Circle Nottingham

NHS

QUALITY ACCOUNT 2017/2018

PART ONE

PART TWO

PART THREE

PART FOUR

PART ONE

ABOUT CircleNottingham

Circle Nottingham belongs to a group of companies owned by Circle, and is the largest Independent Sector Treatment Centre (ISTC) in Europe. Circle is an employee co-owned partnership with a social mission to make healthcare simpler, better and smarter value for patients. Circle is co-founded, co-run, and co-owned by clinicians and healthcare professionals. Because the clinicians and healthcare professionals who work for Circle have a sense of ownership for their work, they are empowered to put patients first in everything that they do. Circle's approach is based on the premise that clinicians are best placed to decide how to deliver the best care for patients and our Credo commits us to being 'above all the agents of our patients'.

The services delivered at Circle Nottingham, as with other Circle Health hospitals are divided into separate business units, named Clinical Units. Each Clinical Unit is led by a doctor, nurse and administrator and the Unit has the freedom and authority to take decisions that impact upon patient care. They are also responsible for managing their own budgets. In this way, power is devolved to the frontline and decisions are taken as close as possible to patients. Our success as a company does not lie in a small group of expert managers at the top of the company but in a large community of expert innovators at the grass-roots.

The core services provided at Circle Nottingham include:

- Dermatology
- Endocrinology
- Surgical terminations
- Hepatology
- Rheumatology

The additional services provided at Circle Nottingham include:

- Respiratory
- Vascular
- Digestive Diseases
- Urology
- Orthopaedics
- Physiotherapy
- Occupational Health
- Rheumatology infusions
- Gynaecology including 3 colposcopy/hysteroscopy treatment rooms
- Pain Services
- Light Therapy
- Ophthalmology
- Diagnostic Services

16 BED

SHORT STAY UNIT

WITH DISABLED AND BARIATRIC FACILITIES.

THEATRES

5 MAIN THEATRES
3 SKIN SURGERY THEATRES

RECOVERY WARD AND DISCHARGE LOUNGE

FACILITIES

PROVIDED AT Circle Nottingham

2 DIGITAL

AND 1 ANALOGUE

X-RAY MACHINE,

CT AND MRI SCANNERS, ULTRASOUND AND DEXA SCANNER

4

ENDOSCOPY SUITES AND

SEGREGATED RECOVERY AREA

ABOUT THE QUALITY ACCOUNT

The Health Act 2009 requires all providers of healthcare services to NHS patients to publish an annual report about the quality of their services; this report is called a Quality Account. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012.

The primary purpose of a Quality Account is to enhance organisational accountability to the public, to engage boards and leaders of organisations in fully understanding the importance of quality across all of the healthcare services they provide, and to promote continuous improvements on behalf of their patients. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

A Quality Account must include:

- A statement summarising the Registered Manager's view of the quality of services provided to NHS patients;
- A review of the quality of services provided over the previous financial year (2017/18);
- The quality priorities for the forthcoming financial year (2018/19)

Circle Nottingham is extremely proud to present its Quality Account for 2017/18. Our Clinical Units have worked very hard to produce their own quality accounts that represent how motivated and driven they are to improve services for their patients.

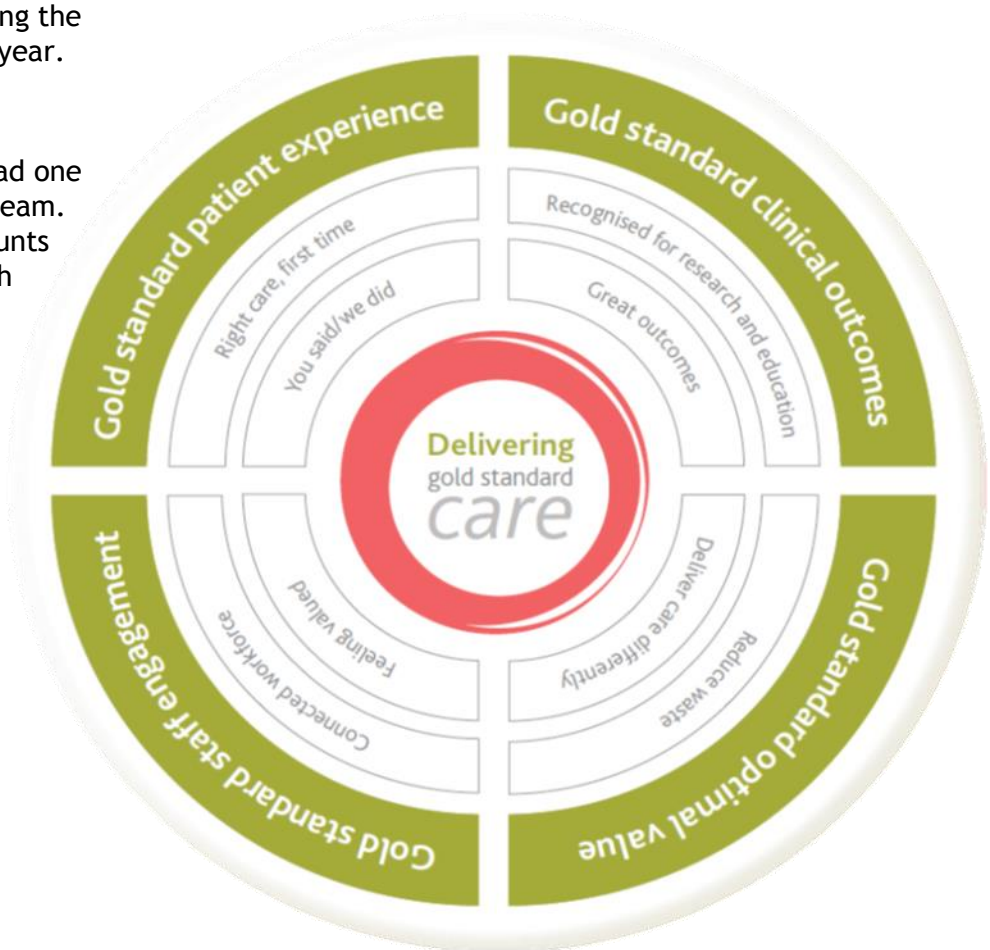
We have also worked closely with the our Commissioners, Patient & Public Engagement Group, Circle Nottingham Executive Board and Circle Nottingham Clinical Governance & Risk Management Committee to produce a Quality Account that provides our patients and the general public with information that demonstrates our commitment to quality as the first and foremost priority in our organisation; and provides the reader with a comprehensive insight into who we are and what we do.

ENGAGEMENT

During the process of preparing our Quality Account for 2017/18, we felt that it was really important to have an integrated approach whereby no one view was more important than another. We consulted with our staff at partnership events, engaged patient and public views, and scanned the NHS landscape. We also discussed quality priorities with our Commissioners at our quality review meetings, General Practitioners via our Primary Care Manager and other stakeholders during the course of the financial year.

As a company, we also wanted to ensure we had one voice, one vision, one team. Individual Quality Accounts were developed by each Clinical Unit but also collective views of the Board and its sub-committees were sought. We have used our quality priorities to influence the corporate quality objectives and have undertaken streams of work (such as Stop The Line and Compassion in Care) across all of the Circle hospitals and intend to continue this going forward.

Our approach was multi-dimensional, we wanted to take a snapshot of the whole year's data and effectively consider all information available to us. We wanted our priorities to be holistic so that our quality priorities could build on the existing excellent work delivered in the previous financial year.



STATEMENT FROM THE HOSPITAL DIRECTOR

We remain a part of the wider health community more than ever before and are committed to working toward integrated pathways of care in line with the strategic direction of the ICP.

HELEN TAIT
HOSPITAL DIRECTOR

The Quality Account for 2017/18 reflects a year of consolidation in sharing best practice, further developing clinical roles and gaining recognition through accreditation.

Our leading teledermatology service has now been expanded to the wider community with patients in Mansfield and Ashfield and Newark and Sherwood localities now able to benefit from a rapid diagnosis and treatment regime through photography and remote diagnosis of their skin conditions. More than half of patients do not need to be seen in hospital and importantly, this service also serves to expedite patients' appointments should their images suggest that there may be potential malignancy.

In house, our teams have increased and improved their audit programmes with more cross-functional reviews of services and outcomes. Our operating model means that teams are empowered to develop their services and processes without board approvals however this has meant that there is opportunity for more rigorous sharing of great ideas and best practice, such as innovative approaches to follow up, triage and patient experience.

Our Imaging teams' skills have continued to evolve resulting in our department now managing the DEXA scanning service in house, providing more opportunity for staff to increase knowledge and job satisfaction. They are also working towards ISAS accreditation for the first time which ensures that patients are receiving a high quality service from competent staff in a safe environment.

We continue to develop apprenticeships, Clinical Nurse Specialists, Advanced Nurse Practitioners and have increased numbers of Nurse Consultants. In the last year, our first Surgical Care Practitioner successfully completed her Masters which means that she will support every part of the patient journey from the initial clinic appointment to pre-op assessment through to undertaking surgery and post-operative care. Such changes to the surgical workforce ensure future continuity, holistic approaches and development opportunities for our dedicated clinical team.

We have also had a full inspection and reaccreditation for our Endoscopy unit by JAG, which recognises high quality endoscopy services by a robust, detailed set of standards. This is no small feat, with considerable focus across the whole team ensuring that this highly efficient service is delivering quality care for over 12 hours every day.

We remain a part of the wider health community more than ever before and are committed to working toward integrated pathways of care in line with the strategic direction of the ICP.

This Quality Account has been ratified by our Executive Board and we confirm that the content reflects a balanced view of the quality of our services and we believe, to the best of our knowledge that the information contained in this document is accurate and informative

Helen Tait
Hospital Director

PART TWO


Circle's Credo
Our purpose – To build a great co pa
to our patients. Our parameters – We
exclusively on: What we are passionate a out.
we can become best at. What drives our econo
sustainability. Our principles – We are abov a
agents of our patients. We aim t exceed
expectations everytime so that w earn their trus a
loyalty. We strive to continuously improve the quality
and the value of the care we give our patients. We
empower our people to do their best. Our people
are our greatest asset. We should select them attentively
and invest in them passionately. As everyone matters,
everyone who contributes should be a Partner in all that
we do. In return, we expect them to give their patients
all that they can. We are unrelenting in the pursuit of
excellence. We embrace innovation and learn from our
mistakes. We measure everything we do and we share
the data with all to judge. Pursuing our ambition to be
the best healthcare provider is a never-ending process.
'Good enough' never is

ACHIEVEMENT AGAINST QUALITY IMPROVEMENT PRIORITIES FOR 2017/18

All the Quality Improvement Priorities for 2017/18 were chosen due to their association with Patient Experience, Patient Safety and Clinical Effectiveness.

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	2017/18 PROGRESS	STATUS
'Simply the best patient experience' We will continue to grow our services and expand our capabilities to meet the needs of our patients.	Work with the STP and ACO to ensure services meet the needs of patients in the health economy.	On-going working with the STP and ACO as service transformation continues.	**Achieved**
	Work with our technology partners to identify how technology at the bedside/clinical area can be used to aid and support decision making and improve care and patient experience.	Reviews of the requirement for the technology requirement on-going and working with the technological partners to achieve this.	**Achieved**
'No decision about you without you' We will continue to empower and support our patients to make informed decisions about their care.	Review the ways in which we engage with our patients and the public to gain views on service developments.	Mystery shopper feedback extended to outpatient areas and feedback provided to PPE representatives. To review the questions and opportunity to extend further.	**Achieved**
	Promote the use of technology to capture patient feedback and the Friends and Family Test.	Family and friend test used extensively and feedback monitored through the clinical governance processes. Use of the PHIN feedback model to be extended from private patients to surgical admitted patients.	**Achieved**

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	2017/18 PROGRESS	STATUS
	Expand our use of Patient Reported Outcome Measures (PROMS) to improve patient care.	PROMS reports are reviewed monthly by the Clinical Lead and at the Executive Board meeting, comparing the outcomes achieved. There has been a review of the outcome measures across the group to aid comparison.	Achieved
	Continue to work with our clinicians to ensure the ability to continue to treat appropriately with antibiotics in line with the national CQUIN and reduce antibiotic consumption.	Antibiotic prescribing and consumption is no longer a CQUIN, however, this is monitored through the Medicines Management Committee.	Achieved
'Right first time' Right appointment, right clinician, most convenient location.	Reducing clinical variation across pathways and movement of services to the appropriate locations.	The reduction of clinical variation and care closer to home where appropriate continues as new services are developed and commissioned. Links with the developments required in the local health economic structure continues.	Achieved
	Prepare for the new CQC regime.	Awaiting CQC regime for independent sector but working with the local inspector to ensure the Treatment Centre maintains compliance. Quarterly visits with local inspector are in place.	Achieved

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	2017/18 PROGRESS	STATUS
'Better than the rest' We will continually improve the quality of our services by delivering our National & Local CQUIN initiatives for 2017/18.	Continue to build our research portfolio and publish results.	Research projects continue either working in partnership with NUH or as an independent provider. Projects are on-going and completion yet to be achieved for sharing of results.	**On-going**
	Work with HEEM to expand the training opportunities offered.	Training opportunities remain active in the the Treatment Centre and liaison with HEEM continues.	**Achieved**
	Develop opportunities for apprenticeships.	Opportunities for staff to undertake apprenticeships continues and staff are either undertaking or identified to commence the programme.	**Achieved**
	Continue to develop our specialist nurse and Consultant Nurse roles.	Development of the Specialist Nurse role continues by the shadowing of roles, enabling staff to develop to cover maternity leave. There is a review of service delivery where extended roles can be utilised. The trainee Surgical Care Practitioner has completed their master's degree October 2017 and they now review patients independently in clinic and as per role requirement.	**Achieved**

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	2017/18 PROGRESS	STATUS
	Develop the role of the Healthcare Assistant and identify training opportunities for Nursing Associates.	Healthcare Assistants continue to undertake additional roles within the treatment centre. Areas where assistant practitioners can be utilised to deliver care differently and supporting Registered Practitioners. Nursing associate roles are being explored across the group and posts identified in the Treatment Centre.	Achieved
	Review our environment to ensure it is more 'Dementia friendly'.	The dementia friendly environment is part of our local CQUIN and review of what we can adapt has been undertaken. Part of the planned changes are awaiting confirmation of the service delivery required from the Treatment Centre.	Achieved
	Continue to promote the flu vaccine for all front line staff.	All frontline staff working within the Treatment Centre were offered the Flu vaccine from October 2017 and the uptake of the vaccine remained over 75%.	Achieved

REVIEW OF QUALITY PERFORMANCE 2017/18

Incident reporting

At Circle Nottingham, we believe that incident reporting provides a unique and valuable opportunity to learn from our mistakes and allows us to implement prompt and effective safety solutions. We recognise that in order to have both a positive and informative reporting system, we need to maintain a culture where staff feel able to report incidents without fear of reprisal or blame.

An organisation with high incident reporting is a mark of a 'high reliability' organisation. Research shows that organisations with significantly higher levels of incident reporting are more likely to demonstrate other features of a stronger safety culture, such as a high patient satisfaction rate, positive peer review assessments and a low number of clinical negligence claims. Our commitment to reporting demonstrates a commitment to our patients and their safety. This is recognised by the Care Quality Commission Essential Standards of Quality & Safety and further reinforced by the Report of the Mid Staffordshire NHS Foundation Trust chaired by Robert Francis QC (February 2013). An organisation with a high reporting rate of no harm incidents is a safe place to be.

Our staff reported a total of 2,623 incidents in 2017/18 as opposed to 2,754 incidents in 2016/17 this is a slight decrease of 131 incidents from the previous year, but still shows the consistent reporting rate at the centre. Incident reporting represented 1.1% of our annual activity for 2017/18 which meets our internal target of 0.9%.

Serious incidents and never events

Serious Incidents are defined as 'incidents where care management failures are suspected, which result in serious neglect, serious injury, major permanent harm or death (or the risk of) to a patient as a result of NHS funded health care.' There was one serious incident reported in 2017/18. This incident was regarding care provided to 3 patients on our Short Stay Unit who experienced Pulmonary Embolisms following surgical procedures. A full investigation was undertaken and the findings shared with the CCG and CQC.

Never Events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'. No never events were recorded in 2017/18.

Safety alerts

Alerts issued via the Central Alerting System (CAS) relate to key safety issues that have the potential to cause harm if not acted upon promptly. Safety alerts are an important source of information which enables us to ensure that the safety of our clinical services is our first priority.

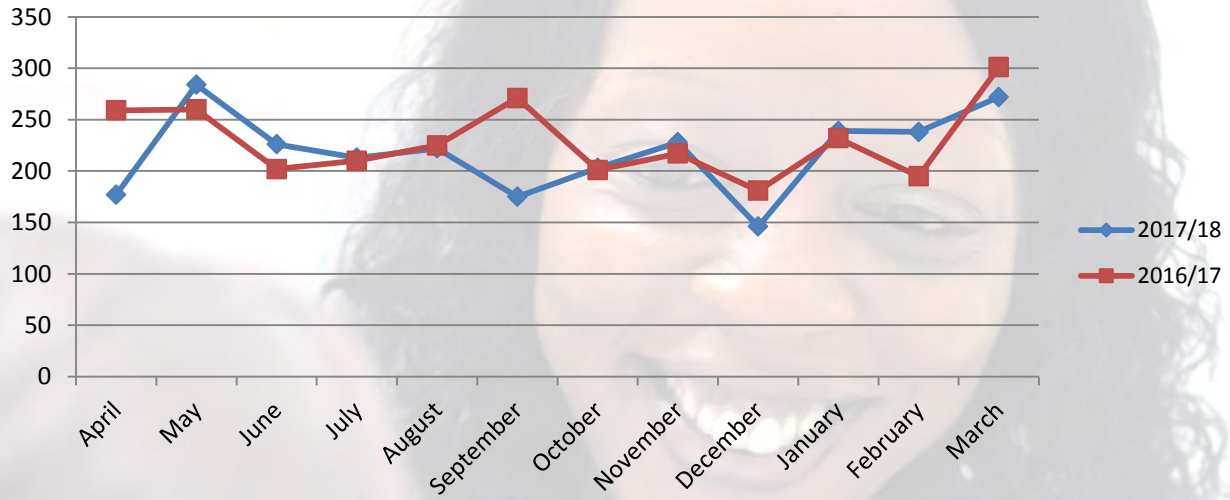
Timely and effective implementation of safety alerts form part of the CQC (Care Quality Commission) Essential Standards of Quality and Safety. Failure to implement safety alerts could result in incidents, complaints, claims and/or inquests and have a significant impact on both staff morale and patient confidence.

Circle Nottingham received 124 safety alerts during 2017/18, 22 of which were applicable to all/some of the services that we provide including 3 NHS England Patient Safety Alerts, 1 Estates & Facilities and 3 Drug Alerts.

All CAS alerts were sent to the Clinical Units within 24 hours of receipt; they were actioned and closed within the relevant timescales.

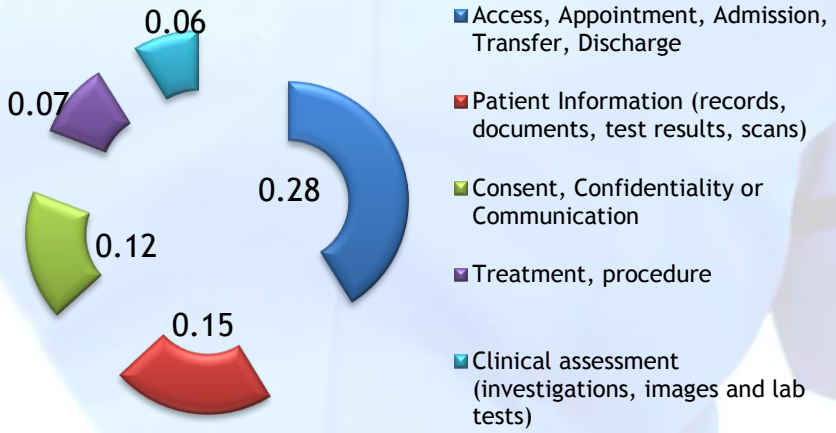
INCIDENT REPORTING

OUR STAFF REPORTED A TOTAL OF **2,623 INCIDENTS**
IN 2017/18 COMPARED TO 2,754 INCIDENTS IN 2016/17



BEST CLINICAL OUTCOMES

THE TOP FIVE INCIDENT CATEGORIES FOR 2017/18 ARE DETAILED BELOW AND WE HAVE USED THIS INFORMATION TO INFORM OUR QUALITY IMPROVEMENT PRIORITIES FOR 2018/19:



REVIEW OF QUALITY PERFORMANCE 2017/18

CONTINUED

BEST PATIENT EXPERIENCE

Claims

There were 5 new clinical negligence claims made against Circle Nottingham, of which 2 claims against Circle Nottingham were closed during 2017/18, 1 was withdrawn and 1 resulted in a settlement.

Patient surveys

At Circle Nottingham, we believe that patient feedback is essential as it provides a rich source of information about the quality of the services we provide. As an organisation we have set out the key principles in our Credo to ensure we listen and act upon what our patients tell us. The most effective way has been through the development of a rapid response card providing real time information which is promptly acted upon by the clinical teams. In 2014/15, electronic tablets were also used to collect feedback on each of our Clinical Units so that patients have increased opportunity to feedback about our services.

Patient & Public Engagement (PPE) Group

The group consists of former and current patients, and members of the public. Circle Nottingham is constantly seeking ways to develop and improve services and patient experience; PPE members assist the centre in providing views, recommendations and support towards implementing various projects and initiatives. Visiting a healthcare facility is an anxious time for most patients, and PPE members appreciate this, therefore their opinions are important in enabling the centre to benefit from a visitor's perspective. Our members have been involved in the following projects in 2017/18.

- Patient information
- Reviewing the centre's Annual Report
- Design of patient letters
- Attending Patient Champion meetings
- Reviewing changes to services
- Involvement in public/patient events
- Attending Partnership events
- Implementing new ideas for patients benefits

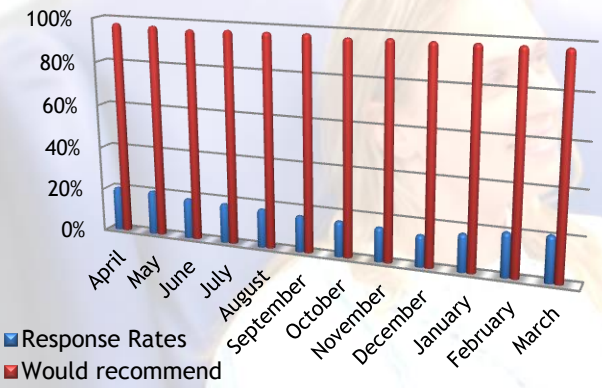
Complaints, Concerns, Comments, Compliments & PALS

At Circle Nottingham, we place feedback from our patients at the very heart of our service and utilise this feedback to ensure that we are maintaining high standards of care. We operate a complaints process that responds flexibly, promptly and effectively to the justifiable concerns of complainants, which therefore enables us to address unacceptable practices promptly, support complainants effectively and promote public confidence in our services.

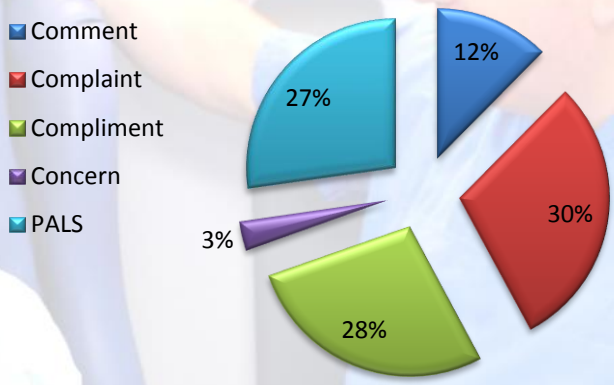
643 pieces of feedback were received during 2017/18; comprised of 191 complaints, 20 concerns, 80 comments, 175 PALS (Patient Advice & Liaison Service) enquiries and 177 compliments.

Complaints and concerns represent 33% of the feedback we received during 2017/18 in opposed to 36% in 2016/17. We have seen an increase in the number of PALS we have received from 171 in 2016/17 to 175 in 2016/17. This is not incidental and is reflective of the excellent work that the gateways have been doing to resolve patient, family and carer concerns as early as possible without the issue needing to be escalated through the 4Cs process. The comparison data demonstrates that our approach is working extremely well. We continue to deal with feedback from our patients, families and carers as patients feel more comfortable raising concerns and queries about their care.

PATIENT SURVEYS

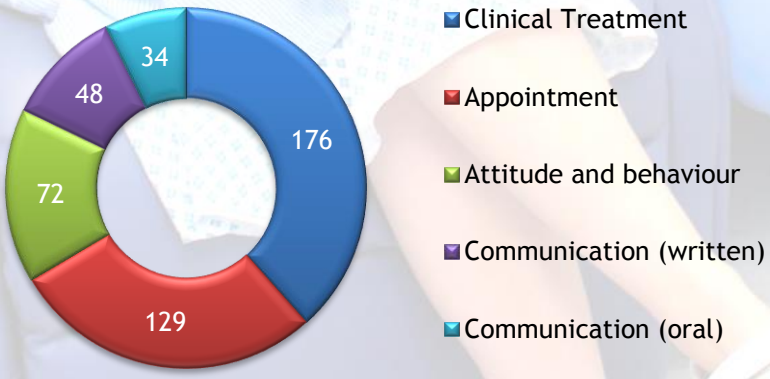


FEEDBACK RECIEVED

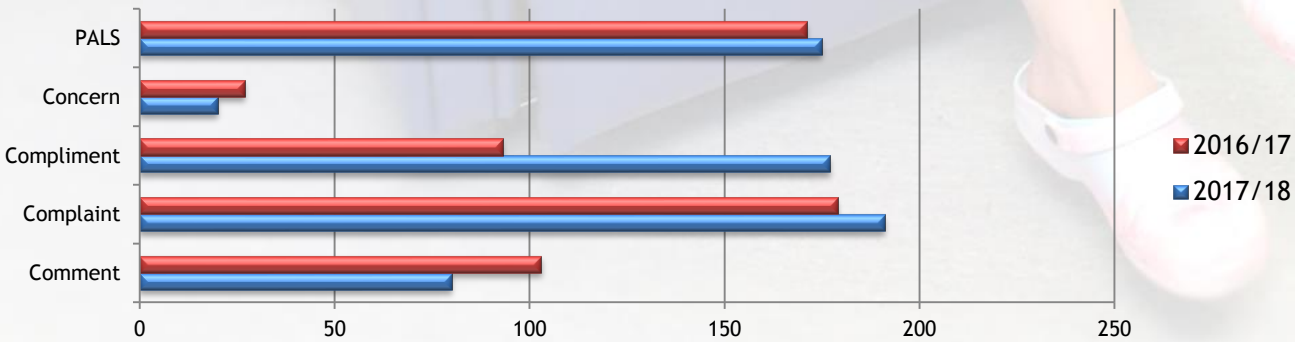


BEST PATIENT EXPERIENCE

THE TOP 5 THEMES FROM COMPLAINTS AND CONCERNS DURING 2017/18



WE HAVE USED THIS INFORMATION TO FEED INTO OUR QUALITY IMPROVEMENT PRIORITIES FOR 2018/19:



QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

All the Quality Improvement Priorities for 2018/19 were chosen due to their association with Patient Experience, Patient Safety and Clinical Effectiveness

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2018/19	2018/19 PROGRESS	MONITORING & REPORTING RESPONSIBILITIES
'Simply the best patient experience' We will continue to grow our services and expand our capabilities to meet the needs of our patients.	To continue to work with the Sustainability Transformation Partnership and Accountable Care Organisation to ensure services meets patient's expectations.	To ensure we meet the needs of the local and national health economy.	Head of Nursing & Head of Operations
	To continue to work with our technical partners to review the requirement needed to improve patient experience.	To improve patient decision making by the use of technology.	Head of Nursing & Head of Operations
'No decision about you without you' We will continue to empower and support our patients to make informed decisions about their care	To ensure we undertake the additional Patient Related Outcome Measures for patients who have undergone cataract and carpal tunnel surgery.	To ensure we review the services we supply and how we can improve patient outcomes.	Head of Nursing
	To undertake Patient Led Assessment of the Care Environment (PLACE).	To review feedback from independent patient representatives who are able to review the current patient environment.	Head of Nursing
	To ensure PHIN feedback is provided by all surgical patients.	To receive detailed feedback from surgical patients.	Head of Nursing

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

All the Quality Improvement Priorities for 2018/19 were chosen due to their association with Patient Experience, Patient Safety and Clinical Effectiveness

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2018/19	2018/19 PROGRESS	MONITORING & REPORTING RESPONSIBILITIES
'Right first time' Right appointment, right clinician, most convenient location	To continue to reduce clinical variation across patient pathways.	To ensure we maintain best clinical practice for all patients.	Head of Nursing
	To ensure clinical services are undertaken in the most appropriate location.	To review if patients can be treated closer to home or in primary care from the use of advice and guidance.	Head of Nursing
	To continue to develop new ways of working to ensure we meet the requirements of the updated Health Economy Strategy.	To ensure we meet the new CQC requirements.	Head of Nursing
'Better than the rest' We will continually improve the quality of our services by delivering our National & Local CQUIN initiatives for 2018/19	To achieve the CQUIN initiatives as agreed with the CCG.	To meet the improvements for patient experience by meeting the CQUIN objectives.	Head of Nursing
	To enable the Nurse Consultants and Clinical Nurse Specialists to meet the needs of the speciality service needs.	To ensure we utilise the specialist nursing workforce to undertake clinical activity in ways to innovate clinical services.	Head of Nursing
	To continue to promote healthy options to our patients by extending Make Every Contact Count and patient education groups.	To ensure opportunities are taken to educate and support patients in managing their health.	Head of Nursing
	To ensure the Patient and Public Engagement group increases its diverse membership to include hard to reach groups.	To advertise to a wider patient group to encourage feedback and participation.	Head of Nursing

MANDATORY STATEMENTS

Review of Services

During 2017/18 Circle Nottingham provided and/or sub-contracted 5 core and a number of additional NHS Services. Circle Nottingham has reviewed all the data available to them on the quality of care provided in all of these NHS Services.

Participation in Clinical Audits & National Confidential Enquiries

During 2017/18, 8 national clinical audits and no national confidential enquiries covered NHS Services that Circle Nottingham provides.

During that period Circle Nottingham participated in 100% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Circle Nottingham was eligible to participate in, actually participated in, and for which data collection was completed during 2017/18 are listed on the following page alongside the number of cases submitted to each audit or enquiry as a percentage of registered cases required by the terms of that audit or enquiry.

The reports of 8 national clinical audits were reviewed by the provider in 2017/18 and Circle Nottingham intends to take the following actions to improve the quality of healthcare provided:

- Continue to proactively support all Clinical Units to ensure participation in national clinical audit and national confidential enquiries where eligible.
- Encourage and promote learning from national clinical audit and national confidential enquiries where they are applicable to the services we offer.
- Share the outcome of national clinical audit and national confidential enquiries at the Clinical Governance & Risk Management Committee (CGRM) to encourage staff engagement, share the learning and ensure continuous quality improvement of all our services.

The reports of 96 local clinical audits, listed on the following pages, were reviewed by the provider in 2017/18 and Circle Nottingham intends to take the following action to improve the quality of healthcare provided:

- Continue to proactively support all Clinical Units in the development of annual clinical audit plans.
- Encourage participation and promote learning from all local clinical audits.
- Utilise the outcome of local clinical audits to build upon the quality of service provision and improve the patient experience.
- Share the outcome of local clinical audits at the Clinical Governance & Risk Management Committee (CGRM) to encourage staff engagement, share the learning and ensure continuous quality improvement of all our services.

MANDATORY STATEMENTS

CONTINUED

Many of our patients have a shared care pathway moving between Circle Nottingham and Nottingham University Hospitals NHS Trust. Where the Treatment Centre only manages a small part of a patient's pathway, an agreement is in place that information will be utilised from the shared healthcare record and included in the relevant shared audits.

In addition to participating in national clinical audits, national confidential enquiries and local clinical audits, Circle Nottingham also undertake a facility wide programme of audits in relation to the following areas: Health & Safety, Information Governance, Medical Records, Infection Prevention & Control, Hand Hygiene, Environmental Hygiene, Fire Safety, Medical Gases, Controlled Drugs and Decontamination. These audits are collected monthly and the responses are monitored through Clinical Governance and Risk Management (CGRM) meetings, Infection Prevention Control (IPC) meetings, and Health and Safety Committee meetings.

NAME OF AUDIT	DEPARTMENT	COMPLIANT	Percentage of cases submitted
Elective surgery (National PROMs Programme)	General surgery, orthopaedic surgery & vascular surgery	Yes	100%
National Joint Registry (NJR)	Orthopaedics	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Rheumatology	Yes	100%
Oesophago-gastric cancer (NAOGC)	Cancer services	Yes	100%
National Prostate Cancer Audit	Cancer services	Yes	100%
Bowel cancer (NBOCAP)	Cancer services	Yes	100%
British Society of Urogynaecology Database	Gynaecology	Yes	100%
National KC65 audit KC65: Colposcopy Clinics, Referrals, Treatments and Outcomes	Gynaecology	Yes	100%

MANDATORY STATEMENTS

CONTINUED

The local clinical audits that Circle Nottingham participated in during 2017/18 are as follows:

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
DERMATOLOGY			
Staff Compliance of PPE in light therapy	The National Institute for Health and Care Excellence (NICE)/British Association of Dermatologists	Complete	100%
Laser Protection Audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Patient satisfaction with Skin Surgery	The National Institute for Health and Care Excellence (NICE) /British Association of Dermatologists	On-going	100%
Biologic Therapy use in Psoriasis against NICE/BAD guidance	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Correct Buzzer Numbers for alerting patients.	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Dermatology Booking	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Do patients with melanoma or squamous cell carcinoma have access to a skin cancer CNS? (ECAG)	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Patch Test Pre-procedure Preparation Letter	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Shared care protocol for Methotrexate	Circle Nottingham in house departmental audit/service evaluation	On-going	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
DERMATOLOGY			
Isotretinoin prescribing	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Are target times for cancer treatment being met for patients with cutaneous squamous cell cancer treated with primary radiotherapy?	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Skin cancer patient satisfaction survey	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Retrospective review of the teledermatology service with quality assurance audit as suggested by the BAD	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
PAIN MANAGEMENT			
Pain Management EQ-5D scores	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
RESPIRATORY			
Non-invasive clinic Audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
DIAGNOSTIC IMAGING			
RRPPS Surveys actioned audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
LMP audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
DIAGNOSTIC IMAGING			
ID audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Sacro iliac joint audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Referral Check : 50% Hand Written, 50% Electronic	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
QA Equipment Tests	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Patients with Frozen Shoulder in need of injection	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Rolling biannual Pregnancy check compliance in X-ray, theatre and DEXA settings audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
RPA Annual Audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Anatomical markers present pre, post processing	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Lateral Knee Technique	Circle Nottingham in house departmental audit/service evaluation	On-going	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
ORTHOPAEDICS			
National Joint Registry (NJR)	National Clinical Audit Programme (NCA)	On-going	100%
Group wide centralised procurement strategy for shoulder and elbow surgery	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Primary arthroscopic anterior shoulder stabilisations using labraltape	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Bias in pre-operative patient recorded outcome measures (proms) for shoulder and elbow surgery	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Impact of a capitated budget whole CCG integrated MSK shoulder service on outcomes and cost efficiency	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Orthopaedic appointment availability	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Exactech Shoulder Arthoplasty	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
MSK triage	Circle Nottingham in house departmental audit/service evaluation	Complete	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
ENDOCRINOLOGY			
Endocrinology 28 day questionnaire	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Hypothyroid telephone audits	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Radioiodine Audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Turners Syndrome Checklist	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Endocrinology Referral	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
RHEUMATOLOGY			
Rheumatoid and Early Inflammatory Arthritis	National Clinical Audit Programme (NCA)	On-going	100%
Audit of use of biologic agents and specifically anti-TNF drugs in RA patients	The National Institute for Health and Care Excellence (NICE)	Complete	100%
Audit of RA management against NICE standards	The National Institute for Health and Care Excellence (NICE)	Complete	100%
Rheumatology 28 day questionnaire	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Iloprost Usage Audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
RHEUMATOLOGY			
Ustekinumab in PsA	The National Institute for Health and Care Excellence (NICE)	Complete	100%
Rheumatology nurse advice line activity (re-audit)	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Pilot an Annual Review Clinic	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
OT/Physio electronic requests	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Compliance of biologic agents against NICE guidelines in Rheumatoid arthritis, Psoriatic arthritis and Spondyolarthritis	The National Institute for Health and Care Excellence (NICE)	Complete	100%
Biosimilar switch	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
GYNAECOLOGY			
British Society of Urogynaecology Database	National Clinical Audit Programme (NCA)	On-going	100%
National KC65 audit KC65: Colposcopy Clinics, Referrals, Treatments and Outcomes	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Colposcopy DNA rates	Circle Nottingham in house departmental audit/service evaluation	Complete	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
GYNAECOLOGY			
Early Returns to Pessary Clinic Audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
DNA audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
DAY SURGERY			
Elective surgery (National PROMs Programme)	National Clinical Audit Programme (NCA)	On-going	100%
WHO surgical safety checklist audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Termination of pregnancy audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Post-Op Telephone Helpline	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
ENDOSCOPY			
Unplanned discharges audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
JAG accreditation for gastrointestinal endoscopy	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Stop moment	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Bowel cleansing audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
ENDOSCOPY			
JAG: Patient Survey	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
JAG: Staff Survey	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
JAG: clinic utilisation	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
JAG: Start and finish time	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
JAG: room turnaround	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
JAG: unplanned transfers and adverse events	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
JAG: 30 day mortality	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
JAG: 8 day readmission	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Pre-assessment Bowel Prep	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
JAG: Endoscopy Key Performance Indicators (KPIs)	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Sedation certificate	Circle Nottingham in house departmental audit/service evaluation	On-going	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
ENDOSCOPY			
IPMS audit (decontamination)	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
IHEEM	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Patient Information	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Nurse feedback on trainers	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Trainer feedback on training	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Peer evalutaion of trainer skills audit	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Environmental checklist	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
DIGESTIVE DISEASES			
Oesophago-gastric cancer (NAOGC)	National Clinical Audit Programme (NCA) N.B - The Nottingham NHS Treatment Centre provide data to contribute to the National Clinical Audit Programme registered by the Nottingham University Hospitals NHS Trust.	On-going	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
DIGESTIVE DISEASES			
National Prostate Cancer Audit	National Clinical Audit Programme (NCA) N.B - The Nottingham NHS Treatment Centre provide data to contribute to the National Clinical Audit Programme registered by the Nottingham University Hospitals NHS Trust.	On-going	100%
Bowel cancer (NBOCAP)	National Clinical Audit Programme (NCA) N.B - The Nottingham NHS Treatment Centre provide data to contribute to the National Clinical Audit Programme registered by the Nottingham University Hospitals NHS Trust.	On-going	100%
Outcomes in patients with IBS, referred for dietetic advice	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
IBD nurse led telephone helpline patient satisfaction audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Patients requiring acute admission from Gateway I	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Review of 2ww LGI patients. How many patients referred fit the NICE criteria and how many could be deferred as routine	Circle Nottingham in house departmental audit/service evaluation	On-going	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
DIGESTIVE DISEASES			
Review of all lower GI referrals. Do they comply with CCG policies?	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
COMMUNITY CLINICS			
Service Evaluation of pre assessment and clinic utilisation	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
SHORT STAY UNIT			
Clinical Audit of Nausea and Vomitting in patients post total knee and Hip replacement.	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
An Audit of the incidence of UTI in Post-op surgical patients in the SSU	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Daily ward checks	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Ward spot checks	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Phone calls incoming to the appropriate location	Circle Nottingham in house departmental audit/service evaluation	Complete	100%
Review of patients who underwent lower limb surgery	Circle Nottingham in house departmental audit/service evaluation	Complete	100%

MANDATORY STATEMENTS

CONTINUED

NAME OF LOCAL AUDIT	AUDIT CATEGORY	COMPLETE/ ON GOING	PERCENTAGE OF CASES SUBMITTED
TREATMENT CENTRE WIDE			
Controlled drugs audit	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
Intentional rounding	Circle Nottingham in house departmental audit/service evaluation/CQUIN	On-going	100%
Antimicrobial Stewardship	Circle Nottingham in house departmental audit/service evaluation/CQUIN	On-going	100%
Making every contact count	Circle Nottingham in house departmental audit/service evaluation/CQUIN	On-going	100%
Prescribing Practices Spot Check	Circle Nottingham in house departmental audit/service evaluation	On-going	100%
QUALITY AND ASSURANCE			
Complaint compliance and quality audit (recordkeeping)	Circle Nottingham in house departmental audit/service evaluation	Complete	100%

MANDATORY STATEMENTS

CONTINUED

Participation in Clinical Research

Circle Nottingham jointly hosts clinical research in conjunction with Nottingham University Hospitals NHS Trust. The number of projects related to NHS services provided by Circle Nottingham in 2017/18, that were undertaken during that period, and that relate to research approved by a Research Ethics Committee, was 12.

All research proposals undergo rigorous checks before clinical research can be undertaken at Circle Nottingham. Applications are made via the Local Research Ethics Committee before approval is considered. The increasing level of agreement to support clinical research demonstrates our commitment to improving the quality of care we offer and contributing to wider health improvement.

Registration and External Review

Circle Nottingham is required to register with the Care Quality Commission and its current registration status is Good. The Care Quality Commission has not taken enforcement action against Circle Nottingham during 2017/18. Circle Nottingham has the following conditions on registration:

SITE	REGULATED ACTIVITY	CONDITIONS
The Nottingham NHS Treatment Centre Lister Road Nottingham NG7 2FT	• Treatment of disease, disorder or injury • Diagnostic and screening procedures • Surgical procedures • Family Planning • Termination of pregnancies (of pregnancy for patients at no more than fourteen weeks (14) gestation within the Nottingham NHS Treatment Centre)	Regulated activity must not be undertaken on persons under the age of 18 years

Circle Nottingham participated in an arranged inspection by the CQC which occurred from 27 to 28 January 2015. The following services were subject to review:

- Surgery
- Outpatients and diagnostic imaging
- Termination of pregnancy

The Treatment centre received an overall rating of 'good' with surgery being graded as 'outstanding'.

CQC inspection area ratings

(Latest report published on 12 May 2015)

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

MANDATORY STATEMENTS

CONTINUED

CQC Inspections and ratings of specific services

(Latest report published on 12 May 2015)

- Termination of pregnancy – Review undertaken in May 2016, assurance provided.
- Surgery - Outstanding
- Outpatients - Good

Two minor compliance actions were identified where improvement was required; action plans were developed immediately and have been implemented. The final report can be reviewed on the CQC website: www.cqc.org.uk.

In May 2016 the CQC visited the Treatment Centre to review the work undertaken regarding the Termination of pregnancy pathway, following the requires improvement rating given in January 2015. The inspectors noted marked improvement and the report on the inspection was published in December 2016. The report can reviewed by visiting the CQC website.

Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of Circle Nottingham's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Circle Nottingham and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Data Quality

Circle Nottingham maintains a high level of data quality and on an on-going basis will be taking the following action to continuously improve data quality:

- Quarterly (at minimum) performance meetings to review performance data, identify any areas of improvement and monitor implementation of those improvements.

Secondary Uses Service

Circle Nottingham submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:

- 99.9% for admitted patient care
- 99.9% for outpatient care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care

Mortalities

Circle Nottingham monitors and records all mortalities and morbidities. All cases are reported and discussed at the monthly clinical unit meetings. Each month at Clinical Governance & Risk Management all cases are presented and discussed for transparency and learning.

MANDATORY STATEMENTS

CONTINUED

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. PROMs are a Department of Health led programme.
CircleNottingham participates in the PROM's survey for hip, knee, groin hernia and vascular vein surgery for NHS. From February 2018, Vascular Vein and Groin Hernia PROMs were no longer required to be monitored. The patient completes the questionnaires prior to their surgery and a second questionnaire is sent to the patient 3 to 6 months post-operatively by a third party, Quality Health, on our behalf.
The outcome data is discussed at Clinical Governance and Risk Management Committee and Executive Board.

Information Governance Toolkit

The Nottingham NHS Treatment Centre Information Governance Assessment Report score overall score for April 2017 – March 2018 was 86% and was graded Green.

NHS Staff Survey Results

In January 2018 Circle Nottingham reported the following trends in the most recent Circle Staff Survey results:

What would you like to keep at CircleNottingham:

- Colleagues/teams/Working relationships
- Working environment/Building
- Patient centred care
- Free car parking
- Credo/Ethos
- Partnership days

What would you want to improve at Circle Nottingham:

- Communication/cross-departmental working
- Space, particularly staff room facilities
- Car parking
- Pay/banding/Salary reviews
- Staff training/development and opportunity for progression
- IT/Systems are slow

Based on the feedback from our staff Circle Nottingham will be:

- Reviewing training opportunities
- Peer teaching sessions from the Clinical Nurse Specialists
- Buddying support between the Theatres and Short Stay Unit teams
- Development for Healthcare Assistants
- Lunch and learn workshops
- Cross departmental working, including joint Partnership Sessions.

Payment by Results

Circle Nottingham was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Duty of Candour

Circle implements the statutory Duty of Candour Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into legal force in 2015 and builds on the requirements set out in the Being Open Framework 2009 "Being Open – Saying Sorry When Things go Wrong" National Patient Safety Agency (NPSA), and Safety Alert 2009.

Circle has a Duty of Candour policy that applies to all facilities including Circle Nottingham, this policy was issued in November 2016. The aim of the policy is to help all health professionals to apply Duty of Candour principles within their daily work. All incidents which involve Duty of Candour are discussed within the

MANDATORY STATEMENTS

CONTINUED

Clinical Governance and Risk Management Committee meetings on a monthly basis, which are then taken to the Executive Board.

Revalidation

Circle Nottingham has embraced the process of revalidation for medical staff in 2017. This is fully implemented and compliance is monitored quarterly by the Circle Integrated Governance Committee.

Safeguarding

The Executive Board is accountable for and committed to ensuring the safeguarding of children and all vulnerable adults in their care. Circle Nottingham also has a responsibility to liaise with other agencies and provide information to them where necessary, to ensure the on-going safety of children and vulnerable adults once they leave our care.

Circle Nottingham's safeguarding team is comprised of an Executive Lead, a Named Nurse and a Named Doctor who attend the Operational Management Board, a sub-committee of the Local Safeguarding Children's Board, and the Safeguarding Partnership meetings.

Circle has a safeguarding policy that applies to all its facilities including Circle Nottingham which was re-reviewed in March 2018. Circle Nottingham adheres to the Nottinghamshire Local Authority safeguarding procedures. All policies are available to staff via the electronic policy library.

Circle Nottingham provides all staff with Level 2 training in safeguarding and provides an update every 2 years. An annual staff leaflet is circulated which provides the contact details of the safeguarding leads and other useful numbers.

In addition safeguarding issues are reported to the Clinical Governance and Risk Management Committee (sub-committee of the Executive Board) which meets monthly. The Executive Board takes the issue of safeguarding extremely seriously, and receives an annual report on safeguarding children.

PART THREE

GATEWAY A

DERMATOLOGY QUALITY ACCOUNT

The Dermatology Department provides a service within an outpatient setting to patients on a chronic skin disease or skin cancer pathway. Consultations consist of a thorough review, diagnostics and a treatment plan, and often require referral for surgery or into specific nurse-led treatments. The Skin Surgery Unit consists of three well equipped theatres, in an outpatient setting. We have a unified team with a cohesive approach to ensure that our patients experience expert, evidence-based and compassionate care throughout their pathway. We adopt a holistic and multi-disciplinary approach to care, to ensure that the social, psychological, medical and physical needs of our patients are addressed.

In 2017/18 the clinical unit has achieved:

- A reduction and reliance of locum Dermatology Consultants through successful recruitment of a Consultant and a second Nurse Consultant.
- Fully operation Sentinel lymph node clinics.
- The implementation of FLO (text messaging service) within the Gateway to support our patients; reducing the number of times our patients need to attend for face to face consultations.
- The introduction of the Mohs ocular reconstruction pathway across both outpatients and day case which has helped reduce the waiting time for this cohort of patients.
- A second rollout of our Teledermatology service across Nottingham to provide advice to primary care as to appropriate treatment plans for patients.
- The establishment of an acne Directory of Service with a detailed work up for primary care to follow to enable patients to commence treatment at the earliest opportunity.
- Participating in multiple trials and studies; ALPHA trial, EXTEND trial, SSCART trial and Raman Spectroscopy.

Lessons learnt in 2017/18:

- Recognised that a Nurse Consultant supporting our general dermatology service would be of benefit to our patients and the service as a whole.
- The expansion of the Teledermatology service has allowed us to provide this service to a wider audience and provide clinical support to primary care without the need to refer to secondary care in the majority of cases.
- Staff training pathways have been altered to meet new challenges.
- Group education is not appropriate for all patients but overall the feedback has been positive from patients using the service.
- Introduction of PLCV has required us to review services and treatment we offer patients to ensure compliance.

GATEWAY A

CONTINUED

Going forward into 2018/19:

- We would like to work with our colleagues in Rheumatology to establish a linked clinic, allowing a multi disciplinary approach to patients requiring input from both areas of expertise to successfully manage their care.
- To expand our current use of FLO to patients who are on Methorexate.
- To gather further evidence to support the need to grow our Clinical Nurse Specialist team based on current activity.
- To ensure that patients are fully informed of their options should their treatment no longer be available on NHS through PLCV.

SERVICES PROVIDED

- A General Dermatology Service for chronic skin disease.
- Skin cancer target clinics.
- Phototherapy.
- Topical treatments including Crude Coal Tar, Dithranol, Corticosteroids, Emollients and Scalp treatments.
- Skin surgery including Mohs micro-graphic surgery and ocular reconstructions.
- Post-operative wound checks.
- Nurse-led biopsy service.
- Leg ulcer clinic.
- Photo dynamic Therapy.
- Patch testing for contact allergies.
- Triamcinolone for Keloid scarring.
- Iontophoresis for Hyperhydrosis (Palmer and Plantar)
- Axillary BOTOX® treatment for hyperhidrosis
- Monitoring clinic for systemic and biological therapy.
- Nurse-led triamcinolone clinic
- Omalizumab clinics for Urticaria

OUR TEAM

Operations Manager 1
Clinical Lead 1
Lead Nurse 1
Gateway Co-ordinator 1
Consultants 7
Surgical Fellow 1
Deputy Lead Nurses 3
Staff Nurses 11
Senior Healthcare Assistant 1
Healthcare Assistants 13
Senior Gateway Receptionists 3
Receptionists 8
Medical Secretaries 5
Skin Surgery Schedulers 2
Data Quality Coordinator 1
General Practitioner with Specialist Interests 6
Registrars 4
Certificate of Eligibility for Specialist Registration 1
Locum Consultants 1
Clinical Fellow 1
Nurse Consultant 2
Advanced Nurse Practitioner 1
Clinical Nurse Specialist 3

GATEWAY A

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To provide convenient care for our patients by: •The Shared Care protocol for patients on Methotrexate. •Care in the community for patients with Acne. •Telephone consultations. •Increase the use of the texting service to include systemic medications.	Commence a database and review monthly to assess uptake of alternative methods of care provision.	Nurse Specialists – Clinical unit meetings.	We support patients on the methotrexate shared care protocol and work closely with our GP partners. An annual review is undertaken by a Dermatologist.	Achieved
			For those patients who have opted out of shared care, the Clinical Nurse Specialist team are looking at using FLO to support our patients.	On-going
			The possibility of implementing an Acne service in the community was discussed and a decision reached not to proceed.	Not Achieved
Increase capacity for Patch, PDT, Triamcinolone and Botox to reduce waiting times.	Review activity and weekly reports.	Gateway leads	Capacity and demand discussions take place within the Clinic Unit Meeting and sessions are either reduced or increased based on need.	Achieved

GATEWAY A

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To continue to develop the service and improve patient experience through the monitoring of feedback and associated actions.	Patient feedback is reviewed regularly by the Dermatology team and responses provided back to the patients through the 'You said, we did' boards.	Feedback steering group	All the data received from the feedback cards is reviewed and any areas of opportunity for improvement is discussed.	Achieved
To engage other teams, such as pharmacy and administration, in the monitoring of feedback.			Feedback is presented visually to our patients on our 'You said, We did' board within the Gateway. There is a quarterly newsletter in place that is circulated to all Dermatology staff.	Achieved
To engage with our Patient and Public Engagement representative and invite to monthly meetings.			The team reviewing the data are represented by both clinical and non-clinical staff, along with our Public and Patient Engagement representative.	Achieved

GATEWAY A

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To continue to liaise with external providers to reduce breaches and to ensure that patients receive treatment within an adequate time frame. e.g. sub-contract for ocular reconstructions.	Continuous monitoring of patient pathways through PTL.	Gateway Co-ordinator and team	We have a joint appointment of a Dermatology Certificate of Eligibility for Specialist Registration (CESR) with University Hospital of Leicester to provide services across both sites. We support the Skin Multi-Disciplinary Team with technology support to allow clinicians out of region to participate. There is a sub contract in place with Nottingham University Hospital NHS Trust (NUH) to provide ocular reconstructions for Mohs patients. We have established strong working relationships with IAPT to be able to signpost patients .	Achieved

GATEWAY A

CONTINUED

QUALITY DOMAIN BEST CLINICAL OUTCOME				
OUR QUALITY PRIORITIES FOR 2017/18	**SUCCESS MEASURES FOR 2017/18**	**MONITORING & REPORTING RESPONSIBILITIES**	**OUTCOME**	**STATUS**
			Mid Nottinghamshire CCG have commissioned Teledermatology . There are community based services in partnership with Keyworth Medical Practice. We have increased the number of local GP's undertaking our pyramid training.	
To enforce the referral of new patients via the Teledermatology pathway, to reduce inappropriate referrals, to support treatment in the community and to ensure that patients requiring secondary care receive it within a timely manner.	To mandate the process.	Gateway Co-ordinator and Operations Manager	We have successfully rolled out Teledermatology to Mid Nottinghamshire CCG offering GP's a fast track clinical triage by a Dermatologist. This has supported a reduction in the overall waiting time for patients being referred in to General Dermatology.	Achieved

GATEWAY A

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To engage in research and audit, to ensure that we are providing the best, evidenced based care.	Data collation.	Lead Nurse with Nursing Team with Consultant Dermatologists	We are participating in multiple trials / studies, including, ALPHA trial, EXTEND trial, SSCART trial and Raman Spectroscopy.	Achieved
To develop the skills of the Skin Cancer Nurse Specialist Team, to enable them to perform skin surgery procedures ,this will reduce waiting times.	Completion of accredited course and in house training.	Nurse Consultant in Skin Cancer with Lead Nurse	Nurse Specialist has been trained to perform skin surgery procedures.	Achieved
To introduce a nurse consultant role for chronic skin disease, to lead and develop the Nurse Specialist service role.	Research and audit.	Lead Nurse and Nurse Consultant	Successfully recruited a Nurse Consultant who is leading the team for Chronic Skin Disease.	Achieved
Review the establishment to ensure there is the required number of nursing and medical staff.	Review of activity and establishment	Lead Nurse with Head of Nursing	Staffing review in progress.	On-going

GATEWAY A

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To encourage and facilitate observation of job roles and to enhance the team knowledge of dermatology.	Identify objective as part of performance review.	All leads	Staff are encouraged to rotate around several areas to enhance their knowledge of the speciality.	Achieved
To engage the nursing team in shared learning with the medical team through attendance at the 'journal club' and other teaching sessions.	Identify objective as part of performance review.	Nursing team leaders	We engage the Education calendar for shared learning to ensure all can attend sessions.	Achieved
Education sessions to include outside guests and Consultants.	Evaluation forms.	Lead nurse	We include guest speakers in our education sessions, including Consultants.	Achieved
Embed COS further across the gateway and engage clinical and non-clinical staff.	Boards and newsletter.	COS champions	We have a weekly newsletter and update the Gateways COS board to inform staff of news and patient experience feedback.	Achieved
Facilitate supervision for the team.	Reflection.	Lead nurse	We have embedded link roles for Healthcare Assistants. We supervise new starters and have supporting competency documents.	Achieved

GATEWAY A

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

96.7%

FORMAL COMPLAINTS AND CONCERNS

32

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

0.70%

NUMBER OF STOP THE LINE EVENTS

4

STAFF TURNOVER %

2.70%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

13.90%

MANDATORY TRAINING - DIRECT HIRE

86%

GATEWAY A

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	Establish a joint clinic with Rheumatology. This will enable improved management of patient medication between departments.	Audit referral rates quarterly and review within the clinical unit.	Clinical Unit Team & Consultant Nurse specialist.
	To continually review and respond to the needs of the service to ensure high quality gold standard care within the agreed timescales for routine and target patients.	Capacity and demand reviews within Clinical Unit in conjunction with the review of patient feedback; alongside regular staffing establishment reviews across both the clinical and non clinical workforce.	Clinical Unit Team & Consultant Nurse Specialist.
	To work with the private patient team to be able to offer treatment to patients that are no longer available via the NHS.	The team will monitor numbers of patients we treat that are private and of those patients who are no longer able to receive their treatment via the NHS.	Clinical Unit Team & Team Leaders.
	To fully embrace and implement the 'getting it right first time' national programme.	On a monthly basis the team will review all feedback from patients and implement feasible changes requested.	Clinical Unit Team.
	To promote the Acne service directory and support GP's with the referral to enable treatment to commence immediately.	The administration team will monitor the number of appointments made and the allocation of these appointments to see if this pathway is working successfully.	Clinical Unit Team.

GATEWAY A

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Clinical Outcome	To expand our current use of FLO to support the management of Methotrexate patients.	Review use of FLO on an ongoing basis.	Clinical Unit Team & Consultant Nurse Specialist.
	Increase shared care with primary care. Isotretinoin clinics to be linked to GP practices for on-going monitoring and prescriptions.	Audit of follow up appointments and the waiting lists on a monthly basis.	Clinical Unit Team & Consultant Nurse Specialist.
	To continue to be a research focused department and support various national and local trials.	A regular review of the results from trials and the effect these have had for our patients.	Consultants & Quality & Assurance Research Facilitator.
Most Engaged Staff	To engage the nursing team in shared learning with the medical team through the attendance of 'journal club' and other teaching sessions.	An objective set for the nursing and medical teams, with the Deputy Lead Nurses monitoring progress.	Deputy Lead Nurses.
	To develop a new starter induction package that provides staff with time to experience each area of Dermatology, to enable them to have a wider understanding of the services we offer.	The package will be reviewed and updated following feedback from staff who have completed the induction.	Clinical Unit Leads.
	To implement and embed 'employee of the month' across the department .	Staff will elect anonymously a staff member on a monthly basis.	Clinic Unit Team.
	To provide support to members of our Dermatology team we will facilitate additional supervision for the team members to ensure they receive all the information they need to feel confident in their roles.	This will be monitored by One to Ones, performance reviews and staff allocated to Team Leaders to review competencies.	Clinical Unit Leads.


Circle

GATEWAY B

HYPERTENSION, RESPIRATORY, PAIN, VASCULAR & OPHTHALMOLOGY QUALITY ACCOUNT

Gateway B is home to a number of different specialities, all led by Consultants and supported by an extensive and experienced team compromising of Registered Nurses, Healthcare Assistants and an administrative team. We have a lung function team led by our Chief Clinical Physiologist who support our Respiratory patients and patients within pre-assessment when required. Where possible we endeavour to support "on the day" testing in our clinics allowing our patients to leave the gateway with a clear understanding of their diagnosis and on-going management plan.

The gateway is pleased to support the teaching of student nurses from both Nottingham and Derby Universities.

In 2017/18 the clinical unit has achieved:

- Successful and safe transition of a large cohort of Pain patients to Primary Integrated Community Service (PICS), following a change of contract with Rushcliffe and neighbouring Clinical Commissioning Groups.
- Medication review clinics were established and have been successful in monitoring prescriptions for pain patients.
- Recruited a team for Lung Function following withdrawal of the service from Nottingham University NHS Hospitals Trust. This ensures a seamless transition for patients. There is one outstanding vacancy to be recruited to.
- Continue to provide educational sessions during our partnership sessions.
- Completion of initial bespoke training for an Registered General Nurse (RGN) to support a new "Cough Clinic" service which is due to commence later in 2018.
- Successful implementation of the Procedures of Limited Clinical Value (PLCV) Policy within the Gateway.

Lessons learnt in 2017/18:

- A new "Cough Clinic" service is required for respiratory patients, enabling patients to be assessed and initial tests completed prior to consultation with the Consultant, this service will run as a One Stop Clinic.
- Opportunity to make changes to the lung function service now this is delivered in house giving positive benefits to the patients.
- Lessons learnt on communication from the transition of Pain patients to PICS where we needed to ensure patients were well informed and communicated with at all stages of the process.

GATEWAY B
CONTINUED

Going forward into 2018/19:

- Safe transition of the next cohort of Pain patients into the community by July 2018.
- A Lung Function staff vacancy to be recruited to.
- Develop a Multi-disciplinary patient feedback group. The group will look at feedback, both positive and negative, from our patients in greater detail. This group will include our Patient and Public Engagement member. Monthly meetings will be held and action plans devised and reviewed.
- Create a "Talking Wall" for staff to share their own feedback and compliments to each other.
- Recognition of individual staff for achievements each month using an employee of the month scheme.
- Explore the feasibility of setting up a Sleep Multi-Disciplinary Team.
- To support Getting it Right First Time (GIRFT) and working with primary care to ensure that patients have the correct information prior to a referral into secondary care.
- To continue to innovate and identify areas for opportunities to improve patient pathways in line with NHS initiatives and new technology.

SERVICES PROVIDED

- Vascular
- Hypertension
- Respiratory
  - General respiratory conditions
  - Sleep problems (including insomnia clinics)
  - Asthma
  - Chronic obstructive pulmonary disease
  - Physiotherapy-led bronchiectasis service
  - Lung Function testing
- Pain
  - Trigger point injections
  - Self-management of back pain
  - Acupuncture (for patients within the City Commissioning area)
  - Biopsycho Social Specialist
  - Medication review clinics
- Ophthalmology (this service is provided to patients of University of Leicester NHS Trust only)
  - Cataracts

OUR TEAM

Operations Manager 1
Clinical Lead 1
Lead Nurse 1
Gateway Co-ordinator 1
Consultants/doctors 20
Team Leaders 1
Staff Nurses 3
Healthcare Assistants 6
Senior Gateway Receptionists 1
Receptionists 6
Medical Secretaries 4
Clinical Nurse Specialists 3
Chief Clinical Physiologists 1
Associate Physiologists 3

GATEWAY B

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To have all services available on NHS E-Referrals and to review the Directory of Services (DOS) to support advice and guidance requested by GP's to support appropriate referrals and the CQUIN.	GP's will book patients into the correct clinic first time. DOS will be updated to allow service user's access to Advice and Guidance and receive a prompt response.	Clinical Unit Team.	All services are on the Choose & Book system. Advice and Guidance is an on-going process. Administration teams are working in conjunction with relevant Clinician to provide a rapid response to any requests.	Achieved
Introduce a more thorough vetting process of referrals to ensure patients are seen in the appropriate clinic.	All referrals to the gateway will be vetted by the correct clinician. Decrease in patients having appointments moved to the correct clinic.	Clinical Unit Team.	A robust vetting process is in place across all specialties.	Achieved
Ensure that where possible diagnostic tests are arranged prior to the patient's consultation.	Increase in patients being offered Lung Function Tests appointments prior to 8 weeks.	Clinical Unit Team.	A vast majority of Lung Function patients have an on the day appointment for testing. Patients results are available for the consultation on the day.	Achieved

GATEWAY B

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To proactively reduce the waiting list for Lung Function Tests to less than 8 weeks.	Increase in patients being offered Lung Function Test appointments prior to 8 weeks.	Clinical Unit Team.	There has been a decrease in the waiting lists for Lung Function testing. The average waiting time is 2-4 weeks for the majority of tests. Pulmonary Function tests have an average waiting time of 6 weeks.	Achieved

GATEWAY B

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To audit the inbound calls received on the Gateway and the types of queries from patients to see how we can change processes to support.	To see a reduction in patients phoning the Gateway with queries. Completion of audit.	Clinical Unit Team.	An audit of the volume of calls to the gateway from patients with clinical queries has shown that these calls have become infrequent.	Achieved
EQ5D data collated within Pain Services.	Evaluation of data to show what improvements the patients have had to quality of life.	Clinical Lead.	This is now a fully embedded process within the gateway. A report is produced each month. This will be an on-going process within the gateway.	Achieved
Nurse-led medication review clinic established within Pain Service to ensure that repeat prescriptions for 'red drugs' are reviewed.	Yearly clinic reviews for patients using red drugs to assess kidney and liver function.	Clinical Unit Team.	Any patients requiring long term 'red drugs' are monitored and liver/renal function is assessed where appropriate.	Achieved

GATEWAY B

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Consultants to support both clinical and non-clinical staff in providing the opportunity to observe clinics/theatre lists to enhance their understanding of conditions/ speciality that are seen within the Gateway.	All staff will have an increased understanding of Specialties/ Conditions within the Gateway.	Clinical Unit Team.	All staff have agreed their objectives and personal development plans through the appraisal process, which includes observations.	On-going
Team events to be included within Partnership Sessions, relevant to the gateway. Specific sessions that have been requested by the team include Communication workshop.	Events will be arranged within the Partnership Sessions, the team will provide feedback on the session.	Clinical Unit Team.	Clinical teaching sessions were identified and delivered to the team via the Partnership Sessions. There is an on-going plan of identified sessions for team members to attend.	Achieved

GATEWAY B

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

97.2%

FORMAL COMPLAINTS AND CONCERNS

15

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

0.5%

NUMBER OF STOP THE LINE EVENTS

0

STAFF TURNOVER %

2.80%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

8.20%

MANDATORY TRAINING - DIRECT HIRE

82%

GATEWAY B

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	Develop a Multi Disciplinary patient feedback group, who will review feedback both positive and negative from our patients in greater detail; this group will include our Patient and Public Engagement member for the gateway.	Monthly meetings will be held with action plans devised and reviewed each month. Results of improvements will be displayed on the "You said, We did" boards.	Clinical Unit Leads.
	Increase the number of telephone follow up clinics in all specialties in the gateway where clinically appropriate. This will reduce unnecessary follow-up appointments and improve waiting times in clinics by increasing capacity for more consultations.	A reduction of all follow-ups and face to face appointments being booked.	Clinical Unit Leads.
	To implement a Sleep MDT to provide a faster and more efficient service to the patients.	A cost saving to the CCG, a faster pathway for the patients and a reduction in the number of follow ups required.	Clinical Unit Leads.
	Ensure a smooth transition for the Pain patients under Nottingham City CCG as they are transferred into a community setting in July 2018.	All patients successfully identified and transferred to the community provider.	Clinical Unit Leads.
	To implement a more robust and thorough vetting process for Vascular referrals; to reduce inappropriate referrals and decrease DNA's within this patient group.	Decrease in DNA rate for Vascular referrals. Reduction in inappropriate referrals from primary care.	Clinical Unit Leads.

GATEWAY B

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Clinical Outcome	Increase participation in clinical research relevant to the specialties within the gateway. Staff to undertake the Good Clinical Practice (GCP) Course to support clinicians.	Increase in research trials on the gateway. Successful completion of GCP by staff.	Clinical Unit Leads.
	Where possible to provide one stop services to our patients and receive treatment on the same day as their first outpatient consultation.	Monitored and reported on our Quality Quartet.	Clinical Unit Leads.
Most Engaged Staff	Create a "Talking Wall" for staff to share their own feedback and compliments to each other.	Staff having an increased awareness of the value they bring to the team and each other.	Clinical Unit Leads.
	Identify individuals for learning opportunities and development to include: • Institute of Leadership and Management Course • Cough Clinic competencies • Health assessment qualifications	Evidence of continuing development/training programme for the team. Competent staff providing clinically effective and efficient respiratory service.	Clinical Unit Leads.
	Recognition of individual staff achievements each month using an employee of the month scheme.	Increase staff engagement.	Clinical Unit Leads.

GATEWAY C

RADIOLOGY QUALITY ACCOUNT

Radiology Services are situated in Gateway C. The unit consists of one magnetic resonance imaging (MRI) scanner, one computerised tomography (CT) scanner, three x-ray rooms, three ultrasound machines, three image intensifiers, a mobile X-ray machine and a DEXA scanner. Our patients come from many different disciplines, such as orthopaedics, rheumatology, respiratory, gynaecology, gastro-intestinal and pain management.

In 2017/18 the clinical unit has achieved:

- Training posts have been established in CT and MRI for members of the plain film team. This has helped strengthen the team and facilitate a more flexible, efficacious service delivery model. This has also meant that we have been able to succession plan in order to future proof the service and create development opportunities for members of the team.
- We have recruited three newly qualified radiographers into their first posts. They have not only undergone corporate and local departmental induction programs, but have been part of a three month preceptorship program which has supported them through the start of their new careers.
- A new senior member of the administration team has been recruited to support the Gateway Co-ordinator and the rest of the team in day to day operational activity.
- The entire DEXA service has now been brought in-house and is delivered solely by the Treatment Centre. This has been an exciting development with the possibility of expanding the service down a sports medicine route as well as developing the existing service. Staff from plain film have been trained. This has enabled them to develop and also create a more robust service delivery model.
- We have established SMS text reminders to patients. This has helped in reducing wasted appointment slots and helped to contribute to a timelier patient pathway.
- We have introduced evening MRI appointment slots for patients who will need an injection of contrast as part of their procedure. This helps with reducing waiting times for patients, leading to a more timely diagnosis and subsequent treatment. This has also made it easier for those patients who are unable to attend during the day because of work and / or child care related commitments.
- Team forums are a regular weekly feature where good practice is shared and problem solving plays a vital role in developing service delivery and patient experience. Fortnightly meetings between the Gateway Co-ordinator and the Radiology Lead have also been introduced.
- We have received feedback from patients regarding out of date information leaflets. These have now been reviewed. We are now getting vital information to the patients in a way that is accessible and coherent.
- We are working collaboratively with other service providers to offer greater patient choice and to assist in reducing waiting times.
- We have set up a drop-in service for patients with a suspected cancer who are referred by our gynaecology consultants. These patients will be referred for a scan and will be offered an appointment the same day. This facilitates a timely diagnosis and a timely start of treatment if appropriate.

GATEWAY C
CONTINUED

Lessons learnt in 2017/18:

A need for service delivery to be responsive to service disruption and resource capacity issues, such as:

- The team has worked very hard through some difficult times including disruptions to the service due to equipment breaking down. Contingencies were put in place and support was provided in line with Business Continuity Planning.
- The demand for the service we provide has grown and innovative ways of re-engineering resources and processes have been key to meet this increase in demand. A move to six day working and additional lists in the evenings on an ad-hoc basis has helped accomplish this.
- The need for collaborative working, this has not only put the patient at the heart of receiving timely service delivery, but has proved to become a pivotal tool in healthcare delivery moving forward.

A need for improved communication between clinical and non-clinical members of the team:

- This has made maintaining service delivery through difficult times possible such as equipment breakdown and capacity shortfalls.
- This has resulted in a stronger appreciation for each other's roles and how these roles contribute to effective service delivery.
- So a pro-active approach can be taken in times of potential service disruption. Instead of working separately, our teams now work parallel to each other.
- A multi-disciplinary approach to problem solving has led to improved patient experience and a stronger resource base.
- Newly introduced scheduling meetings have meant that potential challenges are highlighted earlier and a swift resolution can be achieved.

Going forward into 2018/19:

The team will commence work towards ISAS (Imaging Services Accreditation Scheme). The Nottingham site will learn lessons from the Reading site as they have gone through accreditation first. This will be achieved in stages by:

- Conducting a gap analysis to ascertain where we already have the required documentation, evidence and proof that it is already embedded and being monitored, and where this still needs to be established.
- The Radiology Lead has been trained as an ISAS assessor and has already assessed two other sites. This will enable him to give insight into the process and how best to succeed.
- Staff will be engaged through an introductory open forum, where team members can ask questions regarding the process and resources, and provide ideas for moving forward with the accreditation.
- Fortnightly meetings will be established where progress can be monitored and issues can be raised.

GATEWAY C
CONTINUED

Explore growing the service through:
- Expansion of the DEXA service with potentially sport and exercise medicine referring into the service.
- Referrals for MRI are growing at a rate of 13% year on year. Measures to harness more resources to provide capacity for this expected demand will be crucial in the planning and execution phases.
- Establish a six day working week in MRI as well as extended days to also assist in meeting projected increase in demand.

Explore developing the team through:
- Continuing to train members of the team in MRI and CT, and succession plan for the future.
- Also continuing to train members of the team in DEXA and succession plan for the future.
- Involving the team in ISAS accreditation and giving them an insight into the process as well as possibly encouraging them to become assessors in the future.

Explore growing the service through:
- Expansion of the DEXA service with potential sport and exercise medicine referring into the service.
- Referrals for MRI are growing at a rate of 13% year on year. Measures to harness more resources to provide capacity for this expected demand will be crucial in the planning and execution phases.
- Establish a six day working week in MRI as well as extended days to also assist in meeting projected increase in demand moving forward.

Explore developing the team through:
- Continuing to train members of the team in MRI and CT and succession plan for the future.
- Also continuing to train members of the team in DEXA and succession plan for the future.
- Involving the team in ISAS accreditation and giving them an insight into the process as well as possibly encouraging them to become assessors in the future.

SERVICES PROVIDED
- Plain Film Radiography
- Mobile Radiography
- Image Intensifier Screening for Interventional and Therapeutic Procedures in Theatres
- Image Intensifier Screening for Interventional and Therapeutic Procedures in Department
- Diagnostic Ultrasound
- Interventional Ultrasound
- Ultrasound Guided Therapeutic Procedures
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- DEXA

OUR TEAM
Operations Manager 1
Lead Radiographer 1
Gateway Co-ordinator 1
Radiographers 10
Team Leaders 2
Healthcare Assistants 5
Administrators 6

GATEWAY C

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
ISAS - Imaging Services Accreditation Scheme. This is a patient focused assessment and accreditation scheme. Designed to help diagnostic imaging services ensure that their patients: • consistently receive high quality services, • which are delivered by competent staff, • in a safe working environment.	On-going monitoring – Gap analysis to be completed.	Lead Radiographer PF Team Lead CT/MR Lead.	Reading has been chosen to be the first site to go for accreditation. But lessons learnt throughout the process will be used to advance the Treatment Centre accreditation when the process begins. This should make creation of the narrative and examples of documented evidence, as well as evidence of monitoring, a lot easier to acquire and present.	On-going

GATEWAY C

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Aim to reduce waiting times for US, CT and MRI.	Monitor waiting times, re-engineer where appropriate and act on findings.	Lead Radiographer.	This will always be an on-going objective, going hand in hand with service delivery development and an ever changing demand on the service. Close monitoring by the administration team with cascading of waiting times per modality and per specialty, has seen a more robust process for escalation of concerns at a much earlier stage, thus preventing a fire fighting scenario and subsequent breaches. Engaging external, third parties has also helped to deliver a timely service and avoid out of month breaches wherever possible.	Achieved

GATEWAY C

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Improve the explanatory literature for patients to read and understand prior to CT/MRI procedures. This will empower them and facilitate a better patient experience.	Production of leaflets. Audit patient satisfaction.	Lead Radiographer CT/MR Lead.	Great strides have been made in this area, with clearer instructions and approachable information being incorporated in the patient leaflets. This will be a on-going process as we react to patient feedback with Circle's "You said, We did" ethos. Also recent changes to legislation have meant a more transparent approach to delivering the risks and benefits of radiation be made available to the patient.	Achieved

GATEWAY C

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Meet and aim to exceed expectations regarding reporting turnaround times.	Monitor reporting turnaround times, re-engineer where appropriate and act on findings.	Lead Radiographer.	Reporting turnaround times have proven to be excellent and in most areas have met or exceeded expectations. Where this has not quite always been the case, swift action through robust monitoring and escalation has proven beneficial in remedying the situation. On-going monitoring is taking place.	Achieved
Health Assure – This is a tool which enables narrative and documentary support to be recorded and stored in order to evidence CQCs Key Lines of Enquiry.	Baseline narrative completed – Population of documentation to evidence narrative, started.	Lead Radiographer PF Team Lead CT/MRI Lead.	The narrative has been completed and documentary evidence is well under way with members of the team taking the lead. This narrative and evidence will support and feed into that of ISAS, where cross pollination will make the ISAS process that much easier.	Achieved

GATEWAY C

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Continue program of training staff in different modalities.	Staff member competent in CT / MRI. Staff member competent in DXA scanning.	Lead Radiographer CT/MRI Lead DXA Lead.	The on-going training of staff in MRI and CT continues, with one member of staff completing successfully and another well on the way to completion. A third is receiving training in the future. Two members of staff at different stages are undergoing training in DEXA also. On-going succession planning in all modalities is proving beneficial for a robust and flexible service delivery.	On-going
Explore possibility of radiographers attending reporting courses.	Courses attended and progress measured and recorded against qualification.	Lead Radiographer.	At this present time this has not been explored and more work on this will be taken forward in 2018/19.	Not Achieved

GATEWAY C

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

98.2%

FORMAL COMPLAINTS AND CONCERNS

5

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

1.2%

NUMBER OF STOP THE LINE EVENTS

3

STAFF TURNOVER %

5%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

23.40%

MANDATORY TRAINING - DIRECT HIRE

80%

GATEWAY C

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	Embed a six day working week in MRI as well as extended days to give greater patient choice moving forward, this will be supported by an increase in establishment.	Six day working week and extended hours established in MRI.	CT/MRI Lead Radiographer.
	Continue to promote utilisation of spare capacity in Gateway C to other Gateways, to expand upon where it is possible to facilitate timely patient pathways and enable the best use of Treatment Centre capacity.	Continued collaborative working with other gateways and full use of spare capacity in Gateway C by other gateways.	Radiography Team Lead.
Best Clinical Outcome	Expansion of the DEXA service with potential sport and exercise medicine referring into the service.	New referral pathways established.	Radiography Team Lead.
	Harness more resources to provide additional capacity for expected increase in demand for MRI services year on year, contributing to an efficacious diagnostic pathway.	Establishment increase and additional second scanner in place.	CT/MRI Lead Radiographer.
Most Engaged Staff	To continue to train members of the team in MRI and CT and succession plan for the future.	More rotational staff trained as competent in CT and MRI.	CT/MRI Lead Radiographer.
	To continue to train members of the team in DEXA and succession plan for the future.	More rotational staff trained as competent in DEXA.	Radiography Team Lead.
	To involve the team in ISAS accreditation and giving them an insight into the process as well as possibly encouraging them to become assessors in the future.	Establish an ISAS culture in readiness for accreditation application.	Lead Radiographer.

GATEWAY D

SHORT STAY UNIT QUALITY ACCOUNT

The Short Stay Unit opened in April 2014, has 16 beds and provides inpatient care to those patients who require post-operative care following their surgery. This is a consultant led service. We work closely with the physiotherapist and occupational therapists to support patient's recovery and discharge. We have links with Pharmaxo who support with daily rounds to ensure all patients medications are provided safely. The Resident Medical Officer (RMO) undertakes ward rounds 3 times a day to ensure patients are safe, recovering well and any concerns are quickly raised with the consultant managing their care. The RMO works with the nursing team to provide a high standard of care for all.

We also support patients who need help before and after endoscopies, especially with the preparation for the procedure. The unit also accommodates patients who need infusions of medication over the weekend to allow for continuous treatment plans.

From our patient feedback we have received 100% satisfaction from our patients regarding the nutritional food that is prepared by our trained Chef.

In 2017/18 the clinical unit has achieved:

- Development of training and competency for patients with CPAP machines.
- Our staff Partnership Sessions have included the importance of maintaining accurate fluid balance charts, catheter care and support for patients when removed, venous thrombosis prevention training and care of patients post gynaecological procedures.
- We have increased the number of beds to 16.
- We have installed a monitor to support patients with sleep apnoea.
- We have undertaken audits that show our patients are happy with the food and nutrition they receive.

Lessons learnt in 2017/18:

- The feedback we have received from our patients has reassured us we are giving a good standard of care.
- The staff need the support of a senior nurse throughout the day and we have provided this.
- The dependency of patients can change and we have rearranged our rotas to ensure staff have fewer patients to care for on operation days.
- We need a booklet that holds all the paperwork to support joint replacement patients, and this is being developed.

GATEWAY D

SHORT STAY UNIT CONTINUED

Going forward into 2018/19:

- We want to ask more patients to become mystery shoppers and provide us with in-depth feedback.
- We aim to develop a support service for patients when they have been discharged home to prevent them having to see their own doctor or attend accident and emergency.
- We will be concentrating on training staff and supporting them to reduce drug errors.
- We will introduce link workers to ensure we have experts in the areas that support our patients e.g. diabetes, wound care.

SERVICES PROVIDED

- Complex and day case Gynaecology
- Complex Orthopaedic (joint replacements) and day case procedures
- Monitoring of patients with sleep apnoea following surgery
- Patients requiring extended recovery following day case surgery
- Following surgery the unit cares for those patients requiring care for social reasons
- Endocrinology supporting extended diagnostic testing
- Medical day case extended infusions and weekend infusions
- Endoscopy patients requiring assistance with administration of bowel prep and care post endoscopy for social reasons
- Physiotherapy twice daily for patients who are recovering from a joint replacement surgery
- Occupational therapy support for orthopaedic patients

OUR TEAM

Operations Manager 1
Clinical Lead 1
Lead Nurse 1
Gateway Co-ordinator 1
Resident Medical Officer 1
Staff Nurses 10
Team Leaders 2
Lead Nurse 1
Healthcare Assistants 10

GATEWAY D

SHORT STAY UNIT CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Monitor menu and food provided following SWARM.	Patient feedback and audit.	Team Leaders.	We now have a link worker who undertakes an audit regularly to understand patients' needs and requirements.	Achieved
Monitor documentation and basic nursing care to ensure all patients activities of daily living are met.	Document-ation Audit.	Team Leaders.	Documentation audits are now completed monthly to ensure all activities of daily living are met. This information is reviewed at the clinical unit meeting	Achieved
Provide regular patient feedback to all patients on SSU through embedding COS and regularly updating and auctioning 'You Said, We did' Board.	COS board.	Ward team.	Within the unit we have regularly updated the patient information feedback boards to ensure our patients are aware of the changes we have made from their comments.	Achieved

GATEWAY D

SHORT STAY UNIT CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Consistent medical reviews by Resident Medical Officer (RMO) to promote patient safety, early detection of deteriorating patients and promote patient confidence in ward team.	Clinical Unit meeting. Spot checks – three sets of notes per week reviewed during clinical unit meeting.	Clinical unit team.	The RMO visits the patient three times a day, and regular spot checks are undertaken. A checklist has been provided to the RMO's which they complete to provide assurance that all the necessary checks have been done.	Achieved
Enhance major surgery recovery through audit and research – including but not limited to Orthopaedics and Gynecology.	Re-Audit.	Team Leaders.	Orthopaedic patients are being consistently discharged on day two of their stay on the unit. Going forward we are developing an audit and research project to monitor this.	On-going
Stores and Drug Ordering Process improvement to identify any cost saving/ Improvement.	Patient feedback/ finance feedback .	Team Leaders.	We have developed electronic ordering systems and have nominated leads within the team to take responsibility for any orders made.	Achieved
Improve Occupational Therapy and ward communications ensuring good pathway and processes in place.	Create Pathway.	Ward Team and Occupational Therapy team.	The occupational therapy team visit the ward daily and have developed good communication with the nursing team.	Achieved

GATEWAY D

SHORT STAY UNIT CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Scenario training throughout the year to empower staff.	Training records.	Team Leaders.	We have had some scenario training but recognise this needs to be more robustly planned and actioned.	On-going
Focused, in-depth Partnership sessions, with rotating staff feeding back learning opportunities.	Partnership Session notes.	Ward team.	We have had good attendance with all staff attending the session in December 2017. The agendas have been robust, with positive feedback from the staff.	Achieved
Clinical Education sessions provided from MDT to expand staffs knowledge.	Education material.	All.	This has been well supported by the Lead Nurse from Gynaecology and the Nurse Specialists in Orthopaedics. The Theatre Lead and Clinical Lead have held sessions on airway management and sleep apnoea.	Achieved

GATEWAY D

SHORT STAY UNIT CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

99%

FORMAL COMPLAINTS AND CONCERNS

2

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

7.9%

NUMBER OF STOP THE LINE EVENTS

0

STAFF TURNOVER %

5.10%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

18%

MANDATORY TRAINING - DIRECT HIRE

92%

GATEWAY D

SHORT STAY UNIT

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	The team will be recruiting mystery shoppers in order to receive more information on recommended areas for improvement.	Clinical Outcomes Caller to provide feedback from patients from the mystery shopper questionnaires, information to be reviewed and changes implemented.	Clinical Unit Leads
	A review of the aftercare provided to our patients to ensure we are meeting all their needs when they are discharged following surgery.	A monthly review of the telephone calls received from our patients following discharge to understand any lessons learnt.	Clinical Unit team.
Best Clinical Outcome	Close monitoring of falls within the unit and how changes can be made to ensure our patients do not experience such falls in future.	Monthly monitoring of the Quality Quartet and an ongoing analysis of information following a patient's fall on the unit.	Clinical Unit Leads.
	A review of the drug monitoring to ensure no drug errors occur on the unit, this will be audited, and training will be provided from the Pharmacy team to the nursing team on a regular basis, to ensure all have the relevant and up to date information available to them.	All drug errors to be reported on the risk management system and lessons learnt implemented within the unit.	Clinical Unit Leads.

GATEWAY D

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Most Engaged Staff	Introducing Link Workers, who have completed the AIMS course. 10 members of staff will monitor specific areas focusing on a key topic.	Feedback will be provided by the Link Workers at the Partnership Sessions and resource folders will be produced for all key areas.	Clinical Unit Leads and Link Workers.
	We will launch Employee of the Month so staff receive recognition and appreciation from their colleagues.	An award will be provided to the Employee of the Month on a monthly basis.	Deputy Lead Nurses.
	The staff questionnaire will continue so we can understand and implement changes our team wish to make in the unit and their working life.	The Deputy Lead Nurses will monitor the responses from the questionnaires and make changes where required.	Deputy Lead Nurses.
	Look at embedding a buddy system between Gateway G and the unit to ensure a more efficient work flow and smoother transition for patients. This will help to minimise cancellations on the day and ensure theatre lists run smoothly.	Team leaders to have monthly meetings to review where further communication is needed.	Clinical Unit Leads.


Circle's Credo
Our purpose – **To build a great company dedicated to our patients.** Our parameters – We focus our efforts exclusively on: What we are passionate about. What we can become best at. What drives our economic sustainability. Our principles – **We are above all the agents of our patients.** We aim to exceed their expectations everytime so that we earn their trust and loyalty. We strive to continuously improve the quality and the value of the care we give our patients. **We empower our people to do their best**. Our people are our greatest asset. We should select them attentively and invest in them passionately. As everyone matters, everyone who contributes should be a Partner in all that we do. In return, we expect them to give their patients all that they can. **We are unrelenting in the pursuit of excellence.** We embrace innovation and learn from our mistakes. We measure everything we do and we share the data with all to judge. Pursuing our ambition to be the best healthcare provider is a never-ending process. 'Good enough' never is

GATEWAY E

ENDOCRINOLOGY, RHEUMATOLOGY & ORTHOPAEDICS QUALITY ACCOUNT

Rheumatology

Rheumatology services are provided by a dedicated team of 9 Consultants and 5 Nurse Specialists with specialised clinical services to support the diagnosis and management of patients with rheumatology disorders. These include clinics for patients with rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, vasculitis, lupus and other connective tissue disorders, osteoporosis, crystal arthritis and other rheumatic disorders. There is access to a full range of laboratory blood tests, and imaging with ultrasound, MRI, DEXA and other scans to allow for the comprehensive assessment of patients. There is a daycase infusion unit at the Treatment Centre for biological therapy, chemotherapy and iloprost which are administered to patients with severe inflammatory arthritis and multisystem inflammatory disorders.

Multidisciplinary clinics and one stop clinics have been developed for multisystem disorders and osteoporosis. There are ultrasound clinics and an ultrasound guided injection service. There are dedicated urgent appointments for new patients with suspected rheumatoid arthritis and other inflammatory disorders in line with the NICE quality standards 2013. The rheumatology service, in collaboration with colleagues in ophthalmology, has recently set up a new pathway for patients with giant cell arteritis. There are close links or combined clinics with other specialties including respiratory, renal, ENT, dermatology and orthopaedics. There are dedicated musculoskeletal physiotherapists and occupational therapists who coordinate patient education sessions and there is access to orthotics. There is a nurse advice telephone line for patients who may have queries regarding their medications or any concerns about their symptoms. Advice and guidance requests are increasing in number. Colleagues in rheumatology respond within 48 hours to over 95% of such requests.

The Rheumatology service is registered as a Specialised Commissioned Service by NHS England which supports access to specialised nationally funded treatments for specific rheumatological disorders.

The Rheumatology unit is one of the most active research departments in the UK and is a specialised centre for CTD and vasculitis management. The unit has recently completed a peer review and received an excellent report. The department has been praised for being the highest recruiter to the British Rheumatological Society biologics register in November and December 2017. Audits have shown excellent compliance with national standards for disease management and high cost drug utilisation.

The Rheumatology unit is highly recommended by patients and satisfaction rates are exceptionally high. Patient feedback is constantly reviewed to improve standards and there is a strong commitment to clinical governance in weekly meetings with the Partnership Sessions, which are held quarterly, also reviewing this information, the Sessions are attended by the whole team.

GATEWAY E
CONTINUED

Endocrinology

Endocrinology services are provided by a dedicated team of 10 Consultants and 2 Nurse Specialists who provide general and specialised clinical services to support the diagnosis and management of patients with endocrine disorders. These include clinics for patients with pituitary, thyroid (medical and surgical), adrenal and gonadal disorders, plus calcium and metabolic bone diseases. There is access to a full range of laboratory hormone tests, and imaging with CT, MRI, DEXA and isotopic scans to allow for the comprehensive assessment of patients. There is a daycase and short stay unit at the Treatment Centre which supports dynamic hormone testing. Phlebotomy services (blood tests) are conveniently located on the ground floor of the Treatment Centre.

Multidisciplinary clinics are available for pituitary, adrenal, paediatric transition, and Turner's syndrome patients. Four consultants in the team support the endocrine assessment and management of patients with Gender Identity Disorder in the Nottingham Centre for Gender Dysphoria. This service was established in 2014 and has expanded significantly since then. Further expansion of the service is anticipated due to growing clinical demands of the Gender Identity service. Two consultants have ARSAC licences which enables the service to prescribe radioactive iodine therapy for the treatment of patients with over-active thyroid glands both from the Nottingham area and from the North Nottingham area.

There are established links with Departments of Neurosurgery, Endocrine Surgery, Clinical Genetics and Oncology in Nottingham University Hospitals NHS Trust. The consultant team provide expertise to the multidisciplinary team meetings at the Trust in pituitary disease, thyroid cancer and neuroendocrine tumour disorders.

The Endocrinology service is registered as a Specialised Commissioned Service by NHS England which supports access to specialised nationally funded treatments for specific endocrine disorders.

The Endocrinology service receives a considerable number of advice and guidance requests each year and demand is growing. In 2016 the department dealt with around 350 requests, and this increased to over 500 in 2017. Over 97% of these queries are answered within 2 working days, hence meeting local CQUIN targets.

We provide education and a support group for patients with adrenal insufficiency, as well as a telephone-based clinical follow-up service for patients being treated for thyroid gland over activity (hyperthyroidism). This Hyperthyroid Telephone Clinic (HTC) supports the community follow up of over 400 patients with active thyroid disease, who would otherwise have to attend hospital appointments. A recent audit of the service confirmed high levels of patient satisfaction and was the subject of a poster presentation at the British Endocrine Societies meeting in November 2017. We have developed a number of patient-friendly information leaflets covering common endocrine disorders which are available at the Gateway. Patient feedback consistently shows a high level of satisfaction with the services that are provided.

GATEWAY E
CONTINUED

Orthopaedics
The Orthopaedic service has seen approximately 30,000 patients throughout the year. Orthopaedics is the specialty devoted to the diagnosis, treatment, rehabilitation and prevention of injuries and diseases of the body's musculoskeletal system. As a clinical unit we strive to support all patients with their individual needs, particularly in regard to mobility issues. We offer state of the art diagnostic services, specialist physiotherapy and occupational therapy. These services enable us to provide a one stop service to the majority of our patients. We support patients who have hand, shoulder, elbow lower limb and foot problems. We refer our patients to the Short Stay Unit unless they need more support due to other health issues if this is the case they are referred to Nottingham University Hospital NHS Trust City Campus for surgery.

In 2017/18 the clinical unit has achieved:
- We have recruited a Rheumatology Nurse Consultant who has supported the development of clinics for patients who need urgent support.
- We have introduced annual review clinics which are nurse led.
- We were the highest recruiting Rheumatology department to the BSR when supporting our patients in switching their medications to a biosimilar.
- We have supported moving the Phlebotomy unit to a purpose built space.
- We have increased the number of staff who can undertake Venepuncture to reduce patient waiting times.
- We changed the way we support patients with the Rheumatology helpline by introducing a triage system supported by the Nurse Consultant.
- We undertook our first research study in Endocrinology.
- We have trained more staff to be able to request x-rays which has reduced waiting times for their pre assessments in orthopaedics.

Lessons learnt in 2017/18:
- We need to increase the number of appointments for patients who have urgent flare ups of their symptoms and also for patient annual reviews.
- We need to increase the support the gateway gives to research as this is vital in developing care pathways and treatments.
- We need to increase our number of Nurse Specialists so we can see more patients with follow up appointments, providing our patients with their on-going care needs. Consultants will then see new patients who need a diagnosis and a treatment plan.

GATEWAY E
CONTINUED

Going forward into 2018/19:

- We will provide support sessions for patients with long term diseases which focus‘on their wellbeing alongside their health.
- We will standardise the patients pathway for all patients referred with osteoporosis.
- The number of annual review clinics will be increased to include other Rheumatological diseases.
- We will undertake an audit of our patient outcomes in hand surgery
- Support of the training, will be provided, of non-medical staff in performing joint injections.

SERVICES PROVIDED

- Orthopaedics
- Rheumatology
- Endocrinology
- Medical day case
- Physiotherapy
- Occupational Therapy
- Venesection

OUR TEAM

Operations Manager 1
Clinical Lead 2
Lead Nurse 1
Gateway Co-ordinator 1
Consultants/Doctors 53
Staff Nurses 4
Team Leaders/Nurses 2
Healthcare Assistants 9
Nurse specialists 9
Nurse consultant 1
Occupational therapists 3
Senior Gateway Receptionists 2
Receptionists/Administrators 12
Medical Secretaries 13

GATEWAY E

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To review the helpline services we provide to all patients.	Patients are happy with the support received.	Clinical unit.	The nursing team triages calls with the support of the Nurse Consultant, who answers all questions and queries. This has helped reduce the necessity for the Clinical Nurse Specialists in contacting all the patients.	Achieved
To move rheumatology services closer to home.	Clinics are being held in the community.	Clinical unit.	Unfortunately this is not currently required within the community.	Not Achieved
To increase the opening hours and availability of venesection appointments.	Patients are having flexible appointments to meet their needs.	Clinical unit.	We have trained a second nurse and are currently training a third which has allowed for flexibility in appointments.	Achieved
To increase the opening hours of the medical day case unit to provide capacity for the increased numbers and flexible appointments.	Patients are seen in a timely manner that supports their personal lives.	Clinical unit.	The medical day case unit has been supporting emergency appointments, and we will be looking at ways to further increase flexibility for appointments.	On-going

GATEWAY E

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To monitor the clinical benefits of the Multi-Disciplinary Team clinics to ensure they continue to offer high quality integrated clinical care.	Evidence of patient benefits via audit.	Clinical unit.	We will be completing the audit and the development of the Osteoporosis pathway once it has started.	On-going
To apply to register as a specialist center for our specialties' to allow patients to receive the medication needed within the area.	Successful registration.	Clinical unit.	The registration has been completed and we are now registered as specialist center.	Achieved
To expand the compliment of specialist nurses in both Endocrinology and Rheumatology, to support clinical workloads and deliver increased clinical capacity.	Successful business case for specialist nurse appointments	Clinical unit.	One Nurse Specialist in rheumatology recruited, recruitment commenced for Research Practitioner and Endocrinology Nurse Specialist..	On-going
To undertake mystery shopper questionnaires.	Increased number of feedback received.	Clinical unit.	This objective will be rolled over to 18/19.	Not Achieved

GATEWAY E

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
To provide competency training in skills that are new to staff.	Staff have multiple areas of competency.	Clinical unit.	We have trained 1 nurse in venesection, 4 nurses in phlebotomy skills, and 4 nurses in cannulation skills. We also have 4 nurses who have become competent in simple dressings	Achieved
Integrate the rheumatology nurse consultant in to the gateway supporting staff training and education.	Staff are able to understand the specialties' and the patients specific needs in regard to those specialties.	Clinical unit.	The Nurse Consultant is fully integrated and we have introduced emergency clinic slots and annual reviews, she is also supporting the education of the Nurse Specialists.	Achieved

GATEWAY E

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

97%

FORMAL COMPLAINTS AND CONCERNS

44

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

0.7%

NUMBER OF STOP THE LINE EVENTS

2

STAFF TURNOVER %

2%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

8.8%

MANDATORY TRAINING - DIRECT HIRE

76%

GATEWAY E

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	A "Well Being Day" will be organised for patients in our Rheumatology service. The days will include Yoga, Hair & Beauty and Healthy Eating Planning.	All patients who attend will be asked to provide feedback which will be reviewed and changes implemented.	Rheumatology Nurse Consultant and Clinical Nurse Specialists.
	Expansion of the Endocrinology Nurse led service for patients on the Hypothyroid pathway.	Audit of the service by Clinical Nurse Specialist.	Endocrinology Clinical Lead.
	Clinical review of new referrals, this will mean pre vetting for referrals that have not been through a triage system to ensure that patients have the right appointment first time.	A regular audit will be undertaken of the referrals to ensure we are meeting this objective.	Clinical Unit Leads.
	We will focus on ensuring that we increase the percentage of patients receiving text message reminders.	A weekly report will be reviewed to monitor how many texts we are sending to our patients so this can be increased if required.	Clinical Unit Leads.
Best Clinical Outcome	The introduction of the Musculoskeletal (MSK) triage process, working closely with commissioners to ensure that the patients are referred into the right service.	Data will be collected on the referrals made and reviewed to ensure we are meeting this objective.	Clinical Unit Leads
	A redesign of the Rheumatoid Arthritis pathway which will be dedicated to annual review clinics.	Feedback to be obtained from patients and consultants to ensure we are meeting the demand.	Clinical Unit Leads

GATEWAY E

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Clinical Outcome	The implementation of a Rheumatology unified osteoarthritis pathway in line with National Standards.	Data will be collected from the outcomes of this pathway to review any changes which need to be implemented.	Rheumatology Nurse Consultant.
	Measuring the quality of life our patients have following their Hand Surgery.	An audit on a quarterly basis to be undertaken on the progress made of our patients development following their surgery.	Lead Occupational Therapist.
Most Engaged Staff	Expansion of skill set to Physiotherapy Extended Scope Practioners (ESP).	Monitoring and audit by the lead Physiotherapist who will report their findings to the Clinical Unit Leads which will enable the team to adapt the training as required.	Lead Physiotherapist.
	The Clinical Unit Leads will provide support to team members so they can attend external courses which will benefit them and the unit.	Staff will be offered the opportunities to attend the specific courses; success will be monitored on the feedback received following the completion of the course.	Clinical Unit Leads.


Herbs
Rosemary
Now in season - Basil, chives, mint and parsley
Friday 4th May 2018
Today's Homemade Soup
Leek and Potato
(v)(gf)
£2.60
Atrium Street Eats!!
Deli Style Beetroot Flatbread Pizza topped wi
Pulled Chicken, Roast Aubergine and Mozzare
(Top off your Flatbread with a selection of De
Salads!!)
£4.30
Jacket Potato with a Selection of Fillings
1 Filling - £3.70
2 Filings - £4.00
Chilli con Carne - £4.20
In a rush? Grab one of our innovative
sandwiches or salads from the Grab & Go!
Atrium
Buckwheat flour
WHOLEMEAL
LINGUINE Nº 13
RUMMO
MAESTRI PASTAI
IN BENEVENTO DAL 1848
METODO
Lenta Lavorazione
ECCEZIONALE TENUTA ALLA COTTURA
RADIATORI Nº 137
Il Casolare
Cold Extraction and Unfiltered
Extra Virgin
Olive Oil
CABERNET
SAUVIGNON
RED WINE VINEGAR

GATEWAY F

GYNAECOLOGY QUALITY ACCOUNT

The Gynaecology service is located in Gateway F at the Treatment Centre. The clinical care provided is consultant led and is supported by an experienced team of Registered Nurses, Healthcare Assistants and an administrative team that are responsible for our administrative processes. Where possible we actively promote a "One Stop" service allowing our patients to access diagnostic tests and clinical reviews, this enables the patient to receive a diagnosis and treatment plan at their first appointment.

We also support clinics within the community giving the patient more choice of where they would like to be seen and allowing the patient to see a Consultant closer to home.

We are proud to be a teaching unit, we have both Medical and Nursing students, and junior doctors wishing to specialise Gynaecology. We also support GP training and have participated in GP educational training sessions.

In 2017/18 the clinical unit achieved:

- A decrease in the amount of poor comments from patient feedback relating to waiting times.
- Completion of nurse training for bladder pressure studies and implementation of increased capacity for bladder pressure clinics.
- A research and audit programme being supported by nursing staff following successful completion of the course Good Clinical Practice, allowing us to become more involved in clinical research.
- All Incident investigations have been reviewed by the clinical unit and the lessons learnt shared with the team at Partnership Sessions.
- Staff are empowered to use Circle Operating System (COS) within the gateway, COS champions update COS boards to promote what has been implemented following patient feedback.
- Successful implementation of a process with the Ultrasound and DEXA scanning service, providing a "paper light" process and improving information governance compliance.

Lessons learnt in 2017/18:

- Team members have been invited to attend courses relating to their area of work, this has been offered to both administration and clinical staff. Some courses have already been completed by staff and they are now obtaining further development and skills.
- The Procedures of Limited Clinical Value (PLCV) and Procedures Not Routinely Funded (PNRF) process is embedded within the gateway to ensure that all relevant procedures follow the process in a timely manner.
- New to follow up patient ratio is monitored through the clinical unit, where a trend in follow up appointments has been identified. The relevant clinicians have been made aware and will be monitored for improvements
- A Colposcopy DNA audit was presented to the team; this showed that the DNA rate was below the national standard.

GATEWAY F
CONTINUED

Going forward into 2018/19:

- An audit of new and follow up appointment patients will be conducted to identify why the DNA rate is high and what can we do to decrease this. The results of this audit will be shared with the team and across the Treatment Centre.
- To develop a telephone follow up service for more patients across the specialties on the gateway, this will include Vulval and Target follow up appointment patients.
- Improve the Menopause patient pathway to include more innovative concepts.
- Recognition of individual staff for achievements each month using an employee of the month scheme.
- Audit of telephone follow up appointments to be completed and a clinical research paper to be written and published.
- All patients to receive their appointment letters and patient leaflets direct via the Synatec printing service, this will enable us to reduce our printing costs.
- To provide GP education sessions, the aim of this is to improve the referral process ensuring that the patient is referred to the most appropriate clinic.
- All staff to have regular one to one sessions with their line manager.

SERVICES PROVIDED

- General Gynaecology and suspected cancer outpatient clinics
- Menopause clinic
- Vulval skin disorder clinic
- Female Continence investigations and advice
- Unplanned pregnancy assessment
- Sterilisation
- DEXA (bone mineral densitometry) scanning
- One-stop Hysteroscopy service
- Endometrial ablation and a Morcellation of uterine fibroid clinic.
- Colposcopy including loop excision treatment
- Post Coital Bleeding (PCB) clinics
- Nurse led Pessary and HRT implant clinics
- Ultrasound of the female pelvis

OUR TEAM

Operations Manager 1
Clinical Lead 1
Lead Nurse 1
Gateway Co-ordinator 1
Consultants/Doctors 10
Nurse Consultants 2
Staff Nurses 7
Deputy Lead Nurse 1
Healthcare Assistants 10
Allied Healthcare Professionals 6
Physiotherapists 1
Senior Gateway Receptionist 1
Receptionists 6
Medical Secretaries 8

GATEWAY F

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
An increase in the number of Hysteroscopies that are performed on the Gateway as an outpatient procedure. Improving the patient pathway.	More Hysteros-copies will be performed for outpatients on the Gateway. Audit of patient satisfaction of outpatient procedure.	Clinical Unit Team.	Through vetting and triaging these have now been performed successfully on outpatients on the gateway. We have received patient feedback as part of the audit process. We have also received satisfactory feedback from our patients.	Achieved
Increase the amount of Ultrasound scan appointments that patients can access on the same day as their general gynaecology appointment.	A decrease in the amount of patients having to have a separate appointment for an Ultrasound scan prior to their general gynaecology appointment.	Clinical Unit Team.	This has been successfully completed. This has decreased slightly as we offer one-stop appointments to all our target clinics and we endeavour to offer an ultrasound scan at their general gynaecology appointment if required. Booking rules were reviewed.	Achieved

GATEWAY F

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
A more robust Termination of Pregnancy booking process to be implemented and be managed to ensure Referral To Treatment (RTT) guidance is adhered too.	This group of patients to have been seen and treated in accordance with RTT guidance.	Clinical Unit Team.	This service has been brought in house successfully. We also review the data to ensure we treat patients within RTT guidance.	Achieved
Audit the volumes of Day case Hysteroscopies that can be moved to Gateway F.Working in partnership with Gateway G to manage the capacity of both Gateways.	Commence audit and report findings.	Clinical Unit Team.	Gateway F and Gateway G identified which procedures could be moved from daycase to outpatients. However an audit is yet to be completed.	On-going

GATEWAY F

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Implement a staff "buddy" system within both the clinical and non clinical teams, giving all staff an appreciation of each others roles within the gateway.	All staff to be aware of their "buddy". A planned programmes will be introduced for each "buddy" to spend a period of time with each other.	Clinical Unit Team.	The buddy system was implemented successfully across clinical and administration teams, ensuring staff had an opportunity to build on their knowledge and skills.	Achieved
Introduce a planned regular programme of staff meetings to ensure that staff have an open forum to express matters. Making certain that actions from the meetings are acted upon and fed back to staff.	Bi-monthly meetings to be held. Minutes and actions to be clearly documented.	Clinical Unit Team.	An introduction of regular staff meetings was introduced. Urgent meetings are held accordingly and when required. Feedback is provided to all staff at Partnership Sessions. Separate staff meetings are held is required.	Achieved

GATEWAY F

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

97.8%

FORMAL COMPLAINTS AND CONCERNS

35

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

1.4%

NUMBER OF STOP THE LINE EVENTS

6

STAFF TURNOVER %

0.90%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

11.6%

MANDATORY TRAINING - DIRECT HIRE

91%

GATEWAY F

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	Develop a telephone follow service for patients across the specialties on the gateway, this will include Vulval and Target follow up appointments patients.	Decreased amount of face to face follow up consultations.	Clinical Unit Leads.
	Improve the Menopause patient pathway to include more innovative concepts.	Introduction of patient education groups.	Clinical Unit Leads.
	Engagement with commissioners to support 'hints and tips for GP referrals' to ensure patients are booked into the correct clinics.	Increase in the number of patients booked in the correct clinic first time.	Clinical Unit Leads.
Best Clinical Outcome	An audit of new and follow up appointment patients will be undertaken for all specialities on the gateway, to identify why the DNA rate is high and what can we do to decrease the amount of DNAs.	Decreased amount of DNA's, and the results of the audit to be shared across the Treatment Centre.	Lead Nurse / Gateway Co-ordinator.
	A planned programme of audit of clinical practice for the services within the gateway.	A minimum of 3 audits to be registered with the Quality and Assurance team. Audits to be presented at CGRM and Gateway Partnership Sessions.	Clinical Unit Leads. Clinical Unit Team.

GATEWAY F

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Most Engaged Staff	Recognition of individual staff achievements each month using an employee of the month scheme.	Increase staff engagement.	Clinical Unit Leads.
	Identify individuals for learning opportunities and training.	Introduce the Institute of Leadership and Management course and a rolling training programme for bladder/pessary care.	Clinical Unit Leads.
	Implement monthly unit meeting with staff providing an open forum to discuss concerns/improvements.	Minutes to be taken of clinical unit meetings. Action plans to be devised from the meetings and shared with the team.	Clinical Unit Leads.


pelagonia
GRILLED
ZUCCHINI
grilled zucchini slices for
sandwiches, salads
and antipasti
WHOLEWHEAT
GIANT

GATEWAY G

THEATRES WITH INTEGRATED DAYCASE QUALITY ACCOUNT

We are a consultant led theatre unit and we are undertaking clinical activity six days a week allowing flexibility and choice for patients and clinical staff alike.

We have four pre-assessment rooms, twenty six day case bays, five operating theatres, one anaesthetic room used to support the major orthopaedic activity, and six first stage recovery bays. Two of the day case bays can now be used to support first stage recovery if required. This allows flexibility in delivering extended care for patient's.

We continue to work with the Short Stay Unit to ensure the patients requiring an overnight stay or undergoing a more complex procedure experience a conjoined pathway. We regularly have staff shadowing shifts on either department so everyone has a better insight into each other's role.

In 2017/18 the clinical unit achieved:

- Flexibility within our workforce to allow us to meet the needs of activity which in the Gateway also reduces costs.
- Established telephone pre-assessment service so patients do not have to attend the centre.
- Creation of a patient journey information sheet which allows the patient to gain a better insight into their journey at the Treatment Centre.
- Establish a good relationship with procurement to allow us to continuously look at costing's of consumables and continuously trial new kit; currently we are class leaders in this regard, having saved money on our initiatives since commencement.

Lessons learnt in 2017/18:

- We have engaged with our colleagues in other Gateways who provide similar treatments and care to share lessons learnt.
- We have enriched the audit culture within the Gateway.

GATEWAY G
CONTINUED

Going forward into 2018/19:

- More focused support to be provided to staff to guide them through Standard Operating Procedures and policies.
- We will continue with flexible working, using bank staff and not agency staff.
- We will continue to build the relationship with the procurement team to reduce costs.
- We will establish a formal audit programme within theatres which will be driven by the Team Leaders with associated actions.

SERVICES PROVIDED

- General Surgery
- Gynaecology
- Pain Management
- Orthopaedics
- Urology
- Podiatry
- Vascular
- Ophthalmology
- Ocular reconstruction

OUR TEAM

Operations Manager 1
Clinical Lead 1
Theatre Lead 1
Gateway Co-ordinator 1
Theatre Lead 1
Staff Nurses 35
Deputy Lead Nurses/Allied Healthcare Professionals 8
Operating Department Practitioners 14
Healthcare Assistants 16
Senior Gateway Receptionist 1
Receptionists 5
Booking Team Leader 1
Theatre Administrators 5
Clinical Outcome Caller 1

GATEWAY G

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Improving patient information	Developing slide shows or video to include analgesic regimes, post op discharge/ care information. Following the patient pathway from arrival to discharge. Including 'real' patient feedback during video. Available on circle website for future Patients.	Clinical Lead and Theatre Lead.	The team have developed a patient journey sheet, so patients are aware of the process they will be going through whilst on the unit. All patients receive this on their arrival. The team will be producing a patient video, which will also be available on the website.	Ongoing
Think Drink Campaign	To make improvements to the current fasting guidelines and improve the patient information. Hold regular Think Drink Educational Stands in the main entrance of the treatment centre. Posters and leaflets to be available.	Pre-assessment Lead Nurse and Team Leader.	We will have Think Drink stands in 2018/19, along with posters and leaflets. We have encouraged our nurses on the ward to review and ensure that patients are fully aware of the instructions when it comes to what and when they can drink before their procedure.	Ongoing

GATEWAY G

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Minimising complaints by appropriate patient information/ expectation.	Frequently Asked Question's - Send to patient champion group to establish most frequently asked questions pre and post operation. Once established publish on website. Review after 6 months using patient feedback.	Administration Team.	There is a patient champion meeting on a monthly basis, which our Patient and Public Engagement (PPE) representative attends. Our PPE representative meets patients and provides the meeting with input from a patient perspective so we can review and understand our patient's needs. Going forward we will be publishing this information on our website.	On-going
Post-op Triage Service	Surgical Care Practitioner to provide a wound advice follow-up service. To work along side the current post op advice answerphone. Will provide a more personal approach for patients and provide standardised advice given.	Team Leaders	A process has been created and now used on the ward. Further training will be provided to the team in the Short Stay Unit so they can also use the process for their follow up telephone calls. Audits are being completed on a monthly basis to highlight any trends.	On-going

GATEWAY G

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

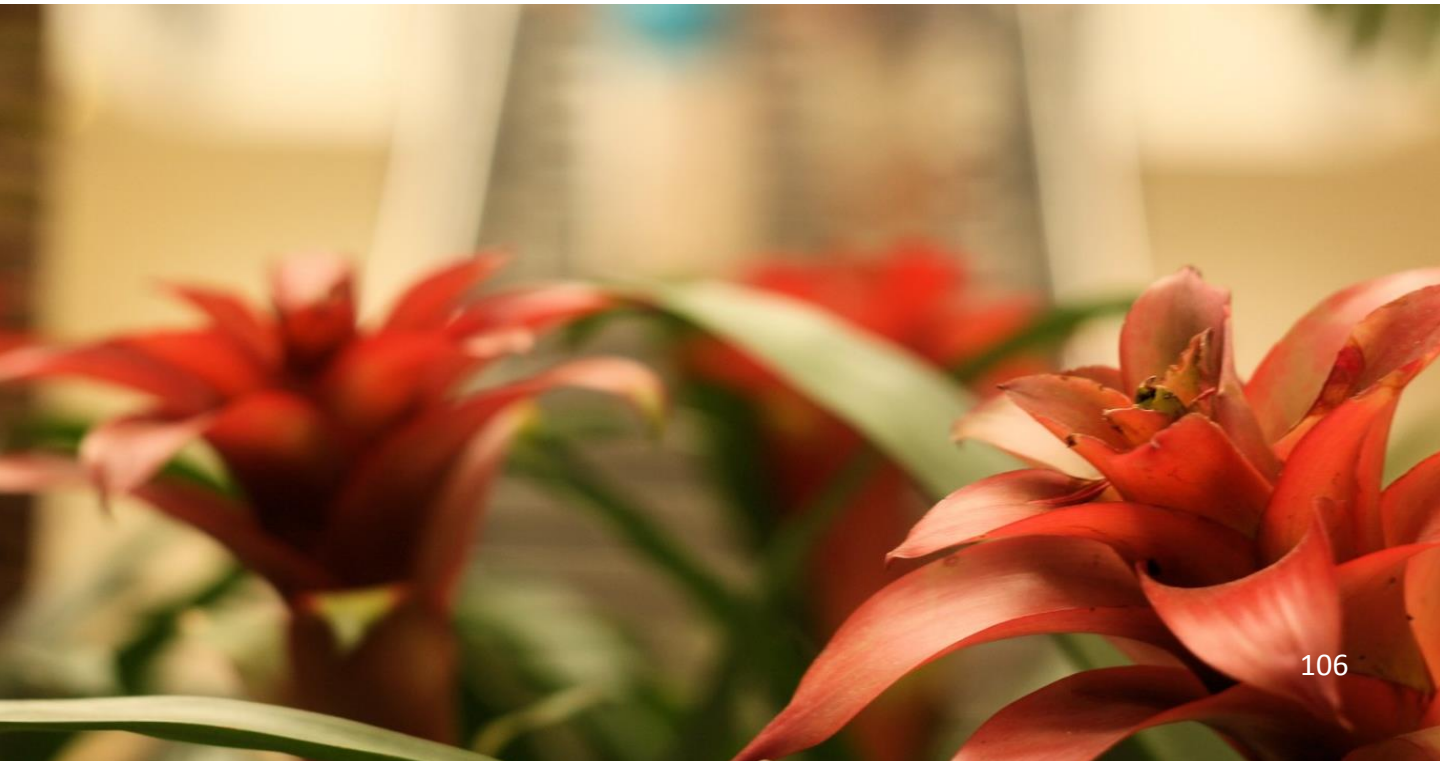
OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Procurement initiatives – Consumables.	Linking bi-monthly with procurement to ascertain the top 10 spends across the consumable portfolio. Reduce spend by competitive tender.	Theatre Lead and Operations Manager.	Monthly phone calls scheduled with procurement to look at spending on consumables and kit to try to keep these as low as possible.	Achieved
Telephone Pre-Assessment	To finalise telephone pre-assessment criteria and implement a telephone pre-assessment service for eligible patients to maximize pre-assessment capacity. Audit/Patient Feedback.	Pre-Assessment Lead Nurse and Clinical Lead.	A telephone pre-assessment clinic is now running every Friday, with the reception team liaising with the pre-assessment team as to whether patients are eligible for telephone assessment.	Achieved

GATEWAY G

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
5 Steps to Safer Surgery	To record the debriefing of every theatre session electronically on to proxima in accordance with CQC recommendations . Audit recovery process and times. Audit nausea, vomiting and pain rates of patient's post-op according to operation type.	Clinical Unit Leads.	Audits have been undertaken on the WHO checklist which reviews the patients care, before during and after their procedure. This is currently at 100%. Work around debriefing continues with actions in place. Theatre leads are driving this initiative with clinicians.	On-going



GATEWAY G

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
FLO - Florence Tele-health System.	Blood pressure measurements taken at home with the goal of reducing 'white coat syndrome' Patients are able to text in blood pressure results taken in their own home. Thereby reducing erroneous results.	Pre-Assessment Lead Nurse.	FLO still regularly used in pre-assessment where it can be. Patients taking own results at home to reduce the need of them having to be made temporary unfit for their procedure.	Achieved
Standardisat-ion of Theatre Booking Rules	Enhancement of routine practice across all gateways minimising double bookings and maximising potential theatre utilisation by removing/realloc ating cases which can be undertaken in either outpatient or community setting. Audits – utilisation/start and end time if theatre sessions.	Theatre Lead and Gateway Coordinator.	Process in place which ensures all departments linked to day surgery can review the available theatre sessions. This has reduced clashes with theatre bookings. We are also trialing theatre lists in different theatres to utilise them more efficiently. Audits are on a monthly basis and the results shared with the clinical unit.	Achieved

GATEWAY G

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Message Of The Day/Week	Enhanced communication across the Gateway – accessible to all staff. Communicated by a white board. Accessed by verbal feedback from all staff including clinical and admin.	Deputy Lead Nurses.	Messages of the week are put on the whiteboard in the staff room every Friday. Clinical staff also have a communication book and have monthly meetings to discuss any concerns.	Achieved
Minimise agency Spend. Focus on recruitment and retention of staff.	On-going recruitment program through 2017 – Focusing particularly on enhanced rates payable in direct response to the Trust removing overtime payments.	Theatre Lead.	Agency spend has been minimised by the use of bank staff.	Achieved
Consultant Engagement	Undertake interview style feedback with surgeons and anesthetists. Looking at areas where improvements could be made, alongside gold standard of care.	Theatre Lead.	Consultant survey to be undertaken in April 2018 and the results widely disseminated.	On-going

GATEWAY G

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

98.8%

FORMAL COMPLAINTS AND CONCERNS

26

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

4.2%

NUMBER OF STOP THE LINE EVENTS

1

STAFF TURNOVER %

1.8%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

10%

MANDATORY TRAINING - DIRECT HIRE

72%

GATEWAY G

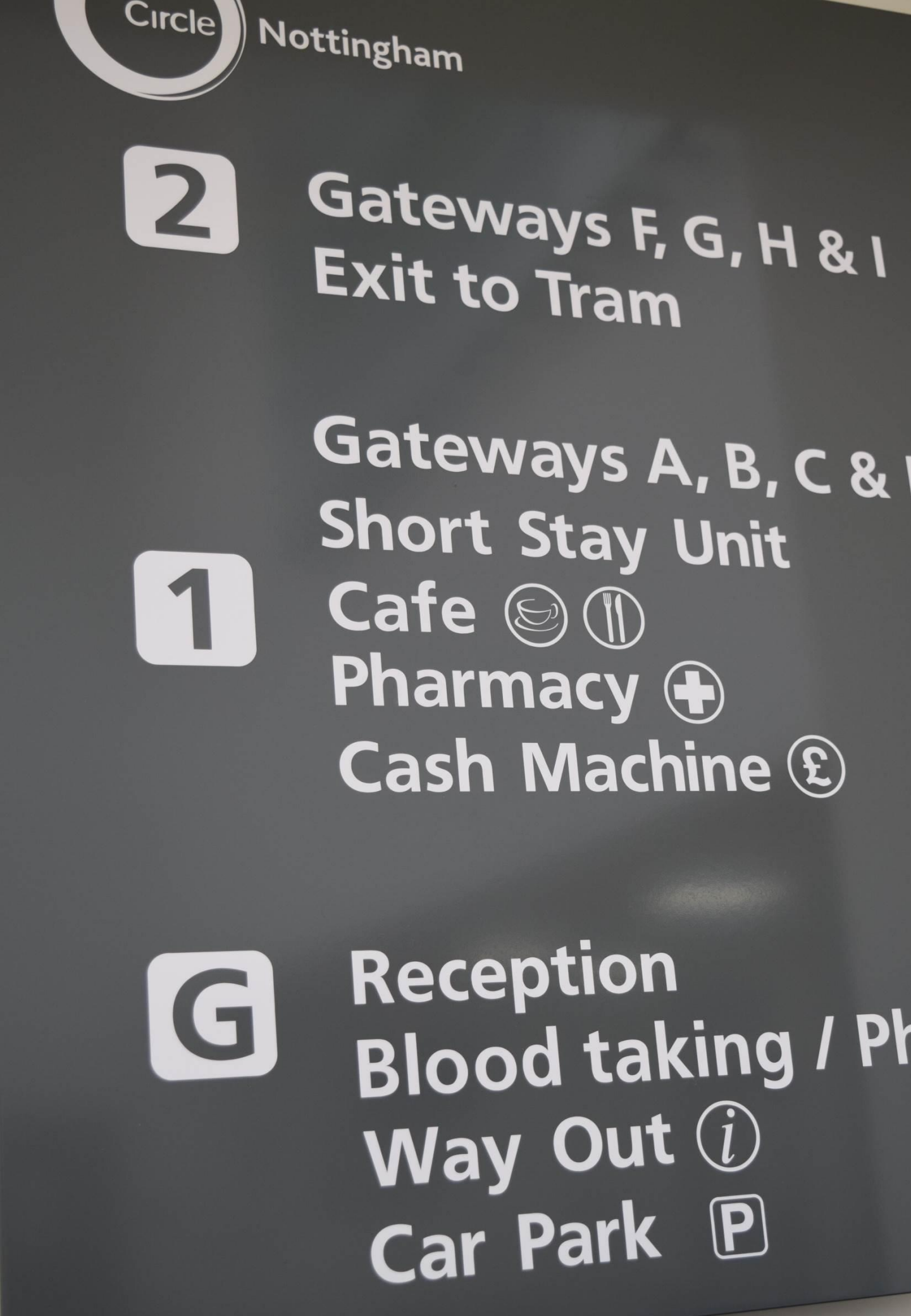
QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	Develop a new patient information video to be used on the website to give patients information on what to expect when they come in.	In order to know if the video meets our patients needs we will obtain feedback from the feedback cards and our Patient Champion will speak with patients on their views and opinions.	Clinical Unit Leads.
	Identify three improvements through the Patient Champion meeting to improve patient experience. A lot of improvements have been made and we want to continue to do this.	Continue to monitor patient feedback through feedback cards and mystery shopper questionnaires.	Clinical Unit Leads.
	To improve patient experience by managing expectations on waiting times.	Information to be available to patients so they can understand the reasons for possible delays, i.e. posters in bays to inform patients.	Clinical Unit Leads.
Best Clinical Outcome	Develop the pre-assessment service to assist other departments, including local anesthetic patients.	By using the Risk Management system and established debriefings we can monitor the reasoning for cancellations of surgeries which could have been prevented. Lessons to be learnt from the findings.	Clinical Unit Leads.
	Engagement with consultants to understand reasoning for delays in theatre start and end times.	We will do a audit which will monitor the start and end times of theatres to ensure continuous improvements are made.	Clinical Unit Leads.

GATEWAY G

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Clinical Outcome	Workshops to be offered to staff who wish to develop their skills and understanding.	Participation from the clinical team to deliver specific workshops. Feedback to be provided from staff members so improvements and developments can be made in the future.	Clinical Unit Leads.
Most Engaged Staff	Embed a buddy system with the administration and clinical staff to ensure theatre lists are fully utilised and eliminate cancellations.	By using the Risk Management system we will monitor any recording of listing errors for procedures, which buddys will monitor and ensure lessons are learnt.	Clinical Unit Leads.
	To support staff learning and knowledge of Standard Operating Procedures and policies by introducing the top ten documents for staff to read.	Obtain a report on staff participation from the Insight system.	Clinical Unit Leads.
	To support communication with staff by having 15 minute catch ups each Friday to go through what went well and areas of improvement in performance.	Meetings to be documented to record actions taken and performance to be monitored.	Clinical Unit Leads.
	To work on reducing costs in recovery and on the ward.	The monthly financial meeting will provide a update to the Clinical Leads, this can be monitored for improvements. Changes will be made around the Gateway to promote recycling.	Clinical Unit Leads.


Circle
Nottingham
2
Gateways F, G, H & I
Exit to Tram
Gateways A, B, C &
1
Short Stay Unit
Cafe
Pharmacy
Cash Machine
G
Reception
Blood taking / Ph
Way Out
Car Park
P

GATEWAY H

ENDOSCOPY QUALITY ACCOUNT

The Endoscopy department is situated within Gateway H and undertakes diagnostic and therapeutic procedures in upper and lower GI Endoscopy. The unit also provides Cystoscopy procedures as part of the Urology cancer pathway. Gateway H is not only the largest GI Endoscopy unit in Nottingham but is the only teaching unit in Nottingham that has JAG (Joint Advisory Group for GI Endoscopy) accreditation. Through its service provision and protected teaching time, the unit is also responsible for the teaching and training of our postgraduate colleagues.

The Gateway consists of four procedure rooms with a 10 bed recovery area; segregated (into male or female) and individual admission rooms. The unit provides single sex accommodation for admission including en suite facilities for administration of bowel cleansing and recovery post procedure. There are two private consultation rooms and a dedicated Discharge Lounge. There is a decontamination unit within the gateway with specialist trained decontamination technicians. The decontamination process throughout the unit fully complies with the latest guidance: Health Technical Memorandum 01-06: Decontamination of Flexible Endoscopes.

In 2017/18 the clinical unit achieved:

- JAG re-accreditation.
- Development of the existing pre-assessment service.
- Our Nurse Practitioner has completed training in upper GI endoscopy (JETS).
- Reduction of unplanned discharges via telephone triage system.
- Implementation of eGFR monitoring prior to bowel cleansing.

Lessons learnt in 2017/18:

Inline with feedback received following JAG accreditation the unit will:

- Review second stage recovery.
- Admin processes and workforce.
- Concerns regarding appropriateness (vetting of referrals).
- Retention of staff (Registered Nurses) has been problematic.
- Challenges are on-going within the decontamination facility, sustainability and reliability.
- Challenges with audit compliance (JAG mandatory audit).

GATEWAY H
CONTINUED

Going forward into 2018/19:
We will monitor and review the:
- National Endoscopy Database.
- Training of an additional Nurse Endoscopist.
- FIT testing impacting Colonoscopy activity via traditional 2 week wait referral pathway.
- Review of the retention and the training of the nursing team.
- Development of the pre-assessment nurse service.
- Procurement of Endoscopy equipment.

SERVICES PROVIDED
- Diagnostic Gastroscopy (sometimes referred to as OGD)
- Diagnostic Colonoscopy
- Diagnostic Flexible Sigmoidoscopy
- Polypectomy
- Endoscopic Mucosal Resection (EMR)
- Balloon dilatation e.g. of oesophageal strictures
- Banding e.g. oesophageal varices, haemorrhoids
- Therapeutic Gastroscopy e.g. botulinum injection, gluing of gastric varices

The Urology team undertake Cystoscopy procedures via the Endoscopy unit.

OUR TEAM
Operations Manager 1
Clinical Lead 1
Lead Nurse 1
Gateway Co-ordinator 1
Consultants/Doctors 30
Nurse Consultant 1
Registered Nurses 15
Deputy Lead Nurses 3
Decontamination assistants 7
Healthcare Assistants 17
Senior Gateway Receptionists 2
Receptionists 4

GATEWAY H

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Information to be available on the Circle website on procedural guidance for patients including how to prepare for diagnostic testing.	Audit on abandoned procedures. Feedback from patients.	Clinical Unit meetings.	A initial meeting has been held, with updates actioned. Further input is required on how to prepare for a diagnostic test.	Ongoing
Audit to be undertaken on the desired clothing patients wish to wear for the procedure, in mind of dignity.	Patient survey.	Clinical Unit meetings.	This question is covered within the detailed patient survey that is carried out yearly. Patients are happy the options of clothing available in the unit.	Achieved
A review of dietary requirements for patients post procedure.	Patient survey.	Clinical Unit meetings.	This was part of the detailed survey which was undertaken as part of JAG, the unit is meeting the dietary requirements of our patients.	Achieved

GATEWAY H

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
The team will review and implement changes to ensure there is an increase in the availability of pre assessment appointments for our patients.	Audit.	Clinical Unit meetings.	We have increased the number of pre-assessment staff on the unit, and will be expanding the availability of the service in 2018/19.	On-going
A review and audit of the reasoning for the unplanned discharges within the Gateway, and a goal to decrease this number.	Audit.	Clinical Unit meetings.	This data has been collected with the Lead Nurse reviewing the results, this will then lead to actions in the Gateway. This audit has proven successful and therefore we will ensure that this is an ongoing audit.	Achieved
Implementation of new techniques to decrease patients requiring a General Anaesthetic.	Audit/monitoring of procedures.	Clinical Unit meetings.	Unfortunately we have been unable to make any progress on this objective this year.	Not achieved

GATEWAY H

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Support Gastrointestinal Nursing (GIN) delivery by nursing team members attending a course to gain an understanding of this role.	Staff attendance at GIN course.	Clinical Unit Leads.	A GIN day was held at the Treatment Centre in 2017, all staff attended.	Achieved
A review of staff facilities to ensure we are accommodating the needs of our team members.	Staff survey.	Clinical Unit Leads.	Gateway staff are using a staff room on Gateway E which has had alterations to accommodate Gateway H staff.	Achieved
Shadowing of job roles within the Gateway to increase awareness and understanding.	Partnership Sessions.	Clinical Unit Leads.	Administration staff have followed a patient journey through from a Healthcare Assistant perspective, which enabled the administration staff to appreciate the intricacies of the patient and clinical journey.	Achieved

GATEWAY H

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

96.3%

FORMAL COMPLAINTS AND CONCERNS

9

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

1.45%

NUMBER OF STOP THE LINE EVENTS

7

STAFF TURNOVER %

1.4%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

6.1%

MANDATORY TRAINING - DIRECT HIRE

72%

GATEWAY H

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	Within the reception area we will review the full booking process to ensure we are respecting our patient's privacy.	A monthly review of the patient feedback to understand if the booking process is meeting our patient's needs.	Gateway Co-ordinator.
	Ensuring our patients receive all the information they require in regards to the usage of bowel preparation for colonoscopies.	This will be reviewed by audit on a six monthly basis.	Clinical Lead.
	Seamless discharge for non-sedated patients, to ensure they can go straight home following their procedure.	In line with JAG accreditation in October 2018 the team will review this based on feedback from our patients.	Lead Nurse.
	Alterations to be made to the quiet room to provide comfort to those patients receiving news.	Adapting the room to ensure patients feel comfortable in line with JAG accreditation.	Lead Nurse.
Best Clinical Outcome	Urgent category adherence to 2 week turnaround timeframe.	Quarterly audit to review timeframes and ensure changes are implemented.	Gateway Co-ordinator.
	Compliance to the National Endoscopy Database (NED).	Implementation of required measures in line with JAG requirements.	Operations Manager.
	Reduction of unplanned discharges.	A quarterly audit to be undertaken of the triage service to ensure we are seeing a reduction in unplanned discharges.	Clinical Lead.

GATEWAY H

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Most Engaged Staff	Engagement with the Midlands Gastroenterological Nurses society.	Lead Nurse and Nurse Consultants to attend and feedback at Partnership Sessions.	Lead Nurse/Nurse Consultants.
	Review of competency documentation.	Training to be implemented. To be monitored and reviewed on a monthly basis.	Lead Nurse and Deputy Lead Nurses.
	Live training course for the staff to attend.	A course will be arranged for January 2019, success of the course will be reviewed from staff feedback.	Training Lead.


Exit To Tram

GATEWAY I

DIGESTIVE DISEASES QUALITY ACCOUNT

The Digestive Diseases Unit delivers its outpatient clinic services in Gateway I. The Urology team also routinely provides outpatient assessment and management of urological diseases.

The Gateway consists of fifteen clinic rooms and two nursing assessment pre-clinic rooms. As well as the main waiting area, the Gateway has a separate waiting area for patients and their relatives.

Gateway I is the largest Digestive Diseases outpatient unit in Nottingham providing comprehensive gastrointestinal services for the diagnosis and integrated care of adult patients. The unit serves the needs of the local population and acts as a regional referral centre. The unit is also responsible for the teaching and training of our undergraduate and postgraduate colleagues through its service provision and protected teaching time.

In 2017/18 the clinical unit achieved:

Participation and leading on introduction of new pathway designs for:

- NDDI and FIT
- Pelvic Floor Patient Support Group
- PLCV embraced and embedded in the department
- Significant progress made within regards the upload to IBD Registry
- Urology suspected Prostate cancer pathway, if a patient has a raised PSA they are redirected to the NUH City hospital, this is complaint with the East Midlands Cancer Alliance (ECOG)

Lessons learnt in 2017/18:

- CCG continue to pose many challenges regarding pathway design
- Biologic pathway for IBD Management is important to demonstrate the effective review of drug expenditure.
- Review the vetting of referrals.

GATEWAY I
CONTINUED

Going forward into 2018/19:

- Review ways of working to ensure right time, first time, every time.

SERVICES PROVIDED

- Luminal gastroenterology:Inflammatory Bowel Disease, (IBD) small bowel disorders
- Coloproctology:bowel cancer, IBD, anorectal disorders, benign stoma care.
- Nurse Led Lower GI Clinic review
- Oesophago-gastric diseases including cancers, Barrett's oesophagus, reflux disorders
- General Surgical Clinic: hernia
- Pelvic Floor Clinic. Consultant and Nurse Specialist Led
- Functional GI disorders including irritable bowel syndrome
- Hepatobiliary medicine: ductal disease, Liver disease and disorders
- Hepatobiliary surgery:Cancers and benign pancreatico-biliary disease
- GI motility assessment (including colonic transit, oesophageal manometry, ambulatory pH studies and anorectal manometry) and their management
- Nutrition and intestinal failure
- Dietitian support
- Inflammatory Bowel Nurse Service

OUR TEAM

Operations Manager 1
Clinical Lead 1
Lead Nurse 1
Gateway Co-ordinator 1
Consultants/Doctors 49
Nurse Specialists 14
Deputy Lead Nurse 1
Registered Nurses 3
Healthcare Assistants 6
Senior Gateway Receptionists 2
Receptionists/Booking Clerks 8
Data Quality Administrators 3
Medical Secretaries 10
Support Secretaries 3
Medical Administrators 2
IBD Administrators 2

GATEWAY I

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
We will look at and implement mechanisms to improve patient education for specific conditions, for example, Inflammatory Bowel Disease (IBD) & Pelvic floor.	Patient feedback from sessions.	Clinical unit meeting.	Pelvic floor Nurse Specialists have held two patient education sessions on a Saturday morning, one of the session involved yoga. Following the success there are further patient education session planned. IBD sessions still require planning .	On-going
A review will be undertaken of patient's privacy and dignity when attending our reception desk to discuss their details.	Patient feedback.	Clinical unit meeting.	No incidents have been recorded within the last year; therefore this objective has not been actioned.	Not Achieved
All clinic start times and finish times will be monitored and reviewed on a daily basis to ensure that there is a consistent approach throughout.	Patient feedback.	Clinical unit meeting.	The Deputy Lead Nurse monitors, alongside any incidents reported on a daily basis.	Achieved

GATEWAY I

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Clinical parameters developed for the Inflammatory Bowel Disease nursing team, which will enable an efficient turnaround time for patient queries.	Patient feedback. An audit of the advice line to be reviewed quarterly.	Clinical unit meeting.	Audit completed with positive feedback from patients onexpectations including turnaround times. One change that has been implemented is live calling between 8am – 12pm daily, this allows patients to speak directly with a Nurse Specialist. This is in line with other local advice lines.	Achieved
Continue to input and develop the Inflammatory Bowel Disease registry, a national registry that will record patients with diagnosed IBD pathways, drugs monitoring of their condition.	Audits on completeness of further national guidance.	Clinical unit meeting.	The registry has over 500 patients registered; the patients have been consented for this. A clinical template has been created to use for consultations that where the information will be collated relevant to the disease.	Achieved

GATEWAY I

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Offer a one stop service for our patients who attend for Upper Gastroenterology so they can have a consultation and the procedure in one day.	Patient feedback on service. To be reviewed quarterly.	Clinical unit meeting.	This has been piloted with a Upper GI Surgeon over a 3 month period, this proved to be an unefficient use of clinical time and lack of patient suitability.	Achieved

GATEWAY I

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Shadowing of job roles within the Gateway to increase awareness and understanding.	Staff survey, individual meetings with team members.	Clinical Unit Leadership team.	Health Care Assistants and the gateway receptionists have been part of the shadowing process and this has enabled the Health Care Assistant's to support the reception team when required.	Achieved
On review of our patient and staff feedback we will celebrate by informing all our team of the Employee of the month.	Patient & staff feedback.	Clinical Unit Leadership team.	The employee of the month is now established within the Gateway.	Achieved

GATEWAY I

CONTINUED

PATIENTS WHO RESPOND TO FAMILY AND FRIENDS TEST %

96.3%

FORMAL COMPLAINTS AND CONCERNS

31

INCIDENTS REPORTED AS A PERCENTAGE OF ACTIVITY

0.54%

NUMBER OF STOP THE LINE EVENTS

0

STAFF TURNOVER %

1.8%

AVERAGE VACANCIES AS A PERCENTAGE OF HEADCOUNT

13.5%

MANDATORY TRAINING - DIRECT HIRE

79%

GATEWAY I

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best patient experience	Working with the Nottinghamshire CCG's to implement the Nottingham Digestive Diseases Interface Pathway, which will mean the patient is seen in the correct clinic first time, with diagnostics requested prior and carried out.	Regular meetings with the CCG to ensure we are meeting all the criteria for the pathway, this will include monitoring of the referral rates.	Clinical Unit Leads.
	Expansion of the Pelvic Floor focus group.	To understand from patient feedback patients requirements and ideas for improvements.	Clinical Unit Leads.
	Increase the percentage of patients receiving a text message for a reminder of their future appointment.	Undertake a quarterly review by audit to understand if this has been achieved.	Clinical Unit Leads.
	Establish a patient focus group for IBD, to be held quarterly.	To understand from patient feedback patients requirements and ideas for improvements.	Clinical Unit Leads.
Best Clinical Outcome	Demonstrate innovation to optimise outpatient experience including an introduction of Trans-Nasal Endoscopy.	Clinical outcomes audit carried out by nominated Gastroenterologist.	Clinical Unit Leads.
	National IBD registry – compliance with the registry.	Regular audit to be undertaken to understand the compliance and provide an opportunity to implement changes.	Clinical Unit Leads.
	Expansion of the Pre-Assessment service for patients requiring a Endoscopy.	A quarterly audit to be undertaken from information provided by Gateway H on their unplanned discharges.	Lead Nurse.

GATEWAY I

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Most Engaged Staff	Continue to access the skills and experience of the wider team to deliver a flexible workforce which meets the demand of the specialty.	From information provided for one to ones, and staff surveys.	Lead Nurse.
	Pelvic Floor Nurse Specialist to attend National Pelvic Floor summit.	Update following the summit and a review of the care provided following this.	Lead Nurse.


LISTER
HOUSE

COMMUNITY CLINICS

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

The Community Clinics service has for the past five years established clinics in Nottinghamshire, Derbyshire and Leicestershire. We offer a variety of specialties at each of our community clinic sites. Our aim is to provide our patients with care in the community which ensures they do not need to travel to the Nottingham NHS Treatment Centre for treatment, but can receive care closer to home.

Clinics and Services are provided in the following areas:

Central Physio
Respiratory
Orthopaedics
Digestive Diseases

Lister House Surgery, Derby
Gynaecology
Orthopaedics

Willington Surgery, Derbyshire
Gynaecology
Digestive Diseases

Nottingham Road Clinic, Mansfield
Urology
Respiratory
Digestive Diseases
Gynaecology
Orthopaedics

Castle Practice, West Bridgford
Orthopaedics

Rosebery Medical Centre, Loughborough
Urology
Orthopaedics
Gynaecology
Respiratory
Digestive Diseases
Ophthalmology

Peacock Healthcare, Carlton
Gynaecology
Urology
Orthopaedics
Digestive Diseases

Bingham Medical Centre, Bingham
Orthopaedics

Torkard Hill, Hucknall
Orthopaedics (Hand and Wrist)

Southwell Medical Centre, Southwell
Gynaecology
Orthopaedics

In 2017/18 the clinical unit has achieved:

- We have increased the number of staff who are competently trained to support all the clinics.
- We have introduced a full time co-ordinator who liaises with all staff and clinics, which has increased communication.
- We have added specialities to each site, for example, upper gastro intestinal and lumps and bumps. All specialities are supported by a Nurse Specialist.
- We have introduced a new service in Carlton.
- Feedback from patients is always positive.

COMMUNITY CLINICS

CONTINUED

Lessons learnt in 2017/18:

- Patients are being supported by a one stop service but we wish to implement changes to further improve the service.
- Having a full time co-ordinator has allowed consistency and given support to all sites.
- Staff have completed their basic competencies and are ready for a challenge.

Going forward into 2018/19:

- Diagnostics and referrals to occupational therapy and physiotherapy to be ordered electronically.
- We will introduce using FP10's to allow patients to get their treatment closer to home and quicker.
- Increase the number of staff who can undertake tasks like taking blood and recording of ECG's to support the pre assessment clinics.
- Improve the communication within the team by introducing huddles and a communication book.

OUR TEAM

Operations Manager 1
Clinical Lead 1
Lead Nurse 1
Gateway Co-ordinator 1
Staff Nurses 2
Support Facilitators 3
ICATS Administrator 1

COMMUNITY CLINICS

CONTINUED

QUALITY DOMAIN
BEST PATIENT EXPERIENCE

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Offer Telephone Pre-Assessment for patients.	Monthly audit.	Clinical unit meetings.	All patients who are eligible receive telephone pre-assessments.	Achieved
Monitor and promote the one stop service for patients.	Monthly audit.	Clinical unit meetings.	All patients who are eligible are pre-assessed at the time of listing for surgery.	Achieved
Promote the Community Clinic service by creating and distributing a brochure highlighting the services provided. And provide our patients with appointment cards.	Review at Partnership Session.	Clinical unit meetings.	Appointment cards have been developed and are in use. We are currently collating information for a brochure for our patients.	On-going

COMMUNITY CLINICS

CONTINUED

QUALITY DOMAIN
BEST CLINICAL OUTCOME

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Build relationships with main hub sites to maximize clinic capacity.	Continue to monitor new referrals – Ensure minimum of 6 new patients attend per clinic.	Clinical unit meetings.	This has been successful. The staff are monitoring the referrals and supporting patients to book earlier appointments as they become available.	Achieved
Introducing a COS Champion.	Review at Partnership Session.	Clinical unit meetings.	We have 2 staff who are now our champions and support with swarms and the maintenance of the COS boards.	Achieved

COMMUNITY CLINICS

CONTINUED

QUALITY DOMAIN
MOST ENGAGED STAFF

OUR QUALITY PRIORITIES FOR 2017/18	SUCCESS MEASURES FOR 2017/18	MONITORING & REPORTING RESPONSIBILITIES	OUTCOME	STATUS
Supporting and training new starters to the team. Regular one to one meetings with new team members to introduce them to their new roles and encourage development.	Regular one to one meetings with all staff members.	Monthly one to one meetings.	All staff have an induction and one to one's are scheduled regularly. We have started completing a huddle book which records discussions from huddles held on a Monday, Wednesday and Friday, so all staff are aware of messages and updates. All staff are encouraged to read and sign if they are aware. All staff encouraged to bring items to the huddle.	Achieved

COMMUNITY CLINICS

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Patient Experience	Promote Community Clinics service by creating and distributing a brochure highlighting the services we provide.	The content and design will be decided by the team as part of their Partnership Session. This will then be produced and distributed to all our sites.	Clinic Unit Team.
	We will be providing the electronic support needed to support the move towards electronic requests for imaging, diagnostics and support services, we will be encouraging the clinicians to comply.	80% of requests will be completed electronically. Audits will be undertaken monthly to monitor the progress and reported to the Clinical Unit Meeting.	Clinic Unit Team.
	Following patient feedback we have obtained FP10 prescriptions, we will use these to reduce the number of prescriptions returned to the Treatment Centre and being posted to the patient.	100% of prescriptions are on an FP10. Any occasion a prescription is returned to the Treatment Centre for supply we will report as a incident and monitor at the Clinical Unit Meeting.	Clinic Unit Team.
Best Clinical Outcome	Patients have a one stop service including treatment and pre assessment if needed.	80% of patients will have a one stop appointment. A report will be completed showing all patients who have to return for any further treatment or pre assessment and investigated by the Clinical Unit team.	Clinic Unit Team.

COMMUNITY CLINICS

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

QUALITY DOMAIN	OUR QUALITY PRIORITIES FOR 2018/19	SUCCESS MEASURES FOR 2018/19	MONITORING & REPORTING RESPONSIBILITIES
Best Clinical Outcome	We will promote good practice to consent patients at the time of listing for surgery.	Report of all patients needing to have consent at a later date to be shared at the Clinical Unit Meeting monthly.	Clinic Unit Team.
	All patients who have a pre assessment will have any bloods or other investigations completed at the same time.	Monthly reports will be shared at the Clinical Unit Meeting.	Clinical Unit Leads.
Most Engaged Staff	To increase the communication between staff we will introduce team meetings three times a week, and ensure there are notes from these meetings so those who are not present are provided with the information.	Staff are updated and are aware of changes and information.	Co-ordinator/Lead Nurse.
	Staff will be supported to undertake competency training in an area that supports their role e.g. venepuncture.	Staff are motivated and multi skilled.	Co-ordinator/Lead Nurse.
	Staff will be supported to attend theatres or clinics to increase their knowledge of the conditions and surgery the patients in their care will have.	Staff have attended one theatre session and one outpatient clinic.	Co-ordinator/Lead Nurse.

PART FOUR

STATEMENT FROM THE

PATIENT AND PUBLIC ENGAGEMENT GROUP

The Patient & Public Engagement Group was pleased to contribute to the Circle Nottingham Quality Account for 2017/18. As members of the Patient & Public Engagement Group and in most cases, active patients ourselves, we aim to represent the 'voice' of the patient and the public community, and our intention is that our opinions and experiences provide a valuable contribution to the quality agenda for 2017/18.

Members of the Patient & Public Engagement (PPE) Group have been actively linking with the Gateways either by attending patient champion meetings, attending partnership sessions, assisting with audit completion or having patient experience meetings within the units, contributing valuable insight to the services from a patient perspective. Members of the PPE group have been involved with the Sustainability and Transformation plans including an update for members during one of the bimonthly meetings held at Circle Nottingham. The members continue to ensure the patient voice continues to be heard and is able to influence the development of services at an early stage.

Active recruitment of members to the group continued during 2017/18 and we are continuing to identify ways in which we can seek the views of a wider group of Circle service users.

We look forward to continuing the programme of joint working and we are excited about the development opportunities that will arise as CircleNottingham develop and grow their services.

Patient and Public Engagement Group

STATEMENT FROM THE

NHS RUSHCLIFFE CLINICAL COMMISSIONING GROUP

NHS Rushcliffe Clinical Commissioning Group (CCG) is the co-ordinating commissioner for Circle Nottingham Independent NHS Treatment Centre for 2017/18 on behalf of a number of commissioners. In this role the CCG has responsibility for monitoring the quality and performance of services at Circle Nottingham. The CCG is satisfied that the information contained within this quality account is consistent with that supplied to us throughout the year.

There are a number of ways in which we review and monitor the performance and quality of the services we commission. This includes visits to services, regular quality and contract review meetings and continuous dialogue as issues arise, for example patient safety incidents or patient feedback. These mechanisms allow us to triangulate and review the accuracy of the information being presented to formulate opinions about the quality of services provided to patients at both organisation and service level.

We commend Circle Nottingham for its governance structure and approach which continues to promote staff engagement and ownership within each clinical gateway and is evidenced by the clinical gateway specific information and quality improvement priorities in this Quality Account. This approach enables clinicians closest to the patient to work as a team to self-regulate the quality of their service, whilst being accountable and reporting centrally to an organisational Clinical Governance and Risk Management (CGRM) Committee, which reports to the Circle Nottingham Board. As co-ordinating commissioners we regularly attend this Committee and receive copies of all of the meeting minutes which supports our quality assurance of the services provided.

Throughout 2017/18 Circle Nottingham has shown continued commitment to quality and patient safety priorities through initiatives such as *'Stop the Line'* aimed at empowering staff to recognise and intervene appropriately if patient safety is compromised. 'Swarms', a gathering of the relevant staff in order to discuss/propose solutions and agree actions following an issue which has arisen, have also taken place throughout the year. In addition, review and development of the Patient and Public Engagement Group to increase membership and encourage members to participate in various promotions and events ensuring patient awareness has been evident.

Circle Nottingham continues to foster a healthy incident reporting culture and uses the learning from incidents to continually improve the quality and safety of services provided. During 2017/18 the organisation reported one Serious Incident and no Never Events. The Serious Incident related to care provided to 3 patients on the Short Stay Unit who experienced Pulmonary Embolisms following surgical procedures. A full root cause analysis

STATEMENT FROM THE NHS RUSHCLIFFE CLINICAL COMMISSIONING GROUP CONTINUED

investigation was undertaken and the findings shared with the CCG and CQC. Duty of candour was enacted as appropriate, lessons learned were identified and appropriate actions taken to prevent similar occurrence in the future. Multi-disciplinary teams are encouraged to come together at regular 'partnership' events to discuss potential safety risks and issues with the aim of continually improving patient safety and fostering a healthy safety culture. This year a number of patient safety incidents were presented as patient stories at the CGRM Committee to ensure the patient voice is heard and the learning from incidents is widely disseminated. Circle Nottingham is a partner in the Nottinghamshire Sustainability and Transformation Plan (STP) and has collaborated with commissioners and other partners to respond to local commissioning intentions and develop integrated care pathways that improve the health of the local community. This includes further expansion of community clinics, providing care closer to home and the roll out of helplines and telemedicine.

We have worked collaboratively with Circle Nottingham to support their continuous quality improvement. They have, and continue to undertake the applicable national Commissioning for Quality and Innovation Schemes (CQUINS) for 2017/19. In addition they identified two specifically local CQUINs to implement during 2017/19. Firstly, development of the Treatment Centre environment to become a dementia friendly space. This has included mandatory dementia training for all staff and making environmental adaptations to support patients with dementia. Education and Support Groups for specific patient groups have also been implemented. These enable improved self-care and reduce the need for healthcare intervention.

A small number of breaches during 2017/18 of the 104 days cancer target (cancer patients waiting 104 days or more from referral to the first definitive treatment) resulted in Circle undertaking reviews of the impact of any harm as a consequence of this missed target. These reviews have been presented to commissioners and there is no evidence of patient harm to date.

Circle Nottingham has continued to demonstrate a high level of commitment to improving patient, carer and staff experiences of the organisation. Mechanisms for receiving real time feedback have been established and it is clear that this feedback is treated seriously and genuine efforts are made to improve services in the light of it. The Friends and Family Test continues to be used and Circle Nottingham are endeavouring to maintain or improve response rates using innovative ways of capturing feedback through postcards, electronic tablets and utilising patient representatives to harness service user opinion.

STATEMENT FROM THE NHS RUSHCLIFFE CLINICAL COMMISSIONING GROUP CONTINUED

The Care Quality Commission (CQC) visited Circle Nottingham in January 2015 and rated it as "Good" overall but the termination of pregnancy service required some improvements. Circle Nottingham responded positively to the CQC findings and implemented an action plan in response which was monitored through our Quality Scrutiny Panel meetings with the organisation. A follow up visit from the CQC in May 2016 identified marked improvements had been made. In preparation for future CQC visits, Circle Nottingham regularly participates in national Circle organisational inspections.

Commissioners are pleased to see that not only has each service reviewed the outcomes for their 2017/18 quality priorities and contributed to setting priorities for the organisation, but that in addition, each service has continued to develop its own distinct quality improvement priorities for 2017/18. This approach is to be commended as it makes clear what needs to be achieved at each service level and enables progress to be reported upon openly within the organisation's CGRM committee.

We will continue to work closely with Circle Nottingham throughout 2018/19 to ensure on-going high quality services are provided in line with commissioning priorities.

Nichola Bramhall, Chief Nurse/Director of Quality
On behalf of Sam Walters
Accountable Officer
NHS Rushcliffe Clinical Commissioning Group
June 2018

STATEMENT FROM THE HEALTH SCRUTINY COMMITTEE NOTTINGHAM CITY COUNCIL

The Nottingham City Health Scrutiny Committee welcomes the opportunity to comment on the Circle Nottingham Quality Account 2017/18. Our comment focuses on the areas in which we have engaged with Circle Nottingham during 2017/18.

No issues relating to the provision of services by Circle Nottingham at the Treatment Centre were identified for scrutiny by the Committee during 2017/18.

Following previous concern regarding the dermatology service, the Committee welcomes the progress made in recruiting to dermatology posts and reducing reliance on locum consultants, resulting in a more stable service and improved patient feedback.

The Committee commends the development of individual gateway priorities, which promotes staff engagement in improvement and enhances accountability for improvements to individual service areas.

The Committee acknowledges the work of Circle in innovating in support of system wide objectives, for example expanding the use of technology to engage with patients and support patient care, and supports continuation of this work during 2018/19, in addition to the other priorities identified for 2018/19.

The Committee hopes that the length of the contract currently held by Circle does not significantly impact on the organisation's ambition and the drive for improvement in services provided at the Treatment Centre, particularly in any way that impacts negatively on service users. For example, while acknowledging that contingencies have been put in place for periods when the MRI scanner has been unavailable the Committee is concerned about the impact on service users if decisions about investment cannot be reached at an early opportunity.

Chair, Counsellor Anne Peach

STATEMENT FROM THE HEALTH SCRUTINY COMMITTEE NOTTINGHAM COUNTY COUNCIL

The Health Scrutiny Committee for Nottinghamshire welcomes this opportunity to comment on Circle's Quality Account for 2017/18.

The committee commends Circle on its work around staff development – particularly the commencement of apprenticeships, but also in allowing staff to identify their own training needs. It is gratifying that endoscopy staff can gain qualifications up to Masters level.

The committee notes that some of the complaints against Circle staff for attitude and behaviour relate to occasions when a clinician is unable to deliver a particular diagnosis.

The committee would like to see from Circle, in future, more anonymised thematic detail on complaints being reported to us so that emerging themes and issues can be properly scrutinised.

The committee congratulates Circle on its comparative success with recruitment of clinical staff and hopes that it procedures could be disseminated to provider Trusts who experience difficulty with recruitment.

Chairman, Counsellor Keith Girling

STATEMENT FROM THE

HEALTHWATCH NOTTINGHAM AND HEALTHWATCH NOTTINGHAMSHIRE

As the independent watchdog for health and care in Nottingham and Nottinghamshire we work hard to ensure patient and carer voices are heard by both commissioners and providers. We are grateful for the opportunity to view and comment on the Circle Quality Account 2017-18. In particular the sections on engagement, patient surveys and patient and public engagement group.

The report provides an in-depth overview of quality and a review of activities and achievements, demonstrating the mandatory reporting requirements set out by NHS Improvement. A number of examples of how patient experiences and opinion is collected are illustrated under each Gateway e.g. in Dermatology 'You said, we did' display boards in clinic, the recruitment of Mystery Shoppers for Gateway D and G and for Gateway H monthly reviews of patient feedback. These examples are all good practice and illustrate to service users Circle's willingness to gather and act on feedback.

The sections on engagement, patient surveys and the patient and public group illustrate Circle's active engagement and consultation ethos. For example a number of patient and staff surveys were carried out e.g. with skin cancer patients, knee, hip and groin hernia patients and post-op triage service. Results and improvements made as a result of the findings have not been shared in this report.

This report provides a clear description of the role of the Patient and Public Engagement Group giving examples of the projects that the group has inputted on. The report does not detail the recommendations this group have made nor how this has impacted positively on service users. We feel it would also be valuable to see the demographics of this group to understand if they are representative of the service users.

Circle operates a complaints process which in 2017/18 received 191 complaints however the report states, *'no apparent trend in terms of clinical unit or theme'* was found. This indicates that a review of their complaints process and the data collection methods would be useful as it is unlikely that no themes have emerged from this volume of complaints. Further these have not been shared with Healthwatch despite requests to do so.

The 2018/19 Quality Improvement Priorities are challenging enough to drive improvement, however the 'Simply the best patient experience' success measures could be more tangible and outcome focused.

STATEMENT FROM THE

HEALTHWATCH NOTTINGHAM AND HEALTHWATCH NOTTINGHAMSHIRE

CONTINUED

Over the last year Healthwatch has received a small number of experiences about Circle from patients. These included ‘very attentive and caring’, ‘I feel we (me and Doctor) are now two people having a conversation and trying to solve a problem together’ and ‘quick and efficient and they really do listen’. The three negative experiences were all about waiting times.

Overall this report demonstrates Circle’s commitment to engaging with services users. Some more detail around what changes this engagement has led to, along with patient stories, could help to evidence positive impacts for patients. Finally outcome focused priorities for 2018/19 written in plain English within a condensed version for the public will make this report more accessible to all.

JARGON BUSTER

ACO	Accountable Care Organisations
Apps/ Applications	A specialised piece of software (which can run on the internet, on your computer, or on your mobile phone or other electronic device) and is designed to undertake a specific task. For example to monitor waiting times in clinic
CCG (Clinical commissioning groups)	They are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
COS	Circle Operating System.
Climbs	Database software used for recording patient experience data at the Treatment Centre.
Clinical Governance and Risk Management Committee (CGRMC)	It is a monthly meeting where clinical leads, lead nurses, administration staff and senior management team meet together to develop, implement and oversee the clinical governance and clinical/non-clinical risk management processes in the Treatment Centre. Also for providing assurance to both the Executive Board and the Integrated Governance Committee about the robustness and effectiveness of the risk management and governance processes within the Treatment Centre.
CQC (Care Quality Commission)	The independent regulator of health and social care in England.
CQUIN (Commissioning for Quality and Innovation)	The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
Credo	A set of fundamental beliefs or a guiding principle. For Circle, a credo is similar to a mission statement that guides the way in which we deliver healthcare. The Circle principles are: • We are above all the agents of our patients. We aim to exceed their expectations every time so that we earn their trust and loyalty. We strive to continuously improve the quality and the value of the care we give our patients..

JARGON BUSTER

CONTINUED

Credo	• We empower our people to do their best. Our people are our greatest asset. We should select them attentively and invest in them passionately. As everyone matters, everyone who contributes should be a Partner in all that we do. In return, we expect them to give their patients all that they can. • We are unrelenting in the pursuit of excellence. We embrace innovation and learn from our mistakes. We measure everything we do and we share the data with all to judge. Pursuing our ambition to be the best healthcare provider is a never-ending process. 'Good enough' never is.
CT (Computed Tomography)	Scan that uses X-rays and a computer to create detailed images of the inside of the body
Dashboards	An easy read, often single page, real-time user interface, showing a graphical presentation of the current status (snapshot) and historical trends of an organisation's key performance indicators (KPIs) to enable instantaneous and informed decisions to be made at a glance.
DEXA Scanner (Dual Energy X-ray Absorptiometry)	Scan is a special type of X-ray that measures bone mineral density (BMD).
DNA	Did not attend.
FLO	Florence Simple Telehealth
FP10's	A standard prescription as provided by a General Practitioner.
HEEM	Health Education East Midlands
HR	Human Resources
Innovator	An individual with the ability to make change
IRMER	Ionising Radiation (Medical Exposure) Regulations
Joint Advisory Group (JAG)	The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) operates within the Clinical Standards Department of the Royal College of Physicians. JAG has a wide remit and its cores objectives include: to agree and set acceptable standards for competence in endoscopic procedures and, to quality assure endoscopic units, training and services.

JARGON BUSTER

CONTINUED

KPI	Key Performance Indicator
MECC	Make Every Contact Count
MRI (Magnetic Resonance Imaging)	A type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
NICE	National Institute of Clinical Excellence
NIV	Non-invasive ventilation
NUH	Nottingham University Hospitals NHS Trust
ONS	Office of National Statistics
Partnership Sessions	Educational, discussion and solution focused sessions held within clinical units and open to all staff involved in the patient pathway. The purpose of the sessions is to improve competence and educate staff, enable discussions of any issues that have arisen and provide the opportunity to develop realistic and effective solutions
PDT	Photodynamic Therapy
PHIN	Private Healthcare Information Network
PLACE	Patient Led Assessment of the Environment
PSA	Prostrate Specific Anitgen
PTL	Patient Tracking List
PUVA (Psoralen combined with Ultraviolet A)	Psoralen is a diluted solution used to soak hands and/or feet prior to treatment; UVA is Ultra violet A light. PUVA treatment is prescribed for psoriasis or eczema that is affecting the hands and/or the feet.
Quality Quartet	A monthly report which provides information on quality measures for each Gateway.
STP	Sustainability Transformation Plan
SWARM	A term used to refer to a gathering of the relevant staff in order to discuss propose solutions and agree actions following an issue which has arisen. This is part of our Circle operating system methodology

JARGON BUSTER

CONTINUED

TRUS biopsies (Transrectal ultrasound)	Ultrasound that provides images of the prostate to allows the examination of the gland for abnormalities.
TUPE	Transfer of Undertakings (Protection of Employment)
WHO	World Health Organisation

THANK YOU

Thank you for taking the time to read our Quality Account.

We hope you found it interesting and useful in understanding our commitment to quality for our patients and partners.

Should you have any further questions, we would be pleased to hear from you.

Please contact us on nottingham@circlehealth.co.uk