentary investigation and the actions taken were not being rigorously upheld. Staff told us they had not been fully informed on the details of what happened or what was being done to prevent similar incidents happening again.
- There was no specific evidence to demonstrate that staff within the outpatient department shared further learning and changed practice as a result of investigations. When speaking to staff they could not share any examples of when further learning had been disseminated but did state that when lessons had been learned they were shared by the outpatient manager during informal discussions, usually as and when they occurred. There were no minutes from the discussions and they took place sporadically rather than in a formalised or structured meeting.
- **Duty of Candour**
- See Surgery section for main findings.
- **Cleanliness, infection control and hygiene**
- Systems and processes were in place to protect people and reduce the risk of cross infection.
- The outpatient environment was visibly clean and staff explained how standards of cleanliness and hygiene were maintained. For example, staff told us how ophthalmology equipment was wiped down using appropriate cleaning materials after every use by consultants and the room cleaned thoroughly by staff and housekeeping after every clinic.
- Cleanliness and hygiene within the outpatient department was thoroughly maintained. Staff within the department adhered to a cleaning schedule that was signed every day to confirm that the task had been completed and who carried it out. We saw that the documentation had been completed correctly for the past 30 days. The tasks included daily cleaning of patient couches in consultation rooms, blood pressure cuffs, data scope, echocardiogram machine, trolleys and equipment in the department.
- There were regular audits for cleanliness, infection control and hygiene. These included audits for infection prevention and control, environment, hand hygiene and surgical site infections. The audits were not department specific but did take into account the areas which were being monitored. The audits were discussed at heads of department and clinical governance meetings. We saw evidence that hand hygiene audits had been carried out in December 2015, April 2016 and July 2016, which was in line with their policy. Compliance rates varied between 88%, 91% and 92% respectively. Reasons for non-compliance included staff wearing jewellery and not being bare below the elbow.
- Bodmin Treatment Centre had a housekeeping team, which included a team of six staff members, who were responsible for cleaning the whole hospital. We observed completed cleaning schedules which were checked by the housekeeping manager. Every six months the hospital was deep cleaned by an external company.
- Reliable systems were in place to prevent and protect patients from healthcare-associated infections. Patients were screened for MRSA in pre-assessment in line with Ramsay Health Care UK Operations Limited policy, this included patients who had been in contact with MRSA. The hospital aimed for MRSA screening to be completed within one month prior to admission. If a patient was identified as positive for MRSA surgery was postponed

until they tested negative, after which admission would be arranged within two weeks. There had been no incidents of MRSA, Clostridium difficile (C. difficile) or Escherichia coli between July 2015 and June 2016.

- The matron was the lead for infection control and had attended a corporate infection prevention and control training course. The senior management team identified how they were struggling at present to meet the demands of the infection control lead and were unable to evidence how they were promoting infection control to staff and patients. Although they had implemented change to promote infection control as part of their Commissioning for Quality and Innovation payments framework (CQUIN) at the centre which included hand hygiene. To promote hand hygiene within the hospital, leaflets had been placed in staff areas and wash hand signs were visible when entering departments.
- An outpatient nurse had recently been appointed as infection control link nurse for the whole hospital and had received corporate training for this role. The lead attended corporate infection control meetings and fed this information back to the matron. The Ramsay Health Care UK Operations Limited infection prevention control lead was available for advice and would review all root cause analysis following identified infections. In the last year, two infection prevention and control meetings had been held. The matron said there were difficulties in making the meetings quorate. We were not told what was being done to address this.
- Staff took precautions to prevent the spread of infection. Personal protective equipment and hand gel was available in all clinic rooms, reception area, in the pre-admission bays and entrances to corridors and waiting rooms. We saw staff employing hand washing techniques.
- The water quality was regularly monitored and we saw evidence of a completed legionella log book which demonstrated there had been no issues.
- As part of the process for cleaning nasopharyngeal endoscopes (, they were sterilised on site in the sterile services department both before and after ear, nose and throat (ENT) clinics. Leak testing was not performed between each patient use, which was a requirement in line with guidance for decontamination, Health Technical Management (HTM) 01/06 part E testing. A three-part decontamination system, using specialist wipes, was in place to decontaminate equipment between patient use. However, we were told goggles were not used as personal protective equipment to protect staff when using the system.
- Although there were systems to protect patients from cross infection, we saw evidence that some members of staff did not always adhere to them. For example, management staff were not always bare below the elbow when visiting clinical departments. Recent audits also identified staff were not always compliant with being bare below the elbow. During one clinic a consultant was observed wearing his jacket while examining patients which increased the risk of cross infection. There was no evidence to confirm senior management were addressing this, although we were told by senior management that compliance had improved.
- **Environment and equipment**
- Facilities and premises were designed in a way that kept patients safe.
- For example, the waiting area was fully visible to staff behind the reception desk. There were emergency call bells on the reception desk and in the outpatient department toilets.
- Equipment was regularly maintained to keep patients safe. All equipment in the outpatients department had been serviced and safety checked throughout 2016 as evidenced by the last serviced stickers. Fire extinguishers in the outpatient department were recently checked for safety and all electrical tests had been completed for portable electrical equipment. An engineer was on site three days a week and they were responsible for the building maintenance which included preventative tests and reactive work should there be a fault. All information in relation to equipment was kept on a spread sheet and monitored by the on-site engineer to ensure maintenance and servicing was undertaken at the appropriate time.
- There were safe systems for managing waste and clinical specimens. We saw that sharps bins were correctly filled, labelled and securely fastened.
- Resuscitation equipment was available at the hospital and a trolley was located in the outpatients department

that was clearly visible and easily accessible. Security was maintained with tamper-evident seals. The top shelf of the resuscitation trolley, including all equipment, was checked daily but the lower drawers were checked once a week. On inspection of the top drawer of the resuscitation trolley, we saw it contained a tracheal introducer that had gone out of date by over three years. This was brought to the attention of the staff and matron during the inspection. Staff told us advice had been sought from an unnamed individual at head office and they were assured it was safe for use but did not say how long for. There was a lack of understanding regarding the safe use of perishable equipment.

- All equipment within the department was visibly clean. Staff told us they took responsibility for making sure equipment was clean after a clinic ends but consultants were responsible for cleaning equipment after each use. When observing clinics, staff and consultants were observed changing cover sheets on patient couches and cleaning equipment after patient use.
- **Medicines**
- There were arrangements for medicine management but issues were found that meant patients were potentially unsafe.
- There was a medicines management policy in place for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines in the outpatients department. Appropriate medicines were stored in a refrigerator and the temperature was checked and recorded daily, with all temperatures being within safe limits. Medicines were also stored in locked cupboards in the outpatient department office, treatment room and eye examination room. The room temperatures were checked and recorded daily. We saw evidence that the temperatures of the rooms were within safe limits over the last 30 days. Keys to the locked cupboards and rooms were limited to the registered nursing staff and were stored securely. The outpatient department did not administer controlled drugs.
- All relevant information about a patient's medication was recorded at pre-operative assessment. The GP referral letter was contained within a patient's records, which highlighted any medicines and/or allergies. As part of the consultation process and pre-operative assessment patients were advised on medicines they needed to stop taking prior to their date of surgery.
- Staff told us that medicines were only prescribed by consultants during consultations but it was a rare occurrence due to the type of patients seen at the centre. If a consultant did prescribe medicine to a patient, staff told us that medication was given to patients from their store or if unavailable, prescriptions would be printed on headed paper and sent directly to their GP by fax with a request to write a formal prescription for the patient. Any medicines given to patients were recorded in their records.
- During our inspection, we did not see any patients being prescribed medicine, however, staff told us that they always explained to patients why they were being prescribed medication, how and when to take medication and what side effects may be experienced.
- Staff monitored the storage of medicines within the outpatient department but the process was not always effective. As part of the monitoring process, the outpatient lead checked the cupboards in the outpatient office and treatment room once a week, with the eye examination room being checked by a registered nurse. The centre had a service level agreement with a local independent pharmacy for a pharmacist to audit their medicine stores once a month. However, on inspection of the cupboard in the outpatient department office, we saw out of date eye drops on a shelf, which had expired in August 2016. We also saw, that there was out of date naloxone (Naloxone in the resuscitation trolley, which had expired in August 2016. The staff and matron were made aware of this at the time of the inspection.
- The pharmacist completed a prescribing audit in May 2016. They identified some issues with a particular medication and the safe management of this. Actions had been taken by a senior member of staff to monitor it was being managed safely. We did not see evidence of any actions being taken in addition to their current practice regarding medicine management.

- The pharmacist also identified that outpatient notes did not have allergies documented or signed by the person completing. However, we saw evidence that allergies had been recorded in the patient records that we reviewed.
- **Records**
- Individual patient records were written in a way that kept patients safe.
- The outpatient department used paper records which included a diagnosis and management plan, nursing assessment, venous thromboembolism risk assessment, pressure ulcer risk assessment, nutritional risk assessment, falls risk assessment, care plan and drug chart. This was part of the patient's care pathway. Discussions during the outpatient consultations and pre-operative assessments were recorded and kept in the records.
- Patient confidentiality was protected by staff. Staff using the patient administration system had their own passwords and signed confidentiality agreements when commencing work at the centre. Patient records were stored securely in a locked cupboard next to the outpatient nurses' desk which was kept locked at all times. The cupboard could only be accessed by key which was kept by the member of staff manning the outpatient desk. Access to the outpatient department was limited to those who had a fob to enter the locked doors at each end of the corridor.
- As part of the centre's auditing programme they carried out an audit of patient records, with 10 being audited per month. According to the data submitted, they achieved a score of between 91 and 98% between July 2015 and June 2016. This meant that completion of patient records did not fully comply with policy requirements. A few of the common omissions from patient records included a failure to record allergies on the drug chart, failure to record the full name of the person initialling entries and ensuring all entries are dated and signed. However, we reviewed four patient records which were all comprehensive, legible and complete.
- **Safeguarding**
- There were systems, processes and practices in place and communicated to staff to safeguard adults from abuse.
- Staff could access a comprehensive resource folder in the outpatient department containing pathways, information packs on abuse, alert forms and contact points for safeguarding referrals, the safeguarding teams and out of hours contacts. Bodmin Treatment Centre also had two safeguarding leads who could be accessed to provide further information and guidance. Although, trained to safeguarding level two there were plans to undertake level three training.
- Staff completed level one safeguarding training for children as part of their mandatory training and we were told they were all up to date. Following the inspection we were sent data that showed that all but four (three of these were bank staff) staff were up to date with safeguarding of adults at level one and level two. At the time of this inspection Bodmin Treatment Centre did not take children.
- We spoke with one of the two safeguarding leads who said their role was to support and advise other staff on safeguarding and possible referrals to the local council. They had completed training to level 2 for but told us they planned to undertake safeguarding training in level 3. If they required further internal support they would contact the safeguarding lead for Ramsay Health Care UK Operations Limited who was trained to level five safeguarding.
- All staff in the outpatients department had been trained in level two safeguarding, however, there were no staff within the department trained to level three.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures. Staff told us they knew what to do if they encountered a situation where they may need to make a safeguarding referral. They stated that they would escalate the matter to their head of department, the matron and if applicable, discuss with the safeguarding lead at the centre. We were told they would also access the appropriate information regarding who to make a safeguarding referral to, which was located in the outpatient department office.

Although, none of the staff in the outpatients department had made a safeguarding referral between July 2015 and June 2016. CQC had received no safeguarding concerns during the same period.

- Staff had received training on female genital mutilation as part of their safeguarding training which was in line with corporate policy.
- Prevent training was being delivered to staff by the matron and hospital personal assistant via a training presentation and three short films. Prevent is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism.
- **Mandatory training**
- Staff received regular mandatory training updates.
- The programme for employed staff included; data protection, emergency management: fire and personal safety, equality, human rights and work place diversity, health and safety, prevention of infection, information security, manual handling, basic life support, safeguarding adults, safeguarding children, customer service, sharps and intravenous drugs.
- Consultants with practising privileges were required to have completed mandatory training in immediate life support, manual handling, health and safety, emergency management, fire and personal safety, infection control, safeguarding, information security and consent.
- The compliance rate for all mandatory training for staff in outpatients was 100%. We were informed that mandatory training was 100% compliant in July 2015 and that staff pay was dependent on their completion of the training. A new e-learning software programme was introduced in June 2016. However, the hospital was unable to pull data to report training compliance as the old system had not transferred to the new system and the system was not recording correctly when staff had completed training. The new system would allow training reports to be run.
- In the first two weeks of employment staff were expected to complete their mandatory training. The hospital personal assistant maintained their own spread sheet which recorded completion of training. They would email the head of department and highlight if there were gaps in training or if training for staff was due to expire. In order for staff to be alerted of their training status they needed to log in to the centre's computer system. Staff said they had access to training and found it to be of good quality.
- **Assessing and responding to patient risk**
- There were systems in place to ensure that individual patient risks were identified and managed safely.
- The majority of patient referrals were received through the NHS e-referral service, which were triaged by the outpatient lead, who was also a registered nurse, and the matron. The referrals were reviewed using the patient eligibility criteria to ensure only those patients whose needs could be safely met by the hospital were accepted. Private referrals were also screened in the same way. All patients were individually assessed and were only excluded if they were unable to provide an appropriate and safe clinical environment. Bodmin Treatment Centre treated patients over the age of 18 years but had an eligibility policy. Examples of the type of patients excluded:
- Patients with blood disorders (haemophilia, sickle cell, thalassaemia);
- Patients on renal dialysis;
- Patients with positive MRSA screen were deferred until negative;
- Patients who were likely to need ventilator support post operatively;
- Patients who were above a stable America Society of Anaesthesiologists (ASA) 3 (i.e. poorly controlled co-morbidities);
- Any patient who would require planned admission to intensive care unit post-surgery;
- Poorly controlled asthma (needing oral steroids or has had frequent hospital admissions within last 3 months);
- Myocardial infarction in last six months.
- Data submitted demonstrated that the eligibility or exclusion criteria was available for use, by the staff and/or consultants in the outpatient department in hard copy. The criteria was outlined in their statement of purpose and in a separate document issued by Ramsay Health Care UK Operations Limited.

Requires improvement

Outpatients and diagnostic imaging

- Patients completed a medical questionnaire before their first outpatient appointment which identified any potential risks associated with their treatment. However, the medical questionnaire and risk assessments carried out at pre-assessment did not always identify risks and appropriate safeguards were not always in place to mitigate risks once a patient had been accepted for treatment. For example a patient, who had mobility issues, arrived at the centre but the appropriate equipment for moving them was not available so she was unable to have treatment carried out at the centre. Staff were able to demonstrate that patients were screened before they arrived but we were told that some patients, in the past, have arrived at the centre who were unsuitable, either because of their physical condition or because of a lack of appropriate equipment. We saw no evidence of actions being implemented or learning being shared to avoid similar incidents occurring again.
- All patients accepted for surgery underwent a pre-operative assessment by the nursing staff in the outpatient department. The pre-operative assessment was carried out after a patient's first consultation. Any diagnostic imaging or further testing, ordered by the consultant, was arranged by the nurses/healthcare assistants and appointments booked accordingly. The additional tests and/or diagnostic imaging did not always take place at the centre.
- Comprehensive risk assessments were carried out for patients who used the service and systems were in place to alert staff to identified patient risk. As part of the pre-operative assessment, staff carried out risk assessments as appropriate for the surgery being carried out, which included venous thromboembolism, waterlow (pressure ulcer risk assessment), malnutrition universal screening tool, manual handling, dementia (if appropriate) and risk of falls. Any risks identified were recorded at the front of patient records in order to alert staff. Staff told us that they documented any important information, including risks, on the front of patient records. We saw evidence that the various risk assessments had been carried out and alerts had been recorded appropriately to ensure staff were aware of any and all risks. We observed two pre-operative assessments and saw patients being asked appropriate questions to identify risk areas.
- Staff were aware of their responsibilities in the event of a medical emergency. Staff told us that they would call 999, which was the pathway followed for escalation to the NHS. We were told that staff would respond in a way to ensure the patient's safety while they awaited the assistance of an emergency ambulance. There were no situations which required emergency transfer, between July 2015 and June 2016. Senior staff told us a service level agreement was in place with the local acute trust that covered all types of admissions to them, for example, critical care. The protocol in place was to call for an ambulance and provide them with the details and then inform the local acute trust about the patient
- Processes for responding to a medical emergency were not safe. A corporate adult resuscitation policy was in force and up to date, however, the local procedure presented risks. The corporate policy stated a medical emergency team should be allocated and include at least one doctor and no fewer than three registered health care professionals. The team leader should hold Advanced Life Support training and all members should have at least Immediate Life Support training. The resuscitation lead was trained in advanced life support and all other staff in immediate life support.
- The local policy did not define roles and the decision on who would do what was made once each member of the team had arrived. There was a risk that the response to a cardiac arrest may not be safely co-ordinated due to delay in responding and deciding on who would have each role. The emergency call system was tested weekly; however, this was not in line with the corporate policy which stated it was the responsibility of the registered manager to ensure the system was tested daily. There were no individual resuscitation bleep holders as there was no allocated resuscitation team.
- We were not provided with evidence that resuscitation scenarios were completed in the last year. The corporate policy stated scenarios must be held bi-monthly in different areas of the hospital, and these could be full arrest scenarios but could also include other emergency situations as appropriate. Staff told us that no scenarios took place in the outpatient department.
- The centre had appointed a resuscitation lead but we were told they did not have protected time to perform their role, which was not compliant with Ramsay Health Care UK Operations Limited policy.

Requires improvement

Outpatients and diagnostic imaging

- All staff received training in Basic Life Support. Additionally, all employed clinical staff received Immediate Life Support training and we saw evidence of 14 clinical staff attending the most recent training.
- **Nursing staffing**
- Staffing levels safely met the needs of patients.
- The outpatient department had one full time registered nurse who was also the department lead, one part time registered nurse and a health care assistant who also worked part time. During our inspection, the needs of patients were safely met as the clinics being run did not place a high demand on staff.
- Staffing was planned on a weekly basis and then reviewed on a daily basis. Daily nursing hours were calculated as per the Ramsey Health Care UK Operations Limited safe staffing guidance and allocated according to activity. They had a rostering system which allowed heads of department to manage rotas, skill mix and staffing requirements. It also monitored staff sickness and annual leave absences. Head of department attended daily huddles first thing in the morning, which highlighted any sickness and how the departments would manage or relocate resources as required.
- No bank/agency nurses or healthcare assistants were employed in the outpatient department throughout the period between July 2015 and June 2016. The only months in which they employed bank or agency healthcare assistants were July and August 2015 and the rate was 1% and 3% respectively, which was better than the average for other independent acute hospitals over the same period.
- There was no staff sickness for outpatient nurses throughout July 2015 to June 2016. During the same period, the rate of sickness for healthcare assistants was better than the average of other independent acute providers over the same period. We were told by the outpatient lead that if there were any staff absences or annual leave, cover would be provided by staff from the theatre department.
- At the time of our inspection there were no staff vacancies in the outpatient department.
- **Medical staffing**
- The arrangements for medical staffing in the outpatient department safely met the needs of patients and all clinics were consultant led and delivered.
- There were 33 consultants with practicing privileges and three consultants directly employed by Ramsay Health Care UK Operations Limited working at Bodmin Treatment Centre. Clinic activity was dependant on consultant availability, therefore safe medical staffing was appropriately arranged according to activity levels.
- The hospital completed relevant checks against the Disclosure and Barring Service. The registered manager and medical advisory committee chair liaised with the General Medical Council and local NHS trusts to check for any concerns and restrictions on practice for individual consultants. The General Medical Council is a public body that maintains the official register of medical practitioners within the United Kingdom.
- There was sufficient consultant staffing to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital outpatient department and administration team.
- Hospital staff told us consultants were supportive and advice could be sought when needed.
- **Major incident awareness and training**
- In the event of a power outage, systems were in place to ensure patient safety. The centre had a standby generator which provided eight hours of back-up power. We saw evidence the fuel was checked weekly and the generator was tested monthly, with checks being recorded. Service of the generator was completed every six months.
- We saw evidence of a local fire policy and arrangements were in place in the event of a fire. The fire alarm was tested weekly and full evacuation drills were completed six monthly. This was evidenced in the fire log book for September and March 2016.
- The hospital had a business continuity plan, which was corporate based but individual details were added in for each location. For example, how to manage a power cut and with details of local companies to contact.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

We inspected effective but it is not rated.

Evidence-based care and treatment

- Relevant and current evidence based guidance was used to develop the outpatient services. For example, staff in the outpatient department told us that they applied the NICE guidelines (NG45) for routine preoperative testing for elective surgery.
- We were told by the matron that NICE guidelines were sent from head office and then disseminated to the clinical governance committee and medical advisory committee which were then shared with staff. NICE produce standards for health care based on evidence of best outcomes.
- We were told that Ramsay Health Care UK Operations Limited policies and documents were based on NICE guidance as appropriate. An employed consultant told us they received updated NICE guidelines or changes to policies via email and were required to sign following reading. However, the chair for the medical advisory committee (MAC) confirmed there adherence to NICE guidelines was not monitored and so had no assurance they were being followed. We were told by the outpatient lead that the NICE clinical guidance NG45 Routine Preoperative Tests for elective surgery were followed in line with policy. However, when asked for further evidence of adherence to NICE guidelines they were unable to provide any evidence or examples.
- The matron said NICE guidelines were sent from head office. However, we saw no evidence of this information being cascaded to outpatient staff or any evidence of process for ensuring gap analysis was done. We saw no evidence of staff training following changes to NICE guidance or monitoring that NICE guidance was being implemented and adhered to. The lead for the MAC told us NICE guidance was discussed at the MAC meetings but the cascading of evidence was from each consultant who attended for their speciality to their peers. Clinical governance meeting minutes did not demonstrate how they were following up-to-date, new or revised clinical guidance. In the three sets of minutes we were sent from the meetings in May 15, September 15 and March 2016 it said to circulate to all consultants but did not specify what NICE or other guidance this was or whether there was anything to report.
- The department of health issued patient safety alerts via the central alerting system; these were received by the matron and heads of department, who were responsible for informing staff at meetings and by email. As there were no formal team meetings in the outpatient department, staff told us this information was shared informally on a daily basis.
- **Pain relief**
- Within the outpatient department patient's pain levels were assessed on an ad hoc basis. Consultants told us that during consultations they asked patients to rate their pain and what analgesia they were currently taking but it was rare to provide pain relief. They told us that their patients were either already taking analgesia prescribed to them by their GPs at the time or patients were not in enough pain to require it. Nursing staff told us they would not routinely provide patients with pain relief as the consultant usually identified patient needs themselves during consultation, but if required they would discuss with the patient's consultant and proceed as advised.
- Ramsay Health Care UK Operations Limited undertook a quarterly survey that asked patients questions on pain relief, nutrition and hydration. The information was shared with the centre and any issues were discussed at clinical governance and head of department meetings.
- We observed consultants asking patients to rate their pain and whether they were taking analgesia during consultations. We also saw consultants explaining to patients the type of pain and discomfort they could expect while undergoing and recovering from certain operations/procedures.
- **Patient outcomes**
- Specific information about patient outcomes in the outpatient department was not routinely collected.
- The centre participated in the patient led assessment of the clinical environment (PLACE) audits. Their scores in

2016 were better than the England average scoring 100% for cleanliness, 99% for condition appearance and maintenance, 97% for dementia, 98% for disability and 93% for privacy, dignity and wellbeing.

- The Commissioning for Quality and Innovation (CQUIN) payment framework had set targets for the centre. The commissioning for quality and innovation payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Throughout 2015 and 2016 the national requirement was 100% achieved but Bodmin Treatment Centre had only achieved a 50% compliance rate with local requirements. The national target was the requirement for the implementation of a staff wellbeing initiative which was met. The local requirements involved hand washing improvement and the availability of hand wash gel.
- Reporting responsibilities for Bodmin Treatment Centre were to corporate and clinical commissioning groups. Compliance with their responsibilities was good with all audit results and outcomes shared promptly and appropriately. However, they did recognise that they were not always using results to drive improvement of outcomes for patients using their services.
- **Competent staff**
- Staff within the outpatients department had the right qualifications, skills, knowledge and experience to do their job.
- All relevant consultants and qualified nursing staff within the outpatient department were subject to revalidation. The outpatient lead told us and we saw that all qualified nursing staff had been revalidated and achieved all competencies applicable for carrying out their role. There was a system in use, which flagged pending registration or revalidation requirements with health care professional's registration. In addition, the rostering system would not allow staff to be booked if their registration was not valid.
- Each new staff member completed an induction. Induction involved a presentation and every new staff member was reviewed weekly, two weekly and monthly for six months by their head of department on their competencies, training and performance.
- Every year each member of staff received an appraisal. At the time of our inspection all staff within the outpatient department had received an appraisal for 2016. As part of their employment, staff had a personal development plan which was maintained and developed to enhance their skills and training. Staff told us there were opportunities to further their learning through corporate training. For example, acute illness management courses had been offered and attended by staff. A member of staff within the outpatient department had attended infection prevention and control training to aid them in their role as infection prevention and control lead.
- All staff received customer excellence training. This training focussed on providing good customer/patient service.
- Practicing privileges was specified in a policy which set out rules on who can practice at the treatment centre. Of the 33 consultants with practicing privileges, the medical advisory committee at the centre were responsible for the annual review of 11 of them, with the other 22 being reviewed by their sister hospital in Truro.
- As part of the process for approving a consultant for practicing privileges, a medical practitioner could only treat patients once they received accreditation to do so. Prior to offering accreditation each practitioner had to obtain approval of a scope of practice within one or more categories specified in the rules. The medical practitioner had to attend a meeting with the general/registered manager to discuss credentials, any special requirements and the needs and strategic direction of the centre. They then had to submit a completed application to the general/registered manager, which included two written references.
- It was the responsibility of the general/registered manager to ensure that the medical practitioner held the appropriate registration with the relevant professional body, had the appropriate certification form, an enhanced disclosure and barring service certificate, two written references and a verbal reference if the applicant was not known to the general manager or medical advisory committee member. The applicant had to hold professional indemnity insurance, complete a conflict of interest form and have a satisfactory annual appraisal.

Requires improvement

Outpatients and diagnostic imaging

- Consultant appraisals were indicative of consultant competency. These were completed by the employing trust or through Ramsay Health Care UK Operations Limited appraisers. The spread sheet of appraisal dates showed three expired appraisals, two were within three months and therefore acceptable and one had expired four months prior but the consultant in question was managed by another Ramsay Health Care UK Operations Limited provider. We reviewed consultant files for three consultants with practising privileges and one employed consultant. An appraisal was not on file for one consultant with practising privileges.
- Consultants with practising privileges were required to complete their scope of practice in their application form which included their annual volumes. This ensured each consultant was competent to carry out their practice.
- Examples were provided of staff suspension due to misconduct or investigation. This showed poor performance was identified.
- **Multidisciplinary working**
- Staff within the outpatient department worked together to assess and plan ongoing care and treatment.
- During our inspection, we observed effective teamwork between reception staff, health care assistants, registered nurses and consultants, which ensured patients received prompt, safe and quality care. We observed clear communication between different health professionals and enthusiasm to provide assistance when requested.
- Staff were positive about their working relationships. Staff told us they worked well with each other and felt able to challenge if there were concerns about practice. Consultants told us staff within the outpatient department were helpful, caring to patients and hard working. Nursing staff told us consultants working in the department were easy to work with and communicated any issues or concerns to them.
- Some staff felt the working relationship between the theatre and outpatient department needed to improve. Staff told us they felt there was a 'them and us' attitude at the hospital, although this feeling was not shared by all staff we spoke to. Staff told us they documented all communication between departments in patient notes to avoid confusion and conflicting information. However, we observed teamwork between the two departments when a theatre staff member approached an outpatient staff member to request assistance with a patient who required additional assessments following surgery. The outpatient staff member was accommodating and assisted the theatre staff member promptly, communicating when they would be able to help.
- Communication with external healthcare providers was productive. Staff told us that they enjoyed positive relationships with GPs and local acute NHS providers which allowed them to obtain any missing patient information quickly which aided them in providing a high quality service to their patients.
- **Seven-day services**
- The outpatient department did not offer seven day services as it was only available Monday to Friday, 8am to 5pm.
- Patients were given an out of hours contact number for the centre's sister hospital in Truro. Healthcare professionals at the sister hospital managed any patient concerns or problems outside of Bodmin Treatment Centre opening hours. A list of activity at the centre was sent to the sister hospital in order to handle any out of hour enquiries. Those at the sister hospital were able contact patients' consultants if required.
- The following services were outsourced and not provided at the treatment centre; pathology, clinical imaging and pharmacy.
- **Access to information**
- The information needed to deliver effective care and treatment was always available to staff in a timely and accessible way.
- Access to patient's full medical records was not available; however, a referral letter was received from patient's GPs, which included a minimum data set for all patients. Staff and consultants told us they had all the appropriate information available to them and the letters received from GPs were sufficiently detailed. They stated if there were any gaps in information, they were able to contact the patient's GP or local acute NHS hospital to request more information, specific tests and/or imaging.

Requires improvement

Outpatients and diagnostic imaging

- Patient alerts were visible at the front of patient records. Any alerts related to specific patient issues or risks were documented on a sheet in the front of the records, allowing those reading the records easy access to important information. For example, we saw two sets of records which had alerts clearly outlined on the front of them which detailed a patient living with dementia and specific drug allergies.
- At the end of consultations, patients were provided with a copy of the consent form they had signed. Patients were provided with a letter detailing their surgery date and time, the telephone number of the outpatient department and fasting instructions, if appropriate.
- Access to diagnostic imaging was not consistent within the outpatient department. All diagnostic imaging, apart from ultrasound scanning, was outsourced to local providers. However, there was no consistent approach as to who provided the services. We were told by staff and consultants that the destination of a request for diagnostic imaging was dependent upon which consultant was making the request. However, all staff told us that this did not cause unnecessary delay or complications.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- Staff we spoke with demonstrated understanding of consent and decision making requirements in line with legislation and guidance, including the Mental Capacity Act 2005.
- The outpatient department staff and consultants ensured patients were fully informed during the consent process. For example, during general surgery consultations, we observed consultants completing the consent procedure. The patient was fully advised of what procedure was being proposed, the risks and benefits were discussed and the patient was asked whether or not they wanted to proceed. The consent form was completed and each patient was advised to read all of the consent form before signing and invited to ask any questions they had. Following signing the consent form, the patient was provided with a copy.
- The process for seeking consent was audited quarterly and the overall compliance rate for the consent process ranged between 94% and 97% throughout July 2015 to June 2016. Areas of non-compliance included staff not completing stage two of the informed consent process and no evidence of risks being discussed with patients.
- We were told by staff within the outpatient department that they had received online training in respect of the Mental Capacity Act 2005 but they were not sure when the training had been delivered. Staff told us they would assume patients had capacity but would reassess this if issues arose. They told us they reviewed GP referral letters carefully to identify any capacity issues before patients attended. When screening referrals, the outpatient lead told us, if a patient has been identified as lacking capacity, they sought clarification on whether there was a lasting power of attorney in force, granting a nominated individual authority to make medical decisions on behalf of that patient.
- We were told they did not treat many patients who lacked capacity. However, staff told us that if they were treating a patient who lacked capacity they would document each capacity assessment carried out.
- Staff within the outpatient department told us they understood their responsibilities if a deprivation of liberty had to be made but said it was unlikely to be required at the centre. We were told an application to the local council would be made. A person can be deprived of their liberty if they do not have the capacity to make their own decisions, and need treatment, care or safety to protect them. An application to deprive a person of their liberty in order to receive care and treatment was unlikely to be required for a patient treated at Bodmin Treatment Centre.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good

Compassionate care

- All staff within the outpatient department treated patients with kindness, compassion, respect and dignity.

Requires improvement

Outpatients and diagnostic imaging

- We observed staff maintaining patient dignity throughout care and treatment with curtains drawn when assessments and/or examinations were being performed. Staff always introduced themselves to patients and addressed them by their surname until invited to do otherwise. Staff remained friendly and helpful whenever treating and caring for patients.
- Patients told us they were happy with the service provided and had been impressed with staff and consultant advice, care and professionalism. Patients told us they were unable to think of any improvements that could be made.
- We observed staff using communication techniques that were clear, simple and effective. Staff were careful not to use jargon but when it could not be avoided, it was explained in simple terms.
- When performing tests, taking swabs or observations, staff explained to patients what they were doing. Patients were told why specific tasks were being performed and they were always asked if they were happy for them to proceed.
- During clinics, consultants were polite, friendly and respectful of patient needs. Consultants introduced themselves, enquired about patients' general health and engaged in brief but friendly conversation before discussing medical issues, which created a friendly atmosphere.
- Staff had adequate time to assess patient needs. Staff told us they had enough time to speak to patients and address their needs during clinics and assessments. We observed staff taking their time with patients and engaging in friendly conversation. Staff appeared calm and caring during clinics and assessments.
- The Bodmin Treatment Centre participated in the friends and family survey for NHS patients. In December 2015 there was a 6% response rate with 100 % recommending the services of the outpatient department, of the 34 patients recommending, 34 were extremely likely to recommend. In June 2016 there was a 3% response rate with 100% recommending the services of the outpatient department, of the 18 responses, 18 were extremely likely to recommend. Within the results, all comments for outpatients were positive, these included:
- "very nice, efficient hospital"
- "So good I am having my other eye done"
- "The care from the nurses and consultant was excellent. Totally faultless, the hospital is modern and clean."
- The availability of a chaperone was advertised to patients and displayed in all consulting rooms. We observed consultants actively asking patients if they would like a chaperone while undergoing examinations. Staff told us that chaperones were always used when gynaecology clinics were run.
- Prior to our inspection patients had submitted comment cards which were all positive. For example, patients said:
- "Absolutely excellent-a brilliant service. Staff are charming"
- "Staff were very caring and pleasant, I couldn't have asked for better".
- "Brilliant in every sense of the word".
- "All the staff have been lovely".
- Patient privacy could not always be maintained. There was a separate reception and waiting area for patients visiting the outpatient department. The waiting area was close to the reception desk and therefore conversations between patients and receptionist could be overheard, although receptionists spoke quietly to limit this risk. Patients who underwent pre-operative assessments would sit in one of two bays in the outpatient department, which were separated with curtains. If and when two patients were in the bays undergoing pre-operative assessments, at the same time, there was a risk that conversations between nurse and patient could be heard. However, this did not occur during the inspection as there was only one clinic taking place at any one time.
- **Understanding and involvement of patients and those close to them**
- Patients and those close to them were involved as partners in their care. One patient said that their proposed treatment had been explained to them in detail and that he fully understood what was happening next and the risks involved.

Requires improvement

Outpatients and diagnostic imaging

- We observed care provided to nine patients, during which communication between patients and staff was clear and concise, ensuring patients understood their care, treatment and condition. For example, we observed a nurse explaining why MRSA swabs needed to be taken and what would happen when the results were received.
- During general surgery consultations, patients were asked whether they wanted to be sedated during certain procedures. The consultants explained to patients that it was their decision and explained the benefits and effects of being sedated. The patient was given time to decide and any questions asked were fully answered by the consultant. Patients told us they could take their time and ask any and all of their questions.
- Patients were able to access further information and advice about their care and treatment. We observed staff and consultants providing patients with opportunities to ask questions and request additional information during consultations and pre-operative assessments. Nursing staff actively encouraged patients to contact the department with any queries, questions or concerns and requested patients update them on any developments in their condition. Patients were given the contact number for the department and we observed, on multiple occasions, staff receiving telephone calls and providing additional information to patients over the telephone.
- Detailed information was given to patients prior to their surgery. During pre-operative assessments, nursing staff explained to patients what was going to happen on the day of their surgery, through to discharge. Staff queried with patients whether they had someone to provide transport to and from Bodmin Treatment Centre and provided information on services available to them, if they did not.
- We observed consultants explaining to patients alternative options, potential outcomes and likelihood of success and involved them in the decision making process. Patients were encouraged to take they time in making a decision and told to ask any questions they had.
- **Emotional support**
- Patients were given support during their care and treatment.
- Reassurance was given to patients. Staff put patients at ease by explaining everything clearly and in a calm manner. We observed a follow-up consultation involving an elderly patient with a history of medical problems. The consultant explained calmly and compassionately to the patient that there was nothing to worry about and that the treatment they received was successful. The consultant reassured the patient that they could return if they had any ongoing concerns but would write to their GP with the good news.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- Services were planned to meet the needs of patients.
- Outpatient clinic days and times were determined by consultant availability and patient demand. This meant they could arrange more clinics if patient demand was high and consultants were available.
- Commissioners were involved in planning services. Bodmin Treatment Centre provided care to patients through an NHS contract which was overseen by local commissioners. They liaised with the commissioners on a regular basis to discuss key performance indicators and Commissioning for Quality and Innovation (CQUINs) set by them. These CQUINs had been met or partially met by the Bodmin Treatment Centre over the last financial year.
- The facilities and premises were appropriate for the services that were planned and delivered. They used patient eligibility criteria to ensure they only treated patients whose needs could be safely met by the facilities offered on site.
- The outpatient department was accessible to patients Monday to Friday, 8am to 5pm. Outreach clinics were held on occasion and were arranged to suit the needs of patients.

Requires improvement

Outpatients and diagnostic imaging

- Before patients attended their first outpatient appointment they were provided with information including; contact details, a location map, their consultant name and healthcare leaflets to provide them with information on what to expect and what to bring relevant to their treatment.
- When services were delayed or cancelled patients were informed in a timely manner. Staff told us that when clinics have to be cancelled for reasons out of their control, patients were told as soon as possible and the reasons explained to them with appointments being rearranged to suit them. If clinics were cancelled or delayed on the day in question, staff within the outpatient department explained the situation to patients and re-booked their appointments at the next available date and are also offered apologies.
- The area surrounding the hospital had a lot of road works at the time of our inspection but patients had not been sent information with regards to the road works and the best way to access Bodmin Treatment Centre. This had been identified by a staff member the week prior to our inspection and the business administration team said they would produce a map and directions to include with the patient letter.
- **Access and flow**
- Patients had timely access to initial assessment, diagnosis and treatment.
- Bodmin Treatment Centre met the national standard which required 90% of NHS patients begin treatment within 18 weeks of referral by their GP. Between July 2015 and June 2016 Bodmin Treatment Centre exceeded this target.
- Access and flow within the outpatient department was efficient and well organised. Patients entered through the outpatient department waiting room and then into the consultation room area via a secure door. They were then guided through the department to the consultation room by the nursing staff. Following their consultation, patients were either escorted by the consultant to the nurse's desk for pre-operative assessment or guided to the exit if further care was not required.
- Patients were able to attend appointments which were convenient to them. Patients were able to access appointments electronically via the NHS e-referral service, and therefore able to select appointments which were suitable and convenient. The schedule for the outpatient clinics were published seven weeks in advance. Appointments offered patients the opportunity to be seen sooner, rather than wait for an appointment at a local NHS trust. Private patients were able to access services through self-referral or a private GP referral.
- When arriving at the centre for an appointment patients did not have to wait very long to be seen. During the inspection we observed patients being called to see consultants promptly.
- Consultations for each specialty were a specified length which ensured appointments did not overrun and reduced disruption to the list. We observed dermatology and general surgery clinics, the lengths of which were scheduled for five and 20 minutes respectively. During observations of consultations, we did not see any appointments lasting longer than the allotted time, which demonstrated the efficiency of both the consultants and nurses.
- The majority of patients were admitted for surgery shortly after initial consultation. The consultation and pre-operative assessment were completed in the outpatient department on the same appointment date. All risk assessments and screening were carried out to avoid unnecessary delay and admission dates for surgery were arranged the same day. The exceptions to this were if patients required diagnostic imaging or further investigations, however, referrals for these were made shortly after initial consultations.
- To improve access for patients outreach clinics were held for general surgery in two locations twice a month, to include initial consultations and follow-ups.
- If a patient required an urgent appointment we were told this would be accommodated by adding the patient as an extra to the list. The schedule was not published until 4pm, which allowed time at the end of the list to run late if patients were required to be seen urgently.
- If patients were unable to book an appointment for the required speciality on the NHS e-referral service they

would be placed on a waiting list. We were told this waiting list would be reviewed and discussed with the consultants to see if they had the capacity to hold an extra clinic.

- A manager told us it was rare for outpatient appointments to be cancelled. In the event a consultant was unable to attend, all patients would be phoned and an alternative appointment arranged as soon as convenient. The manager worked with the consultant to find an appropriate date to hold a list.
- If patients did not attend (DNA) their outpatient appointment it was flagged on a daily report. A manager reviewed the report and phoned the patient to rebook their appointment, however, patients were only allowed two DNAs before being referred back to their GP.
- Weekly activity meetings were held and attended by the matron, theatre manager, outpatient manager and business administration manager. These meetings were used to review the clinic lists and identify any gaps. For example, patients could be brought forward should a gap be identified.
- **Meeting people's individual needs**
- The individual needs of patients were being met.
- Patients told us that they had been kept informed about their consultation, further investigations, diagnosis, proposed treatment and could access information when required. We observed five follow-up consultations and witnessed consultants advising patients on whether they needed follow-up treatment, medicines or on-going monitoring. After each consultation, consultants wrote detailed letters to patient's GPs regarding what had been advised, the treatment given and any instructions on prescribing medication or further referrals to be made. Nursing staff also reminded patients of the departments contact number and advised them to call if they required any additional information.
- Patients with mobility difficulties had easy access to the department. The outpatient department was located on the first floor of a two story building which had corridors with wide access for patients using a wheelchair or walking aids. The building also had a lift for patients who were unable to use the stairs.
- Where possible, appointments were arranged to take into consideration specific issues relevant to certain groups of people. Staff told us that patients living with dementia were identified prior to their first consultation and all staff were made aware of this prior to their appointment. In order to limit distress for patients living with dementia, where possible appointments were arranged at a time when the department was quiet or they were placed first on the list.
- When patients were identified as living with dementia, staff told us that any issues were discussed with patients' families and/or carers to determine whether additional requirements or measures were needed. However, the outpatient department did not have any formalised care plans, there was no dementia champion within the hospital and staff had not received any formalised training for caring for patients living with dementia or learning disabilities.
- Systems were in place to aid patients, who did not speak English, to communicate. Staff told us that they had access to an external interpreter service. The service was provided in person and arranged at the earliest opportunity. Staff confirmed that they would never ask family members to interpret for patients. If a patient was identified as requiring an interpreter, availability would be confirmed and then the patient would be booked accordingly. In the last year the hospital had used approximately 12 interpreters for patients. However, in the waiting area, patient information guides were printed in English only and there were none in braille or any other language.
- The centre had a chaperoning policy which all staff had access to. Patients told us that they had been offered a chaperone when attending consultations and we observed chaperones being offered while consultations took place.
- When a patient booked through the NHS e-referral service they were automatically sent information which included information on booking patient transport should they have difficulties in attending the hospital. This information could also be supplied by Bodmin Treatment Centre if the patient was identified as requiring a patient transport service.
- There was a disparity between the care and treatment provided to NHS patients compared to that given to

private patients. Private patients were offered longer appointment times for consultations. For example a dermatology private patient would have a 20 to 30 minute appointment comparative to a five minute appointment on the NHS.

- **Learning from complaints and concerns**
- Patients were aware of how to make a complaint or raise concerns.
- Information on how to make a complaint was available within a leaflet which set out how to make a complaint and what to expect. The leaflets were available in the waiting area at reception. NHS patients had the opportunity to make a complaint using the Ramsay Health Care UK Operations Limited complaints process. If the complaint was not resolved to their satisfaction the complaint was escalated to the Ramsay Health Care UK Operations Limited regional director for investigation. If the complaint remained unresolved it could be escalated to the Ramsay Health Care UK chief executive. If it could not be resolved patients could raise their concerns with the Parliamentary and Health Service Ombudsman.
- There was a clear complaint process which was followed when a complaint was received. The general/registered manager had overall responsibility for complaints but it was the matron who managed them on a day to day basis. Once a complaint was received it was documented on a complaints form by the general/registered manager's personal assistant. A holding letter was sent within two days of receipt, indicating the timeframe for completion and expressing regret that the patient had to make a complaint. The details were sent to all parties implicated in the complaint, with a request for investigation and statements within a set time. Once all statements were received the general/registered manager collated them and wrote to the complainant within 20 working days. If the investigation was ongoing they wrote to the complainant to explain why a response was not yet available.
- If patients were not satisfied with the response to their complaint, systems were in place to escalate them. Patients who were not satisfied with the response from the general/registered manager would write or call with regard to the response and in some cases may appoint independent representation, for example independent complaints advocacy service, to seek further clarification. This was made clear in the Ramsay Health Care UK Operations Limited complaints leaflet. Patients were always given the opportunity to call the general/registered manager directly if they wished to discuss the response further. If no feedback was received they assumed that the complainant was satisfied with the response and the complaint was closed. However, a complaint could be reopened if requested.
- The number of complaints received was low, they received four between July 2015 and June 2016. The CQC did not receive any complaints during the same period of time. None of the complaints had been referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service. We reviewed three complaints and saw that timely responses were provided to the complainant, which were in line with the time frames set out in the complaints procedure.
- Staff within the outpatient department took an active role in trying to resolve complaints. Patients were encouraged to raise concerns as they arose so they could be dealt with immediately. Staff were supported to manage complaints at the point of care and resolve them if possible. If the issue could not be resolved a member of senior management team were advised and visited the patient if required. If this did not resolve the problem the patient could make a formal complaint via the complaints procedure. Staff told us a record of the patient's initial concerns and steps to address them were documented in their notes but we were not shown any evidence of this. Documenting patient complaints in their notes is against guidance as there is a risk patients can be discriminated against.
- The centre also provided "We Value Your Opinion" leaflets which also contained a section that allowed patients to make a complaint or raise an issue.
- Patients were also encouraged to complete a Friends & Family questionnaire and post it into the feedback box themselves so they could give an honest answer without having to pass it onto staff.
- Complaints, outcomes and learning points were discussed with staff. Complaints were discussed at senior management team meetings, clinical governance

meetings and head of department meetings. Outpatient staff told us that any learning outcomes from complaints were shared with them. Although, there was no documentary evidence to support this.

- The outpatient service tried to improve following learning from a complaint. One complaint received identified improvements needed and staff spoken with used this as an example of how they had learned from a complaint. A patient had difficulties standing and the staff within the outpatient department were unable to support or meet their individual needs, as they did not have the appropriate lifting equipment. As a result of this complaint standing aids and transfer boards were purchased. However, the outcome and learning was not evidenced on the reporting system and the training to use the equipment had not been delivered, despite the fact that it had been purchased a number of months before our inspection.
- The senior management team recognised that feedback to staff on individual complaints required improvement. For example they received a complaint from a patient living with learning difficulties did not feel they were treated in a way that met their needs. Staff told us that they were aware of the complaint but did not know exactly how it was being addressed.

Are outpatients and diagnostic imaging services well-led?

Inadequate

We rated well-led as inadequate.

Vision and strategy for this core service

- There was a clear vision for the outpatient service which was aligned to the Ramsay Health Care UK Operations Limited vision.
- Their vision was to be the leading independent sector provider in Cornwall, consistently achieve high quality outcomes; deliver outstanding customer service; recognise staff recognition and team success; to be profitable and enable future growth and to respect the environment. The strategy for achieving their vision was to have robust clinical governance systems; respond to patient feedback; have fully trained, competent and engaged staff who are accountable and supportive.
- Staff within the outpatient department did not know what the vision or strategy of the core service was. Staff were unable to tell us what the vision and strategy was when specifically asked.
- Plans for future development of Bodmin Treatment Centre had been established. The planned improvements had been submitted but as they were only contracted to provide services to NHS patients on a rolling 12 month contract, investment in the premises was on hold until there was increased long term certainty.
- **Governance, risk management and quality measurement for this core service**

  See the surgery section for main findings
- There was a governance framework at the centre but there were issues with how actions were implemented.
- There was a clinical governance committee comprised of a consultant chair person, the matron and a representative from each department. The minutes of the clinical governance meetings were disseminated to the medical advisory committee members and all staff by email. The outpatient lead told us they did not attend the clinical governance meetings and only had access to the minutes. We saw evidence that clinical governance meetings took place but their effectiveness was uncertain as action plans were not always followed through or reviewed. We were told by senior staff that they tried to hold the Clinical Governance Committee every two to three months, however the hospital had found challenges in achieving a quorate committee as they were a small location and the staff required were not always on duty. We were sent minutes of three meetings and these had taken place between four and six months.
- A corporate audit programme was followed. However, the general/registered manager and matron acknowledged that there were gaps in the auditing process and identified this as an area for improvement. Audits were carried out but audit results were not reviewed in detail and actions from previous audits were

not followed through or completed. There was no evidence of learning from audits being shared with staff. Audits were completed treatment centre wide and therefore departmental actions were not clearly identifiable.

- As part of their governance process, head of department meetings were held monthly. Attendees included the general/registered manager, matron, finance manager, theatre lead, outpatient lead, lead engineer and administration lead. The meetings followed a set agenda including activity levels, finance issues, hours worked, changes in legislation/policies, incidents/ complaints, training, risks and audit results. Some meetings, for example the infection control meeting, were not taking place regularly due to problems with quoracy.
- The arrangements for identifying, recording or managing risks were not robust. The risk register was a corporate risk register with only one local risk. This local risk was with regards to patients from a neighbouring mental health unit entering the premises and was added to the risk register following direction from an external provider. There were no risk registers for departments and the outpatient lead was not aware of the hospital risk register even though risks were discussed at head of department meetings. When we spoke with the general/registered manager they were unable to tell us what was on the hospital's risk register and they were unaware that local risks were not recorded. Over the course of the inspection areas were identified which would be suitable to be included on the risk register, including problems with the centre's blood fridge.
- The medical advisory committee (MAC) was held quarterly with attendance of consultants from each speciality, however, we were told the MAC was not always well attended. During our inspection we interviewed a MAC representative and the MAC chair. We discussed the roles and responsibilities of the committee with a MAC representative. This representative was aware of their responsibilities relevant to their own speciality but areas which were outside of their responsibility tended to be overlooked. We discussed areas for improvement identified in the consent audit with regards to risks not being recorded on the consent forms; however they did not have knowledge of this.
- During our interview with the MAC chair they acknowledged a number of gaps in assurance provided to the MAC. For example, they did not monitor adherence to NICE guidelines or investigations into consultant conduct or complaints.
- There was no process in place to disseminate, implement or monitor changes to practice required as a result of NICE guidance.
- The hospital had a process in place for accepting consultant practising privileges and ensuring appropriate checks were completed at recruitment and on an on-going basis. Although, there were 33 consultants on practising privileges, some consultants worked across different Ramsay sites and therefore the administrative responsibility was delegated to just one site and the information was recorded on a credentialing database. The hospital personal assistant maintained their own spread sheet of checks to allow them to monitor expiry of registration, indemnity and appraisals of 11 of those consultants. We were told a consultant would not be permitted to work if they could not provide evidence of in date registration, indemnity or appraisal.
- To accept consultants on practising privileges they must complete an application form and attend an interview with the registered manager. If successful a completed file was sent to the MAC Chair for approval and the MAC were able to grant temporary privileges. The Ramsay medical director then reviewed the record and completed the final approval for full privileges. We saw examples in files of the medical director requesting further information before final approval.
- Consultants on practising privileges were expected to comply with the Ramsay Health Care UK Operations Limited facility rules.
- The outpatient team felt information was relayed to them effectively and they were able to escalate concerns or issues. Although, there were no formal

meetings between the staff in the outpatient department and no minutes were taken. The team was small but all information was shared informally by the outpatient lead after head of department meetings.

- There was no formal process for reviewing and monitoring incidents or complaints involving consultants. When an incident had taken place, there were no records to demonstrate their conduct was being monitored and actions put in place to ensure they were following safe policies and procedures. The MAC lead was also not involved in this process contrary to the centre's facility rules. Action following incidents was inconsistent as staff of different levels were treated differently.
- The administration team felt the local management team were very approachable, however things were not always actioned.
- Two staff representatives attended the National Safety Standards for Invasive Procedures (NatSSIPs) Ramsay Health Care UK Operations Limited working group, this allows local safety standards to be developed. Two examples provided of changes made following attendance at the NatSSIPs working group were no late additions to theatre lists and for each theatre list to have a World Health Organisation surgical safety checklist champion.
- **Leadership / culture of service**
- The outpatient lead had the skills, knowledge, experience and knowledge to lead the outpatient department.
- The lead was a registered nurse and had been in post four years. Staff told us that the service was managed effectively, safely and care delivered was of high quality. During our inspection we observed the outpatient service running to time, with staff demonstrating good communication and organisational skills.
- Leaders at corporate level were not always visible. Staff told us that the corporate management team do not visit regularly and some staff would not recognise these leaders if they visited.
- Operational information was shared and communicated daily. A daily huddle was attended by the matron, outpatient manager and theatre manager every morning before services began. The meeting was used to discuss any issues from the previous day and any perceived risks for upcoming day. We observed a daily huddle during which staffing, use of bank staff and the appointment or theatre lists for the day were discussed. We were told incidents, complaints or staff issues would be discussed as required. The heads of department would feedback information to staff if relevant.
- The general/registered manager informed us they were at the hospital site once a week and on occasion, twice a week. They identified their role to ensure governance was in place, the hospital was safe, and provide leadership and direction. They felt there was good communication when they were absent and they spoke to the matron daily.
- The matron was the clinical lead; however, in the absence of a full time general/registered manager their role was also operational. Staff within the outpatient department told us that the matron was visible, approachable and supportive. They stated that they had an open door policy and would raise concerns with them in the absence of the outpatient lead.
- Staff within the outpatient department told us they saw the general/registered manager and had a good working relationship with them. Although, they told us that they would raise concerns and issues with the matron in the first instance.
- Understanding and communication between the outpatient and theatre department was not always effective. Staff told us there was a 'them and us' attitude between specialities and teams which could make communication and cooperation more difficult. Staff told us that they would like a more harmonious approach and suggested this could be facilitated by spending time with their counterparts.
- Bodmin Treatment Centre was trying to implement a well-being initiative. For example a well-being lead had been appointed and a well-being walk for staff was completed once a month, however the surgical team were unable to participate in this due to their workload.
- Teamwork within the outpatient department was effective and consistent. We observed staff communicating what tasks needed to be done and how

they were going to complete them. Each member of the team offered to help each other if needed. The outpatient lead would cover staff if they were on break, off sick or at times of high demand.

- The matron said staff at the hospital were excellent, they look after patients and ensure each patient has a good experience.
- Staff within the outpatient department felt respected and valued.
- **Public and staff engagement**

  Bodmin Treatment Centre participated in initiatives to collect and disseminate patient feedback. As part of this initiative they shared weekly hot alerts on patient comments, whether good or bad. The comments were received by staff and used to increase morale or highlight any issues with care.
- Patients were given the opportunity to provide brief but anonymous feedback at the time of their visit. There was a comment book in the outpatient department reception area. However, it was not clear when these comments were reviewed or a sign off to confirm they had been read, shared or actioned where necessary.
- Bodmin Treatment Centre participated in the patient led assessment of the care environment audits. As part of the process two patients completed an audit for the period between February and June 2016. The results of which demonstrated that the centre scored the same or better than the England average for cleanliness, privacy, dignity and wellbeing, condition, appearance and maintenance, dementia and disability.
- Patients were offered a 'We Value Your Opinion Leaflet' which has a section to complete on what the centre do well and what they could improve upon. It was not clear how this information was used to improve their services or if any improvements had been made as a direct result.
- Ramsay engagement survey for staff dated 2016 showed Bodmin Treatment Centre scored 83% for engagement as a whole, which was rated as good.
- Bodmin Treatment Centre held a staff forum. It was used to keep staff informed but did not allow staff to ask questions. Staff said they did not feel they could say anything because they needed to get back to work.
- Staff were not always sure when and how they would receive information from senior management.
- Staff told us they were aware of the uncertainty regarding the NHS contract but did not know if, when or how they would be updated.
- Staff received a monthly newsletter informing them of updates within the centre.
- **Innovation, improvement and sustainability**
- The general/registered manager was proud of the cataract service provided at the hospital as patients travelled long distances to receive this service.

Outstanding practice and areas for improvement

Outstanding practice

- England average scores in the PLACE assessments were exceeded.
- PROMs data for groin hernia repairs also exceeded the England average.

Areas for improvement

Action the provider MUST take to improve

- Ensure all incidents are reported, investigated and trends analysed to mitigate the risks relating to safety.
- Have a complete and accurate systematic programme of clinical and internal audit, which can be used to monitor quality systems to identify what actions should be taken.
- Comprehensive audits should be completed specific to departments to allow performance and compliance to be monitored at departmental level.
- Have systems and processes that enable them to identify and assess risks to the health and safety and/or welfare of patients who use the service.
- Ensure all medicines and equipment within the centre are safe for patient use.
- Ensure all guidance is followed when cleaning specialist equipment to reduce the risk of infection.

Action the provider SHOULD take to improve

- Create and implement action plans following audits, complaints and meetings to monitor performance and improve their services.
- Adapt guidance on quality standards for sepsis screening and management.
- Review its policy and process for reviewing, implementing and monitoring NICE guidance.
- Improve duty of Candour training for all staff.
- Provide training on lifting aids for staff.
- Record observations for patients undergoing cataract surgery.
- Monitor surgical site infections for all patients.
- Consider its processes for monitoring infection control, including convening regular meetings that are quorate and review findings from infection control audits.
- Collate, review and monitor reasons for cancelling operations.
- Standardise the procedures for the administration of controlled drugs within their theatres.
- Record patient temperatures pre, during and post operation to ensure adherence to NICE guidance.
- Address the temperature issues within theatres.
- Provide incident reporting training to all staff.
- Provide Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding training to all staff.
- Stop recording patient concerns, issues and complaints in their records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users c) Assessing the risks to the health and safety of service users of receiving the care and treatment. d) doing all that is reasonably practicable to mitigate any such risks. e) ensuring that the equipment used by the provider for providing care or treatment to a service is safe for such use and is used in a safe way. g) the proper and safe management of medicines. • Arrangements to respond to a medical emergency in theatre/day unit were not clear among staff or practiced regularly to be assured the response to an emergency by staff would be safe. • A tracheal introducer within the resuscitation trolley was out of date by three years and therefore not safe for patient use. • Eye drops within the outpatient medicines cupboard and naloxone within the resuscitation trolley were out of date in August 2016. They had not be removed which presented a risk that they could be used when treating patients.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises 1. All premises and equipment used by the services must be a) clean.

This section is primarily information for the provider

Requirement notices

2. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for purposes for which they are being used.

In outpatients nasopharyngeal endoscopes, were not leak testing between each patient use as part of the decontamination process to avoid cross infection.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to- (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; • There was not a complete and accurate systematic programme of clinical and internal audit to monitor quality systems and identify action. Comprehensive audits were not completed specific to departments so performance and quality was not monitored at a departmental level. • Action plans developed from audits were not properly implemented or reviewed which prevented improvements being achieved. • Although the centre had a risk register, it was a corporate one, which did not contain all local risks.

This section is primarily information for the provider

Requirement notices

- Incidents were not always reported via the providers system to enable risks to be identified, monitored and appropriate actions taken.