The Westbourne Centre

Quality Account
2023/24

Contents

Introduction Page		
Welcome to Ramsay Health Care UK		
Introduction to our Quality Account		
PART 1 – STATEMENT ON QUALITY		
1.1	Statement from the Hospital Director	
1.2	Hospital accountability statement	
PART 2		
2.1	**Priorities for Improvement**	
2.1.1	Review of clinical priorities 2023/24 (looking back)	
2.1.2	Clinical Priorities for 2024/25 (looking forward)	
2.2	**Mandatory statements relating to the quality of NHS services provided**	
2.2.1	Review of Services	
2.2.2	Participation in Clinical Audit	
2.2.3	Participation in Research	
2.2.4	Goals agreed with Commissioners	
2.2.5	Statement from the Care Quality Commission	
2.2.6	Statement on Data Quality	
2.2.7	Stakeholders views on 2023/24 Quality Accounts	
PART 3 – REVIEW OF QUALITY PERFORMANCE		
3.1	The Core Quality Account indicators	
3.2	Patient Safety	
3.3	Clinical Effectiveness	
3.4	Patient Experience	
3.5	Case Study	
Appendix 1 – Services Covered by this Quality Account		
Appendix 2 – Clinical Audits		

Welcome to Ramsay Health Care UK

The Westbourne Centre is part of the Ramsay Health Care Group

Statement from Nick Costa, Chief Executive Officer, Ramsay Health Care UK

Established in Sydney, Australia in 1964, Ramsay Health Care celebrates its 60th anniversary in 2024. Outside of the NHS, we are one of the longest running healthcare providers in the world. In the UK, we are incredibly proud to be part of a responsible, global healthcare provider widely respected with a strong reputation of delivering, safe, high quality, patient centred care with positive outcomes.

Patients are confident when they come to Ramsay because we are unwavering in our commitment to the highest standards of clinical quality and providing exceptional care. We see this in our patient feedback and independent accreditation awards. All of our endoscopy services inspected by the Royal College of Physicians Joint Advisory Group (JAG) are JAG accredited, we have 97% of our hospitals rated as 'Good' by the Care Quality Commission, and Bupa recognises two of our hospitals providing cancer services as Breast Centres of Excellence.

In 2023, we published our Social Impact Report in partnership with The Purpose Coalition, a purpose-led organisation focused on bringing together businesses that are breaking down barriers and improving social mobility. The report highlights fantastic examples of Ramsay teams supporting patients in local communities with access to care when they need it through robust partnership working within local health systems. It also showcases our continued support for staff to develop their careers through a range of training and development opportunities, often breaking down social-economic barriers for individuals. With a clear focus on delivering the highest standards of care for patients with outstanding outcomes and a commitment to being a responsible employer and member of our local communities, we acknowledge that the impact we have is both in and outside of our hospital walls.

Everyone across our organisation is responsible for the delivery of clinical excellence and our organisational culture ensures that the patient remains at the centre of everything we do. We recognise that our people, staff, and doctors are the key to our success and teamwork is the central foundation in meeting the expectations of our patients.

I am very proud of Ramsay Health Care's reputation in the delivery of safe and quality care and it gives me great pleasure to share our results with you.

Nick Costa
Chief Executive Officer

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Statement from Jo Dickson, Chief Clinical and Quality Officer, Ramsay Health Care UK

I am incredibly proud of the care and service our teams, both clinical and operational, deliver for patients every single day across our 34 hospitals, mobile diagnostic fleet, three decontamination hubs and two corporate offices. The saying, 'the whole is greater than the sum of its parts,' has two very real meanings in Ramsay UK. The overall service and experience that our teams deliver for our patients continues to deliver on our organisational purpose of People caring for People, evidenced through our fantastic patient feedback scores, which includes our group NPS rating of 87 and 96% Friends and Family rating. However, those teams and colleagues are all providing an outstanding individual contribution which we seek to recognise, support and champion across our organisation.

Our ability to deliver first-class healthcare services in our hospitals is underpinned through an ongoing cycle of investment into our facilities, equipment and staff, alongside an ongoing programme of digital advancements to support the seamless delivery and management of patient services. With an exciting schedule of projects that will increase the use of digital services to improve care over the coming years, we are clear in our commitment to support our patients with greater engagement and autonomy throughout their experience with Ramsay UK.

We are committed to the professional development of all our colleagues and have an ethos of continuous improvement. We celebrate when things go well, and we improve where we can do so. Our patients can expect openness and transparency from all colleagues, and all colleagues have confidence that if they raise a concern or identify a risk then they will be listened to, and appropriate action will be taken.

I am looking forward as we continue our commitment to provide high-quality health services to our patients with investment and a focus on utilising digital systems to support the patient journey.

Jo Dickson
Chief Clinical and Quality Officer

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Introduction to our Quality Account

This Quality Account is The Westbourne Centre's annual report to the public and other stakeholders about the quality of the services we provide. It presents our achievements in terms of clinical excellence, effectiveness, safety and patient experience and demonstrates that our managers, clinicians and staff are all committed to providing continuous, evidence based, quality care to those people we treat. It will also show that we regularly scrutinise every service we provide with a view to improving it and ensuring that our patient's treatment outcomes are the best they can be. It will give a balanced view of what we are good at and what we need to improve on.

Our first Quality Account in 2010 was developed by our Corporate Office and summarised and reviewed quality activities across every hospital and treatment centre within the Ramsay Health Care UK. It was recognised that this didn't provide enough in depth information for the public and commissioners about the quality of services within each individual hospital and how this relates to the local community it serves. Therefore, each site within the Ramsay Group now develops its own Quality Account, which includes some Group wide initiatives, but also describes the many excellent local achievements and quality plans that we would like to share.

Part 1

1.1 Statement on quality from the Hospital Director

Mr Harry Wallace, Hospital Director

The Westbourne Centre

Welcome to The Westbourne Centre Quality Account. As Hospital Director, it gives me great pleasure to work with our outstanding teams to again deliver and improve our quality outcomes and patient satisfaction. This report outlines the hospitals approach to quality improvement, progress made in 2023/2024 and plans for the forthcoming year.

Our Vision; “As a committed team of professional individuals we aim to maintain high standards of services with patient care remaining our focus for everything we do.”

The Westbourne Centre has been established for 15 years and we offer a range of services to private and NHS patients, ensuring that patient care is at the centre of what we do. This is delivered through a commitment to teamwork and professionalism between all parties.

Our Quality Accounts details the actions that we have taken over the past year in order to ensure that our high standards in delivering patient care are maintained and for those areas where we have identified where we can improve, we have implemented changes to our processes in order to be able to deliver the required improvements to the delivery of our patient care.

The team at The Westbourne Centre, have worked incredibly hard over the past 12 months to ensure the strong flow of patients through the hospital, and to assist in the increased activity needed to support patients in a timely manner.

This has been undertaken to support the long waiting list patients have had in the NHS and to support the long waiters on our own patient waiting lists. Private activity has remained strong across all specialties at the Centre.

In our last CQC inspection in November 2016 I am pleased to say we were rated as ‘GOOD’. This was a pleasing outcome for The Westbourne Centre.

We were rated ‘GOOD’ for caring, effective, responsive and well led. We were rated ‘Requires improvement’ for safety. We were issued requirement notices under 2 of the regulations, and these have all been actioned and remain a focal area since the inspection.

An action plan following publication of the report was put together and remains a focus point for the SLT to ensure the standards are maintained with a focus on achieving ‘outstanding’ with the next inspection. This action plan is continuously reviewed and revisited in line with

the CQC regulations in order to ensure that CQC compliance is at the forefront of care delivery at The Westbourne Centre.

The Westbourne Centre has a very strong track record as a safe and responsible provider of Day Case services and we are proud to share our results.

At The Westbourne Centre we believe that each member of staff plays a part in the success of the unit. We have a training and education plan which involves all members of our administrative and clinical teams.

Our Quality Accounts have been developed with the involvement of our staff who have very much involved with developing a systems approach to risk management which focuses on making every effort to reduce the likelihood and consequence of an adverse event or outcome associated with treatment of a patient.

To ensure a coordinated approach to the delivery of care for patients and to monitor the adherence to professional standards and legislative requirements the Clinical Effectiveness Committee/Clinical Governance and Medical Advisory Committee meet on a quarterly basis to review the clinical and safety performance of The Westbourne Centre.

These committees have reviewed and commented on the details within these Quality Accounts. The quality accounts give all parties and providers access to quality activities and patient treatment outcomes at The Westbourne Centre. If you would like to comment or provide me with feedback, then please feel free to contact me on the following number or via email;

0121 456 0880 or harry.wallace2@westbournecentre.com

1.2 Hospital Accountability Statement

To the best of my knowledge, as requested by the regulations governing the publication of this document, the information in this report is accurate.

Mr Harry Wallace

Centre Director, The Westbourne Centre

This report has been reviewed and approved by:

Mr H Nishikawa

MAC Chair & Clinical Governance Committee Chair

The management team & Heads of Department at The Westbourne Centre work in partnership with the MAC and the Clinical Governance committee to ensure high quality patient care is at the centre of what we do. Regular meetings with the above committees ensure best practice and sharing of results.

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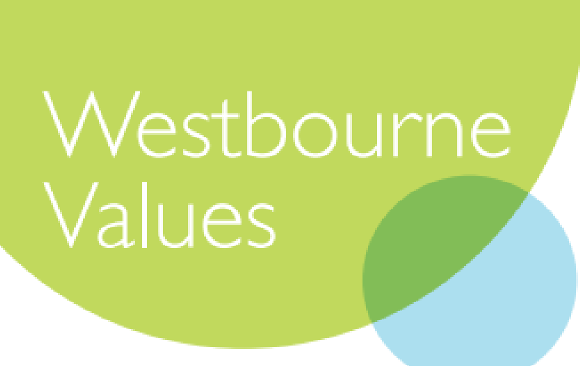
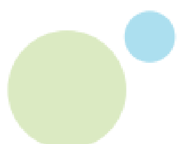
Welcome to The Westbourne Centre





Welcoming	We strive to ensure all of our patients, visitors, staff and clinicians feel welcome
Expertise	All of our clinicians are experts in their respective fields and we pride ourselves on our specialist and unique knowledge base
Supportive	We aim to support the individual needs of all of our patients and staff to ensure the best outcomes
Teamwork	We value teamwork to achieve our aspirations and goals through sharing ideas and responsibilities in an environment of mutual respect
Being the Best	We aspire to provide the best possible care and outcomes to all of our patients
Ownership	We take pride and ownership in our work practices, professionalism and service to the community
Unique	We are unique in our approach to healthcare and are invested in providing an exclusive experience
Responsive	We are always looking for ways to improve our service and respond quickly to any feedback or concerns
NICE Compliant	Our quality standards are in line with the National Institute for Health and Care Excellence
Ethical	Our clinical practices are strictly governed and regulated to the highest ethical standards

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Welcome to The Westbourne Centre

The Westbourne Centre is a day case hospital in the heart of the Edgbaston Medical Quarter in Birmingham. We provide fast, convenient, effective and high quality treatment for patients whether self-funding, medically insured or from the NHS. We treat private and NHS patients from the age of 18 years across a wide range of specialities.

All of our theatre cases are performed under local anaesthetic with or without sedation, which enables patients to be discharged on the same day. We do not have the facilities for general anaesthesia so patients requiring general anaesthetic may be treated at our sister hospital, the West Midlands Hospital, in Halesowen.

Our specialties include:

- Cosmetic surgery
- Restorative dentistry
- Oral and maxillofacial surgery
- Orthodontics
- Ophthalmic surgery
- Orthopaedic surgery
- General and vascular surgery
- Dermatology
- Mohs Clinics
- Vascular surgery

The Westbourne Centre is centrally located with free on-site parking and is easily accessible via public transport. We also have disabled access to The Centre.

Currently we employ a total of 38 contracted staff and this includes a mix of qualified nurses, HCAs, theatre practitioners, administration staff and receptionists. We are supported by a well-qualified and experienced regular team of 12 bank staff.

All Consultants undergo rigorous vetting procedures, ensuring only those who are qualified and experienced are granted practicing privileges. The hospital is strictly regulated and audited by the Care Quality Commission, the governing body responsible for maintaining standards in healthcare, and the latest report can be found on the CQC Website, for which we were rated GOOD.

Additional services The Westbourne Centre has access to Cavendish Imaging, an independent company based at The Centre. Cavendish Imaging provides a specialist imaging service (x-ray and CT scans) for the dental, oral and maxillofacial, facial, plastic and ENT surgeons. To note – we do not have disabled access for this external service.

We also provide neurophysiology diagnostics in the form of Electromyography and Nerve Conduction Studies and access to an interventional radiologist for orthopaedic patients.

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Part 2

2.1 Quality priorities for 2024/25

Plan for 2024/25

On an annual cycle, The Westbourne Centre develops an operational plan to set objectives for the year ahead.

We have a clear commitment to our private patients as well as working in partnership with the NHS ensuring that those services commissioned to us, result in safe, quality treatment for all NHS patients whilst they are in our care. We constantly strive to improve clinical safety and standards by a systematic process of governance including audit and feedback from all those experiencing our services.

To meet these aims, we have various initiatives on going at any one time. The priorities are determined by the hospitals Senior Management Team in conjunction with our Heads of Department and Team Leaders taking into account patient feedback, audit results, national guidance, and the recommendations from various hospital committees which represent all professional and management levels.

Most importantly, we believe our priorities must drive patient safety, clinical effectiveness and improve the experience of all people visiting our hospital.

Priorities for improvement

The Westbourne Centre develops an operational plan on an annual cycle to set objectives for the year ahead and review the last year and targets met and achieved. We have a clear commitment to our private patients as well as working in partnership with the NHS ensuring that those services commissioned to us, result in safe, quality treatment for all patients whilst they are in our care. We constantly strive to improve clinical safety and standards by a systematic process of governance including audit and feedback from all who experience our services.

To achieve these aims, we have various initiatives underway, which remain on going, as we are consistent in our approach. The priorities are determined by the hospitals Senior Leadership Team taking into account patient feedback, audit results, national guidance, and the recommendations from various hospital committees which represent all professional and management levels. Most importantly, we believe our priorities must drive patient safety, clinical effectiveness and improve the experience of all people visiting our hospital.

2.1.1 A review of clinical priorities 2023/24 (looking back)

Last year's clinical priorities were based on the CQC's five domains. Reviewing the priorities from last year please see below for outcomes:

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Safe

1. Continued adherence to NICE guidelines has been achieved via Clinical Effectiveness Committee (CEC) and Medical Advisory Council (MAC). This has been rolled out at the centre by disseminating all information, guidance and policies with staff and departments and highlighting any changes at the Team Leaders meetings.

2. Safeguarding training continues to be on an annual basis e-learning platform and working closely with our ICB to ensure high standards are maintained and coordinated. This has been maintained throughout the year at a higher than 95% throughout the year.

3. Speaking Up for Safety education programme, which encourages staff to speak up at any time about any safety issues, is still ongoing.

4. Reporting of SUI's and Never Events plus learnings and any changes to practice. There were no Never Events although there was one SUI and this was robustly investigated and learnings shared and practice developed following this.

Effective

1. MRSA zero tolerance continues and no reported cases of MRSA this year 2023-24.

2. Internal audits continue and discussed on a monthly basis at team leader meeting and quarterly at the Clinical Governance Meeting as well as an overview presented at MAC quarterly.

3. IPC Audits and Effectiveness continue to be undertaken and actions logged.

Caring

1. Caring elements from feedback and Patient Satisfaction were discussed and this has formed actions throughout the centre in a 'You Said –We Did' format with post operative telephone calls for all patients continuing and disabled access reviewed and improved to name two of the elements of feedback actioned.

Responsive

1. Friends and family feedback continues to be obtained and generally positive staff professionalism, clean facility, great service.

2. Complaints continue to be managed and learning outcomes and themes discussed at both Clinical Governance, Team Leaders and MAC meetings.

Well-led

1. Senior Leadership Team continues to have overall visibility around the hospital. Risk assessments, incident reporting and lessons learnt discussed with all Heads of Department at monthly team leader meetings and health and safety forums. Currently our PDRs are 100% complete.

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2.1.2 Clinical Priorities for 2023/24 (looking forward)

Patient Safety

1. Speaking Up for Safety is a programme to skill health workers to effectively communicate concerns to colleagues that unintended harm to patients or consumers may be about to occur. It will give all staff a 'toolkit' of phrases and actions to effectively and respectively raise safety concerns. This was introduced to Ramsay Healthcare in 2018 and all staff are trained.

2. Surgical Safety Checklist- As highlighted in our recent Theatre Audit our compliance to the Surgical safety checklist needs to be maintained. Safer surgery is ensured by using a surgical safety checklist based on the tool devised by the World Health Organisation (WHO). This ensures every patient undergoing a surgical/radiological intervention (including local anaesthesia) undergoes a series of safety checks before any treatment. Through a robust clinical governance audit program, training, documented evidence and monitoring quality assurance can be attained.

3. Risk assessment and Incident reporting - The SLT will focus on improving the hospital and departmental risk registers with training of staff in the system. Staff will be made aware of the priorities on the risk register as well as recognising any risks within their areas and ensuring patient and staff safety is maintained. The SLT will emphasise the 'closing of the loop' from actions identified to improve patient safety and lessons learnt will continue to be discussed and shared with staff through local Committees and huddles.

4. Safeguarding - The Westbourne Centre is committed to ensuring the safety and wellbeing of all its patients. All staff have a responsibility to help prevent abuse and to act quickly and proportionately to protect people where abuse is suspected, they should act professionally,

discreetly and with the maximum possible confidentiality. The hospital operates within The Department of Health Document Caring for our future: reforming care and support.

5. Our Senior Leadership Team (SLT) will focus on providing clear guidance and leadership with an open door policy. Our SLT team is focused on gaining engagement and trust with the centres teams as this is essential. Staff will continue to be encouraged to share ideas and concerns and SLT recognise the essential process of feeding back after any concerns are raised. The Senior Leadership Team will continue its high level of visibility around the hospital. Communication remains an important aspect and methods to improve communication will be explored. The daily huddle was introduced at the start of the COVID pandemic and remains in place. Daily walk rounds occur with all SLT members at the start of the day. Internal notice boards in staff and patient areas have been introduced and these will be regularly updated and a focus on appropriate topics and learnings to be undertaken. In addition, daily huddles to commence by theatre team to ensure a safe briefing approach to cover safe staffing and briefing of the operating day. Trust and engagement with the centres teams is essential to ensure patient safety.

Clinical Effective

1. Informed Consent Process - By gathering information through patient surveys we can continue to ensure the patient has been given all information in terms of what the treatment involves, including benefits and risks. Staff will be re-trained and new staff trained in the consent principles and processes as part of mandatory elearning to ensure patients are able to provide informed consent as per the Informed Consent Process and Policy.

2. MRSA Zero tolerance methicillin-resistant Staphylococcus aureus - The hospital has never had an MRSA outbreak and the hospital plans to maintain this standard in 2023/24. This will be achieved by following the DOH 2010 High Intervention Impact Care Bundles e.g. the surgical site infection.

3. Internal Audits - The Westbourne Centre will continue to follow the organisations prescribed clinical and non-clinical audit programme on a monthly basis. This process has been reviewed and the new Audit programme will be rolled out with training for appropriate staff. To ensure quality and gain assurance these assessments will be reviewed monthly at HoDs and team Leaders meetings and action plans agreed as necessary rolling out the new audit programme in July 2023.

Patient Experience

1. The hospital will continue to ensure the highest standards of care, ensuring the dignity and respect for all patients and maintaining professionalism at all times. Staff are encouraged to be empathetic and all staff will complete the Inclusion Awareness Training.

2. The organisation has developed a Duty of Candour policy. The Westbourne Centre will continue to ensure all events are reported in line with the regulations as stated in the Health and Social Care Act 2008 Regulations 2014, the Care Quality Commission Regulations 2009 and the Duty of Candour policy process is followed.

Patient Experience

1. At The Westbourne Centre feedback from our patients is at the very heart of our service. Our friends and family questionnaires and external audits give us the feedback required to improve services. The focus for this 2024/2025 will be to significantly improve our response rates and share the findings hospital staff.

2. Compliments received verbally or written are recorded on the hospital reporting system. Staff are fed back the information individually or as a group.

3. All complaints will continue to be managed in line with the organisations policy. The lessons learnt from these events are communicated and shared with all colleagues to improve our services and this will be a continual priority. We operate a complaints process that responds, flexibly, open and honestly to the patients concerns or complaints, which enables us to support complaints effectively and promote public confidence in our service.

4. The Centre meets every month for patient experience and the recommendation going forward is to analyse all the data from Cemplicity, our online feedback portal, Friends and Family and formal complaints, in order to analyse trends and themes of feedback using the graph data and key driver analysis and create positive actions which can then be shared with the teams through our Outcomes With Learning meetings. The aspiration would be to have a patient present a potential negative experience back to the team twice a year to ensure we close the loop with our patients as well.

2.2 Mandatory Statements

The following section contains the mandatory statements common to all Quality Accounts as required by the regulations set out by the Department of Health.

2.2.1 Review of Services

During 2023/24 The Westbourne Centre provided and/or subcontracted 10 NHS services.

The Westbourne Centre has reviewed all the data available to them on the quality of care in this NHS services.

The income generated by the NHS services reviewed in 1 April 2023 to 31st March 2024 represents 76 per cent of the total income generated by The Westbourne Centre.

The Westbourne Centre has reviewed all the data available to them on the quality of care in all 10 NHS services provided.

Ramsay uses a balanced scorecard approach to give an overview of audit results across the critical areas of patient care. The indicators on the Ramsay scorecard are reviewed each year. The scorecard is reviewed each quarter by the hospitals Senior Leadership Team

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together with Corporate Senior Managers and Directors. The balanced scorecard approach has been an extremely successful tool in helping us benchmark against other hospitals and identifying key areas for improvement.

In the period for 2023/24, the indicators on the scorecard which affect patient safety and quality were:

Human Resources	
Sickness %	8%
Appraisal %	98%
E-Learning %	98%
Mandatory Training %	96%
Number of Significant Staff Injuries	1%
Patient	
Formal Complaints per 1000 HPD's	2.54%
Patient Satisfaction Score	96.8%
Significant Clinical Events per 1000 Admissions	0.14%
Readmission per 1000 Admissions	0%
Quality	
Workplace Health & Safety Score	97%
Infection Control Audit Score	96%

2.2.2 Participation in clinical audit

The national clinical audits, national Implant Register and national confidential enquiries that The Westbourne Centre was eligible to participate in during 1 April 2023 to 31st March 2024 are as follows:

- Elective Surgery (National PROMs Programme) NHS Digital Cataract procedures, ICHOMs
- Total HES Augmentation Mammoplasty
- Total HES Nasal Septoplasty

Local Audits

The reports of The Westbourne Centre local clinical audits from 1 April 2023 to 31st March 2024 were reviewed by the Clinical Governance Committee.

The audit program follows the Tendable national Ramsay program. This enables staff to undertake audits using an IPad or laptop to record details and photos in real time, as well as utilizing the analytic dashboard to effectively feedback to the teams and follow up on open and ongoing actions.

The Hospital intends to take the following actions to improve the quality of healthcare provided:

- Close monitoring of all audits by the Head of Clinical Services and Heads of Department
- There is now a greater emphasis on teaching all clinical staff to understand the audit cycle and to take part in the clinical audits themselves;
- Audit as part of the quality cycle will now be being discussed at all future staff induction and clinical mandatory training days;
- Clinical indicator data set measured in real time within general orthopaedics and spinal surgery.

Core audits were carried out throughout the period covering all aspects of clinical practice. All audits generate and action plan for shared learning and clinical development/improvement.

The clinical audit schedule can be found in Appendix 2.

2.2.3 Participation in Research

There were no patients recruited during 2023/24 period to participate in research approved by a research ethics committee.

2.2.4 Goals agreed with our Commissioners using the CQUIN (Commissioning for Quality and Innovation) Framework

The Westbourne Centre income from 1 April 2023 to 31st March 2024 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

2.2.5 Statements from the Care Quality Commission (CQC)

The Westbourne Centre is required to register with the Care Quality Commission and its current registration status on 31st March 2024 is registered without conditions. The Westbourne Centre has not participated in any special reviews or investigations by the CQC during the reporting period.

The Westbourne Centre

Quality Report

53 Church Road
Edgbaston
Birmingham
B15 3SJ
Tel: 0121 456 0880
Website: www.westbournecentre.com

Date of inspection visit: 18th November 2016 and 24th November 2016
Date of publication: 13/04/2017

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

2.2.6 Data Quality

Statement on relevance of Data Quality and your actions to improve your Data Quality

The Westbourne Centre will be taking the following actions to improve data quality. Ramsay has invested in the information services and clinical data analyst in the business. As a result, this ensures the data integrity analysed by site is clear and specific. This allows the Multi-Disciplinary team to use this data to benchmark the outcomes locally, regionally and nationally.

NHS Number and General Medical Practice Code Validity

The Westbourne Centre submitted records during 2023/24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included:

The patient's valid NHS number:

- 99.83% for admitted patient care;
- 100% for outpatient care; and
- N/A for accident and emergency care (not undertaken at our hospital).

The General Medical Practice Code:

- 100% for admitted patient care;
- 100% for outpatient care; and
- N/A for accident and emergency care (not undertaken at our hospital).

Information Governance Toolkit attainment levels

Ramsay Health Care UK Operations Ltd submitted it response on 30.6.23 for 2022/2023. The status is 'Standards Met'. This has been published on 28th June 2023.

Info available on the DSP website at:
https://www.dsptoolkit.nhs.uk/

Clinical coding error rate

The Westbourne Centre was subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Hospital Site	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
Westbourne Centre	98.3%	94.9%	96.6%	95.7%

**Ramsay Health Care DSPT_IG Requirement 505 Attainment Levels as at September 2020*

2.2.7 Stakeholders views on 2023/24 Quality Account

Copies of this Quality Account were sent to our quality leads for the Integrated Care Boards, the MAC and Clinical Governance Committee Chair for comments prior to publication.

NHS Birmingham & Solihull (BSOL) Chef Nursing Officer – Interim – Helen Kelly

NHS Birmingham & Solihull (BSOL) Contract Quality Lead – Deborah Collins

NHS Birmingham & Solihull (BSOL) Clinical Quality Manager - Esther Whitten

The Westbourne Medical Advisory Committee Chair – Mr H Nishikawa

NHS Birmingham and Solihull Integrated Care Board
First Floor Wesleyan
Colmore Circus
Birmingham
B4 6AR

Telephone: 0121 203 3300
www.birminghamandsolihullicb.nhs.uk

The Westbourne Centre
Quality Account 2023/24

Statement of Assurance from NHS Birmingham and Solihull Integrated Care Board

June 2024

1.1 Birmingham and Solihull Integrated Care Board (ICB) as coordinating commissioner for The Westbourne Centre, welcomes the opportunity to provide this statement for inclusion in the Providers 2023/24 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 17th June 2024 and the review has been undertaken in accordance with the Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

1.3 The information provided within this account presents a balanced report of the healthcare services that The Westbourne Centre provides. The report demonstrates the progress made by the Providers against the 2023/24 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2024/25.

1.4 We have worked closely with The Westbourne Centre over the course of 2023/24, working collaboratively to review the organisations' progress in implementing its quality improvement initiatives. We are committed to continuing to engage with the Provider in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2024/25.

Yours sincerely

Helen Kelly
Chief Nursing Officer – Interim
NHS Birmingham and Solihull Integrated Care Board

Part 3: Review of quality performance 2023/24

Statements of quality delivery

Head of Clinical Services (Matron), SJ Smallpage

Review of quality performance 1st April 2023 - 31st March 2024

Introduction

This was my first full year at The Westbourne Centre and I am incredibly proud of the care and service our teams, both clinical and operational, deliver for patients every single day. Without the collaboration with our Operational Teams we would not be able to continue to deliver the high standards of patient focused and centred care we deliver.
We are committed to the professional development of all our colleagues and have an ethos of continuous improvement. We celebrate our patient successes and great feedback but also listen to all feedback and improve care when our patients tell us that we did not meet their expectations of care and we improve where we can do so.
Our patients can expect openness and transparency from all colleagues, and all colleagues have confidence that if they raise a concern or identify a risk then they will be listened to, and appropriate action will be taken.
We will continue to grow and develop within the centre, with our teams and strive for high quality care keeping patients at the centre of all we do.

Ramsay Clinical Governance Framework 2024/5

The aim of clinical governance is to ensure that Ramsay develop ways of working which assure that the quality of patient care is central to the business of the organisation.

The emphasis is on providing an environment and culture to support continuous clinical quality improvement so that patients receive safe and effective care, clinicians are enabled to provide that care and the organisation can satisfy itself that we are doing the right things in the right way.

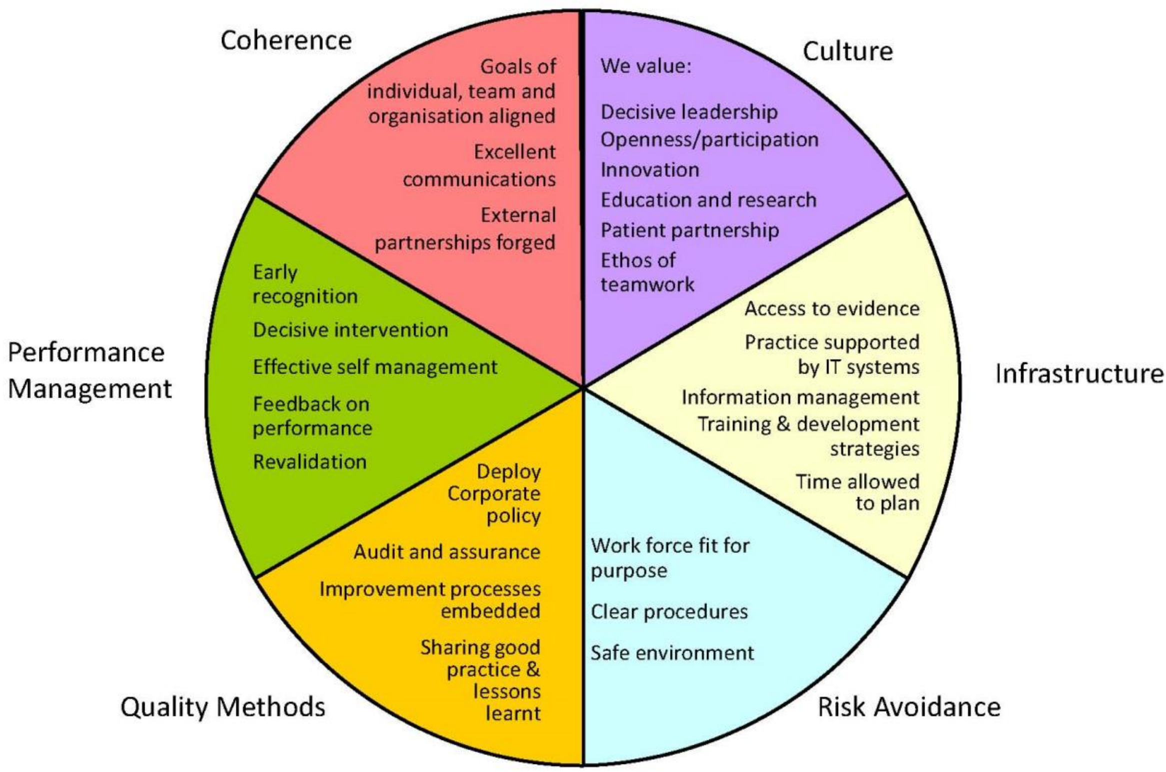
It is important that Clinical Governance is integrated into other governance systems in the organisation and should not be seen as a “stand-alone” activity. All management systems, clinical, financial, estates etc, are inter-dependent with actions in one area impacting on others.

Several models have been devised to include all the elements of Clinical Governance to provide a framework for ensuring that it is embedded, implemented and can be monitored in an organisation. In developing this framework for Ramsay Health Care UK we have gone back to the original Scally and Donaldson paper (1998) as we

believe that it is a model that allows coverage and inclusion of all the necessary strategies, policies, systems and processes for effective Clinical Governance. The domains of this model are:

- Infrastructure
- Culture
- Quality methods
- Poor performance
- Risk avoidance
- Coherence

Ramsay Health Care Clinical Governance Framework



National Guidance

Ramsay also complies with the recommendations contained in technology appraisals issued by the National Institute for Health and Clinical Excellence (NICE) and Safety Alerts as issued by the NHS Commissioning Board Special Health Authority.

Ramsay has systems in place for scrutinising all national clinical guidance and selecting those that are applicable to our business and thereafter monitoring their implementation.

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3.1 The Core Quality Account indicators

Where the necessary data was made available to The Westbourne Centre by NHS Digital, the table also includes the national average for the same; and the highest and lowest of the same, for the reporting period.

Mortality

Mortality:	Period	Best		Worst		Average	
	Apr20 - Mar 21	RRV	0.6908	RM1	1.201	Average	0.0078
	Dec21 - Nov22	R1K02	0.2456	RHCH	2.1583	Average	1.0965
	Nov22-Oct23	RQM	0.7215	RXP	1.2065	Average	1.0021

Period	Westbourne	
21/22	NVC44	0.0000
22/23	NVC44	0.0000
23/24	NVC44	0.0000

The mortality data is related to NHS Outcomes Framework Domain 1 "Preventing from People Dying Prematurely" and Domain 2 "Enhancing Quality of Life for People with Long Term Conditions"

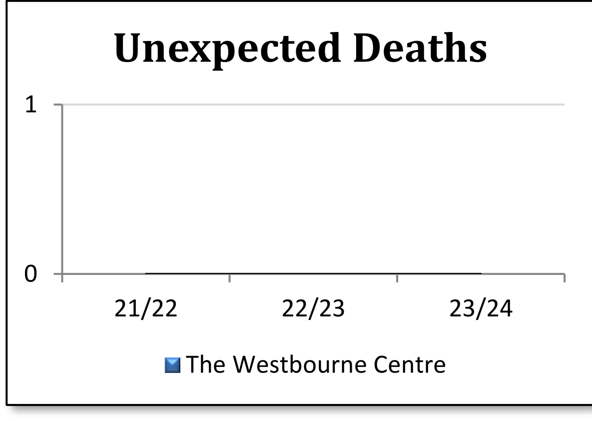
Above is a table showing mortality/death of patient data made available to The Westbourne Centre by NHS digital. The table covers two reporting periods and shows the worst performer for the period, the best performer and The Westbourne Centre site performance.

The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to:

(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.

The Westbourne Centre considers that this data is as described for the following reasons: there were no unexpected deaths in the reporting period.

Rate per 100 discharges:



National PROMs

Patients undergoing elective NHS funded inpatient surgery for common elective procedures (such as hip replacement and knee replacement, ENT septoplasty, transurethral prostatectomy and Carpal Tunnel Decompressions) are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves. This involves asking patients to complete a questionnaire before their operation and six-months after their operation. These questionnaires are known formally as the National Patient Reported Outcomes Measures (PROMs) programme and are designed to ask patients for their perspective on the effectiveness of care they received in the NHS in England.
The Westbourne Centre is a day-case centre and carries out septoplasty & carpel tunnel decompressions and the reporting reflects Hip and knee replacements which are not carried out.

The PROMS quality indicators are related to the NHS Outcomes Related NHS Outcomes Framework Domain 3: *"Helping people to recover from episodes of ill health or following injury."*

Hips

PROMS: Hips	Period	Best		Worst		Average	
	Apr19 - Mar 20	NTPH1	25.5465	NT411	17.059	Eng	22.6867
	Apr20 - Mar 21	NV302	25.7015	NVC20	17.335	Eng	22.9812
	Apr21 - Mar 22	NT333	26.0042	NVC20	7.31011	Eng	22.8474

Period	Westbourne	
Apr19 - Mar 20	NVC44	no data
Apr20 - Mar 21	NVC44	no data
Apr21 - Mar 22	NVC44	no data

The Westbourne Centre considers that this data is as described for the following reason: The Westbourne Centre does not undertake this type of procedure.

Knees

PROMS: Knees	Period	Best		Worst		Average	
	Apr19 - Mar 20	RR7	20.6878	R1K	12.6215	Eng	17.4858
	Apr20 - Mar 21	NVC23	20.2502	RXP	11.9159	Eng	16.8858
	Apr21 - Mar 22	RCF	20.6336	NT209	14.2667	Eng	17.6247

Period	Westbourne	
Apr20 - Mar 21	NVC44	no data
Apr19 - Mar 20	NVC44	no data
Apr20 - Mar 21	NVC44	no data

The Westbourne Centre considers that this data is as described for the following reason: The Westbourne Centre does not undertake this type of procedure.

Readmissions within 28 days

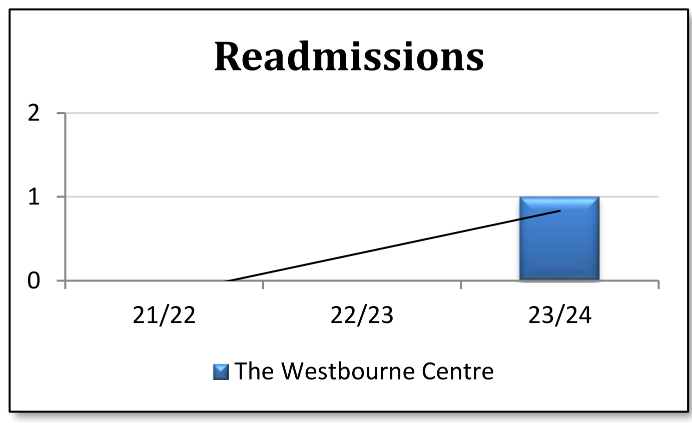
Readmissions:	Period	Best		Worst		Average	
	18/19	N/A	N/A	N/A	N/A	**Eng**	14.3
	19/20	N/A	N/A	N/A	N/A	**Eng**	13.7
	20/21	N/A	N/A	N/A	N/A	**Eng**	15.5

Period	Westbourne	
21/22	**NVC44**	0.00
22/23	**NVC44**	0.00
23/24	**NVC44**	0.00

The Westbourne Centre considers that this data is as described for the following reasons: Nil readmission over period

The data made available to The Westbourne Centre by NHS Digital with regard to the percentage of patients aged 18 or over, Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Below is a bar graph for the previous 3 years' readmissions as a total number for the last 3 years (Rate per 100 discharges)
The Westbourne centre considers that the data is as described.



Whilst we have seen an increase over the year this represents one patient who has needed to be readmitted during their surgical pathway with us and was appropriate for the patient's care.

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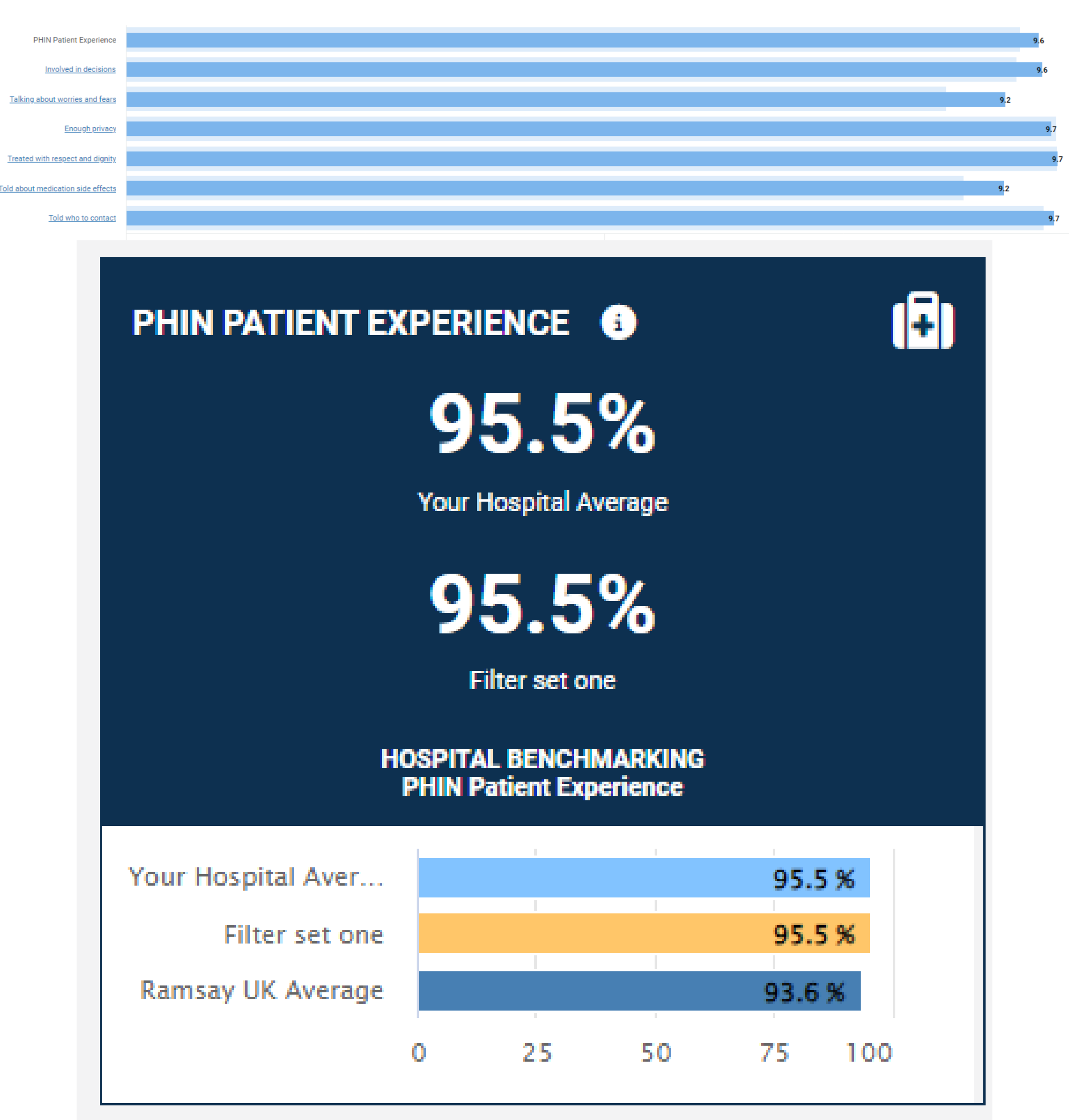
PHIN Experience score (suite of 5 questions giving overall Responsive to Personal Needs score):



VTE Risk Assessment

The VTE quality indicator is related to NHS Outcomes Framework Domain 5 "Treating and caring for people in a safe environment and protecting them from avoidable harm."

Below is a table showing the percentage of patients who were admitted to The Westbourne Centre and who were risk assessed for venous thromboembolism during the reporting period is shown on the graph and was made available to The Westbourne Centre by NHS digital.

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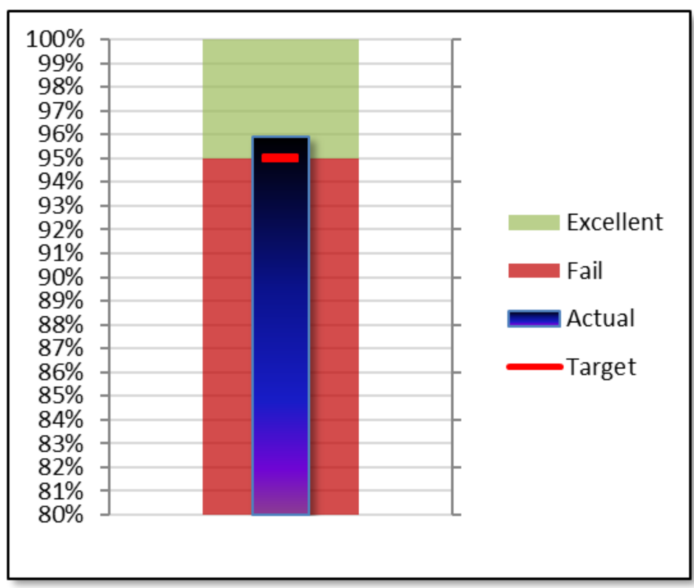
VTE Assessment:	Period	Best		Worst		Average		Period	Westbourne	
	Q1 to Q4 18/19	Several	100%	NVCOM	41.6%	Eng	95.6%	Q1 to Q4 18/19	NVC44	93.8%
	Q1 to Q3 19/20	Several	100%	RXL	71.8%	Eng	95.5%	Q1 to Q3 19/20	NVC44	95.9%

Due to Covid this submission was paused. There is no data published after Q3 19/20

The Westbourne Centre considers that this data is as described for the following reasons: All clinical staff are aware of the need for VTE assessment, our clinical care pathways direct the staff member to ensure completion and we have excellent communication with Consultants to ensure compliance.

Due to Covid-19 this submission was paused. There is no data published after Q3 19/20.



C difficile infection

The C. difficile data is related to the NHS Outcomes Framework Domain 5 "Treating and caring for people in a safe environment and protecting them from avoidable harm."

Below is a table showing data made available to The Westbourne Centre by NHS digital with regard to the rate per 100,000 bed days of cases of C difficile infection reported amongst patients during the reporting period.

The table covers two reporting periods and shows the worst performer for the period, the best performer for the period and The Westbourne Centre's own site performance.

C. Diff rate: per 100,000 bed days	Period	Best		Worst		Average		Period	Westbourne	
	2020/21	Several	0	RPC	81.0	Eng	15.0	2021/22	NVC44	0.0
	2021/22	Several	0	RPY	54.0	Eng	16.0	2022/23	NVC44	0.0

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The Westbourne Centre considers that this data is as described for the following reason: The Westbourne Centre has no cases to report. IPC practices are in place and monitored. Patients are requested to not come to the hospital should they have any illness including diarrhoea and/or vomiting.

Patient Safety Incidents with Harm

The serious incident data is related to NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

The data made available to The Westbourne Centre from our Riskman/Radar reporting system with regard to the number and, where available, rate of patient safety incidents reported during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. England average rates are based on data from NRLS.

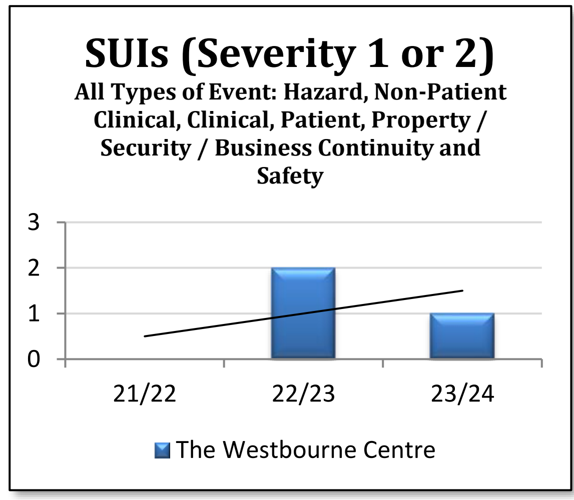
Below is a table showing serious incident data made available by NHS digital (level 1). The table covers two reporting periods and shows the worst performer for the period, the best performer for the period and The Westbourne Centre's own site performance.

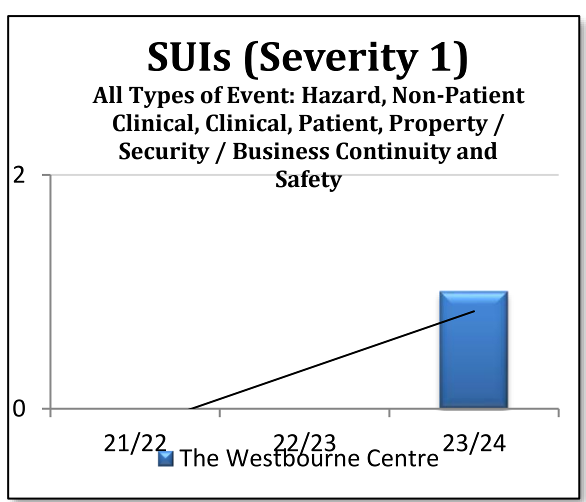
SUIs: (Severity 1 only)	Period	Best		Worst		Average	
	Oct19 - Mar20	Several	0.00	Several	0.50	Eng	0.20
	2021/22	RAX	0.03	RJR	1.08	Eng	0.30
	2022/23	N/A	N/A	N/A	N/A	N/A	N/A

Period	Westbourne	
2021/22	NVC44	0.00
2022/23	NVC44	0.00
2023/24	NVC44	0.14

The Westbourne Centre considers that this data is as described for the following reasons: The Westbourne Centre provides elective care and there is an effective pre admission process to ensure patient's condition is optimised prior to surgery. There were no incidents in the reporting period.

Below is a bar graph for the previous 3 years' SUIS at both level 1&2 as a total number for the last 3 years.
Rate per 100 discharges:





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All SUIs are reported in line with Ramsay Health Care and ICB reporting requirements. All SUIs have a full and transparent investigation. This is shared with the patient under "Duty of Candour" regulations. All incidents will have learning with outcomes which are shared with the wider team to prevent recurrence through our Safety Flash Alerts Outcomes With Learning and monitored through Clinical Governance Committee.

Friends and Family Test

The data made available to The Westbourne Centre by NHS Digital as a provider of adult NHS funded care, covering services for inpatients is shown in the graph below and is related to NHS Outcomes Framework Domain 4 "Ensuring that people have a positive experience of care". The table covers two reporting periods and shows the worst performer for the period, the best performer for the period and The Westbourne Centre's own site performance for patients who would recommend.

F&F Test:	Period	Best		Worst		Average	
	Feb-22	Several	100%	RTK	77.0%	Eng	94.0%
	Feb-23	Several	100%	RAL	56.0%	Eng	95.0%
	Jan-24	Several	100%	RTK	74.0%	Eng	94.0%

Period	Westbourne	
Feb-22	NVC44	100.0%
Feb-23	NVC44	100.0%
Jan-24	NVC44	100.0%

The Westbourne Centre considers that this data is as described for the following reasons: We actively encourage patients to undertake the friends and family test and we put the patient at the centre of everything we do.

The Westbourne Centre intends to take the following actions to improve this rate and so the quality of its service: We will continue to encourage patients to take the test and try to make it easier for them to do so via digital means.

3.2 Patient safety

We are a progressive hospital and focussed on stretching our performance every year and in all performance respects, and certainly in regards to our track record for patient safety.

Risks to patient safety come to light through a number of routes including routine audit, complaints, litigation, adverse incident reporting and raising concerns but more routinely from tracking trends in performance indicators.

Our focus on patient safety has resulted in a marked improvement in a number of key indicators as illustrated in the graphs below.

3.2.1 Infection prevention and control

The Westbourne Centre has a very low rate of hospital acquired infection and has had no reported MRSA Bacteraemia in the past 13 years.

We comply with mandatory reporting of all Alert organisms including MSSA/MRSA Bacteraemia and Clostridium Difficile infections with a programme to reduce incidents year on year.

Ramsay participates in mandatory surveillance of surgical site infections for orthopaedic joint surgery and these are also monitored.

Infection Prevention and Control management is very active within our hospital. An annual strategy is developed by a Corporate level Infection Prevention and Control (IPC) Committee and group policy is revised and re-deployed every two years. Our IPC programmes are designed to bring about improvements in performance and in practice year on year.

A network of specialist nurses and infection control link nurses operate across the Ramsay organisation to support good networking and clinical practice.

Programmes and activities within our hospital include:

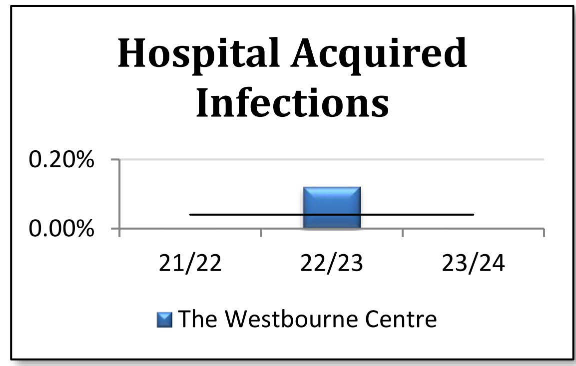
- Quality Lead Partner, Link personnel from Ramsay corporate team, supports our own lead IC nurse at The Westbourne Centre and we have access to a Consultant Microbiologist within the West Midlands Cluster.

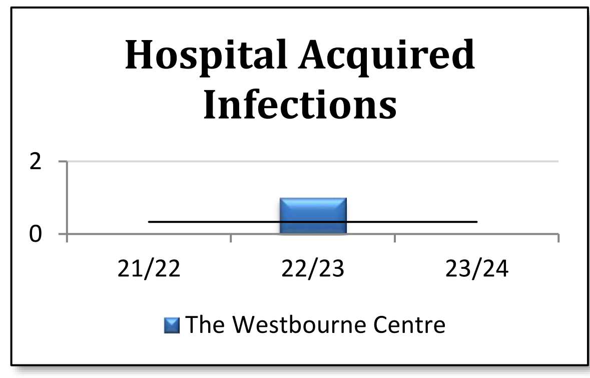
- E-Learning and Mandatory training sessions held for all clinical staff.

- Actively involving the infection control nurse in working in the clinical environments to audit and advise staff members and consultants in infection control issues including hand hygiene.
- Our lead Infection control nurse advises staff on reporting mechanisms for infections /wound problems using examples of reporting tools and policies available as well as undertaking training with clinical and operational staff.

The Westbourne Centre is proud of the low figure of less than 0.12% of all admissions and will aim to continue with such vigilance in monitoring and auditing infection control, in the forthcoming year.

Rate per 100 discharges:





As can be seen in the above graph our hospital acquired infection rate has decreased over the last year. In comparison to the national average it is below this. We have a robust culture of learning from root-cause analysis that have taken place.

3.2.2 Cleanliness and hospital hygiene

Assessments of safe healthcare environments also include **P**atient-**L**ed **A**ssessments of the **C**are **E**nvironment (**PLACE**)

PLACE assessments occur annually at The Westbourne Centre, providing us with a patient's eye view of the buildings, facilities and food we offer, giving us a clear picture of how the people who use our hospital see it and how it can be improved. The main purpose of a PLACE assessment is to get the patient view.

Due to COVID-19 restrictions the PLACE audit was unable to be carried out for 2021/22. A PLACE audit took place in September 2023 and the action plan is detailed below:

PLACE Action Plan September 2023

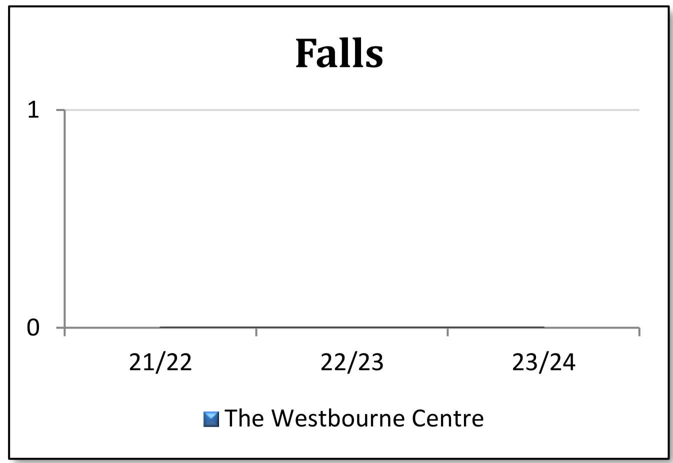
Conducted on 24th November 2023

Area of concern	Action	Who is responsible?	Complete?
Patients no food facilities on site	Reviewed the possibility of Vending machine but space does not lend itself to this. Unable to accommodate	Louise Holloway	Completed January 2023 – Upgraded coffee machine in place.
Waiting room has uneven surfaces of floor area	Flooring to be investigated and repair works carried out	Louise Holloway	Scheduled to be completed 17th June 2024
Wheelchairs not visible in Reception area for use	Due to lack of space – stored in separate area and brought out when required. Sign notifies patients to request if needed.	Louise Holloway	Addressed and closed
Pot holes present in car park	Was completed March 2023 / Additional pot holes now present due to wear and tear and weather conditions	Louise Holloway	Completed Feb 2024
External signage difficult to see from road	New brighter / additional signage to be ordered	Louise Holloway	Completed Feb 2024

3.2.3 Safety in the workplace

Safety hazards in hospitals are diverse ranging from the risk of slip, trip or fall to incidents around sharps and needles. As a result, ensuring our staff have high awareness of safety has been a foundation for our overall risk management programme and this awareness then naturally extends to safeguarding patient safety. Our record in workplace safety as illustrated by Accidents per 1000 Admissions demonstrates the results of safety training and local safety initiatives.

Effective and ongoing communication of key safety messages is important in healthcare. Multiple updates relating to drugs and equipment are received every month and these are sent in a timely way via an electronic system called the Ramsay Central Alert System (CAS). Safety alerts, medicine / device recalls and new and revised policies are cascaded in this way to our General Manager which ensures we keep up to date with all safety issues.



Rate per 100 discharges

3.3 Clinical effectiveness

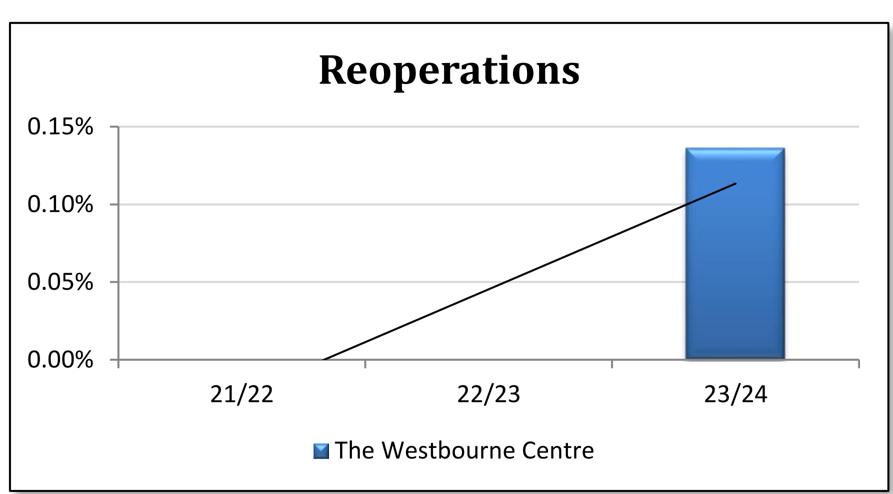
The Westbourne Centre has a Clinical Governance team and committee that meet regularly through the year to monitor quality and effectiveness of care. Clinical incidents, patient and staff feedback are systematically reviewed to determine any trend that requires further analysis or investigation. More importantly, recommendations for action and improvement are presented to hospital management, medical advisory committees and to the departmental meetings to ensure results are visible and tied into actions required by the organisation as a whole.

3.3.1 Return to theatre

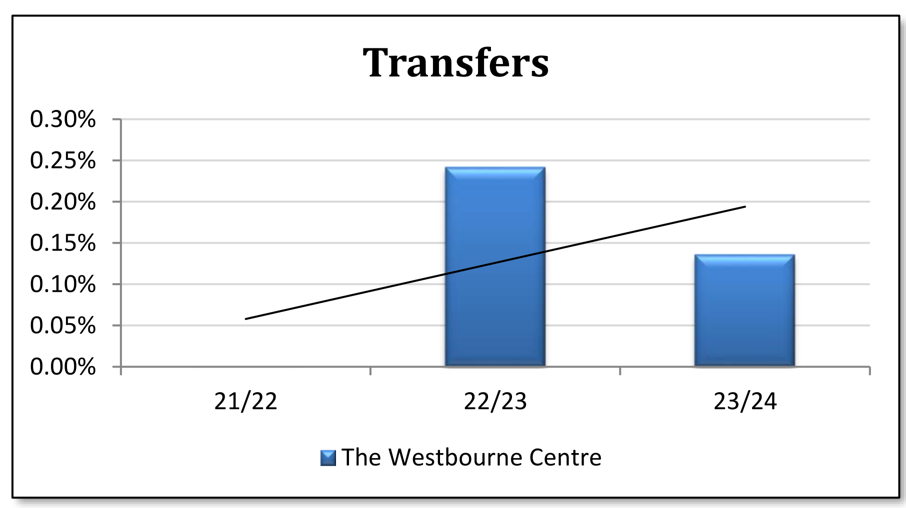
Ramsay is treating significantly higher numbers of patients every year as our services grow. The majority of our patients undergo planned surgical procedures and so monitoring numbers of patients that require a return to theatre for supplementary treatment is an important measure. Every surgical intervention carries a risk of complication so some incidence of returns to theatre is normal. The value of the measurement is to detect trends that emerge in relation to a specific operation or specific surgical team. Ramsay's rate of return is very low consistent with our track record of successful clinical outcomes.

As can be seen in the graph below shows our returns to theatre & transfer rate have remained low over the last year with only one patient requiring reoperation.

Rate per 100 discharges:



Rate per 100 discharges:



3.3.2 Learning from Deaths

There were no unexpected deaths in the reporting period.

3.3.3 Staff Who Speak up

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS Trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS Trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment by doing so. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

In 2018, Ramsay UK launched ‘Speak Up for Safety’, leading the way as the first healthcare provider in the UK to implement an initiative of this type and scale. The programme, which is being delivered in partnership with the Cognitive Institute, reinforces Ramsay’s commitment to providing outstanding healthcare to our patients and safeguarding our staff against unsafe practice. The ‘Safety C.O.D.E.’ enables staff to break out of traditional models of healthcare hierarchy in the workplace, to challenge senior colleagues if they feel practice or behaviour is unsafe or inappropriate. This has already resulted in an environment of heightened team working, accountability and communication to produce high quality care, patient centred in the best interests of the patient.

Ramsay UK has an exceptionally robust integrated governance approach to clinical care and safety, and continually measures performance and outcomes against internal and external benchmarks. However, following a CQC report in 2016 with an ‘inadequate’ rating, coupled with whistle-blower reports and internal provider reviews, evidence indicated that some staff may not be happy speaking up and identify risk and potentially poor practice in colleagues. Ramsay reviewed this and it appeared there was a potential issue in healthcare globally, and in response to this Ramsay introduced the ‘Speaking Up for Safety’ programme.

The Safety C.O.D.E. (which stands for Check, Option, Demand, Elevate) is a toolkit which consists of these four escalation steps for an employee to take if they feel something is unsafe. Sponsored by the Executive Board, the hospital Senior Leadership Team oversee the roll out and integration of the programme and training across all our Hospitals within Ramsay. The programme is employee led, with staff delivering the training to their colleagues, supporting the process for adoption of the Safety C.O.D.E through peer to peer communication. Training compliance for staff and consultants is monitored corporately; the company benchmark is 85%.

Since the programme was introduced serious incidents, transfers out and near misses related to patient safety have fallen; and lessons learnt are discussed more freely and shared across the organisation weekly. The programme is part of an ongoing transformational process to be embedded into our workplace and reinforces a culture of safety and transparency for our teams to operate within, and our patients to feel confident in. The tools the Safety C.O.D.E. use not only provide a framework for process, but they open a space of psychological safety where employees feel confident to speak up to more senior colleagues without fear of retribution.

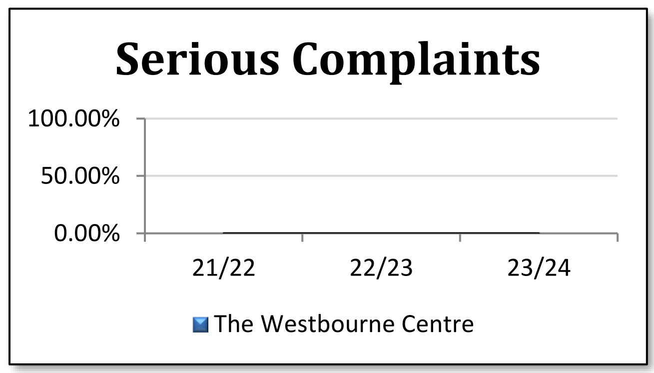
Ramsay Health Care UK is continuing with it's Speaking up for Safety Programme and is currently training up some master trainers to ensure that speaking up for safety continues to be a priority within the organisation. The Promoting Professional Accountability (PPA) training will also continue in liaison with Ramsay Australia and the Vanderbilt University in America.

3.4 Patient experience

All feedback from patients regarding their experiences with Ramsay Health Care are welcomed and inform service development in various ways dependent on the type of experience (both positive and negative) and action required to address them.

All positive feedback is relayed to the relevant staff to reinforce good practice and behaviour – letters and cards are displayed for staff to see in staff rooms and notice boards. Managers ensure that positive feedback from patients is recognised and any individuals mentioned are praised accordingly.

All negative feedback or suggestions for improvement are also feedback to the relevant staff using direct feedback. All staff are aware of our complaints procedures should our patients be unhappy with any aspect of their care.



Patient experiences are fed back via the various methods below, and are regular agenda items on Local Governance Committees for discussion, trend analysis and further action where necessary. Escalation and further reporting to Ramsay Corporate and DH bodies occurs as required and according to Ramsay and DH policy.

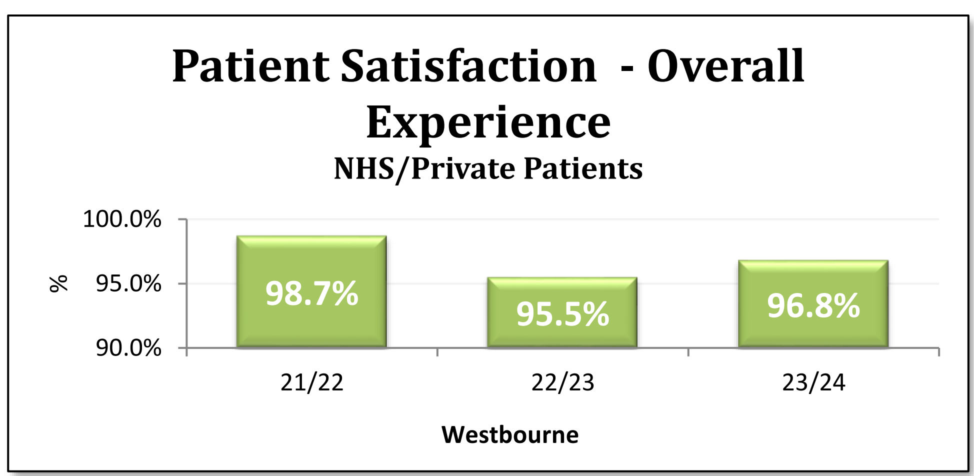
Feedback regarding the patient's experience is encouraged in various ways via:

- Continuous patient satisfaction feedback via a web based invitation
- Hot alerts received within 48hrs of a patient making a comment on their web survey
- Yearly CQC patient surveys
- Friends and family questions asked on patient discharge
- 'We value your opinion' leaflet
- Verbal feedback to Ramsay staff - including Consultants, Heads of Clinical Services / Hospital Directors whilst visiting patients and Provider/CQC visit feedback.
- Written feedback via letters/emails
- Patient focus groups
- PROMs surveys
- Care pathways – patient are encouraged to read and participate in their plan of care

3.4.1 Patient Satisfaction Surveys

Our patient satisfaction surveys are managed by a third party company called 'Qa Research'. This is to ensure our results are managed completely independently of the hospital so we receive a true reflection of our patient's views.

Every patient is asked their consent to receive an electronic survey or phone call following their discharge from the hospital. The results from the questions asked are used to influence the way the hospital seeks to improve its services. Any text comments made by patients on their survey are sent as 'hot alerts' to the Hospital Manager within 48hrs of receiving them so that a response can be made to the patient as soon as possible.



As can be seen in the above graph our Patient Satisfaction rate has increased over the last year. In comparison to the national average it is above average however there is still some further work to continue to lift this to the previous high standard.

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Appendix 1

Services covered by this quality account

	Services Provided	Peoples Needs Met for:
Treatment of Disease, Disorder Or injury	Dermatology (pigmented lesions), General medicine, Neurology, Pain management, Orthopaedic medicine, vascular	All adults 18 yrs. and over.
Surgical Procedures	Cosmetics, Dermatology, General surgery, Ophthalmic, Minor Orthopaedic, minor oral/periodontal surgery, dental implants - Day case surgery.	All adults 18 yrs. and over,-excluding: • Patients with blood disorders (haemophilia, sickle cell, thalassaemia) • Patients on renal dialysis • Patients with history of malignant hyperpyrexia • Planned surgery patients with positive MRSA screen are deferred until negative • Patients who are likely to need ventilatory support post operatively • Patients who are above a stable ASA 3. • Any patient who will require planned admission to ITU post-surgery • Dyspnoea grade 3/4 (marked dyspnoea on mild exertion e.g. from kitchen to bathroom or dyspnoea at rest) • Poorly controlled asthma (needing oral steroids or has had frequent hospital admissions within last 3 months) • MI in last 6 months • Angina classification 3/4 (Limitations on normal activity e.g. 1 flight of stairs or angina at rest) • CVA in last 6 months BMI >40 (non bariatrics) However, all patients will be individually assessed and we will only exclude patients if we are unable to provide an appropriate and safe clinical environment.
Diagnostic and screening	Phlebotomy, Specimen collection, histology, nerve conduction studies & MOHs	All adults 18 yrs. and over.

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Appendix 2 – Clinical Audit Programme 2023/24. Findings from the baseline audits will determine the hospital local audit programme to be developed for the remainder of the year.

Clinical Audit Programme

The Clinical Audit programme for Ramsay Health Care UK runs from July to the following June each year, 2020 saw the migration of audit activity from the traditional excel programme to an 'app' base programme initially called Perfect Ward. In 2022 Perfect Ward rebranded to "Tendable." Staff access the app through iOS devices and ease of use has much improved. Tailoring of individual audits is an ongoing process and improved reporting of audit activity has been of immediate benefit.

Appendix 2a – Local Clinical Audit Programme

Audit	Department Allocation	Frequency
Hand Hygiene Technique (Assurance)	Ward, Theatres, Radiology, Physio, Outpatients, Amb Care, Pharmacy	July, October, January, April
Hand Hygiene observation (5 moments)	Ward, Theatres, Radiology, Physio, Outpatients, Amb Care, Pharmacy	Monthly
Surgical Site Infection (One Together)	Theatres (IPC)	October, April
IPC Governance and Assurance	IPC	July, January
IPC Environmental infrastructure	IPC	August, February
IPC Management of Linen	Ward	August *February (as required)*
Sharps	IPC	August, December, April
High Risk PPE	IPC	August, February
Standard PPE	IPC	July, January
Cleaning (50 Steps)	Ward, Theatres, Radiology, Physio, Outpatients, Amb Care, Pharmacy	Monthly
Peripheral Venous Cannula Care Bundle	Ward, Theatres, Ambulatory Care	July to September
Peripheral Venous Cannula Care Bundle	Theatres, Ambulatory Care	July to September
Surgical Site Infection	IPC	October, April
Urinary Catheterisation Bundle	Ward, Theatres	July to September
Isolation	IPC	October

Patient Journey: Safe Transfer of the Patient	Ward	July/August, January/February
Patient Journey: Intraoperative Observation	Theatres	August/September, February/March
Patient Journey: Recovery Observation	Theatres	September/October, March/April
NatSSIPs LSO	Theatres, Outpatients, Radiology	July/August, January
NatSSIPs Safety Brief	Theatres, Outpatients, Radiology	August, February
NatSSIPs Sign In, Time Out & Sign Out	Theatres, Outpatients, Radiology	September, March
NatSSIPs Site Marking	Theatres, Outpatients, Radiology	October, April
NatSSIPs Stop Before You Block	Theatres	November/December, May/June
NatSSIPS Prosthesis	Theatres	December July
NatSSIPs IOLs	Theatres	July, January
NatSSIPs Swab Count	Theatres	July, February
NatSSIPs Instruments	Theatres, Outpatients, Radiology	August, Mar
NatSSIPs Histology	Theatres, Outpatients, Radiology	September, April
Blood Transfusion Compliance	Blood Transfusion	July/September
Blood Transfusion - Cold Chain	Blood Transfusion	As required
Walkabout	SLT / HoCS	As required
Staff Questions	SLT / HoCS	As required
Complaints	SLT	November
Duty of Candour	SLT	January
Practicing Privileges - Non-consultant	HoCS	October
Practicing Privileges - Consultants	HoCS	July, January
Practicing Privileges - Doctors in Training	HoCS	July, January (as applicable)
Observation Audits - Physio	Physio	July/August *January/February (as required)*
Observation Audits - Ward	Ward	August/September *March/April (as required)*
Observation Audits - OPD	Outpatients	July/August *January/February (as required)*
Privacy & Dignity	Ward	May/June, November/December

Medical Records	Physio, Theatres, Ward, Pre-Op Assess, Radiology, RDUK	July/September January/March (as required)
Medical Records - Cosmetic Surgery	Outpatients	July/September January/March (as required)
Medical Records - NEWS2	Ward	October, February, June
Medical Records - VTE	Ward	July, November, March
Medical Records - Patient Consent	HoCS	March September
Non-Medical Referrer Documentation and Records	Radiology	July, January
MRI Reporting for BUPA	Radiology	July, November, March
CT Reporting for BUPA	Radiology	August, December, April
No Report Required	Radiology	August, February
MRI Safety	Radiology, RDUK	January, July
CT Last Menstrual Period	Radiology, RDUK	July, October, January, April
RDUK - Referral Forms - CT	RDUK	July, September, November, January, March, May
Safe & Secure	Pharmacy	August, February
Prescribing	Pharmacy	September, March
Medicines Reconciliation	Pharmacy	September, March
Controlled Drugs	Pharmacy	September, December, March, June
Governance - Pharmacy	Pharmacy	July
Operational (Ward)	Ward, Theatres, Physio, Outpatients, Radiology, RDUK	October to December
Operational - Safeguarding	SLT / HoCS	July
Decontamination - Sterile Services	Decontamination (Corporate)	June
Decontamination - Endoscopy	Decontamination (Corporate)	June

Appendix 3

Glossary of Abbreviations

ACCP	American College of Clinical Pharmacology
AIM	Acute Illness Management
ALS	Advanced Life Support
CAS	Central Alert System
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DDA	Disability Discrimination Audit
DH	Department of Health
EVLT	Endovenous Laser Treatment
GP	General Practitioner
GRS	Global Rating Scale
HCA	Health Care Assistant
HPD	Hospital Patient Days
H&S	Health and Safety
IHAS	Independent Healthcare Advisory Services
IPC	Infection Prevention and Control
ISB	Information Standards Board
JAG	Joint Advisory Group
LINk	Local Involvement Network
MAC	Medical Advisory Committee
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
NCCAC	National Collaborating Centre for Acute Care
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NVC	Code for The Westbourne Centre used on the data information websites
ODP	Operating Department Practitioner
OSC	Overview and Scrutiny Committee
PLACE	Patient-Led Assessment of the Care Environment
PPE	Personal Protective Equipment
PROM	Patient Related Outcome Measures
RIMS	Risk Information Management System
SUS	Secondary Uses Service
SAC	Standard Acute Contract
SLT	Senior Leadership Team
STF	Slips, Trips and Falls
SUI	Serious Untoward Incident
VTE	Venous Thromboembolism

Confidential Patient Information

The Westbourne Centre

Part of

Ramsay Health Care UK

We would welcome any comments on the format, content or purpose of this Quality Account.

If you would like to comment or make any suggestions for the content of future reports, please telephone or write to the Hospital Director using the contact details below.

For further information please contact:

Centre phone number

0121 456 0880

Centre website

www.westbournecentre.com

53 Church Road, Edgbaston, Birmingham B15 3SJ