

THE WESTBOURNE CENTRE

Quality Account 2026/27



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Welcome to Ramsay Health Care UK

The Westbourne Centre is jointly part of the Ramsay Health Care Group

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

Founded in 1964 in Sydney, Australia, Ramsay Health Care is a leading global healthcare provider, recognised for outstanding patient care and integrated services across Australia, Europe and the United Kingdom.

Patients choose Ramsay UK because they trust us to deliver the highest standards of clinical quality and provide exceptional care. This year, we have achieved several significant milestones that recognise excellence in clinical care. Ramsay UK became the first independent provider to secure JAG accreditation across all our 25 endoscopy units; we were awarded Gold National Joint Registry (NJR) Quality Data Provider status across all hospitals, for the second consecutive year and we received consistently positive outcomes from Care Quality Commission (CQC) inspections. These achievements were further strengthened by the positive findings of the Getting It Right First Time (GIRFT) review of Ramsay's orthopaedic and spinal services.

Over the last 18 months, we have reinvested £55 million into diagnostic imaging, equipment upgrades, digital platforms, estates, and early intervention. These investments ensure our hospitals remain modern, high-performing and able to meet growing demand; alongside strengthening patient experience and doctor engagement.

With Net Promoter Scores above 90, we are prioritising patient care by launching the "It starts with me" customer service training to further improve the patient experience and uphold a patient-first culture.

Together, our achievements highlight Ramsay UK's commitment to healthcare excellence, patient experience and making a positive impact in our local communities.

I am proud to share these results with you.



Nick Costa

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

At Ramsay Health Care UK, patient safety and the quality of care are paramount. As Chief Clinical and Quality Officer and Chief Nurse, I am immensely proud of the dedication and passion demonstrated by our clinical teams. Their unwavering commitment to delivering compassionate, evidence-based care ensures that patients always remain our foremost priority.

Across the UK group, I am continually inspired by the outstanding care provided by both our clinical and operational teams. Every day, they deliver exceptional service that embodies our core value of "People Caring for People." This dedication is clearly reflected in our impressive patient feedback scores, as well as the positive engagement received from colleagues and doctors. The contribution of every team member is vital, and we remain steadfast in our commitment to recognising, supporting, and championing their efforts.

This year, I have been particularly proud of the achievement of our first 'Outstanding' rating from the Care Quality Commission for one of our hospitals. This recognition was not easily attained, but it is a well-earned reflection of the exceptional practice and service that are consistently delivered. As we look to the future, our focus is on sharing best practice and learning so that this recognition may be more widely achieved throughout our organisation.

I am eager to continue this journey, building on our unwavering commitment to providing high-quality healthcare. With sustained investment and a dedication to innovation, we will further strengthen our promise to patients and the communities we serve.

A handwritten signature in black ink, appearing to read 'Jo Dickson', with a stylized, cursive script.

Jo Dickson

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.

Each site within the Ramsay Group 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

Mrs Louise Holloway, Hospital Manager, The Westbourne Centre

Thank you for taking the time to review The Westbourne Centre Quality Account. As Hospital Director, I am delighted to collaborate with our dedicated teams to continually advance both the quality of our services and the satisfaction of our patients. This comprehensive report highlights the hospital's strategy for quality improvement, details the progress achieved during 2025/2026, and outlines our ambitions for the year ahead.

Our vision remains clear and steadfast: "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." Over the past 18 years, The Westbourne Centre has established a reputation for excellence, offering a diverse array of services to both private and NHS patients. Patient care is the guiding principle behind all our efforts, which are underpinned by a strong culture of teamwork and professionalism.

The Quality Account provides an overview of the initiatives implemented over the past year to uphold our high standards in patient care. Where opportunities for improvement have been identified, we have proactively refined our processes to enhance the delivery of care and ensure exceptional outcomes. Our staff have demonstrated remarkable dedication, working tirelessly to facilitate a robust patient flow throughout the hospital and to increase activity levels in support of timely patient care. These efforts have been particularly vital in addressing the extended waiting lists experienced by NHS patients, as well as those on our own waiting lists. Meanwhile, private patient activity has remained consistently strong across all specialties.

Reflecting on our most recent CQC inspection in November 2016, I am pleased to share that The Westbourne Centre was rated as 'GOOD' in the areas of caring, effectiveness, responsiveness, and leadership. While we received a 'Requires improvement' rating for safety, all requirement notices issued under two regulations have been fully addressed and continue to be a focal point since the inspection. Following the publication of the report, our Senior Leadership Team developed a comprehensive action plan which is regularly reviewed and updated to ensure ongoing compliance and drive our pursuit of an 'outstanding' rating at the next inspection. Maintaining CQC compliance remains central to our care delivery.

Our track record as a safe and responsible provider of Day Case services is strong, and we take pride in sharing these positive results. We firmly believe that every staff member contributes to the unit's success. To foster professional growth, we have established a robust training and education plan that encompasses both administrative and clinical teams. The development of our Quality Accounts has been a collaborative effort, with staff actively engaged in implementing a systematic approach to risk management. This approach is designed to minimize the likelihood and impact of adverse events associated with patient treatment.

To ensure coordinated care and adherence to professional standards and legislative requirements, the Clinical Effectiveness Committee, Clinical Governance, and Medical Advisory Committee convene quarterly to review and assess both clinical and safety performance at The Westbourne Centre. Their insights and feedback have shaped the content

within these Quality Accounts, which offer all stakeholders transparent access to our quality initiatives and patient outcomes.

Should you wish to share comments or offer feedback, I encourage you to contact me by phone or email. Your input is invaluable as we strive to continuously improve the quality of care at The Westbourne Centre.

0121 456 0880 or Louise.holloway@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.

Mrs Louise Holloway
Hospital Manager
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.

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

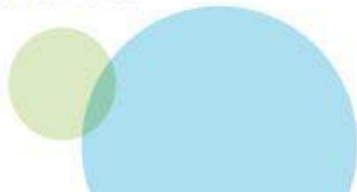
We are always looking for ways to improve our service and respond quickly to any feedback or concerns.

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.



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 and we can treat children from the age of 3 for dental procedures.

All of our theatre cases are performed under local anesthetic with or without sedation, which enables patients to be discharged on the same day. We do not have the facilities for general anesthesia so patients requiring general anesthetic are 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 surgery
- Dermatology
- 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 44 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 14 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 a dental Imaging Department providing a specialist imaging service (x-ray and CT) for the dental, oral and maxillofacial plastic surgeons.

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

Part 2

2.1 Quality priorities for 2026/27

Plan for 2026/27

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 Leadership Team taking into consideration 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

2.1.1 A review of clinical priorities 2025/26 (looking back)

During 2025/26, The Westbourne Centre has made strong progress in delivering its key quality priorities across patient safety, clinical effectiveness and patient experience.

In relation to **patient safety**, the Centre has embedded a positive safety culture through the ongoing delivery of the Speaking Up for Safety programme, ensuring staff are equipped and confident to raise concerns. Compliance with the Surgical Safety Checklist has been maintained through audit, training and regular monitoring, strengthening safer surgery processes. Improvements have also been made in risk management, with a more robust approach to risk registers, incident reporting and “closing the loop” on learning, supported by regular governance forums and safety huddles. Safeguarding responsibilities remain well embedded, with staff continuing to demonstrate awareness and appropriate action to protect patient wellbeing. This has been underpinned by visible and accessible leadership, with daily huddles, walk-rounds and improved communication processes supporting staff engagement and patient safety.

For clinical effectiveness, the Centre has strengthened the informed consent process through staff training and patient feedback, ensuring patients are supported to make well-informed decisions about their care. The organisation has maintained its zero-tolerance approach to

MRSA, supported by adherence to infection prevention and control standards and care bundles. The Centre has also achieved GOLD ANTT accreditation, demonstrating a high standard of aseptic non-touch technique practice and a continued commitment to infection prevention excellence. The internal audit programme has been fully implemented and actively monitored, with outcomes reviewed at departmental and governance meetings to drive continuous improvement. In addition, the continued embedding of the Patient Safety Incident Response Framework (PSIRF) has enhanced how incidents are reviewed, with greater emphasis on system learning and organisational improvement.

In terms of patient experience, the Centre continues to place patient feedback at the heart of service delivery. Our Net Promoter Score (NPS) remains consistently above 90%, reflecting high levels of patient satisfaction, and complaint rates remain very low. Actions have been taken to improve response rates to feedback tools and to ensure learning is shared across teams. Complaints and compliments are consistently captured, reviewed and used to inform service improvements, with a strong focus on openness, responsiveness and Duty of Candour requirements. Monthly patient experience reviews and enhanced data analysis have supported the identification of themes and the development of targeted actions. The Centre has also maintained its commitment to dignity, respect and inclusion, ensuring all patients receive compassionate and personalised care.

Overall, the Centre has successfully delivered its key priorities, with clear evidence of sustained improvement, strong governance oversight and a continued commitment to high-quality, safe and patient-centred care.

2.1.2 Clinical Priorities for 2025/26 (looking forward)



For 2025/26, The Westbourne Centre will continue to build on strong foundations, focusing on a small number of high-impact priorities aligned to patient safety, clinical effectiveness and patient experience. These priorities have been identified through review of performance data, audit outcomes, incident trends, patient feedback and engagement with staff, consultants and governance forums.

Patient Safety Priority: Embedding a Proactive Safety Culture through PSIRF and Learning Systems

The Centre will further embed the Patient Safety Incident Response Framework (PSIRF), alongside strengthening approaches to shared learning through Safety Flashes, Outcomes with Learning (OWL) meetings and Speaking Up for Safety (SUFS). This supports national patient safety priorities and a move towards system-based learning.

This priority has been identified through internal incident review, audit findings and national expectations for PSIRF implementation, with a focus on improving learning, transparency and staff confidence in reporting.

Aim

To achieve:

- 100% of incidents reviewed using a PSIRF-aligned approach
- 95% of incidents with documented learning and actions shared with staff

Actions

- Establish regular PSIRF/PSIRG site review groups
- Strengthen the use of Safety Flashes and OWLs to share learning across teams
- Improve the quality of incident investigations with a systems-based approach
- Ensure timely escalation of risks through RADAR and governance structures

Monitoring and Measurement

- Monthly review of incident reporting rates, themes and action completion
- Audit of quality of investigations and evidence of learning dissemination
- Staff survey feedback regarding confidence in speaking up

Reporting

- Progress will be reported through Clinical Governance Committee, Medical Advisory Committee (MAC) and Head of Department meetings, with escalation to the Senior Leadership Team (SLT) and inclusion within Quality and Safety reports.

Clinical Effectiveness Priority: Strengthening Clinical Audit, GIRFT Alignment and Theatre Standards

The Centre will enhance its clinical audit programme, align practice with Getting It Right First Time (GIRFT) and NICE guidance, and focus on achieving AFPP accreditation for theatres, demonstrating compliance with nationally recognised perioperative standards.

This priority reflects audit findings, external inspection feedback and the commitment to achieve external accreditation to evidence high-quality, standardised theatre practice.

Aim (add measurable target)

- Achieve AFPP theatre accreditation by end of the year
- Maintain $\geq 95\%$ compliance with key theatre safety standards (e.g. WHO checklist, documentation)

Actions

- Undertake a full gap analysis against AFPP standards
- Develop and implement a theatre-specific action plan
- Strengthen compliance with perioperative documentation (e.g. VTE, consent, WHO checklist)
- Provide targeted training and competency assessment for theatre staff
- Align practice with GIRFT and national perioperative safety guidance

Monitoring and Measurement

- Regular internal audits against AFPP standards
- Tracking progress against accreditation action plan
- Theatre governance metrics (checklist compliance, documentation, incidents)

Reporting

- Progress reported through Clinical Governance Committee and MAC
- Escalation through SLT with formal updates on accreditation readiness

Patient Experience Priority: Enhancing Use of Patient Feedback and Data Insights Introduction

The Centre will further develop its approach to capturing, analysing and acting on patient feedback through Cemplicity, Friends and Family Test (FFT), and patient engagement initiatives.

This priority is informed by the need to maximise learning from feedback, improve response rates and strengthen the link between patient insight and service improvement, aligned to national patient experience expectations.

Aim

To achieve:

- Sustained NPS score >90%
- 100% of complaints demonstrating clear learning and action

Actions

- Expand use of the Cemplicity dashboard, including key driver analysis and trend reporting
- Continue proactive management of complaints and compliments
- Maintain compliance with Duty of Candour requirements

Monitoring and Measurement

- Monthly review of NPS, and complaints data
- Thematic analysis of feedback, trends and key drivers
- Tracking of actions arising from patient feedback

Reporting

Findings and progress will be reported at Patient Experience and Clinical Governance meetings, with shared learning cascaded through team meetings, huddles and organisational reporting structures.

These priorities reflect The Westbourne Centre's continued commitment to delivering safe, effective and patient-centred care. Progress will be closely monitored through robust governance frameworks, ensuring accountability, transparency and continuous improvement throughout 2025/26.

2.2 Mandatory Statements

2.2.1 Review of Services

During 2025/26 The Westbourne Centre provided and/or subcontracted 5 (ophthalmology, general surgery, vascular surgery, trauma and orthopaedic and oral surgery) NHS services.

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

The income generated by the NHS services reviewed in 1 April 2025 to 31st March 2026 represents 68% per cent of the total income generated by The Westbourne Centre.

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 hospital's Senior Leadership Team together with Corporate Senior Leaders 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 2025/26, the indicators on the scorecard which affect patient safety and quality were:

Human Resources	
Mandatory Training	98.8%
Sickness	5.6%
Appraisal	100%
Staff Turnover	6.9%
Agency Usage	0.7% of total hours
Staff Satisfaction Score	78%
Patient	
Patient Satisfaction Score	96%
Formal complaints per 1000HPD's	0%
Significant clinical Events per 1000Admissions	0%

Readmissions per 1000 Admissions	0%
Quality	
Workplace Health and Safety Score	95.7%
Infection Control Score Audit	100%
Consultant Satisfaction Score	91%

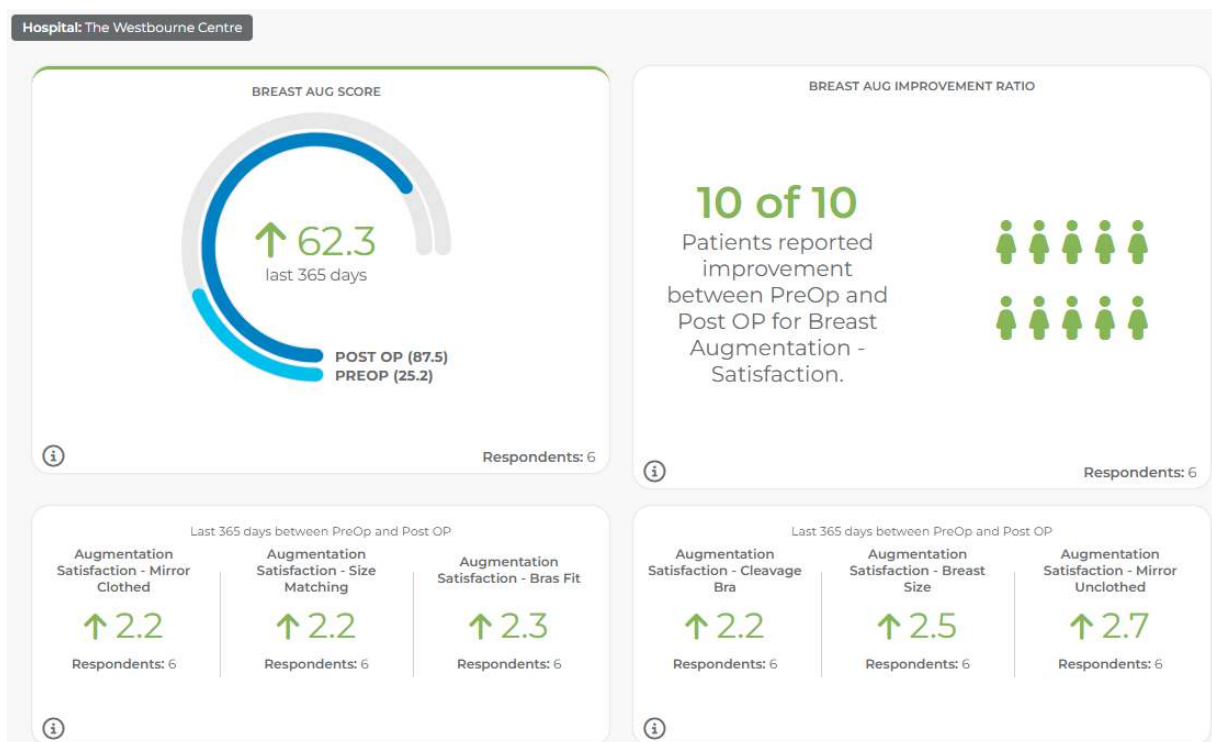
2.2.2 Participation in clinical audit

During 1 April 2025 to 31st March 2026 The Westbourne Centre participated in national clinical audits, national implant registers and national confidential enquiries which it was eligible to participate in.

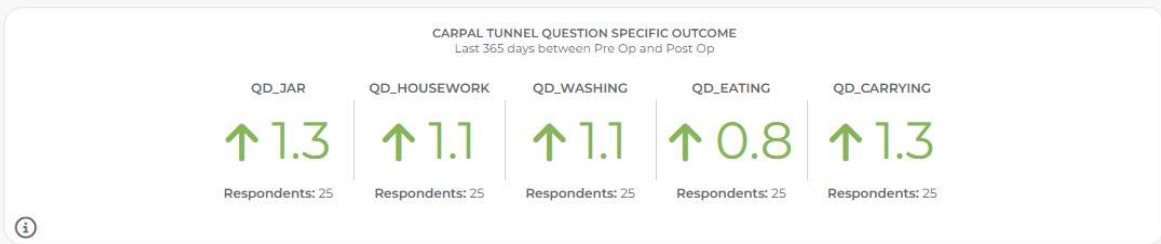
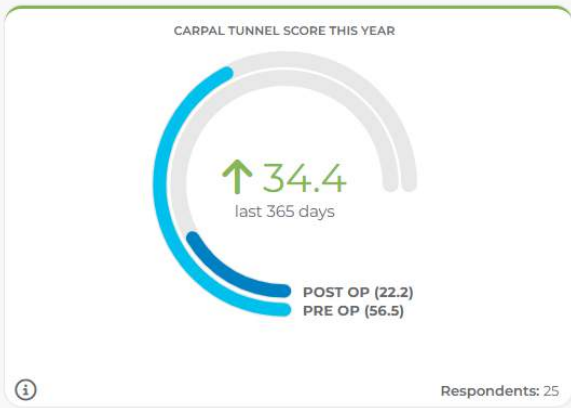
The Westbourne Centre was eligible to participate in the following based on the clinical activity:

Elective Surgery (National ePROMs Programme)

- Total HES Augmentation Mammoplasty



- Carpal tunnel PROMS



- NHS Digital Cataract procedures, ICHOMs



Local Audits

The reports of 190 local clinical audits from 1 April 2025 to 31st March 2026 were reviewed by the Clinical Governance Committee and The Westbourne Centre intends to take the following actions to improve the quality of healthcare provided:

- All audits are now closely monitored by the Head of Clinical Services and Heads of Department, with progress, outcomes, and associated action plans formally reviewed on a monthly basis through HoD 1:1 meetings, as well as at the Medical Advisory Committee and Clinical Governance Committee.
- The audit action process has been strengthened, ensuring actions are meaningful, clearly owned, and tracked through to completion, with a clear focus on closing the loop and evidencing improvement.
- There is increased emphasis on developing staff capability in audit processes, ensuring all clinical staff understand the full audit cycle and are actively involved in both departmental and cross-departmental clinical audits.
- Audit as a core component of the quality improvement cycle is now embedded within staff induction programmes and reinforced through all clinical mandatory training sessions.

The clinical audit schedule can be found in Appendix 2.

2.2.3 Participation in Research

There were no patients recruited during 2025/26 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's income from 1 April 2025 to 31st March 2026 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 2026 is registered without conditions.

The Care Quality Commission has not taken enforcement action against The Westbourne Centre during 2025/26.

The Westbourne Centre has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.6 Data Quality

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

High data quality is crucial for superior care at The Westbourne Centre. Accurate and timely information enhances clinical decisions, patient safety, and care efficiency, ultimately reducing errors and improving care coordination.

Our data's integrity is vital for the credibility of our quality claims, impacting patient outcomes, satisfaction levels, and guideline compliance. This allows us to identify improvement areas and transparently report to stakeholders.

Actions to Monitor and Improve Data Quality

We implement various measures to enhance our data quality:

Clinical Records Audits

Regular audits of clinical records ensure accuracy, completeness, and adherence to documentation standards, with ongoing staff training to address discrepancies.

Electronic Data Audits

Periodic audits of our Electronic Patient Pathway system verify the accuracy and completeness of digital data, using automated tools to highlight inconsistencies and gaps which can then be actioned.

Year-on-Year Metrics

Our commitment to data quality is also demonstrated through:

- **Staff Training Programs:** Regular sessions on accurate data entry and documentation practices.
- **Feedback Mechanisms:** Collecting feedback to identify and address data management challenges.
- **Technology Upgrades:** Investing in advanced technologies to streamline data entry and enhance data security.

High-quality data is the foundation of excellent patient care and value for money at The Westbourne Centre. Through continuous monitoring, auditing, and improvement, we ensure top-tier care and operational efficiency.

NHS Number and General Medical Practice Code Validity

The Westbourne Centre submitted records during 2024/25 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 published in the data which included:

The patient's valid NHS number:

- 99.69% for admitted patient care.
- 99.94% 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 status is 'Standards Met'. The 2025/2026 submission is due by 30th June 2026.

This information is publicly available on the DSP website at:

<https://www.dsptoolkit.nhs.uk/>

Clinical coding error rate

The Westbourne Centre was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

Ramsay Health Care DSPT IG Requirement 505 Attainment Levels as of April 2026

Hospital Site	NHS Admitted Care Sample 50 Episodes of Care	Primary Diagnoses % Correct	Secondary Diagnosis % Correct	Primary Procedure % Correct	Secondary Procedure % Correct	DSPTK Attainment Level
Westbourne	Completed Aug 2024	96%	84%	92%	95%	Level 2

2.2.7 Stakeholders views on 2025/26 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 – Sally Roberts

NHS Birmingham & Solihull (BSOL) Contract Quality Lead – Interim - Nickie Burgess

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

The Westbourne Medical Advisory Committee Chair – Mr H Nishikawa

Part 3: Review of quality performance 2023/24

Statements of quality delivery

Rebecca Mushambi

Head of Clinical Services (Matron), The Westbourne Centre

Review of quality performance 1st April 2025 - 31st March 2026

Introduction

Having recently joined The Westbourne Centre as Head of Clinical Services, I am delighted to begin my journey within a team that is clearly committed to delivering high-quality, patient-centred care. In this short time, I have already seen the dedication, professionalism, and compassion demonstrated daily by both our clinical and operational colleagues, and I am proud to be part of such a collaborative and supportive environment.

The strength of The Westbourne Centre lies in its teamwork. The close collaboration between clinical and operational teams enables us to consistently meet the needs of our patients and deliver safe, effective, and high standards of care. It is evident that a shared commitment to quality underpins everything we do, and I look forward to continuing to strengthen these relationships as we move forward together.

As a new leader within the Centre, my focus is on listening, learning, and understanding both our strengths and the opportunities for improvement. I am committed to fostering an open and transparent culture where colleagues feel confident to speak up, raise concerns, and contribute to continuous improvement. Ensuring that staff feel heard and supported is fundamental to maintaining a safe and positive environment for both patients and colleagues.

Looking ahead, I am excited to work with our teams to build on the strong foundations already in place. Together, we will continue to drive forward quality improvement, strengthen governance processes, and ensure that patient safety and experience remain our top priorities.

Clinical Excellence

Commitment to clinical excellence remains a key priority. As I settle into my role, my immediate focus has been on understanding our current clinical governance processes, ensuring alignment with best practice, and identifying opportunities to strengthen patient safety and outcomes. We will continue to support staff through training, audit, and the implementation of robust clinical standards to ensure high-quality care is consistently delivered.

Patient Feedback

Patient feedback shapes our approach to care. We actively review feedback to understand what we are doing well and where we can improve. I have already seen the value placed on patient voice within the organisation, and we will continue to ensure that feedback directly informs our quality improvement plans and service development.

Operational Efficiency

Efficient processes are essential to delivering high-quality care. Working closely with our operational teams, we will continue to review patient pathways, reduce delays, and optimise the use of resources to ensure patients receive timely and effective treatment.

Professional Development

Investing in our people is fundamental to delivering excellent care. We will continue to prioritise staff training, competency development, and leadership support, ensuring our teams have the skills and confidence to provide safe and effective care.

Collaboration & Teamwork

Collaboration remains central to our success. I am committed to strengthening multidisciplinary working and ensuring clear communication across all teams. By working together, we can continue to enhance patient outcomes and respond effectively to challenges.

Future Goals

- As we move forward, our priorities will include:
- Strengthening clinical governance and risk management processes
- Enhancing patient experience and engagement
- Supporting service development and future growth opportunities
- Continuing to invest in staff development and wellbeing

Ensuring readiness for future regulatory requirements and inspections

While I am new in post, it is clear that The Westbourne Centre has a strong foundation of high-quality care and a dedicated workforce. I look forward to working collaboratively with colleagues to build on these strengths, driving continuous improvement and ensuring that our patients remain at the centre of everything we do.

Ramsay Clinical Governance Framework 2025/26

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.

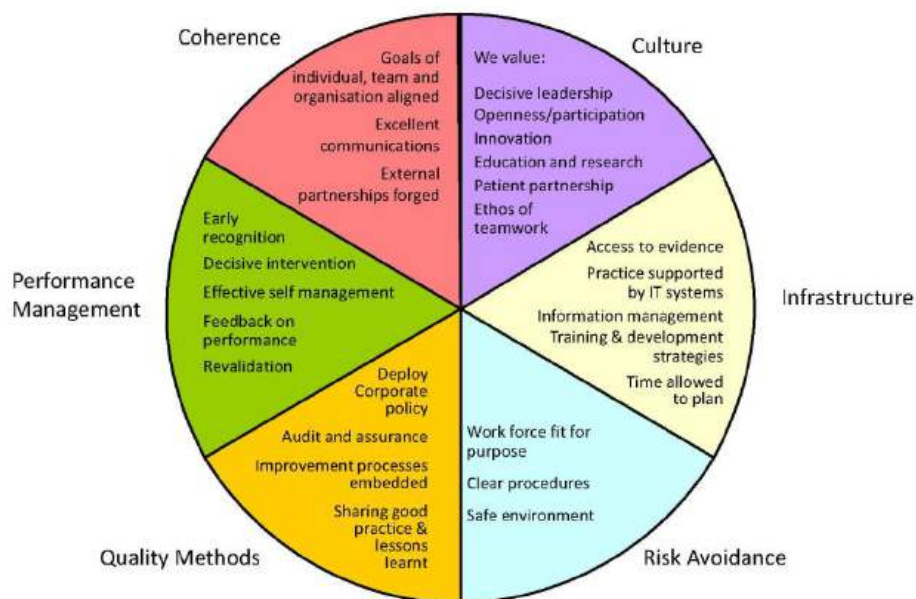
The emphasis is on providing an environment and culture to support continuous clinical quality improvement so that patients receive safe and effective care, clinicians are enabled to provide that care and the organisation can satisfy itself that we are doing the right things in the right way.

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.

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

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”

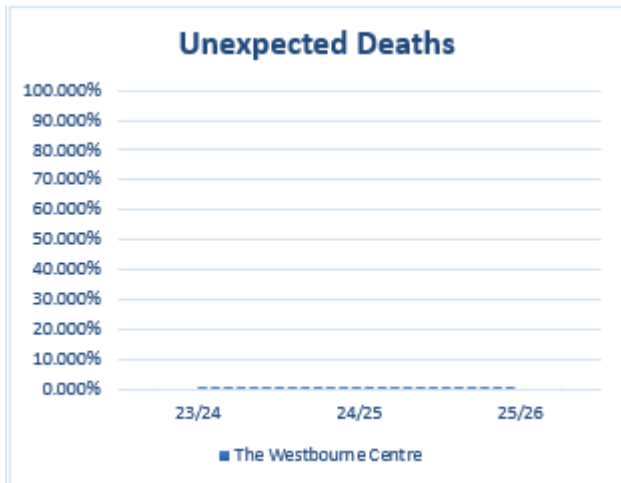
Above is a table showing mortality/death of patient data made available to The Westbourne Centre by NHS digital. The table covers two reporting periods and shows the worst performer for the period, the best performer and The Westbourne Centre site performance.

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.

Mortality:	Period	Best		Worst		Average		Period	Westbourne	
	Nov22 - Oct23	RQM	0.7215	RXP	1.2065	Average	1.0021	23/24	NVC44	0.0000
	Nov23 - Oct24	RQM	0.6967	RXR	1.2985	Average	1.0036	24/25	NVC44	0.0000
	Nov24 - Oct25	RYJ	0.7194	RXL	1.3183	Average	1.0092	25/26	NVC44	0.0000

Rate per 100 discharges:



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

National PROMs

Patients undergoing elective NHS-funded inpatient surgery for common procedures (including hip and knee replacement, ENT septoplasty, transurethral prostatectomy, and carpal tunnel decompression) are invited to complete questionnaires both before and after their operations. These questionnaires assess improvements in health from the patient's perspective, with follow-up typically undertaken six months post-procedure.

This process forms part of the National Patient Reported Outcome Measures (PROMs) programme, which captures patients' views on the effectiveness of care delivered within the NHS in England.

The Westbourne Centre operates as a day-case facility and undertakes septoplasty and carpal tunnel decompression procedures only. It does not perform hip or knee replacement surgery; however, reporting includes these procedures in line with national PROMs requirements.

PROMS:	Period	Best		Worst		Average		Period	Westbourne	
	Apr21 - Mar22	NT333	26.0042	NVC20	7.31011	Eng	22.8474	Apr21 - Mar22	NVC44	no data
	Apr22 - Mar23	NT402	25.4426	NVC04	14.9221	Eng	22.4505	Apr22 - Mar23	NVC44	no data
	Apr23 - Mar24	RYJ	25.6601	RF4	18.6003	Eng	22.5744	Apr23 - Mar24	NVC44	no data

PROMS:	Period	Best		Worst		Average		Period	Westbourne	
	Apr21 - Mar22	RCF	20.6336	NT209	14.2667	Eng	17.6247	Apr21 - Mar22	NVC44	no data
	Apr22 - Mar23	RWJ	20.8622	RJ1	13.1198	Eng	17.4879	Apr22 - Mar23	NVC44	no data
	Apr23 - Mar24	NT412	19.7877	NVC20	11.7164	Eng	16.8868	Apr23 - Mar24	NVC44	no data

The Westbourne Centre considers this data to be accurate as described, as these procedures are not undertaken at the centre.

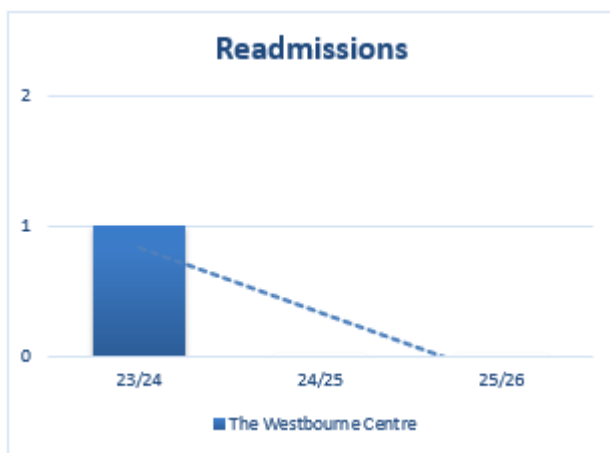
Readmissions within 28 days

The data made available to The Westbourne Centre by NHS Digital relates to the percentage of patients aged 18 or over who are readmitted to a hospital within the same trust within 28 days of discharge during the reporting period.

A bar graph below illustrates total readmissions over the past three years, presented as a rate per 100 discharges.

Readmissions:	Period	Best		Worst		Average		Period	Westbourne	
	20/21	N/A	N/A	N/A	N/A	N/A	Eng	15.5	23/24	NVC44
23/24	N/A	N/A	N/A	N/A	N/A	Eng	14.2	24/25	NVC44	0.00000
24/25	N/A	N/A	N/A	N/A	N/A	Eng	14.7	25/26	NVC44	0.00000

Rate per 100 discharges:



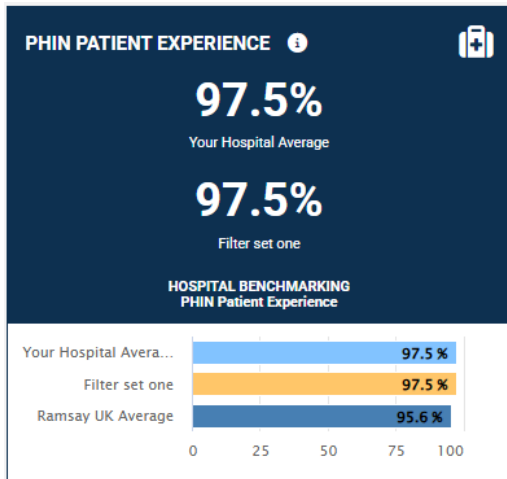
The Westbourne Centre considers this data to be accurate as described.

Responsiveness to Personal Needs

Break down per question and overall responsiveness score taken from Ramsay's external patient experience survey, Period April 2025 - March 2026:

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





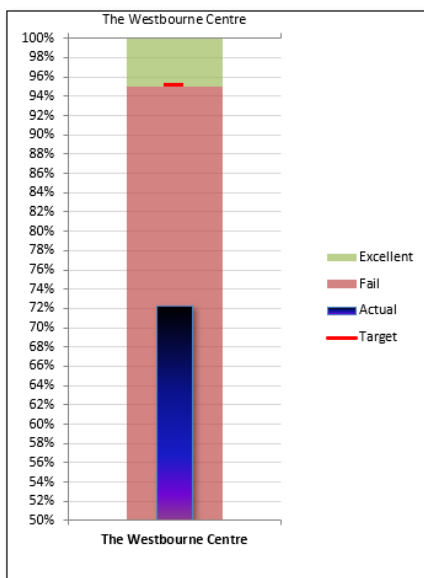
VTE Risk Assessment

The VTE quality indicator is aligned to NHS Outcomes Framework Domain 5: *“Treating and caring for people in a safe environment and protecting them from avoidable harm.”*

The table below presents the percentage of patients admitted to The Westbourne Centre who received a venous thromboembolism (VTE) risk assessment during the reporting period. This data has been made available to The Westbourne Centre by NHS Digital.

VTE Assessment:	Period	Best		Worst		Average		Period	Westbourne	
	Q1 to Q3 19/20	Severall	100%	RXL	71.8%	Eng	95.5%	Q1 to Q3 19/20	NVC44	95.9%
Q3 24/25	Severall	100%	RCB	13.7%	Eng	90.3%	Q3 24/25	NVC44	23.7%	
Q1 to Q3 25/26	Severall	100%	NVCOY	3.08%	Eng	91.3%	Q1 to Q3 25/26	NVC44	72.3%	

VTE Q1 to Q3 25/26



The Westbourne Centre considers this data to be accurate as described for the following reasons:

All clinical staff are aware of the requirement to complete VTE risk assessments, and clinical care pathways clearly direct staff to ensure this is undertaken. There is also effective communication with consultants to support compliance.

The data relates to patients admitted for care; however, the nature of the dental and oral surgery pathway, which accounts for approximately 60% of activity, does not require VTE risk assessment. Despite this, these patient episodes are included within the reporting dataset. As a result, the reported VTE assessment rates do not fully reflect true compliance levels.

Whilst the underlying process for data collection has remained unchanged, the method of recording has been revised which accounts for the improvement in the scores. Further work is ongoing to ensure that VTE assessment data is accurately captured and appropriately reflects clinical practice.

C difficile infection

The C difficile quality indicator is aligned to NHS Outcomes Framework Domain 5: *“Treating and caring for people in a safe environment and protecting them from avoidable harm.”*

The table below presents data made available to The Westbourne Centre by NHS Digital, showing the rate of C. difficile infections per 100,000 bed days reported during the reporting period. The table covers two reporting periods and includes benchmark comparisons, identifying the best and worst performers, alongside The Westbourne Centre’s own performance.

C. Diff rate:	Period	Best		Worst		Average		Period	Westbourne	
	2021/22	Severall	0	RPY	54.0	Eng	16.0	2023/24	NVC44	0.0000
2023/24	Severall	0	RPY	56.6	Eng	18.8	2024/25	NVC44	0.0000	
2024/25	RQ3	2	RPY	81.0	Eng	23.0	2025/26	NVC44	0.0000	

The Westbourne Centre considers this data to be accurate as described for the following reasons: there have been no reported cases of C. difficile infection during the reporting period. Robust infection prevention and control (IPC) practices are in place and are regularly monitored. In addition, patients are advised not to attend the hospital if they are unwell, including if they have symptoms such as diarrhoea and/or vomiting.

Patient Safety Incidents with Harm

The serious incident quality indicator is aligned to NHS Outcomes Framework Domain 5: *“Treating and caring for people in a safe environment and protecting them from avoidable harm.”*

All serious incidents (SIs) are reported in accordance with Ramsay Health Care and Integrated Care Board (ICB) reporting requirements. Each incident undergoes a full and transparent investigation, with patients informed in line with Duty of Candour regulations.

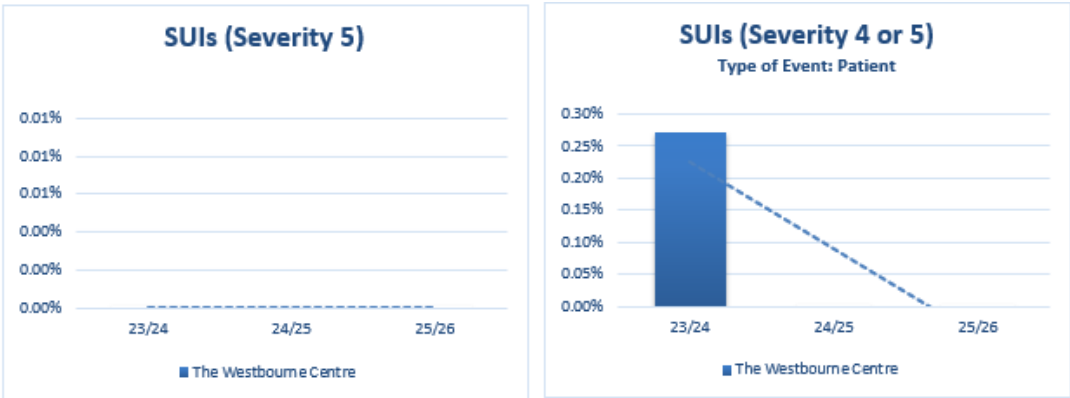
Learning from incidents is identified and translated into actions, which are shared across the wider team through Safety Flash alerts and “Outcomes with Learning” communications. Implementation and ongoing compliance are monitored through the Clinical Governance Committee to support continuous improvement and prevent recurrence.

The data made available to The Westbourne Centre is derived from the RADAR incident reporting system and relates to the number, and where available, the rate of patient safety incidents reported during the reporting period. It also includes the number and percentage of incidents resulting in severe harm or death. National comparison rates are based on data from the National Reporting and Learning System (NRLS).

The table below presents serious incident data (Severity 5) made available by NHS Digital.

SUIs:	Period	Best		Worst		Average		Period	Westbourne	
	2022/23	N/A	N/A	N/A	N/A	N/A	N/A	2023/24	NVC44	0.0000
2023/24	N/A	N/A	N/A	N/A	N/A	N/A	2024/25	NVC44	0.0000	
2024/25	N/A	N/A	N/A	N/A	N/A	N/A	2025/26	NVC44	0.0000	

Rate per 100 discharges:



The Westbourne Centre considers this data to be accurate as described for the following reasons:

The Westbourne Centre provides elective care only, supported by a robust pre-admission process to ensure that patients are clinically optimised prior to surgery.

There were no reported serious incidents during the reporting period.

Friends and Family Test

The data made available to The Westbourne Centre by NHS Digital, as a provider of adult NHS-funded care, is presented in the graph below and aligns to NHS Outcomes Framework Domain 4: “Ensuring that people have a positive experience of care.”

F&F Test:	Period	Best		Worst		Average		Period	Westbourne	
	Jan-24	Severall	100%	RTK	74.0%	Eng	94.0%	Jan-24	NVC44	100.0%
Jan-25	Severall	100%	RL4	71.0%	Eng	95.0%	Jan-25	NVC44	*	
Jan-26	Severall	100%	RTK	74.0%	Eng	95.0%	Jan-26	NVC44	*	

The table covers two reporting periods and includes benchmarking information, identifying the best and worst performers, alongside The Westbourne Centre’s own site performance for the percentage of patients who would recommend the service.

The Westbourne Centre considers this data to be accurate as described for the following reasons: patients are actively encouraged to complete the Friends and Family Test (FFT), and a patient-centred approach remains at the core of service delivery.

To improve response rates and further enhance service quality, The Westbourne Centre will continue to promote completion of the FFT and explore opportunities to make participation easier through digital methods. However, due to low response rates, the data set has not been considered sufficiently robust for formal reporting this year. Although the available data indicates a 100% recommendation rate, this has been interpreted with caution given the limited returns and a report was not submitted.

3.2 Patient safety

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

Risks to patient safety come to light through several 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 several 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 14 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.

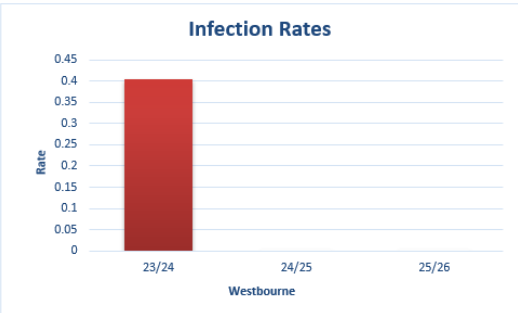
Ramsay participates in mandatory surveillance of surgical site infections for orthopaedic joint surgery, and these are also monitored.

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.

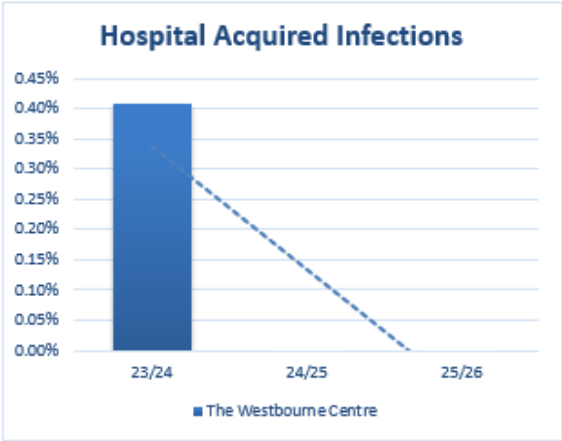
A network of specialist nurses and infection control link nurses operate across the Ramsay organisation to support good networking and clinical practice.

Programmes and activities within our hospital include:

- An IPC Clinical Quality Partner and link personnel from the Ramsay corporate team support the site’s IPC Lead Nurse in ensuring a robust IPC programme at the centre.
- Access is available to a Consultant Microbiologist within the West Midlands Cluster.
- E-learning and mandatory classroom training sessions in IPC and ANTT are provided for all clinical staff.
- The IPC Lead Nurse is actively involved in clinical areas, undertaking audits and providing advice to staff and consultants on infection prevention and control practices, including hand hygiene.
- The IPC Lead Nurse supports staff with infection reporting processes, providing guidance on reporting tools and relevant policies, alongside delivering training to both clinical and operational teams.
- The centre has also achieved ANTT Gold Accreditation, demonstrating robust infection prevention and control (IPC) arrangements and a strong commitment to maintaining high standards and preventing avoidable infections.



Rate per 100 discharges:



As demonstrated in the graphs above, the infection rate at The Westbourne Centre has remained consistently low and is significantly below the national average. This reflects our maintenance of high standards in infection prevention and control.

3.2.2 Cleanliness and hospital hygiene

Assessments of safe healthcare environments also include **Patient-Led Assessments of the Care Environment (PLACE)**

PLACE assessments occur annually at The Westbourne Centre, giving us a clear picture of how the people who use our hospital see it and how it can be improved.

Organisation Code	Organisation Name	Commissioning Region	Site Code	Site Name	Organisation Type	NHS or Independent	PLACE Site Type	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
NVC	RAMSAY HEALTHCARE UK OPERATIONS LIMITED	MIDLANDS COMMISSIONING REGION	NVC44	THE WESTBOURNE CENTRE	INDEPENDENT SECTOR	Independent Sector	Treatment Centre without in-patient facilities	99.50%	N/A	N/A	N/A	88.89%	100.00%	N/A	100.00%

The Westbourne Centre continues to demonstrate a strong commitment to maintaining a safe, clean, and well-maintained environment for patients, staff, and visitors, as evidenced by the most recent Patient-Led Assessments of the Care Environment (PLACE).

The Centre achieved excellent results in the most recent PLACE assessment, including 100% for condition, maintenance, dementia and disability, and 99.5% for cleanliness, demonstrating a consistently safe and well-maintained environment.

These results reflect the high standards maintained across the hospital environment and the commitment of both clinical and non-clinical teams in ensuring a safe and welcoming setting for patient care.

The score for Privacy, Dignity and Wellbeing was 88.9%, which, while positive, highlights an opportunity for further improvement. We have reviewed the detailed feedback from the assessment and are implementing targeted actions to strengthen privacy and dignity standards across all patient areas. This includes reinforcing best practice with staff, reviewing signage and environmental factors, and ensuring that patient experience remains at the centre of all interactions.

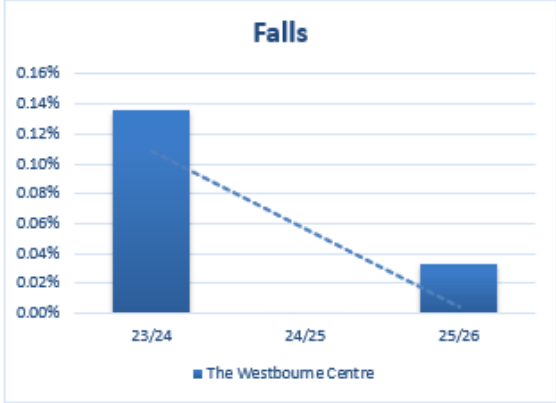
Food-related domains were not assessed as these are not applicable to the services provided at The Westbourne Centre.

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 Hospital Manager which ensures we keep up to date with all safety issues.

Rate per 100 discharges:

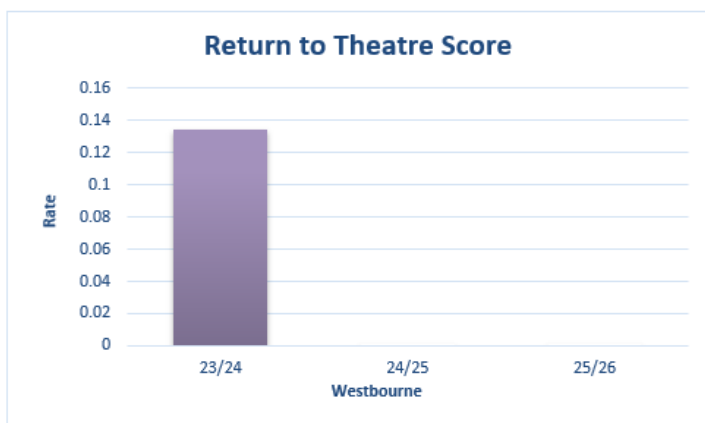


3.3 Clinical effectiveness

The Westbourne Centre has a Clinical Governance 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 and medical advisory committees to ensure results are visible and tied into actions required by the organisation as a whole.

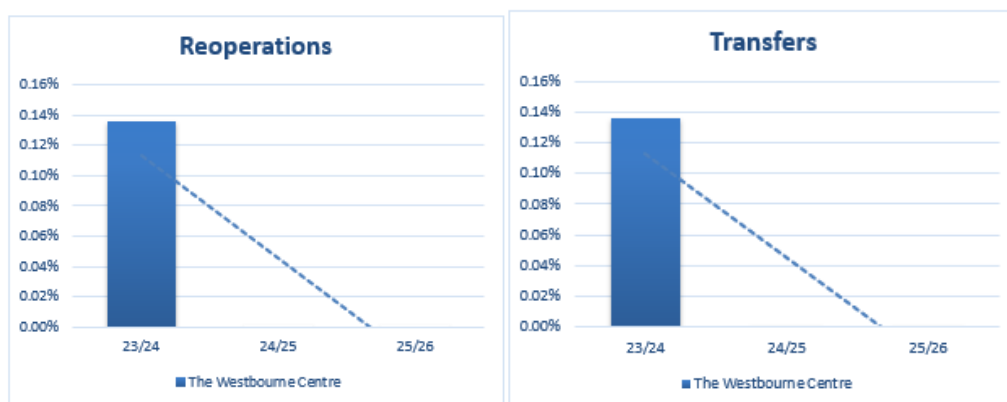
3.3.1 Return to theatre

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 demonstrated in the graph above, the return to theatre rate has remained stable over the past year and continues to be very low compared to the national average.

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%.

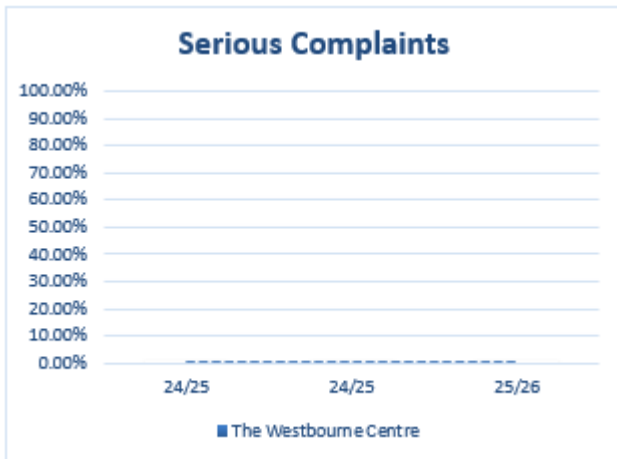
Since the programme was introduced serious incidents, transfers out and near misses related to patient safety have fallen; and lessons learnt are discussed more freely and shared across the organisation weekly. The programme is part of an ongoing transformational process to be embedded into our workplace 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.

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 complaint's procedures should our patients be unhappy with any aspect of their care.



Patient experiences are feedback 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

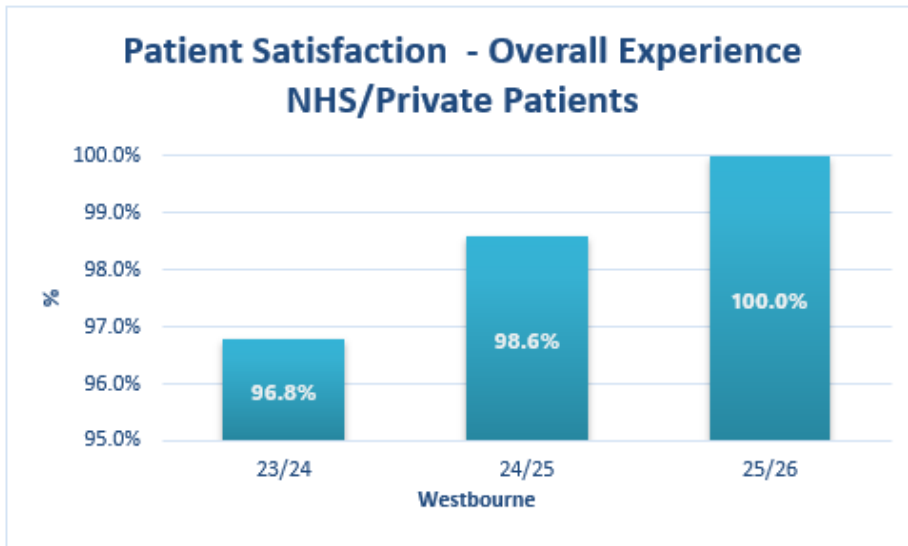
Patient focus groups

PROMs surveys

Care pathways – patient are encouraged to read and participate in their plan of care

3.4.1 Patient Satisfaction Surveys

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 demonstrated in the graph above, patient satisfaction has continued to improve year on year. This performance is significantly above national benchmarks and reflects consistently high levels of patient satisfaction.

The improvement is attributed to a continued focus on patient-centred care, proactive management of feedback, and strengthened governance processes around patient experience. This has been supported by the effective use of feedback platforms, regular review of themes and trends, and the sharing of learning across teams. The Centre will continue to build on this by maintaining high standards, further improving response rates, and enhancing the use of data analytics to drive continuous improvement.

Appendix 1

Services covered by this quality account

Regulated Activities – The westbourne Centre

Service Type – Regulated Activities	Acute Services (ACS)
Treatment of Disease, Disorder or Injury	<ul style="list-style-type: none"> • Ambulatory and day surgery
Surgical Procedures	<p>All surgical treatments under LA/Sedation:</p> <ul style="list-style-type: none"> • Dental implants • Minor oral/periodontal surgery • Cosmetic • Dermatological • General Surgery • Ophthalmic • Minor Orthopedics • Pain Management
Diagnostic	<ul style="list-style-type: none"> • Phlebotomy • Specimen collection – swabs • Histology

All services provided are designed to meet the needs of adults over the age of 18 and dental services for children over the age of 3 excluding:

- Patients with blood disorders (haemophilia, sickle cell, thalassaemia)
- Patients on renal dialysis
- Patients with history of malignant hyper pyrexia
- 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. one flight of stairs or angina at rest)
- CVA in last 6 months

Appendix 2 – Clinical Audit Programme 2025/26.

The Clinical Audit programme for Ramsay Health Care UK runs from July to the following June each year. “Tendable” is our electronic audit platform. Staff access the app through iOS devices. Tailoring of individual audits is an ongoing process and improved reporting of audit activity has been of immediate benefit.

The RHCUK clinical audit programme sets out a rolling schedule of assurance and improvement activity across RHCUK (July 2025 to June 2026). Audits span infection prevention and control (IPC) practice (e.g., hand hygiene, One Together elements, environmental infrastructure and linen management), medicines optimisation and pharmacy governance (e.g., medicines reconciliation, controlled drugs and prescribing processes), radiology governance and image quality (e.g., IR(ME)R, CT/MRI modality audits and reporting for BUPA), theatre safety and patient journey checks (including NatSSIPs elements and peri-operative observations), essential care standards (e.g., wound management, falls prevention, nutrition and hydration), and corporate/operational assurance (e.g., health & safety themes and occupational health record management and screening).

Each audit has a named owner to ensure accountability for data collection, analysis and reporting. Findings are reviewed through local governance structures (e.g., IPC, Pharmacy, Radiology, Theatres and SLT/Ops oversight as appropriate) to agree actions, assign leads and timescales, and assess risk. Where audits identify gaps in compliance or variation in practice, each site is responsible for implementing targeted quality improvement (QI) activity. Where organisational trends are identified, QI initiatives may be led by the corporate clinical team (for example: refresher training, process redesign, documentation changes, environmental or equipment controls, or focused observational re-checks). Progress and impact are monitored through repeat measurement at the next scheduled audit point (monthly/fortnightly cycles for high-frequency measures and seasonal blocks for specialty audits), with re-audit providing assurance that changes have been embedded and sustained.

Findings from the baseline audits will determine the hospital local audit programme to be developed for the remainder of the year.

RHCUK Clinical Audit Programme v18.1 Summary		
Month / frequency	Audit	Owner(s)
Monthly	Hand hygiene observation (5 moments) 50 Steps Cleaning (FR2)	Ward, Ambulatory Care, SACT, Theatres, IPC, RDUK Ward, Ambulatory Care, Outpatients
Fortnightly	50 Steps Cleaning (FR1)	SACT; Theatres
Annually	One Together Patient Washing; Hair Removal; Antiseptic Skin Preparation; Preventing Skin Recolonisation; Reducing Nasal Recolonisation; Prophylactic Antibiotics; Maintaining Asepsis (Surgical Practice; Instrument Management); Surgical Environment; Incision Management (Closure; Wound Care)	IPC
As required	IPC Aseptic Non-Touch Technique: Standard; Surgical	IPC

	<p>Blood Transfusion – Cold Chain; Autologous; Compliance Decontamination – Sterile Services; Endoscopy OH: Occupational Health Delivery On-site; Managing Health Risks On-site Privacy & Dignity Resuscitation & Emergency Response Patient Journey: Intraoperative Observation; Recovery Observation; Safe Transfer of the Patient Department Governance</p>	<p>Blood Transfusion Decontamination (Corp) Corporate OH; HoCS, RDUK Ward HoCS Theatres; Ward Ward, Ambulatory Care, Theatres, Physio, Outpatients</p>
July	<p>One Together Peri-Operative Warming: Pre-Operative; Intra-Operative; Post-Operative (Jul–Aug) One Together Surveillance of Surgical Site Infection (Jul–Aug) One Together Practice Review (Jul–Aug and Jan–Feb) IPC Governance and Assurance (Jul–Sep) Safe & Secure (Jul–Sep and Jan–Mar) 50 Steps Cleaning (FR5) – Receptions (Jul; Jan) Practising Privileges – Doctors in Training (Jul; Jan, where applicable) Medicines Reconciliation (Jul; Oct; Jan; Apr) MRI Reporting for BUPA (Jul; Nov; Mar) H&S Fire Safety (Jul; Jan)</p>	<p>IPC IPC One Together Practice Review IPC OPD, SACT, Radiology, Theatres, Ward, Ambulatory Care, Pharmacy SLT HoCS Pharmacy Radiology Ops Managers, RDUK</p>
August	<p>IR(ME)R (Aug–Sep) Complaints (Aug–Sep and Feb–Mar) CT (Aug–Sep and Mar–Apr) Sharps (Aug; Dec; Apr) CT Reporting for BUPA (Aug; Dec; Apr) IPC Management of Linen (Aug; Feb) Essential Care: Wound Management (Aug; Nov; Feb; May) Duty of Candour (Aug–Sep and Feb–Mar)</p>	<p>IR(ME)R Lead, RDUK SLT Radiology, RDUK IPC Radiology Ward HoCS SLT</p>
September	<p>Paediatric Outpatients H&S Slips Trips & Falls LSO and 5 Steps Safer Surgery (Sep–Nov and Feb–Apr) Essential Care: Nutrition & Hydration (Sep–Oct) Controlled Drugs (Sep; Dec; Mar; Jun) OH: Vaccination Records (Sep; Mar) SACT Services (Sep–Oct) X-Ray; Ultrasound (Sep–Oct and Mar–Apr)</p>	<p>Paediatric Ops Managers, RDUK Theatres, Outpatients, Radiology HoCS Pharmacy Corporate OH Pharmacy; SACT Radiology</p>
October	<p>H&S COSHH IPC Environmental infrastructure (Oct–Dec) Urinary Catheterisation Bundle (Oct–Dec) Antimicrobial Stewardship & Prescribing; Prescribing, Supply & Administration; Medical Records – Patient Consent (Oct–Dec and Apr–Jun) Pain Management (Oct; Apr) 50 Steps Cleaning (FR4) (Oct; Jan; Apr; Jul)</p>	<p>Ops Managers, RDUK SLT HoCS HoCS; Pharmacy Pharmacy Physio, POA; Pharmacy; Radiology, RDUK</p>
November	<p>H&S Electrical Safety</p>	<p>Ops Managers, RDUK</p>

	IRR (Nov–Dec) MRI; Interventional Fluoroscopy (Nov–Dec and May–Jun for MRI) OH: Immunity Screening (Nov; May) OH: Case Management Referrals (May; Nov)	RPS, RDUK Radiology, RDUK; Radiology Corporate OH Corporate OH
December	Safeguarding H&S Violence at Work	SLT Ops Managers, RDUK
January	One Together Warming Intravenous & Irrigation Fluids (Jan–Feb) MHRA (Jan–Feb) Medicines Governance (Jan–Mar)	IPC MR Lead, RDUK Pharmacy
February	IPC Management of Linen (Aug; Feb) Peripheral Venous Cannula Care Bundle (Jul–Sep)	Ward HoCS
March	H&S PUWER/LOLER OH: UKAP & Hep B Non-Responders	Ops Managers, RDUK Corporate OH
April	H&S Management	Ops Managers, RDUK
May	H&S Moving & Handling Medical Records – SACT Consent	Ops Managers, RDUK SACT
June	Cleaning Standards Efficacy H&S Work at Height	Head of Operations Ops Managers, RDUK

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
EVLТ	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
NVCXX	Code for XXXX Hospital 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

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.

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