The Westbourne Centre

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Westbourne Centre (the Centre) is operated by The Westbourne Centre, Birmingham Limited. It is a joint venture between Ramsay Healthcare UK (40%) and the Cosmetic Surgery Partnership (CSP- 60%). CSP consists of four consultants who also operate at the Centre. The service provides day case surgery, outpatients and dental diagnostic imaging, which we inspected.We inspected this service using our comprehensive inspection methodology.

We carried out the announced part of the inspection on 18th November 2016 along with an unannounced visit to the Centre on 24 November 2016.

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

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

The main service provided by this service was surgery. Where our findings on surgery for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We rated this service as good overall because:

- There were systems and processes in place to promote practices that protected patients from the risk of harm. Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an open culture where staff felt encouraged to report incidents and lessons learned shared across the Centre.
- The service had a consistent track record for safety.
- There were policies and procedures in place to assess and respond to patient risk and staff understood their responsibilities to do so.
- The environment was visibly clean and well maintained and there were measures to prevent the spread of infection. We observed all staff adhering to hand hygiene practices.
- There were adequate numbers of suitably qualified, skilled and experienced staff (including doctors and nurses) to meet patient's needs. There were arrangements to ensure staff had and maintained the skills required to do their jobs.
- Staff were proud of the service they provided including day-surgery care provision under local anaesthetic meaning patients did not stay overnight.
- There were arrangements to ensure people received adequate food and drink that met their needs and preferences.
- Care was delivered in line with national guidance and the outcomes for patients were good when benchmarked.
- Patients could access care when they needed it. Waiting times, delays and cancellations were minimal and appropriately managed.
- Staff treated patients with compassion and their privacy and dignity was maintained.Feedback from patients was consistently positive with few complaints made to the service.
- Improvements were made to the quality of the service as a result of complaints or concerns. Consent was gained and recorded in line with relevant national guidance.
- There was a stable leadership team who were highly regarded by staff. Staff felt supported, valued and proud to work at the Centre.
- The senior leadership were responsive to issues identified at the time of the inspection and took immediate remedial action where possible.

Summary of findings

We found areas of practice that require improvement in both surgery and in outpatients and dental diagnostic imaging services.

In surgery:

- Staff did not adhere to the safe storage and administration of medicines policies and the processes failed to store medications safely.
- Staff did not consistently check resuscitation equipment in line with local policies and procedures.
- Psychological and mental wellbeing was not consistently recorded in cosmetic patient care pathways as recommended by national guidance.
- Some mandatory training modules fell below the target including mental capacity training for all clinical staff.
- Completion of documentation including vital observations on the National Early Warning Score was inconsistent.
- The Centre-wide risk register did not identify all clinical risks. Some governance processes required strengthening such as serious incident investigation documentation and meeting records.

In outpatients and dental diagnostic imaging:

- There was no clear strategy for the outpatient department despite the high-level of activity within this department.
- There were no specific policies written for dentistry, although this represented 52% of the centre's service at the time.
- Adults safeguarding level 2 training for outpatients staff was low at 50%.
- Five mandatory training modules for dental staff were below the Centre's target of 85%.
- Management of medical emergencies was not robust for dental staff including some standard items of medication missing from the medical emergency kit in dentistry.
- There was no Radiographic Protection Folder, received from the Radiographic Protection Authority in place, with proper local rules clearly outlining dosages and identifying the clinicians operating them.
- Audit data was lacking within outpatients and dentistry.
- There was no information available in dentistry or outpatient's signposting patients to additional emotional support services if they needed them.

We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

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

Ellen Armistead
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the Centre. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed centrally across all departments with management and governance processes being the same across the Centre.We rated this service as good because it was effective, caring, responsive and well-led, although it requires improvement for safe. We have only rated caring in this section of the report.
Outpatients and diagnostic imaging	Good 	We rated this service as good because it was safe, responsive and well-led. We rated caring once (see surgery) for the Centre overall. We do not currently rate effective for this core service.

Summary of findings

Contents

Good

The Westbourne Centre

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to The Westbourne Centre

The Westbourne Centre (the Centre) is managed by The Westbourne Centre, Birmingham Limited. The Centre is a joint venture between Ramsay Healthcare UK (40%), a network of 36 hospitals nationally and internationally and the Cosmetic Surgery Partnership (CSP) made up of four consultants (60%).

The Centre opened in 2009 and is located in a period property on the Calthorpe estate in Edgbaston, Birmingham. The Centre primarily serves the communities within Birmingham but also accepts referrals outside of the area. The nearest NHS acute hospital is 2.1 miles away.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector, and two-specialist advisors with expertise in dentistry and providing care within the private sector. The team reported to an inspection manager, Donna Sammons.

How we carried out this inspection

During the inspection, we visited the outpatient consulting areas, theatre and the recovery suite, which had three bays. We observed the care and treatment provided within these areas. We spoke with 19 staff including; registered nurses, dental nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with nine patients. We also received 38 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed a sample of 11 patient records including those of NHS and privately funded patients.

Information about The Westbourne Centre

The Centre offers elective day case surgery, outpatient consultations and dental diagnostic imaging to adults over 18 years old. Care is available for both NHS and privately funded patients.

The Centre is a day unit facility only and therefore there are no inpatient or emergency services provided. Surgical procedures were performed under sedation and/or local anaesthetic only, no general anaesthesia is provided.

The service provides only outpatient consultations and non-intervention dental treatments for children over the age of three, for private patients only.

The service operates Monday- Friday 8am- 8pm. Theatre lists also run two to three Saturday's per month.

Facilities include one laminar flow operating theatre, one recovery suite (consisting of three bays), three consulting rooms, three dental suites, and a treatment room. We did not inspect the non-surgical cosmetic therapy room or the ophthalmic suite.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures (31 January 2011).
- Surgical procedures (31 January 2011).
- Treatment of disease, disorder, or injury (31 January 2011).

There were no special reviews or investigations of the Centre on-going by the CQC at any time during the 12

Summary of this inspection

months before this inspection. We inspected the service previously in September 2013 and found that the service was meeting all standards of quality and safety it was inspected against.

The Centre's registered manager has been in post since 2011. The Centre also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

A diagnostic imaging service operates at the Centre but is registered and regulated with us separately and therefore we did not inspect this service.

Activity (July 2015 to June 2016):

- There were 2,803 day-case episodes of care recorded at the Centre in the reporting period (July 2015 to June 2016); of these 51% were NHS funded and 49% were other funded.
- There were 6,159 outpatient total attendances in the reporting period (July 2015 to June 2016); of these 39% were NHS funded and 61% were other funded.
- There were 29 outpatient attendances and one-day case discharge of children aged 3-15 years within the reporting period.
- There were 23 outpatient attendances of young people aged 16-17 years within the reporting period.
- There were 936 visits to theatre, with the average of 234 visits per quarter during the reporting period of July 2015- June 2016.
- No patients stayed overnight at the Centre during the same reporting period.

Outpatient activity by speciality:

- Dental (54%)
- Plastics (including cosmetic surgery) (12%)
- Ophthalmology (15%)
- Orthopaedic (11%)
- General and vascular (3%)
- Dermatology (2%)
- Ear, nose and throat (2%)
- Psychology (2%)

Surgical activity

The Centre offers the following surgical specialities:

- Orthopaedic (carpel tunnel and trigger Finger)
- Podiatry (bunionectomy)
- General surgery (open hernia repair and excision of lesion)
- Ophthalmology (cataracts)
- Cosmetic surgery (liposuction, breast augmentation and face lifts)

The ten most common surgical procedures (July 2015 - June 2016):

- Tooth extraction - 674
- Restorative dental procedures - 574
- Cataract surgery - 399
- Excision of lesion - 138
- Root canal treatment - 133
- Dental implants -126
- Fat grafting - 53
- Carpel tunnel - 46
- Breast augmentation - 45
- Dental bone grafting - 43

Staffing:

There were 58 doctors and dentists who worked at the Westbourne Centre under practising privileges.The Westbourne Centre employed 5.8 whole time equivalent (WTE) registered nurses, 3.4 (WTE) health care assistants and operating department practitioners (ODPs) and 9.9 (WTE) other non-clinical staff, as well as having its own bank staff.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- No never events reported since the service began up until October 2016.
- No deaths reported from the opening in 2009 up until October 2016.
- Thirty-two clinical incidents; 30 no harm/harm with no loss of functioning (level four), one harm with temporary loss of functioning (level 3) and one harm with permanent loss of functioning reported in the period July 2015 - November 2016.
- One serious injury reported in the period July 2015- October 2016.
- No incidences of health care service acquired MRSA in the period July 2015 - October 2016.

Summary of this inspection

- No incidences of health care service acquired MSSA in the period July 2015 - October 2016.
- No incidences of health care service acquired Clostridium difficile (C.difficile) in the period July 2015- October 2016.
- No incidences of health care acquired Escherichia coli (E-Coli) in the period July 2015- June 2016.
- Two surgical site infections reported in the period July 2015 - November 2016.
- Nine formal complaints during the period of July 2015 - November 2016.

Services provided at the service under service level agreement:

- Clinical waste removal
- Dental imaging
- Pathology (accredited by UKAS)
- Radiography
- Sterilisation services (accredited by AMTAC)

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Documentation to evidence discussions and learning from incidents in meeting minutes needed strengthening.
- Documentation for serious incident investigations were fragmented and did not support managers to evidence their findings or meet the needs of the service. A more robust framework was needed to demonstrate a clear and robust audit trail.
- The service did not display clinical safety metrics.
- Medicines management in theatre and recovery was a concern. This included poor storage management and fridge temperature monitoring. All areas needed improved medicines management.
- Local processes for the duty of candour needed strengthening.
- Safeguarding adults training level two was below the Centre's target (85%) at 50% for outpatient staff.
- Mandatory training was overall above target however, for dental staff five modules were below the 85% target.
- Early warning score documentation needed improvement from our observations of records and audit results.
- Management of medical emergencies was not robust for dental staff including some standard items of medication missing from the medical emergency kit in dentistry.
- There was no Radiographic Protection Folder, received from the Radiographic Protection Authority in place, with local rules clearly outlining dosages and identifying the clinicians operating them.

However:

- Incidents were reported, investigated and feedback given. Staff demonstrated a positive and open culture to report incidents and felt able to raise concerns.
- The service had a consistent safety track record with no deaths or never events reported since the Centre opened.
- The environment equipment was visibly clean and well maintained. Infection control policies were followed including hand hygiene and theatre scrub techniques.
- Staffing levels were planned and implemented to keep patients safe. Medical cover was appropriate.

Summary of this inspection

- There was a service level agreement in place with a local NHS hospital to transfer any patient who became acutely unwell and a further service level agreement with another Ramsay Healthcare UK hospital if an overnight stay was required.
- Staff followed the World Health Organisation's (WHO) 'five steps to safer surgery' practice guidance and records showed the practice had improved over time.

Are services effective?

Good

We rated effective as good because:

- The Centre provided care and treatment in line with national guidance and standards including the National Institute for Health and Care Excellence (NICE) guidance.
- New policies, procedures and national guidance was shared across the Centre and staff knew how to access this information.
- The Centre submitted data to the NHS Digital Breast and Cosmetic Implant Registry. The Centre engaged with the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- At the time of our inspection, 100% of staff had an up to date appraisal there were effective systems in place to check the competence of medical practitioners with practising privileges.
- Staff demonstrated a good understanding of consent and mental capacity.
- The service was collecting and monitoring the effectiveness of care through national and local audits, taking appropriate actions to improve when necessary.
- There was effective multi-disciplinary working both internally and externally.
- Staff assessed pain provided and pain relief based upon individual patient needs.

However,

- The cosmetic surgery care pathway was missing psychological well-being assessment, which was not in line with national standards.
- Mandatory training rates for mental capacity and deprivation of liberty safeguards was below the target (85%) for theatre staff at 77%.
- There were few specific audits undertaken during 2015/16 for any of the outpatient clinics such as oral radiograph data or use of anti-biotics in dentistry.

Summary of this inspection

- Some tasks were given to staff to do without appropriate guidance, for example the charge of the medical emergency box in dentistry.
- Not all dental nurses who took radiographs had up to date radiography and radiation protection competencies.
- There were no specific policies written for dentistry, although this represented 52% of the centre's activity at the time.

Are services caring?

Good

We rated caring as good because:

- All patient feedback was positive and we observed staff providing caring and compassionate care.
- Staff protected patient privacy and dignity at all times.
- Patients confirmed they were involved in their care and were given the opportunity to ask questions.
- The Centre welcomed patient feedback to continually improve the patient experience.
- We saw that results of the friends and family test and other patient satisfaction surveys demonstrated that patients would recommend the Centre to others.
- The Centre ensured private patients were aware of the costs of their treatment in advance.

However:

- There was no information available in dentistry or outpatient's signposting patients to additional emotional support services if they needed them.
- The Friends and Family Test response rate was below the England national average.

Are services responsive?

Good

We rated responsive as good because:

- The service planned and delivered care to meet patient needs and met all targets for accessing timely care. People could access the right care at the right time.
- The service treated NHS and private patients equally with choice offered for their convenience.
- The service was exceeding the NHS referral to treatment 18 week targets.
- Treatment and care was planned and co-ordinated following full consultation and pre-admission assessment. Staff confirmed discharge arrangements prior to leaving the service including aftercare advice.

Summary of this inspection

- The service assessed patient's individual needs including those living with dementia and responded appropriately to meet those needs.
- The Centre took complaints and concerns seriously and responded in a timely way. There was a process for sharing learning from complaints.
- The Centre provided a translation service to patients whose first language was not English and all services were accessible for patients with mobility problems.
- The service protected patient confidentiality at all times.

However:

- Staff knowledge and awareness varied about the needs of people with learning disabilities.
- There was no specific written patient information about how to make a complaint. Staff could not give examples of resulting learning or changes from patient complaints.
- The dental service's 'did not attend rate' (DNA), for which there was no threshold set by NHS England, was high for April to October 2016 and there was no strategy in place to address this.

Are services well-led?

Good

We rated well-led as good because:

- There was a clear statement of vision and values, driven by quality, with defined objectives that staff understood.
- The senior management team were visible and provided stable, strong leadership to the Centre.
- Managers supported and encouraged a high-quality care culture and staff development to achieve this.
- The staff valued the positive team-working ethos and felt valued and listened to by managers. There were effective systems for engaging with staff.
- Staff were proud of the care they provided at the Centre and were enthusiastic to expand the service.
- Senior leaders were responsive to concerns raised at the time of inspection and took immediate remedial action where possible.

However:

- Although overall governance arrangements promoted patient and staff safety, some processes such as audit trails for internal discussions and decision making needed strengthening.
- There was no clear or specific strategy for the outpatient service.
- Senior management did not have robust governance and oversight of medicines management.

Summary of this inspection

- The risk register did not include all clinical risks of the Centre.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Surgery

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

Are surgery services safe?

Requires improvement

The main service provided by this service was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as requires improvement.

Incidents

- The Centre used an electronic reporting system to record clinical and non-clinical incidents. All staff we spoke with demonstrated knowledge and understanding of how to use the system to report incidents. They were aware of the range of incidents that would require reporting and gave examples of recently reported incidents.
- Staff told us about a recent incident where a patient had an allergic reaction to medication given in recovery. This patient had been asked several times pre-operatively about medication allergies but none were declared. All theatre staff were aware of this incident and said that as a result they were more vigilant when asking patients this question.
- All staff had access to the electronic incident reporting system. Staff described how the system gave them access to report an incident, easily find an incident already logged, view the stage of the process it had reached, see whom was reviewing the incident, flag time targets and attach supporting documents as required.
- All staff felt encouraged to report incidents and felt able to raise safety concerns. A member of staff told us that at their job interview there was a strong emphasis placed on patient safety, which attracted them to the post.
- Some staff had never personally reported an incident but could explain how to do so and gave examples of when one would be required. All staff received training on the risk management system during the mandatory training day.
- Between July 2015 - November 2016, staff reported 19 clinical incidents relating to theatre/surgery (out of 32, 59%). Of these, there were 17 (89%) level four (no harm/ harm with no loss of functioning), one (3%) level three (harm with temporary loss of function) and one (3%) level two (harm with permanent loss of functioning), which was reported and investigated as a serious incident. There were two 'other' clinical incidents related to administration errors and both were level 4 harms.
- The investigation for the serious incident of severe harm from a surgical site infection was delayed due to poor communication of the diagnosis from a local specialist hospital. During the investigation, appropriate actions were taken including theatre closure and microbiology testing to find a cause and to prevent reoccurrence. Discussions between staff and the relevant consultants were evident in the relevant surgical specialty meetings. Procedures and processes were reviewed following a suspected two further infections, in line with national guidance to ensure safety of the procedure in question at the Centre. No root cause was found but changes were made to practice to assure safety including adjusting the airflow in theatre to be in line with national guidance.

- Since the Centre opened in 2009, there had been no surgical never events reported. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- We tracked the reporting and review of the serious incident that occurred in May 2016 and another incident that occurred in November 2016 on the electronic system and through the supporting paper records. We saw the policy had been followed for these. The incidents were escalated to the Centre's clinical lead, investigations were undertaken and outcomes were discussed in the governance meeting. Actions were identified on the electronic report record with dates for completion. Lessons learned were fed back to local staff for discussion and learning at senior management team meetings and clinical heads of department meetings.
- The Centre had conducted two root cause analysis (RCA) investigations for the serious incident and for an identified breast augmentation trend of increased return to theatre for infection and or revision. We viewed both of these and although investigations were appropriate, we found that the RCA model and documentation was ineffective as an audit trail for robust investigation. The Centre used the Ramsay Healthcare UK investigation template but the local leaders supplemented this with their own narrative to support this due to gaps in the template.
- Records showed that incidents were a set agenda for clinical governance, senior team leader (STL) and heads of departments (HODs) and the Medical Advisory Committee (MAC). The level of detail contained in meeting minute records evidencing incident discussions was limited and therefore no audit trail to evidence such discussions. Data for incidents and complaints for the October 2016 STL meeting was missing despite it being an agenda item.
- The general manager produced a 'lessons learnt sheet' for incidents and there was evidence staff were encouraged to read these.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person in relation to the incident and an apology.
- Staff we spoke to were able to describe the basic principle of being open and honest when things go wrong, but not the level of harm for when this would trigger DoC. Mandatory training for staff included DoC awareness. Ramsay Healthcare UK had a 'Being Open' policy due for review in December 2016.
- The Centre's electronic incident reporting system did not provide a mandatory field for the duty of candour requirement and the general manager said it was not integrated into the system. At our unannounced visit, the general manager updated us that any moderate harm or above incident did flag on the system and Ramsay's clinical director monitored this. Although there were few incidents at the centre that triggered DoC, the process locally needed strengthening to demonstrate the Centre complied fully with every aspect of the regulation.
- We saw that as part of the investigation into the serious incident, DoC was applied and the patient was provided with an apology and explanation, verbally and in writing and was invited to a meeting following completion of the investigation.

Clinical Quality Dashboard or equivalent

- The Centre did not participate in the NHS safety thermometer because it did not provide overnight care.
- Contracts for care and treatment delivered at private services but funded by the NHS have a target of 95% completion of for venous thromboembolism (VTE) screening. For the period July 2015 to June 2016, The Westbourne Centre achieved 100% compliance against this target.
- The Centre's policy was to risk assess all surgical patients having a local anaesthetic and sedation for VTE's. There were no service acquired VTE's or pulmonary embolisms reported in the period July 2015 - October 2016.
- We observed six surgical patient records, which showed out of three eligible patients, one VTE assessment was incomplete. VTE assessment audit results for August and November 2016 showed a 100% compliance rate.

Good

Surgery

- No patient falls were reported in the period July 2015 - November 2016. Two non-clinical related falls were reported and incident forms submitted.
- The Centre displayed Patient Led Assessment of the Care Environment (PLACE) audit results in the main reception but there were no displayed clinical quality dashboards or metrics in any of the clinical areas.

Cleanliness, infection control and hygiene

- Information provided by the Centre stated that from July 2015 - November 2016, there had been no cases of methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile, Escherichia coli or methicillin-susceptible staphylococcus aureus (MSSA) infections.
- The February- June 2015 Patient Led Assessment of the Care Environment (PLACE) audit identified a score of 99% for cleanliness. This was above the NHS England average of 98%.
- We observed staff washing their hands and using sanitising hand gel. Staff adhered to the 'bare below the elbows' policy. Staff were seen to follow the Centre's infection prevention and control policy by washing their hands between seeing patients and wearing correct personal protective equipment (PPE), such as gloves, aprons and appropriate theatre wear within theatres. There were sufficient supplies of PPE for staff to use.
- Managers observed hand hygiene for each clinical staff member annually at least and performed monthly hand hygiene audits. Results for August and October 2016 showed 100% compliance. Staff did not know when they were being observed.
- Hand wash sinks and sanitising hand gel dispensers were available throughout the theatre department and in the recovery suite. Several patient feedback cards commented on the high standard of staff hand hygiene practices.
- Infection prevention and control was overseen by the theatre lead and the clinical lead. There were plans to create a designated post for a link nurse. The Centre recognised protected time was needed for this role. The Centre received support from the Ramsay Healthcare UK specialist infection control nurses.
- We saw appropriate cleaning schedules in place and had been appropriately completed and detailed what had been cleaned and by whom.
- Curtains in the recovery suite were disposable and had been changed recently. The date was visible and curtains were changed during the deep clean of the area.
- We saw a certificate for the most recent deep clean of the operating theatre dated August 2016.
- There was an SLA in place with an accredited sterile services provider to ensure that appropriate surgical equipment was available for procedures. The system promoted the correct flow of dirty to clean equipment and theatre instruments, which reduced the risk of contamination. Theatre staff told us the system worked well and there was a good working relationship with the provider.
- There were clear waste segregation practices in place and we observed these were adhered to in theatre. This included safe storage and disposal of sharps.
- Theatre staff adhered to strict theatre area restrictions including changing theatre shoes when moving away from the theatre area.
- We observed a scrub nurse's hand washing 'scrub' technique and the maintenance of the sterile field within theatre, which were both thorough and followed local and national policies. Surgical aseptic technique is a method employed to maintain asepsis and minimise the risk of introducing pathogens into a surgical wound.
- The operating theatre and the recovery suite were visibly clean. We observed staff cleaning the recovery suite following use at the end of the day, which was a thorough process, cleaning all equipment such as the trolley and the surrounding environment.
- Equipment in both the theatre and the recovery suite was visibly clean with labels showing they had been cleaned and were ready for use.
- Staff told us and records confirmed that patients who attended a pre-assessment appointment for surgery were risk assessed for potential infections such as Methicillin-resistant Staphylococcus Aureus (MRSA). All NHS patients and those who received implants during surgery were routinely screened for MRSA. Planned surgery patients with a positive MRSA screen were delayed until a determined infection free period.
- There were four identified surgical site infections reported within the period July 2016- November 2016, three were following breast augmentation procedures

and the one following eye surgery. Investigations were conducted for both the identified breast augmentation trend and the eye surgery infection with appropriate actions taken.
- The Centre was in the process of developing an SLA for consultant microbiologist input from a local hospital for a focus on reviewing surgical site infections.

Environment and equipment

- The recovery area included three bays, which were small but staff said there was sufficient room in the event of an emergency to access the patient.
- Patient-led assessments of the environment took place each year. In the period February- June 2016, the service scored 94% for the condition, appearance and maintenance of their premises compared to a national average of 93%.
- Theatre access was secure with designated single sex staff changing areas. The storage of surgical equipment and instruments was well organised with appropriate stock levels.
- Staff told us suitable and sufficient equipment was available to support the surgical procedures undertaken. The theatre manager told us there were plans in place to update some of the ageing equipment. Staff told us that senior management welcomed appropriate requests for new equipment, which were sourced quickly.
- There was a process for reporting faulty equipment and an audit trail for when the problem was reported and when the problem was resolved.
- Theatre equipment had in date maintenance checks. The theatre manager was in the process of updating the documentation of equipment maintenance checks.
- We saw that theatre staff carried out daily equipment and instrument checks within theatre. We observed that the scrub practitioner and another staff member checked theatre instrument trays as per the Association for Perioperative Practice (AfPP) guidelines for safe practice. We saw that swabs, blades and sutures were counted and recorded on the 'count board' as appropriate and safe practice. At the end of the procedures swabs, instruments and other equipment were confirmed to be correct.
- The theatre air filtration system for laminar flow was regularly checked to ensure compliance with UK Health Technical Memorandum (HTM 2025). We saw records that confirmed a check in February 2016.
- The adult emergency resuscitation trolley was located in the corridor near to the recovery suite. The process included daily checks of the top shelf and weekly checks of the entire trolley. There were two days in November 2016 with missing signatures for the daily check. A manager confirmed the checks had been missed. The process also included sealing the trolley once it had been checked but this was missing. The medicines stored on the trolley had broken seals on and therefore were not tamper proof. The pharmacy audit in September 2016 identified the lack of tamper proof tagging; this meant the process was not yet embedded and required improvement.
- There was a theatre equipment log that detailed all of the equipment and when it was due for service and maintenance. The local manager was in the process of ensuring this log was up-to-date at the time of our inspection.
- The Centre had a system for recording all surgical implants and had a theatre register.
- The Centre had a process in place for hiring equipment such as hoists as required.
- Environmental and equipment audits were undertaken quarterly. The audit results showed in August 2016 compliance of 99% and November 2016 98% against a target of above 90%. Issues identified were rusting on a trolley and signage for colour coding of waste bags. Actions were identified and a re-audit was due in January 2017.

Medicines

- There were two reported medicine errors during the period July 2015 - November 2016. This included wrong take home eye drops given and a local anaesthetic prepared without adrenaline. Actions were taken to prevent reoccurrence.
- Controlled drugs (CD's) require special storage arrangements because of their potential for misuse. There were suitable arrangements in place within theatre to store and administer CDs. Stock levels were appropriate and staff checked these several times daily. The most recent pharmacy results from September 2016 showed 96% compliance in relation to CD's. There was an action plan to improve to reach the 100% target.
- The storage and management of other medications was a concern. The main theatre medicines storage cupboard was unlocked when a staff member took us to it. They told us it was usually locked. The cupboard was

locked immediately after. At our unannounced inspection, we found the same medicine cupboard was again unlocked. The general manager told us she had performed spot checks since our announced visit and they were locked. A nurse each day was designated to hold the medicine cupboard keys.

- In the most recent Ramsay Healthcare UK pharmacy audit for medicines management in September 2016, the compliance score was 93% and areas identified for improvement included a signature list with relevant standard operating procedures (SOPs) and evidencing monthly date checks.
- The fridge within theatre that contained medicines was unlocked. A local manager confirmed the fridge was always left unlocked, as the lock was broken. We raised this as a concern on the day of our announced inspection and senior managers told us they would get the lock fixed immediately. At the unannounced visit, the lock had been repaired and the fridge was locked.
- We found that although staff monitored and recorded daily fridge temperatures and room temperatures within the theatre department, there was no record of what the minimum and temperature should have been. There were standard operating procedures (SOPs) for the monitoring of fridge and room temperatures and these outlined the safe parameters. We saw evidence of staff signatures to say they had read these. The SOPs were due for review the month prior to our inspection.
- The intravenous fluid warming cabinet that was located immediately outside the theatre was not temperature monitored. This specialised equipment was required to be temperature controlled to ensure safe storage of the fluids it contained. We asked the manager about this who said they were unsure of what the maximum temperature should be and confirmed they did not monitor the temperature daily. We were told a checklist was due to commence in December 2016. This was a recognised issue but immediate steps were not taken to correct it.
- There was a service level agreement (SLA) in place for the supply of all medicines including those to take out (given to patients on discharge) from a pharmaceutical company. The Ramsay Healthcare pharmacist visited the Centre bi-annually to support the SLA service. The last audit was September 2016. There was an action plan to improve with responsible persons assigned to actions.
- Staff checked for patient medication allergies at the pre-op assessment and on admission for surgery. We saw evidence of this on medicine records and we heard a consultant and a nurse ask a patient in the recovery suite pre-operatively.
- The pharmacy audit in September 2016 included a prescribing component for the first time and identified a compliance score of 82% against a target of 100% with the documentation of allergies requiring improvement.
- There was Control of Substances Hazardous to Health (COSHH) within a cupboard but this was unlocked when we looked. Not all medication inside was COSHH but the cupboard was organised and stored appropriately.

Records

- The Centre used a paper-based system and utilised Ramsay Healthcare care pathway documentation.
- We saw that patients' medical and nursing notes were accessible as required and securely stored in all areas.
- We saw that staff recorded the patient's pre admission assessment, results of tests and investigations and their operative procedure and recovery care.
- We viewed six patient records that were at least six weeks post-surgery. We saw evidence of post-operative follow-ups with a consultant in all notes. In two of the six records we viewed, the consultant documentation was illegible. Medical record audit results for October 2016 showed 100% compliance rate in line with national record keeping guidance standards.
- All records were securely stored at the Centre until the patient had been discharged. Once the patient was discharged, the records were stored off-site securely and could be re-accessed within 24 hours if the patient re-attended the Centre.
- NHS record audit results for October 2016 identified 100% compliance with standards. All Ramsay Healthcare audit compliance targets were set at above 90%.
- There was evidence of learning from previous record audits including increasing staff awareness of ensuring all entries were signed and dated and documenting post discharge phone calls. A staff member told us that bank staff in particular needed more training around documentation. We saw evidence of this communication in team meeting minutes and additional training provision.

- We saw evidence of the use and completion of the World Health Organisation (WHO) safety checklist specific to cataract surgery in patient records.
- In one patient record, we saw the patient had declined the offer of a chaperone and the appropriate signed disclaimer was enclosed.
- We saw appropriately completed patient risk assessments for VTE's, manual handling and falls.

Safeguarding

- All staff at the Centre (all staff groups) received level one children's and adult safeguarding training. The compliance rate was 100% for all staff groups for both of these (target of 85%).
- All clinical staff received level two children's safeguarding training and the compliance rate at the time of the inspection was 100%. For adult safeguarding level two, 100% of permanent theatre staff and dental staff had this level. Compliance was below the 85% target at 50% for outpatient staff (two out of four) holding level two.
- Three senior managers held level three safeguarding children training with a compliance rate of 100% at the time of our inspection. The safeguarding lead was the deputy general manager/clinical lead and staff were able to identify this person.
- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children. Staff were aware of these and told us they accessed them electronically as required.
- No safeguarding concerns were reported in the reporting period July 2015 - June 2016.

Mandatory training

- The Ramsay Healthcare UK group set the target compliance for all mandatory training at 85%.
- Training records showed that 92% (11 out of 14) of theatre staff had completed the 14 mandatory e-learning modules. Modules included infection control, data protection, information security, health and safety, emergency management fire and safety, equality and diversity, informed consent, clinical basic life support, safeguarding children levels one and two, manual handling, workplace diversity and sharps and blood borne virus training.
- Theatre staff received immediate life support training and 92% (11 out of 14) were up-to-date. Eighty-five percent (12 out of 14) of theatre staff were up to date with the face-face fire training, 85% were compliant with the face-face risk management module and 85% had received prevent training (counter terrorism strategy).
- For dental staff (five), 100% were up to date with the mandatory training e-learning but for five of the additional 12 face-face mandatory training modules, compliance was below the target at 80% (basic life support, Prevent, mental capacity and deprivation of liberty safeguards. The average compliance for all modules was 91% for dental staff.
- All outpatient staff (seven) achieved the compliance target with 100% up to date with 12 of the face-face modules required and 86% had completed the 15 required mandatory e-learning modules.
- For non-clinical staff (13), all required mandatory training was above the target compliance with a range of 92% (Basic life support, prevent and risk management) to 100%.
- Acute illness management was another mandatory training module required for all clinical staff. Not all clinical staff met the target of 85% with theatre staff compliance of 9% and outpatient staff 80%. The training was booked for January 2017.
- VTE assessment training was mandatory for all theatre and outpatient staff. Records showed 0% of theatre staff had received this and 67% of outpatient staff. The general manager told us this was because the module was previously done on the mandatory training day but has now moved over to an e-learning module. We were told compliance was in fact 100%.
- Two members of the theatre team had completed drug calculation training.

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

- The Centre placed importance on ensuring patients understood and accepted the concept of day surgery including the environment and facilities provided. This was supported by an acceptance criteria and threshold, as set out in the Centre's statement of purpose. This outlined the exclusion criteria to ensure safe care and treatment for day surgery. The pre-operative assessment determined whether a patient was fit for day surgery.
- When patients booked for a procedure at the Centre, they completed a health questionnaire, which was based upon the National Institute for Health and Care

Excellence (NICE) guidance prior to the pre-assessment appointment. The pre-assessment process was nurse-led and until recently, there was only one nurse to complete all pre-assessments. The service had allocated a second nurse to the pre-assessment role in October 2016.

- The type of pre-operative assessment (questionnaire only, telephone or face-to-face) was determined by clinical risk, according to the answers on the medical questionnaire and was done within two weeks of admission for surgery.
- A nurse told us that due to workforce capacity in pre-assessment clinic, more telephone assessments were undertaken but felt all should be face-face to ensure robustness. There was no formal data collection for the mode of the pre-assessment appointment.
- Pre-assessment and discharge audits were completed twice a year with the most recent completed in July 2016. Results showed 100% compliance of correct clinical assessment. Of the six patient records we viewed, three pre-assessment records were incomplete. The next audit was due in January 2017.
- The Ramsay Healthcare cosmetic surgery care pathway did not include appropriate psychological pre-assessment as recommended by The Royal College of Surgeons. We saw evidence in patient notes and staff confirmed this was discussed during consultations; however, the service could not provide assurances that this was always considered and discussed with every cosmetic surgery patient.
- The service based the acceptance and admission criteria based on The American Society of Anaesthesiologists (ASA) physical status classification system, a scale describing fitness to undergo an anaesthetic. The Centre did not accept any patients over ASA 2, this means that all patients accepted were healthy adults (ASA 1) or patients with mild and controlled medical conditions.
- On the day of our inspection, a patient had their surgery cancelled due to high blood pressure at the pre-assessment and was referred to their general practitioner (GP). This ensured patient suitability and safety for day surgery.
- We observed that the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist completed in practice on the day of our inspection. This process, recommended by the National Patient Safety Agency (NPSA) should be used for every patient undergoing a surgical procedure; the process involves specific safety checks before, during and after surgery.
- The theatre manager undertook observations of the WHO safety checklist process and a retrospective medical note review of 10 records as part of the regular quarterly audit programme. In May 2016, the audit identified poor practice in both the observation (at sign in and surgical pause) and of completion of the checklist in nine out of 10 patient records, the overall compliance was 92% against the target of 90%. The action put in place was training for new staff. The Audit was repeated in November 2016 and compliance was 100%.
- Guidelines for the Provision of Anaesthetic Services (GPAS) guidelines state that at all times at least one advanced life support level trained person should be available in the immediate recovery period. An identified risk was that recovery nurses were only immediate level trained. Anaesthetists could only gain practising privileges at the Centre if they were advanced life support trained and they were required to be available until all patients discharged. There was an appropriate risk assessment completed for this identified risk.
- The Centre used the national early warning score (NEWS) to record patient observations. The tool alerted clinical staff to any vital signs that fell outside normal parameters and therefore to the deteriorating patient. A service level agreement was in place with a local NHS hospital in the case that a patient required emergency transfer and care.
- Out of four NEWS charts we viewed, two did not calculate the score. Audit results of EWS charts found this to be a persistent issue. Although the most recent audit in September 2016 was above the target of 90% at 91%, the score was affected by missing observations and missing total scores. As a result, management put actions in place to improve including identifying non-compliant staff, increasing training and re-auditing in January 2017.
- We saw evidence in the October 2016 governance meeting that the outpatient lead had raised this as a concern and suggested that consultants write to GPs of all cosmetic surgery patients to enquire about mental health history to determine suitability. The committee

decided to keep the item on the agenda for review. Following our inspection feedback, the general manager said they would seek to resolve this issue with the care pathway documentation.

- A day case theatre protocol outlined a clear process for all staff to follow. All theatre admissions were discharged the same day of surgery and any patients requiring sedation were scheduled for the morning list, allowing sufficient time for recovery. Each patient was allocated at least an hour in the recovery suite prior to being discharged.
- The day case theatre protocol outlined guidelines for maximum safe dosages for infiltration for cosmetic surgery.
- Once patients were assessed fit for discharge by the anaesthetist, the discharge process was nurse-led. The discharge nurse provided patients with the relevant procedure information, both verbal and written aftercare advice and medication management advice. We observed staff providing discharge information and advice, including specific wound care advice and the out of hours contact number. Staff contacted patients within 24 - 48 hours after discharge, to check their progress and we saw evidence of this in patient records.
- The on call nurse assessed the patient over the telephone or if they felt necessary could see the patient at the Centre. The on call nurse was responsible for documenting any advice or care given out-of-hours in the patients records as soon as possible after the event.
- If a patient required an out-of-hour's return to theatre, the nurse on call contacted the senior management team to initiate the out of hour's theatre team. The service did not formally record the number of times the theatre team had been called in to theatre out-of-hours. The clinical lead told us this was because the occurrence was very rare and estimated it happened twice yearly.
- There was a 'safety list responder' process in place at the Centre, which meant a senior nurse would be on duty daily to respond if an emergency occurred. All staff were aware of the emergency number '2222' to put out an emergency call and all the Centre's phones had an alert system if this call was made.
- The Centre had an SLA with the local acute NHS trust if patients needed an emergency transfer. If patients were unfit for discharge following day surgery, there was an agreement in place with the sister Ramsay Healthcare hospital for an inpatient overnight stay.
- The service did not hold blood products on-site but staff were able to describe the emergency process in the event that a patient had a major bleed. Staff told us about a severe haemorrhage flowchart and the availability of a vascular tray in this event.

Nursing and support staffing

- Theatre staffing included three WTE members. There were two theatre vacancies, one for a WTE registered nurse and one WTE ODP.
- The Centre followed the RCN guidance on safe nurse staffing levels in the UK and planned staffing requirements around patient needs. During our inspection, we saw that the staffing levels were sufficient to meet patient's needs, both in theatre and in the recovery suite.
- The bank usage rate ranged between 33% and 85% during the reporting period July 2015 and June 2016. This rate was higher than the average when compared to other independent acute services that we hold this type of data. Although the percentage was high, it was based on three bank staff that had worked at the Centre for a number of years but chose not to have a permanent contract. These reasons included alternative contracts held at NHS hospitals and casual working due to retirement. Staff told us that they felt staffing was sufficient and the skill mix was correct. Staff said that the staffing levels meant they had time for their patients and were able to give high quality care they wanted to give and that the patient required.
- Staff told us that theatre staffing had been stable despite vacancies. Recruitment to permanent theatre posts was a continued issue but recent successful recruitment had helped and regular bank staff ensured safe staffing levels. There was an active recruitment advertisement for theatre vacancies.
- We found that theatre was staffed in line with Association for Perioperative Practice (AfPP) recommendations. Surgical first assistant's (SFA) were not regularly required due to the minor procedures undertaken. Occasionally an SFA was required and these were booked from an agency. The theatre manager was in the process of completing this competency course.

Good

Surgery

Medical staffing

- There were 58 doctors and dentists with practising privileges to work at the Centre. Practising privileges is an established process for medical practitioners permission to work in a private facility.
- Medical staffing was scheduled based on speciality surgery allocation. Based on practising privileges this meant for each surgery there was a consultant surgeon and a consultant anaesthetist.
- All consultant surgeon's and anaesthetist's were on call for 24 hours following the end of their surgery list. This was part of the practising privileges contract. This facilitated continuity of care if a patient returned to theatre.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. They also arranged cover from another consultant with practising privileges at the hospital, in the event that they were not available. We saw in meeting minutes reminders for consultants to provide cover to ensure smooth running of surgery lists and avoidance of cancellations.

Emergency awareness and training

- Ramsay Healthcare UK had a business continuity management policy. Staff were aware of this policy, emergency scenarios and told us that they attended regular drills for situations such as in the event of a fire.
- Staff told us the Centre recently had a simulation for both fire evacuation and for a collapsed patient. A fire simulation was planned in November 2016.
- Staff could describe the process they would follow if emergency action was needed including who to contact and this process was displayed in clinical areas.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Most care and treatment was provided in line with national guidance such as National Institute for Health and Care Excellence (NICE) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

  However, we found that care pathway documentation for cosmetic surgery was not in line with the Royal College of Surgeons (RCS) 'professional standards for cosmetic surgery' (2016), specifically relating to pre-assessment of psychological and mental well-being. We saw evidence in patient records that consultants were assessing suitability for cosmetic surgery but the pathway lacked this prompt.
- Cosmetic surgery patients received a detailed discussion about financial implications, reasons for surgery, a two-week cooling off period, opportunity to ask questions and a two-stage consent process. This was in line with national guidance. The Centre was submitting data to the NHS Digital Breast and Cosmetic Implant Registry.
- Local audit reference standards were based upon national guidance such NICE and the British Association of Day Surgery. The target compliance for all local audits was above 90%. If any audits were 90% or less, actions were in place and repeated more frequently than planned.
- We saw evidence in MAC meeting minutes that new NICE guidance was shared and further discussion held in the clinical effectiveness committee. An example of NICE guidance shared was 'Controlled drugs: safe use and management' (NG46 published April 2016).
- Local and national policies were shared with staff via email and in team meetings. We saw updates displayed in the theatre/recovery staff room. Staff told us the clinical lead/matron would disseminate information about recent local policy updates. Staff were required to sign to say they had read updates and told us they accessed them on the intranet.

Pain relief

- Staff assessed pain based on a nought-10 scale and documented this on the EWS chart. We heard a recovery nurse perform a pain assessment whilst a patient was in recovery post-operatively. Staff responded to pain requirements promptly.
- Patients told us their pain was well managed and were informed pre-operatively of the options available.
- Pain relief information was displayed in the recovery bay, which included common side effects.

- Anaesthetists and surgeons were available during the day to review pain relief options and prescribe as required. Patients could call the provided contact number to speak with a nurse if required once discharged.

Nutrition and hydration

- The service was a day surgery facility only and therefore only offered patient's food and drink post-operatively. A patient told us there was a good choice of food offered.
- Staff discussed pre-surgery fasting with patients at the pre-op assessment and documented in patient records.

Patient outcomes

- Patient reported outcome measures (PROMs) assess the quality of care delivered to NHS patients from their own perspective. PROMs calculate the health gains after surgical treatment using pre and post - operative surveys to measure health status or quality of life at a single point in time.
- During the period July 2015 - June 2016, there were eight groin hernia repairs and 22 varicose vein procedures. The Centre participated in PROMs audits for groin hernia and varicose vein procedures however, due to the small number of procedures performed; the Centre could not be benchmarked against other services.
- The Centre was not participating in Q-PROMs for cosmetic surgery as recommended by the Royal College of Surgeons but we saw evidence that discussions with consultants about doing so in the future had taken place. Q-PROMs are distinct from more general measures of satisfaction and experience, being procedure-specific, validated, and constructed to reduce bias effects.
- The Ramsay healthcare group had decided to participate in an international pilot study to collect and submit data to ICHOM for cataract PROMs from January 2017.
- The Centre participated in a Commissioning for Quality and Innovation (CQUIN) for NHS patient dementia assessments (2015-2016). CQUINs are a payment framework that encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The service exceeded the target and achieved 100%.
- The Ramsay Healthcare group monitored patient outcomes corporately and benchmarked all hospitals and services and outliers identified. We saw funnel reports for June 2016 for re-operation and surgical infection rates, which showed the Centre was not an outlier for either of these outcomes.
- The Centre had begun engagement with the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA). This involves data collection and submission to PHIN to provide information about the quality and safety of care in the private healthcare sector. We saw evidence of the data submission for quarter two 2016. PHINs proposed publication of the data is April 2017.
- There were seven unplanned returns to theatre in the reporting period July 2015 - November 2016. Reasons included three haematomas and four re-suturing of wounds. Five of these were after 28 days post discharge.
- There were no unplanned transfers of patients to another service or hospital during the same reporting period.
- The Centre investigated an identified trend in bilateral breast augmentation (BBA) procedures requiring returns to theatre due to poor wound integrity over a period October 2014 to September 2015. The trend identified that nine out of 18 BBA's (50%) returned to theatre, of which nine wound breakdowns involving six patients (one patient returned three times and one patient twice). The investigation looked at consultant practice, patient histories and monthly audits followed with appropriate action plans. Although no overall cause was identified, a theme of patient non-compliance with post-operative advice was attributed. The Centre continued to monitor BBA trends and the consultant with regular six monthly audits. As of November 2016, the service had not identified any further return to theatre trends.

Competent staff

- Practising privileges was the process the Centre used to grant rights and permission to medical staff to enable them to practice at the Centre. This is a well-established process used within the private sector.
- As part of the practising privileges process, medical practitioners were expected to have up to date

mandatory training and appraisal through their employment at their NHS place of work. Medical practitioners had an obligation to declare their scope of practice in both NHS and the private sectors.

- The Centre used an electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process. During the reporting period of June 2015 and July 2016, 100% had revalidated and had an up to date appraisal. Practising privileges were reviewed every two years and were reviewed and discussed at the Medical Advisory Committee (MAC). As part of the practising privileges process, complaints and incidents for each consultant were reviewed.
- The general manager liaised with the local NHS trusts' if any concerns found with any of the medical practitioners working under practising privileges.
- At the time of our inspection, 100% of staff working at the Centre had a completed appraisal in the current appraisal year (December - January). The target rate was set at 90%. Staff told us they felt this was a beneficial process and there were developmental and progression opportunities available to them.
- Nursing staff told us they felt supported well through the revalidation process and that checks were conducted to make sure all nurses were registered with the Nursing and Midwifery Council (NMC).
- Induction training was mandatory for all new starters, providing them with an overview of the Centre and supernumerary time to familiarise themselves with their area of work. We spoke with a new member of staff who said the induction period was beneficial, and they felt welcomed, and supported. We saw that the new starter induction pack was comprehensive and evidence it was reviewed regularly with departmental managers.
- We spoke with both bank and new starter staff who confirmed they had received a role specific induction and competencies. New starters including consultants were allocated a 'buddy' to help orientate them to the Centre.
- We saw records to show staff completed competencies for specialised equipment.

Multidisciplinary working

- We saw evidence of communication with general practitioners (GPs) via letters in patient records both pre and post - operatively. A patient on the day of our inspection had their surgery postponed because of high blood pressure and was referred back to the GP for review.
- For all NHS patients, the service routinely wrote to GP's post-operatively to communicate treatment given and a copy given to the patient. The discharging nurse would give private patients the letter to give to the GP themselves.
- Due to the small scale of the building, internal MDT working was easy and encouraged face-face communication. We saw evidence of this with staff from different departments moving around the facility to communicate. The general manager recognised that although this was positive, meeting minutes required improvement to provide an adequate audit trail of internal communication. We found this to be the case when reviewing meeting minutes; more detail was required to evidence the discussion and actions taken.
- The general manager attended regular meetings with other Ramsay services managers to share information.
- A consultant described how effective communication between all members of the theatre team ensured patient safety and effective care delivery.

Access to information

- There was a patient record system in place for storage and handling. Patient notes were kept on the premises until the patient had been seen for their six-week follow up post-operatively. The notes were stored securely off-site when the patient care episode was completed. If notes were required after this time, notes could be requested and delivered on-site within 24 hours.
- Policies we looked at were accessible on the intranet and referenced good practice guidelines and professional body guidance.
- Patient records were kept secure in theatre and recovery at all times. Staff told us that notes were available when they were needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental capacity and deprivation of liberty safeguards training was mandatory. Overall compliance for this training was 86% for all staff at the Centre. Training records showed that 77% of theatre staff had received face-face training. This was below the target of 85%; an update day was booked for November 2016.

Good

Surgery

- We saw evidence in patient records and patients told us that for cosmetic surgery, there was a two-week 'cooling off' period and a two-stage consent process, in line with national guidance (Royal College of Surgeons professional standards for cosmetic surgery, 2016).
- Written consent for surgical procedures was gained in line with the Ramsay consent policy. We saw on the day of our inspection that the consultant discussed the potential risks to the surgery and gave an opportunity for the patient to ask any further questions prior to getting written consent. A patient told us they felt they were given sufficient time to consider before the day of surgery.
- Staff had an understanding of informed consent and could describe what they would do if they were concerned regarding a patient's mental capacity to give consent. One nurse carried a mental capacity card, which identified the main principles.
- There were no 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms in use at the time of our inspection. This was in line with Ramsay policy that all patients were to be resuscitated in an emergency.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Patients told us they were 'delighted' with the care they were provided with one patient saying the care they received was 'first class' and another 'exceptionally good'. Other comments included that the staff were' friendly, caring and highly professional'.
- One patient said they were treated as a human as opposed to a patient. Another comment was "The Centre operates at an excellent standard of care and hygiene. I highly recommend it".
- The Centre participated in the Friends and Family Test (FFT) for the NHS patients they treated. Data for January 2016 to April 2016 and June 2016 showed that between 94% and 100% of the responses stated they would recommend the service to their friends and family should they need similar care and treatment. There was no data available for the month of May. The England national average was 93%.
- The response rates for the FFT varied from 2% (January 2016) and 17% (March 2016), which were lower than the national England average of 40%. The centre had implemented a new process from 1 October 2016 to improve response rates. Staff told us they gave patients feedback cards prior to discharge or when most appropriate.
- Data from the Centre's own patient satisfaction survey for August to December 2016 showed 100% of respondents would recommend the service to friends and family. The average response rate was low at 31% with 15% in November but this improved in December with 63%. The target response rate was at least 50%. We saw evidence that staff were trying new strategies to improve response rates.
- We received 38 patient comment cards prior to our inspection. All feedback was positive and complimentary about the service. Patients praised theatre staff for making them feel at ease both in theatre and in the recovery suite.
- Staff maintained patient's dignity and privacy at all times and there was a system in place that all staff knocked before entering the recovery suite. We saw that staff adhered to this practice.
- We observed nurses speaking kindly to the patients and responded compassionately to their needs.

Understanding and involvement of patients and those close to them

- Patients told us they felt they were fully informed to make decisions about their treatment and received full explanations about procedures. NHS and private patients followed the same admission process and received the same information pre and post-operatively.
- We observed an anaesthetist during surgery provide reassurance to a patient throughout the procedure and kept them informed of what was happening.
- Staff listened attentively to patients, responded appropriately to their needs and explained actions including taking of blood pressure readings.
- Patients felt staff gave them plenty of time to have their questions answered.
- Cosmetic surgery patients were informed of all fees upfront and were given sufficient time prior to surgery to pay. A patient we spoke with confirmed this.

Good

Surgery

Emotional support

- Cosmetic surgery patients told us that staff considered and discussed their emotional well-being prior to surgery. A nurse and a consultant told us this was routine practice.
- It was routine practice that all surgical patients had an adult chaperone (chosen by them) to collect them from the Centre and to stay with them 24 hours post-operatively. Patients that lived further than one hour away from the Centre were required to stay locally for 24 hours post-operatively with their chosen chaperone.
- All patients were given an out-of-hours contact for the nurse on call for if they have any concerns post-operatively.
- Staff told us that they could refer patients to a psychologist at the Centre if they felt this additional support was required.
- Patients we spoke with and feedback received prior to the inspection said that the one thing they would change was to have a relative or partner to be able to go down to the recovery suite pre and post- operatively for emotional support.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- NHS patients made up 51% of the day case activity, a steady increase since the Centre gained an NHS contract in 2012. The general manager met with the clinical commissioning groups to discuss care offered to NHS patients and review contracts.
- The service did not provide emergency care; all care and treatment was planned and arranged in advance including pre and post- surgery follow up appointments.
- The service planned and delivered care to suit patient needs. Surgery dates were offered based on individual choice but also considering the complexity of the surgery. This would be reflected in the number and order of procedures on a given day.
- The Centre recognised car parking was an issue for both staff and patients. The Centre had gained planning permission to extend their car parking capacity and commencement was imminent.

Access and flow

- The pre-assessment process, care pathways and treatment plans were the same for private and NHS patients.
- Private patients were offered an appointment as soon as possible after their request. If no appointment slots were available, the consultant was contacted to make further slots available. NHS patients were also given the choice of availability but this was managed and monitored in line with the accessing NHS treatment policy.
- In the reporting period July 2015 and June 2016, the Centre achieved 100% against the 92% standard for admitted patients beginning treatment within 18 weeks of referral. During the same period, 100% of NHS non-admitted patients began treatment within 18 weeks of referral.
- Patient admissions to theatre were staggered throughout the day to ensure adequate time between patients to clean and prepare theatre and recovery for the next patient. This was also to reduce the risk of delays.
- Patients were given any necessary post-op appointments prior to discharge and a nurse followed up each patient 24 - 48 hours post-operatively by telephone. Consultants would review their patients at six weeks and six months post-operatively. We saw evidence of these reviews in patient records.
- The service staggered admission times so that there was sufficient time in between patients to aid flow. There were usually only two patients within the recovery area at one time, one pre-surgery and one post-operative.
- There was designated and suitably trained recovery nurses within the recovery area. The recovery staff had the support of the anaesthetist for patients who may deteriorate or for pain relief reviews as required.
- The service was a day surgery facility only and therefore discharge occurred before 8pm and the anaesthetist did not leave the building until they assessed the last patient as fit to go home.
- The service planned surgical procedures to ensure adequate recovery time was allocated to facilitate same

day discharge. If a patient was not fit for discharge by 8pm, there was an agreement in place with a Ramsay Healthcare hospital to transfer patients for an overnight stay.
- Discharge arrangements were discussed pre-operatively to ensure adequate arrangements in place. The Centre called 48 hours in advance of surgery to ensure the patient understood discharge and post-op arrangements.
- If a patient lived over an hour away from the Centre, they were advised to arrange a local overnight stay in the event of post-surgery complications. All patients were required to have a relative to chaperone them home and to have someone with them for 24 hours post-surgery.
- There were 38 cancelled procedures for non-clinical reasons in the reporting period of July 2015 - November 2016. All of these patients were offered an alternative appointment within 28 days. Reasons related to consultant unexpected illness (15), bereavement (10) or family emergencies (13). We saw records that showed that consultants were reminded to ensure they covered any planned leave.
- The service managed unplanned returns to theatre with an on-call rota. We saw the record of this rota that staff referred to. As part of the practising privileges, consultant surgeons and anaesthetists covered the days that they operated surgery lists for events such as unplanned surgery.

Meeting people's individual needs

- The Centre was accessible for people with mobility problems. Although there was no lift, all services were operational on the ground floor. Theatre and recovery was located on the ground floor.
- Chaperone posters were visible areas around the Centre, encouraging patients to ask staff if needed.
- There was patient language support available and could be accessed as required. Staff showed us the process for doing this. Interpreters were booked in advance of appointments and staff told us that patient relatives would be used only to translate for non-clinical needs only.
- The Centre's PLACE score of 91% was higher than the England average (83%) for privacy, dignity and wellbeing for the period February - June 2016.
- Theatre staff would escort patients from the waiting area to theatre and from theatre to the recovery area. This nurse would usually be the same to ensure continuity for the patient.
- We saw theatre staff communicate well with a patient when there was a delay in bringing them to theatre and kept them informed of the process.
- Staff asked about dietary preferences and meals offered based upon these.
- Patients with complex needs were risk assessed as to whether the service could meet their needs. Staff awareness about learning disabilities varied. Staff told us they rarely saw patients with such needs.
- All patients over the age of 75 were assessed for dementia. The service saw 5 - 10% of patients living with dementia. One member of staff described how a patient living with dementia had been provided with a chaperone throughout their care. Training records showed that 100% of clinical staff had completed online learning for dementia awareness.
- Patients were given written information on discharge including procedure specific information, wound care, medicines and pain management.
- A physiotherapist was available to provide treatment for both post-operative NHS and self-funding patients.
- There was one patient toilet facility within the theatre and recovery area. When there was a mixed sex surgery list, the service ensured segregation of toilet facilities by using staff toilets. The general manager acknowledged this was not ideal but the building limited capacity. The manager told us this was not problematic because mixed sex lists were rare.
- Patient relatives were not allowed to go to theatre and the recovery area. A patient told us this was the one thing they would change about their experience. This was also commented on from a patient feedback card. The general manager explained this was to protect the privacy of those recovering and to ensure staff can carry out care safely in the small space.
- Staff respected patient confidentiality at all times. There was no confidential patient information displayed in any of the areas of the Centre.

Learning from complaints and concerns

- The general manager held the overall responsibility for dealing with complaints. The manager investigated formal complaints with the clinical lead matron leading the investigation for concerns regarding clinical care.

Good

Surgery

The process for responding to complaints included an acknowledgment within 48 working hours by either telephone or letter and recorded on the electronic risk management system. All complainants received written feedback following investigations with a target timescale of 20 days.

- There were nine formal complaints received in the reporting period July 2015 - November 2016 with no complaints referred to the Parliamentary and Health Service Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service in the same period. The assessed rate of complaints was lower than the rate of other independent acute services for which we hold this type of data.
- The minutes for meetings, where complaints were discussed contained little information around the discussions held. The general manager produced a 'lessons learnt' record from complaints and shared these at the heads of department and senior team leader meetings. There were no identified themes from complaints and evidence of learning was evident from records. Staff were encouraged to read this.
- No complaints were received by the CQC within the period July 2015- June 2016.
- There were no specific 'how to make a complaint' leaflets available or displayed information however, the Centre did seek patient feedback with 'we value your opinion' cards, which gave the opportunity to give negative or positive feedback. The contact details of the general manager were displayed in the two main waiting areas.
- Staff were unable to give examples of any changes as a result of recent complaints and confirmed that there were no patient leaflets specifically about how to make a complaint.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- All staff at the Centre reported to the general manager. A deputy general manager whom was also the clinical matron supported the general manager. The senior management team consisted of the general manager, the deputy general manager and a business development executive. There were clinical team leaders for theatre, dental and outpatient departments. There was a finance manager worked corporately across Ramsay Healthcare. The general manager reported to a Ramsay Healthcare regional manager.
- The Westbourne Centre was a partnership between Ramsay Healthcare UK (40%) and the Cosmetic Surgery Partnership (CSP- 60%). On the board for the Centre, there were two consultants from CSP (one specialised in cosmetic surgery and the other in restorative dentistry) and two directors from Ramsay Healthcare UK, one of which was the regional manager.
- We looked at the personnel files of the four directors of the board in relation to the 'fit and proper person's' (FPP's) regulation. The provider had a system in place to ensure directors of the company were 'fit and proper persons' to carry on a health service. We saw the clinic maintained a paper file of required information on each director/consultants that worked at the service.
- The general manager told us two of the files had been set up following our announced inspection. One of the files was lacking an up to date appraisal and a declaration. The consultant was abroad at the time of our inspection but we saw evidence of an email signing the declaration in lieu of their return from abroad.
- There was an electronic corporate consultant credential database used to identify when paperwork was due for renewal. We saw that the use of a cover page checklist with clear criteria was effective in identifying when renewal was due.
- All staff were complimentary about the leadership both at a departmental level and at senior management team level. They told us all managers were visible and approachable with an 'open door' policy. We saw staff engaging with senior management and the general manager.
- The theatre lead had been in post for eight months and was improving the organisation and daily running of the theatre and the theatre team.
- Local and senior managers had not identified some of the issues we found at the inspection such as medicines issues. However, the general manager and clinical lead were responsive and enthusiastic to resolve issues immediately or as soon as possible.

- Staff reported an open and supportive culture and enjoyed working at the Centre. Staff felt able to raise concerns regarding patient safety, respected by consultants to do so. Staff felt motivated by the management team.
- Staff we spoke with told us they felt listened to by their managers. They described an inclusive working culture with a teamwork 'feel'. One staff member said that teamwork within theatre and recovery had improved recently from a previously chaotic atmosphere and it now felt more organised.
- Staff said they felt proud of the quality of care they were able to give to their patients and to work at the Centre. This was reflected in the Ramsay staff survey with 95% of the Centre's staff responding they felt proud to work there and 90% responding that they had a strong sense of belonging to their workplace.
- Staff told us knowledge and skill development was encouraged and supported, demonstrating a learning culture in line with the provider's continuing education policy.

Vision and strategy for this this core service

- Staff were able to summarise the vision of the Centre, which was in line with that of Ramsay Healthcare UK. The vision was to be committed to being a leading provider of health care services by delivering high quality outcomes for patients and ensuring long-term profitability. Delivering high quality care was something all staff said they strived for.
- 'The Ramsay way' was the phrase to encompass the values of all Ramsay Healthcare UK services. The Westbourne Centre additionally developed their own set of values 'WESTBOURNE' used as an acronym for 'Welcoming', 'Expertise', 'Supportive', 'Teamwork', 'Being the best', 'Ownership', 'Unique', 'Responsive', 'NICE compliant' and 'Ethical'. This was to recognise their differences from other Ramsay Healthcare UK services and for the Centre's staff ownership. Staff were aware of both values and felt all staff worked to these and reflected their aim of putting the patient first.
- The strategy, within the Centre's operational plan was a framework based on the nursing '6 Cs' which are Care, Compassion, Competence, Communication, Courage and Commitment (NHS, 2012). Staff were aware of the '6 Cs' and showed us the display in the recovery bay, along with the Centre's vision and values, in poster format.
- We noted the services' vision statement on the reception notice board for patients to see.
- Staff demonstrated pride for the day surgery service provided and were keen to be involved to develop this further in the future.

Governance, risk management and quality measurement

- The service governance processes are the same throughout the Centre. We have reported about the governance processes under this service only.
- The provider had a governance structure in place for escalating and managing risk and overseeing clinical practice. Clinical services produced a monthly update bulletin and provider clinical reports produced after the organisation's own routine inspection and audit visits to services.
- We saw from reports that the Westbourne Centre had a routine inspection and audit visit from Ramsay in December 2015 and a follow up visit in September 2016. The registered manager and clinical lead at the Centre produced an action plan for improvement and we noted they monitored progress on this weekly.
- Below the senior management team level at the Centre were clinical heads of department. These included outpatient and dental team leaders. The registered manager told us heads of department meetings were held monthly to discuss matters that overlapped departments on an 'as needed' basis.
- The clinical governance meeting where incidents were discussed filtered down into the heads of departments (HODs), senior team leader and the Medical Advisory Committee (MAC) meetings. Department leads held departmental meetings monthly.
- We viewed several recent meeting minute records and the detail provided about discussions and actions taken varied with some lacking this detail completely. We noted the general manager highlighted this internally with an action to improve the level of detail and audit trail.
- The Medical Advisory Committee (MAC) held quarterly meetings, which were attended by speciality lead consultants, the general manager and the clinical lead. The role of the committee was to oversee quality and safety issues at the service. This included approval of new procedures and equipment that consultants wanted to introduce, approving practising privileges and

reviewing quality and safety reports. Minutes we looked at showed a number of incidents and complaints were discussed but the outcome of the discussions was not clear, nor if any learning or actions had taken place.

- The general manager of the Centre was responsible for ensuring timely reporting of incidents and adverse events. Additionally, for ensuring the investigation lead was appropriately trained and competent in carrying out investigations in line with the policy and ensuring departmental managers were trained in root cause analysis (RCA).
- There were processes in place to ensure all staff including consultants received governance and risk management training including incident reporting.
- The provider had a written policy for investigating serious incidents and there were timescales for completing stages of the procedure and a 40-day target for a final report.
- The provider has systems in place to monitor quality and safety. The Centre identified and appropriately investigated a return to theatre trend for bilateral breast augmentations. Managers continued to monitor outcomes for this procedure after the action plan was completed.
- The policy cross-referenced the 'being open' principles in place under the Ramsay Healthcare UK policy, dated October 2015, to address the requirements of the duty of candour regulation. However, this duty had come into force six months earlier for independent healthcare providers in April 2015.
- The duty of candour policy also addressed evaluation of openness practice. This took place through specific reference to adverse event investigation reports, complaints management, and claims investigations in governance reports to the clinical governance and risk management committees across its group of services.
- The registered manager confirmed the clinical director provided oversight for the duty of candour requirement. The clinical director flagged and audited the clinic's response to any incident graded level two or above in severity. There was a time target of five working days for local leaders to respond to an incident through the duty of candour process.
- Although the Centre collected and monitored quality data, it was not collated into a quality or safety dashboard or report. Clinical quality or safety metrics were not displayed for patients or staff to view.
- The Centre complied with the corporate audit programme and all audits we saw achieved the target of over 90% with the exception of the pharmacy audits. Relevant heads of departments carried out audits and were responsible for improvement actions.
- The Centre had a long history of no/low harm incidents and therefore the need to conduct serious investigations was infrequent. We discussed the route cause analysis (RCA) undertaken for two incidents with the general manager and their deputy (clinical lead). They agreed that although they had added a supporting document to the process, the investigation documentation still did not meet the requirements of the service and it lacked robust detail.
- Senior managers told us The Ramsay Healthcare UK group were reviewing the RCA model as their own internal routine inspection (December 2015) identified concerns with the one currently used. The Centre's clinical lead had recently undertaken RCA training to update on the issue. The general manager said they would look into an alternative model to best suit the Centre's needs.
- There was one risk register for the whole centre, which logged all the issues identified on site as requiring attention, replacement or review. There were 88-logged risks in total with 25 relating to theatre, 17 to dental, 16 to outpatients and the remainder to administration, reception, marketing and beauty.
- The general manager told us the risk register was discussed at the health and safety meeting. However, records for September 2016 meeting did not have a risk register set agenda item. The discussions around the risk register were therefore not audit trailed. The general manager told us health and safety was a particular area of focus for the Centre and an identified lead was attending an accredited training course in November 2016.
- Risks such as the high bank and agency use for theatre staffing and below target mandatory training for dental staff were not on the risk register. It did not include risks specifically identified through serious incidents or patterns of reported incidents.
- The theatre manager had put actions in place to improve documentation and compliance with the WHO safer surgery practice and was in the process of building a stable and appropriately trained team.

Good

Surgery

- We also found several issues with medicines management within theatre. The internal pharmacy audit did not identify these issues but had raised other areas for improvement and the audit fell below the 100% target.
- There were no formal arrangements for the monitoring of the usage of the out-of-hours theatre team. The clinical lead told us this was because it was an infrequent occurrence however; this could be a lost opportunity to identify themes and trends.

Public and staff engagement

- Staff told us the general manager welcomed and encouraged feedback to make suggestions for improvements.
- The Ramsay Healthcare UK staff survey in April 2016 showed that the Westbourne Centre scored the highest overall of other Ramsay Healthcare UK locations with staff responding positively to questions about their environment, work purpose and local management.
- Departmental team meetings occurred monthly and staff said this was an opportunity to receive updates and share concerns. Bank members of staff said they did not attend team meetings but felt they were informed of relevant information.
- The Centre used social media to engage with the public. There were active plans to commence a patient forum in the near future.
- When the Centre received comments from patients about specific staff members, they fed back to the relevant person and staff told us that they appreciated positive feedback. This was evident in meeting minute records.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- The provider's incident reporting systems have been reported under surgery.
- The number of reported clinical incidents within the outpatient's including dentistry department between 1st July 2015 and 1st November 2016 was eleven. This represented 34% of the total for The Westbourne Centre (the Centre). One hundred percent of these were rated by the Centre at level 4 (no harm/harm with no loss of functioning).
- This was similar to the rate of other independent acute providers we hold this type of data for. No non-clinical incidents occurred in outpatient and dentistry services.
- One serious incident was reported in May 2016. This was in relation to an infection post refractive surgery, non-sterile Endophthalmitis.
- The registered manager told us a second similar, but sterile Endophthalmitis incident later in the year, had triggered the provider's internal red alert threshold with the Royal College of Surgeons. The local clinical commissioning groups (CCG) and the provider closed the Centre's theatres for external investigation but this investigation identified no local cause.
- An incident concerning the outpatient pre-assessment process occurred early in November 2016 was under investigation at the time of our inspection visit. This involved the clinic requiring emergency paramedic attendance when a patient experienced a severe reaction to an analgesic.
- We noted the Centre had investigated each incident reported in outpatients and dentistry and identified learning actions to avoid repetition.
- The incidents were escalated to the provider's clinical lead, investigations were undertaken and outcomes and were discussed in governance forum. Actions to be put in place were identified on the electronic report record with dates for compliance.
- Lessons learned were fed back to local staff at the Centre for discussion and learning at senior management team meetings and clinical heads of department meetings.
- We noted for example from minutes, an ophthalmology department meeting was held in September 2016 to review ophthalmic procedures at the Centre in line with the Royal College of Ophthalmologists (RCO) guidelines following three cases of Endophthalmitis within a 12 month period.
- There was discussion across a range of relevant issues and a timetable developed of actions with time lines for starting and completion. We noted however, the completion dates were not on the copy of the document we were sent.
- These actions included for example, to confirm the procedure of all cataract patients offered a follow up appointment within two to four weeks after surgery and to follow up any post-operative no show patients in outpatients. This was expressed as another opportunity to capture cases for those patients who take themselves to another provider such as a local NHS acute service without contacting the Westbourne Centre first.

- Staff we spoke with confirmed they had received feedback about these serious incidents and been involved in considering how improvement could be made.

Cleanliness, infection control and hygiene

- The clinical rooms and consulting rooms used for dentistry and outpatient's clinics were visibly clean, well-organised and free from clutter.
- We observed the decontamination and cross infection procedures in dentistry were effective and staff followed them correctly.
- Policies and protocol files were available in consulting rooms and oral surgery procedure rooms. However, we noted there were no specific policies written for dentistry, for example infection control, although this represented 52% of the Centre's activity at the time. However, there were no significant infection control issues within dentistry.
- Posters displayed safety information such as sharps injury flow charts and effective handwashing to prompt staff. However, some procedures on display in dentistry consulting rooms, such handwashing were out of date.
- We noted staff wore personal protective equipment including gloves during procedures. Hand sanitising dispensers were distributed around the waiting rooms and corridors for patients, staff and visitors to use and posters prompted patients to do so.
- Consulting rooms were stocked with single use equipment. There was a resuscitation trolley on the ground floor.
- We observed dentists/oral surgeons and nurses cleaning machines in between patient use.
- The registered manager told us the provider's policy was dentists working at the service must hold Exposure Prone Procedures (EPP) clearance. This means they must be free from infection with a blood borne virus because they undertook 'exposure prone' procedures in oral surgery. The test requirement was monitored through the provider's consultant 'credentialing' data base and we saw this on electronic records.
- The Centre reported three cases of Endophthalmitis within a 12 month period over 2015/16. Independent investigation into a possible source for these found no discernible cause within the environment or equipment.
- We noted a water hygiene survey report of February 2016 on file with an action plan in place for some further actions required.

Environment and equipment

- Clinical and consulting rooms and waiting areas for dental services and outpatients clinics were appropriate for their purpose. Most dentist/oral surgery procedure rooms were situated on the first floor and were appropriately equipped. One appropriately equipped procedure room was on the ground floor as the building had no lift.
- Consultants told us the provider carried out the servicing of all equipment. This was confirmed by the records we reviewed kept by the clinic. They showed dentistry equipment and installations were serviced and repaired as appropriate.
- We saw from records outpatient's department equipment was systematically accounted for and reviewed in line with the provision and use of work equipment regulation 1996 (PUWER), including lists of authorised users.
- For example, the manual/electronic blood pressure machine and the nasal scope were accompanied by the names of five staff members with their training declaration forms and signatures. Appropriate risk assessments were on record as were repair reports.
- The refractive eye surgery clinic used only an IPL (Intensed Pulsed Light) laser. However the Centre had arrangements in place for the laser protection officer (LPA) to visit annually to carry out a risk assessment and audit on the laser. The provider told us the LPA issued the local rules and was responsible for updating them as necessary. The one member of staff who carried out IPL had direct access to the LPA.
- We noted there was no system in place for checking the contents of the medical emergency box and we found some items were missing. We raised this with the manager who undertook to address it immediately.

Medicines

- We saw safe systems in place to store medication that needed refrigeration including monitoring the temperatures of the 'fridges.
- We noted some standard items of medication were missing from the medical emergency kit in dentistry. We raised this with the registered manager at the time of our visit. They provided us with evidence they had acted to rectify this before we left the Centre. The provider reported its patient satisfaction survey for overall services at the Centre 2015/16 indicated it could

improve the information it gave to patients about their medication prior to discharge, including potential side effects. The manager told us this was recognised and they developed an information leaflet and gave this to all patients on discharge. Records

- Staff had access to patient records cards. Consultants told us there was no electronic patient records system in place for outpatients or dentistry. They said this meant they spent a lot of their time hand writing records and letters.
- In the reporting period August 2016 to 1 November 2016 the provider told us no patients were seen in outpatient's clinics without all relevant medical records being available.
- The provider told us most records were kept on site and therefore readily available. Notes for patients who finished their care were archived off site regularly. Archived notes could be retrieved within 24 hours and particular documents could be scanned and sent within a few hours in an emergency.
- The provider told us most private dental records were kept off site. A risk assessment had been carried out and a process put in place to ensure any record could be retrieved within an hour, from the personal assistant of those particular consultants. There was no local policy detailing the safe storage of these records off-site.No records were taken off site by any members of staff. All clinics were prepared at least seven days in advance and this enabled notes to be located or retrieved from archive.
- We found no issues regarding retrieving records during our inspection and patient's records we looked at were complete and legible.

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- The provider told us some private dental records were kept off site by two consultants. A risk assessment had been carried out and a process put in place to ensure any record could be retrieved within an hour, from the personal assistant's of those particular consultants. There was no local policy detailing the safe storage of these records off-site.
- No records were taken off site by any other members of staff. All clinics were prepared at least seven days in advance and this enabled notes to be located or retrieved from archive.
- We found no issues regarding retrieving records during our inspection and patient's records we looked at were complete and legible.

Assessing Risk

- We looked at a sample of five patient's record cards, two from ophthalmology outpatient's clinic and three from dentistry. They contained appropriate information, including medical history, treatment plans and test results.
- The clinic provided emergency clinical cover by telephone over weekends. We saw from records of a serious incident that this cover had worked effectively.
- We noted management of medical emergencies was not robust. For example, dental nurses told us they were not practised at cardiac pulmonary resuscitation (CPR); we noted there was no emergency 'grab bag' in place.
- There was an automated external defibrillator (AED) on the ground floor of the Centre but none on the first floor where most of the oral surgery took place. The registered manager told us that there was timely access to the AED because it was stored centrally near theatre. This had not been formally risk assessed but was scenario tested in October 2016. The AED was provided to the first floor within one minute of the call for assistance.
- Provider records showed 100% of outpatients and dentistry staff attended basic life support training in October 2016.

Good

Outpatients and diagnostic imaging

Safeguarding

- The outpatients and dentistry departments treated children over three years old but not for any invasive procedures.
- We noted the Ramsay routine internal inspection report of December 2015 identified some shortfalls against the Safeguarding children and young people: roles and competences for health care staff intercollegiate guidance third edition 2014. For example it noted no clear description for the delivery of children's services and how the different areas were managed. The Centre was working to address these through an action plan.
- The provider reported the clinical lead, dental lead and outpatient lead nurses had attained level 3 safeguarding competence and were the safeguarding children leads for the Centre. Also that all children had planned appointments so staffing rotas could be decided in advance and reflect the need to have a level 3 nurse on duty for that shift.
- All clinical staff received level two children's safeguarding training. The provider's records showed the compliance rate at the time of our inspection was 100%.
- The Centre's clinical lead (and matron) was the adult safeguarding lead. For adult safeguarding training at level two, although 100% of permanent dental staff had this level of training, compliance was at 50% (the provider's target was 85%) for relevant outpatient staff.
- Staff we spoke with were aware of the Centre's safeguarding leads, had undertaken training and were able to describe to us the action to take if they had concerns about children's or vulnerable adults.
- We noted no safeguarding information on display in out patient's and dentistry waiting areas for patients to see.
- They were not clear about the safeguarding process beyond the local response but did know there were policies and procedures available to consult on the provider's intranet. Managers we spoke with were aware of the provider's and local authority processes.

Mandatory training

- Data sent to us by the provider showed as at November 2016, 100% of dental staff and 86% of outpatient staff were compliant with mandatory training. The provider's target was 85% compliance.

Medical staffing

- The Centre's medical staffing arrangements have been reported on under the surgery service within this report.

Nursing staffing

- The outpatient's departments had 4.4 full time equivalent nurses. There were also 1.7 health care assistants in post. This appeared to be sufficient to meet the needs of booked in patients.
- There was no staff turnover for outpatient nurses in the reporting period July 2015 to June 2016.
- The rate of use of bank and agency nurses working in outpatient departments was higher than the average of other independent acute services we hold this type of data for in the reporting period (July 2015 to June 2016). By 1 November 2016 the provider reported in pre inspection visit data; 'The level of bank and agency staff usage across out-patients includes dental nurses. Of all of the bank/agency staff used across out patients, 76% of the usage is from two members of staff, one of which has now converted onto a contract. There was no agency staff used in this period, only bank staff.'
- There was no use of bank and agency health care assistants working in outpatient departments in the same reporting period, except for in August 2015 and September 2015 when the rate was above the average of other independent acute services we hold this type of data for.
- Sickness rates for nurses working in outpatient departments were lower than the average of other independent acute services we hold this type of data for in the reporting period (July 2015 to June 2016), except for in January 2016 when the rate was higher than the average.
- Sickness rates for health care assistants working in outpatient departments were mainly 0% or lower than the average of other independent acute services we hold this type of data for in the same reporting period. The exception was in July 2015, February 2016 and April 2016 when the rates were higher than the average.
- There were no unfilled nursing and health care assistants' shifts for the reporting period of April, May and June 2016.

Good

Outpatients and diagnostic imaging

Emergency awareness and training

- Provider records showed 90% of outpatients and dentistry staff undertook training in the business continuity plan during November 2016.
- One dental nurse was not aware of the medical emergency process. The manager told us that communication they sent to all staff via email in October and shared in the clinical heads of department meeting in November.

Are outpatients and diagnostic imaging services effective?

We do not currently rate effective for outpatients and diagnostic imaging.

Evidence-based care and treatment

- We observed and noted from records clinical staff explored a full history with patients. Relevant care plans were agreed and staff arranged appropriate referrals for further tests, investigations and radiographs.
- Radiographs were done digitally by another provider on site and dentists viewed them on line.
- The Centre provided x-ray facilities using a mini C Arm and dental intra oral x rays. Head and neck CT scans and x Rays were provided by an independent imaging provider that was based at the Centre.
- We noted however, there was no Radiographic Protection Folder, received from the radiographic protection authority, with proper local rules clearly outlining dosages and the clinicians operating them.•The refractive eye surgery clinic offered Intensed Pulsed Light laser (IPL) treatment and biometric analysis for cataracts. It did not offer class 4 laser treatment.

Pain relief

- The Centre offered treatment under local anaesthetic and sedation. For oral surgery there was a sedation nurse and an anaesthetist for sedation.
- The provider told us if, through the pre-assessment process, a patient identified a possible pain management issue, they may be referred for an anaesthetic assessment. This aimed to provide a better service for the patients and to enable pain to be managed more effectively.

Patient outcomes

- The Centre undertook a programme of audit of clinical outcomes set at corporate level by the provider.
- We saw evidence in medical advisory committee (MAC) meeting minutes that new NICE guidance was shared and further discussion held in the clinical effectiveness committee.

Local audit

- The Centre audited its outpatients and dentistry services. For example we noted the minutes of the MAC in October 2016 reported dental surgical safety and hand hygiene and outpatient and dentistry patient records achieved 100% compliance.
- The Centre's audit programme for July 2015 to June 2016 showed a rolling alternating monthly audit for dentistry services of environment, decontamination and medical devices and the same was planned for 2016/17. The score was consistently 100% from July 2016 to September 2016.
- NHS outpatient's notes were audited in July 2016 and achieved 98% compliance against a target of 100%. The Centre repeated the audit in October 2016 and achieved 100% compliance.
- There were no other specific audits during 2015/16 for any of the outpatient's clinics. This was confirmed by the clinical lead who told us the Centre intended to 'firm' up 'did not attend' (DNA) audits of ophthalmology clinics as learning from an incident.
- We noted there was no audit of oral radiograph data or use of anti-biotics and the registered manager confirmed this to be the case.

Competent staff

- The registered manager told us doctors had to be on a specialist register for practicing privileges at the service. This was confirmed by a sample of two consultant's files we viewed.
- We observed two oral procedures, two ophthalmology and one neurology outpatients' clinics. We noted consultants and nurses were knowledgeable about their practice.
- However in a few instances, tasks were given to staff to do without appropriate guidance, for example taking responsibility for maintaining the medical emergency box. This meant there could be a delay in the member of staff performing their duty well.

Good

Outpatients and diagnostic imaging

- The registered manager told us the Centre did not have a paediatric nurse as invasive procedures were not undertaken with child patients. Dental nurses saw children regularly and the provider reported these staff had completed their children competencies.
- Dental nurses took radiographs. We were concerned that the radiography and radiation protection competencies for two dental nurses had lapsed. The General Dentist Council states that the minimum is at least five hours in a five year cycle. We raised this with the manager and the clinical lead for The Westbourne Centre confirmed lapsed competency applied to one nurse only and undertook to address this as soon as possible.
- We noted from the minutes of the outpatients department (OPD) meeting in October 2016, following the training provided by two lead nurses a discussion around National Safety Standards for Invasive Procedures (NatSSIPs) had taken place commencing within the OPD procedures.
- Provider records showed four out of five outpatients nursing staff but only one of four dentistry nursing staff undertook some diabetes awareness training in May 2016.
- We noted from consultant's files that where they had no NHS contract, the provider arranged an annual appraisal. This was identified on the consultants credentialing data base that the provider had in place.
- The outpatient clinics for dentistry, ophthalmology and electromyogram (EMG) and nerve conduction studies (NCS) diagnostics (nerve health) we observed were run well. The consultants were knowledgeable.
- The provider reported 100% of outpatient nurses had their appraisals completed in the current appraisal year (January 2016 to December 2016) to the date of our visit. All outpatient health care assistants had their appraisals completed in the same appraisal year to the date of our visit.
- New health care assistant starters follow an induction programme with three and six monthly reviews. An appraisal was undertaken once the staff member had completed a full year of employment.

Multidisciplinary working

- Outpatients and dentistry services took referrals from local GP's and dentists and worked appropriately within the Centre's service level agreements with local independent hospitals and NHS acute services.
- We observed consultants and nursing staff working well together for the benefit of patients.
- Consultants and nurses had an effective professional relation with the separate organisation, based on the same site, which provided x ray and other imaging services to Westbourne Centre patients.

Access to information

- We looked at the record cards of two ophthalmology and three oral surgery patients and noted they were hand written. Consultants we spoke with expressed the view that a computerised system would improve the service and enable them to manage their time more effectively.
- Staff told us the clinic did not get any 'flags' for specific vulnerability on GP referred patients records.
- Dentists told us, for example, they wrote back to patients' own referring dentists after their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Provider records showed 100% of outpatients and dentistry staff attended Mental Capacity Act and Deprivation of Liberty safeguard training in November 2016.
- The registered manager and clinical lead told us the service did not see patients in outpatients or dentistry who did not have capacity to consent to treatment or were unaccompanied children.
- We observed dentistry staff explaining care plans and procedures to patients and written consent being taking during dentistry appointments.

Are outpatients and diagnostic imaging services caring?

We rated caring once within the surgery core service.

Compassionate care

- We observed the consultation and treatment of four patients using outpatients' ophthalmology, nerve health and oral surgery including post-operative reviews and noted consultants and nurses demonstrated empathy for all patients.
- For example during oral surgery dentists kept patients engaged throughout the procedure. Staff warmly greeted patients including at the end of a long clinic list.

Good

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- We observed out patients and dentist consultants and nurses listened to patient's concerns, spent time undertaking examinations and explaining results.
- Patients were offered whatever choices were available for procedures and given leaflets explaining them.
- The provider commissioned patient satisfaction questionnaires through a third party company. The 2015/16 quality accounts showed overall satisfaction scores for the whole service and not particular departments. The overall score was 90.5% for 2015/16 and this represented a slight decrease from the year before (92.3%). The provider accounted for this by 'the significant increase in business'.

Emotional support

- The Centre's policy was to inform surgery patients, including for oral surgery of all fees upfront to gives the patient sufficient time prior to surgery to pay.
- We noted no information available in dentistry or out patients that sign-posted patients to additional emotional support services if they needed them.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The outpatients and dentistry services were signposted within the Centre and the reception desk was close to the entrance door and the main waiting room. We noted reception staff on the ground floor kept patients informed and directed them to consulting rooms. On the first floor staff came out to escort patients to the treatment rooms when it was time for their appointment.
- Outpatient's and dental services were available between 8am and 8pm Monday to Friday and some Saturdays between 8am and 4pm. There were five consulting rooms including an ophthalmic suite, a treatment room and three dental suites.
- Provider data reported there were 6,159 outpatient total attendances between July 2015 and June 2016. Of these 39% were NHS funded and 61% were other funded. 5,424 were aged 18 to 74 years with 684 over 74 years. Fifty one were children and young people from three to 18 years of age.
- Referrals were mostly from dentists and GP's in Birmingham and from private patients.
- Data from the provider as at November 2016 showed dentistry and ophthalmology were the largest proportion of outpatients and diagnostic services on offer. Dentistry represented 54% of the services offered and ophthalmology was 15%.
- The statement of purpose for the Centre set out it offered 'dental procedures that were primarily of a specialist nature, with most patients being treated on a referral basis from general dental practices. Treatments included all aspects of maxillo-facial surgery, restorative dentistry, orthodontics and endodontics'. The statement of purpose made clear which conditions the service could not meet, for example patients with blood disorders (haemophilia, sickle cell and thalassaemia).
- The Centre offered outpatient consultations and dental treatments only, for children from the age of three. Services offered to children over three years of age were; outpatient consultations, general dental check-ups, minor restorative dental treatments e.g. fillings and minor orthodontic treatments e.g. extractions and fitting of braces.
- Other outpatients services offered were for cataracts and general ophthalmology, oral and maxillofacial clinic and treatments, a general gynaecology clinic and Electromyogram (EMG) and nerve conduction studies (NCS) diagnostics. There was a nurse clinic that supported pre-operative assessment and post-operative wounds and stitch removal.
- The Centre had on site access to an independent imaging company, a provider registered with the CQC in its own right. This provided a specialist imaging service (x ray and CT scans) to support the dental service.
- On the day of our announced visit the outpatients department was running: an EMG and NCS diagnostic clinic; general gynaecology clinic; cataract clinic; cataract and general ophthalmology clinic; nurse clinic and oral and maxillofacial clinic and treatment.
- The provider quality account for 2015/16 reported patients requiring NHS services were referred via their

Good

Outpatients and diagnostic imaging

general practitioner or other primary care providers (such as optometrists and dentists) directly to the Centre, either by Extended Choice Network or paper referral.

Access and flow

- NHS England data showed 100% of NHS funded patients on incomplete pathways waiting 18 weeks or less from time of referral in the reporting period of July 2015 to June 2016. 100% of patients started non-admitted treatment within 18 weeks of referral in the same reporting period.
- Data from the provider showed referral time to treatment rates for NHS patients at February to September 2016 was on average 13 weeks. The lead nurse audited NHS surgical outpatient's notes on a monthly basis for referral time to treatment (RTT).
- There were only two recorded incidents of patients waiting in excess of 30 minutes for their appointments after they arrived. These were both in September 2016 and both were NHS ophthalmic patients.
- An ophthalmology patient we spoke with on the day of our first visit said they had been referred to the clinic by their optician and got an appointment within one week. They were able to book through NHS choices. They were not kept waiting beyond their appointment time when they arrived at the clinic.
- The outpatients lead nurse told us fresh appointments were booked immediately for any patient who did not attend as planned (DNA). The policy was patients were given three opportunities to attend and then discharged if they did not, but this was a clinician's decision. The lead nurse contacted DNA patients by phone and they usually attended at the second appointment. We noted on the day of our first visit there were three oral surgery DNA's.
- The Centre had a threshold from the clinical commissioning group (CCG) of 6% for all DNA other than dental. Data showed the service was well below this threshold for five out of seven months April to October 2016. For August, it was 6% and September 5%. NHS England (NHSE) did not set a threshold for dental services and the Centre DNA rate for April to October 2016 was high. They were typically 16% and 24% with a peak of 29% in October 2016.
- We noted a board in reception area informing patients if outpatient's clinics were running late. Wound care clinics ran over a long day to enable patients to attend around other commitments if necessary.

Meeting people's individual needs

- The outpatients and oral surgery facilities were accessible to people with disabilities. Out patients consulting rooms were on the ground floor and although most oral surgery rooms were on the first floor, there was one on the ground floor. Entry to the Centre was accessible from both sides of the building.
- The provider Quality Account for 2015/16 reported all patients had the option to access a chaperone. We saw large posters with this information in waiting rooms and signs on consultant's desks in the outpatient's clinics. Healthcare assistants undertook this role.
- Patient information sheets were available in a variety of different languages and there was access to language line and interpreter service if required.

Learning from complaints and concerns

- The Centre's learning from complaints and concerns processes have been reported on under the surgery service within this report.
- We noted from minutes of the Centre's medical advisory committee (MAC) that complaints for outpatients and dentistry services and their progress through the procedures were reported to this forum.
- The outpatients lead nurse confirmed there was a good flow of information up and down the organisation including feedback and learning from complaints.
- We have included the number of complaints received by the service within our report of the Surgery service.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good. See the Surgery section for main findings.

Leadership and culture of service

- The Centre's leadership and culture have been reported on under the surgery service within this report.

Good

Outpatients and diagnostic imaging

- Staff we spoke with in outpatients and dentistry told us the organisation had an open culture and they felt able to raise any concerns they had about patient safety
- Nursing staff told us they felt well supported by managers with sufficient training opportunities.
- Each specialty had a lead clinician and they were the MAC representative for the service.

Vision and strategy for this this core service

- We noted there was no clear specific strategy for the outpatient's service which appeared to developing piece meal. The service was predominantly dentistry yet there were no policies and procedures that were oral surgery specific. A lead clinician for dentistry represented the service at the Medical Advisory Committee.

Governance, risk management and quality measurement

- The Centre's governance, risk management and quality assurance processes have been reported on under the surgery service within this report.
- Ramsay Health Care visited the Centre to undertake a routine internal inspection and audit in December 2015. The registered manager and clinical lead at the Centre produced an action plan for improvement including outpatients and dentistry services and monitored progress on this weekly.
- We noted from minutes that monthly medical advisory committee (MAC) meetings incidents and complaints from the outpatients and dentistry services were reported to this forum and action monitored through it.
- Team meetings were also held monthly, for example we saw minutes for the ophthalmology service.
- We saw no evidence of any strategy to address the high did not attend (DNA) rates in the dentistry service for which there was no threshold set by NHSE.
- There was a risk register for the Centre that included the outpatients department which, was reviewed and updated regularly. However, we noted the risks assessed and managed were standard risks for the service and did not include what had been specifically identified through serious incidents or patterns of reported incidents.
- There were systems in place to ensure equipment and installations used by the outpatients and oral surgery department were kept in working order.
- Some systems were not robust, such as audit of oral radiographs, anti-biotic medication and medical emergency, although the latter had been identified for improvement by the provider's own routine internal inspection report of December 2015.We saw evidence of the risk assessment for the dental records for two consultants held off-site however, there was no local policy in place.
- We saw evidence of the risk assessment for the dental records for two consultants held off-site however, there was no local policy in place.

Public and staff engagement

- The Centre's public and staff engagement processes have been reported on under the surgery service within this report.
- Staff we spoke with in outpatients services were very proud of their clinics and wanted us to demonstrate to us how hard they worked to make their clinic manageable. Team leaders told us the Centre was well managed and the clinical lead was supportive. We observed staff in dentistry services worked well together.
- The outpatient's department lead nurse confirmed the feedback from the patient satisfaction questionnaires was discussed at monthly heads of department meetings.
- We saw patient experience feedback card and pens at the reception desk and reception staff prompted patients to use them. Staff gave NHS patients Friends and Family test cards after each outpatient consultation, there was also a form for private patients. The feedback from these came to staff through the Centre's clinical lead.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure:

- All staff are up to date with their mandatory training including safeguarding and mental capacity act awareness for the safety of patients.
- Staff consistently complete risk-assessments such as early warning scores to ensure patients are kept safe.
- Sufficient and appropriate medical emergency equipment and medicines are in the right place, stocks are complete and staff are competent in and understand emergency medicine procedures for the safety of patients.
- All staff operating dental imaging equipment hold up to date competencies.
- The risk register must reflect all service risks.
- There must be a robust and fit for purpose serious incident investigation template and model to meet the service's needs.
- Maintain at the service, a complete and contemporaneous record for each service user.

Action the provider SHOULD take to improve

Outstanding practice and areas for improvement

The provider should:

- Evidence assessment for psychological and mental wellbeing and history within the cosmetic care pathway prior to surgery.
- Display clinical quality and safety data for patients and staff to see.
- Improve meeting records to ensure discussions and decision-making can be audit trailed.
- Put in place a Radiographic Protection Folder, received from the radiographic protection authority, with proper local rules clearly outlining dosages and the clinicians operating them.
- Undertake a broader range of appropriate specific local audits for outpatient's clinics to monitor the effectiveness of the services.
- Audit oral radiograph data and use of anti-biotics in dentistry.
- Improve the uptake of diabetes awareness training for dentistry nursing staff.
- Put in place an 'at a glance' grid at the front of the hazardous products (COSHH) records file for easier staff access to information and audit.
- Produce policies and protocols specific to dentistry.
- Improve the uptake of Mental Capacity Act/DoLs training for all relevant staff.
- Ensure there is written information explaining how patients can complain if necessary.
- Provide some information in dentistry or outpatients' department signposting patients to additional emotional support services if they needed them.
- Set a reasonable and appropriate threshold for dental services DNA rates and develop a strategy to achieve it consistently.
- Develop a clear specific strategy for the development of outpatient's services at the Centre.
- Produce a local policy to evidence the governance process around the dental records stored off-site. Including accessibility and transportation of these records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(a)(b)(c)(e)(g) – Safe care and treatment:** (1) Care and treatment must be provided in a safe way for service users, (2) the things which a registered person must do to comply include- (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (g) the proper and safe management of medicines; **How this regulation was not being met:** Radiography and radiation protection competencies including professional development hours were out of date for some dental nurses. Medicines were not stored safely.Staff did not follow medicines management policies. Dentistry did not have adequate and appropriate emergency medicines and equipment and staff were not competent in the event of an emergency. Not all staff were up to date with their mandatory training including safeguarding and mental capacity act awareness for the safety of patients.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(b)(c) - Good governance:(2) systems or processes must enable the registered person, in particular, to** (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise fromthe carrying on of the regulated activity (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; **How this regulation was not being met:** Not all clinical risks were listed on the risk register. Serious incident investigation documentation and the root cause analysis model was unable to demonstrate robust and thorough investigation processes.