Quality Accounts 2020/21

City Health Care Partnership CIC

Excellence. Compassion. Expertise.

chcp

Our vision is to lead and inspire through excellence, compassion and expertise in all that we do.

Contents

Andrew Burnell
Chief Executive, City Health Care Partnership CIC

Statement and Introduction from the Chief Executive

Hello and welcome to City Health Care Partnership CIC's (CHCP) Quality Accounts.

Each year, as an organisation funded from NHS money, we are required to produce our Quality Accounts to clearly outline the quality of our services and I am pleased to present the ninth set of Quality Accounts from CHCP.

2020–2021 has been a challenging year for everyone across the globe. The outbreak of the COVID-19 pandemic has pushed health and social care providers to their very limits in order to be able to deliver and maintain care provision.

Our response has called for some exceptional creative thinking and our staff have rapidly had to make profound changes in order to adapt and evolve to meet the challenge of delivering safe, effective health and supportive care during the pandemic.

We have seen new care pathways being developed and services rapidly being remodelled and redesigned; for example, from delivering home-based assessments to offering a mix of face to face and virtual 1:1 consultations, offering virtual consultations using GP tailored computer software within our primary care practices, whilst also maintaining face to face appointments including from 'hot sites', ie sites where patients with COVID-19 could be seen.

All changes to care delivery were supported by appropriate research, best practice guidance and equality impact assessments.

Never before has the significance and functionality of digital access and mobile working been so valued, enabling our practitioners to access real-time information and patient care records, and in line with national guidance we moved to offering full access to GP patient records.

We worked collaboratively with our care provider partners and commissioners in rapidly expanding multi-agency working and models of shared care to support hospital avoidance and early discharge; for example, we successfully implemented a 'Discharge to Assess' pathway and worked with local partners to offer designated beds to enable people with a COVID-19 diagnosis to be cared for in dedicated community facilities.

We developed and offered via the Jean Bishop Integrated Care Centre a 12 hour a day, seven day a week Frailty and Care Home Advice Line, manned by Community Geriatricians and GPs with Enhanced Roles, supporting people to stay within their own home or care home when clinically this was the best for the patient. Locally we implemented a requirement for COVID-19 testing prior to hospital discharge back into community care, before this was nationally mandated.

Across the world, learning from the pandemic is just beginning. Like all healthcare providers we will be reviewing available evidence to identify the effectiveness of new approaches to care, embed learning and ensure all service users continue to receive the best possible care. For example, having implemented the learning from COVID-19 in relation to lower leg wounds, we have been chosen to be a pilot site for the national wound care strategy and look forward to reporting the outputs of this in next year's Quality Accounts.

This year, more than ever, our collaborative, system-minded approach been called into action, enabling new and adapted ways of working. In Chapter 5 of this publication we offer some examples illustrating how our staff have met the challenges of the previous year, including those posed by the COVID-19 pandemic, by delivering high quality, responsive and innovative care.

Despite the unprecedented demands upon our colleagues and the services that they deliver, our 2020 Colleague Survey confirmed that 9 out of 10 members of staff say that they would be happy to recommend their family or friends to one of our services for treatment, with the following themes noted from their responses:

- Good quality of care
- Good services
- CHCP valuing their patients
- Good attitude of staff
- Having had a personal positive experience

We recognise that our staff are our most valuable asset. Their collective, collaborative work both within CHCP and with our key health and social care partners, has enabled us to sustain our response in delivering quality care.

We know that 2020–2021 will go down in the history books and digital solutions, redesigned pathways and effective safe and timely referral and discharge processes will be continued and will help to shape the possibilities of 21st Century community health care provision.

This publication and the process for compiling the content acts as an open and honest review of our quality achievements and challenges.

I would like to offer my sincere thanks to all of our stakeholders, those who have supported the production of the content and those who have reviewed and given statements for these accounts.

To the best of my knowledge the information within these Quality Accounts is true and accurate.

Review of our Services

During 2020-2021 CHCP provided in excess of 36 contracted health care services funded through NHS commissioning and 14 public health services, which were commissioned by local authorities. The services are managed within two portfolios held by each of our Deputy Chief Operating Officers.

OUR FULL RANGE OF SERVICES CAN BE FOUND ON OUR WEBSITE AT:

chcpcic.org.uk

Health and Wellbeing Portfolio*

- Urgent Treatment Centres
- Anticoagulation and Deep Vein Thrombosis (DVT)
- Carers Support and Information Service
- Prison Healthcare
- Community Dental
- Primary Care
- Community Children's Nursing
- Tier 3 Weight Management
- Public Health – North West
- Let's Talk – Improving Access to Psychological Therapies

Integrated Community Services Portfolio*

- Cardiac and Pulmonary Rehabilitation
- Integrated Community Stroke
- Speech and Language Therapy
- Nutrition and Dietetics
- Podiatry
- Occupational Therapy and Physiotherapy
- Bladder and Bowel Care
- Musculo-Skeletal
- Community Nursing Services – Hull and East Riding of Yorkshire
- Palliative Care

*Please note that these services are not exhaustive but offered as an illustration of the breadth of services which CHCP provides. Our full range of services can be found on our website at: https://www.chcpcic.org.uk/

All our services are supported by our business support services which include:

Human Resources, IT Support, Communications, Marketing and Engagement, Quality Improvement and Compliance, Safeguarding, Business Intelligence, Health and Safety, Infection, Prevention and Control, & Medicines Service.

In 2020-21 we provided services in the geographical areas of Hull, East Riding of Yorkshire, Knowsley, St Helens and Wigan. We provide a wide and diverse range of services in community settings from health visiting to palliative care, school nursing to stroke services and many more.

In addition, we manage inpatient facilities at East Riding Community Hospital, a stroke rehabilitation unit, and Intermediate Care Beds. During the COVID-19 pandemic we also opened additional beds to support the discharge of COVID-19 positive patients who needed further clinical care post discharge from hospital.

Income

The income generated by the NHS services reviewed in 2020 – 2021 represents 100% of the total income generated from the provision.

Participation in Clinical Audit

Clinical audit is a structured quality improvement tool where service delivery is measured and analysed against specific standards such as NICE (National Institute for Health and Care Excellence) and clinical standards published by professional bodies such as the Royal College of Nursing.

By using a clinical audit approach, we can identify 'quality' and monitor achievement of standards and any areas for further improvement.

National Audits reportable within Quality Accounts

CHCP's engagement with National Clinical Audit programmes is guided by the advice from the Healthcare Quality Improvement Partnership (HQIP).

In April 2020, in response to the impact of the COVID-19 pandemic upon health care services across the country, HQIP suspended 'all national clinical audit, confidential enquiries and national joint registry data collection'.

From July 2020 HQIP key reporting and management functions began to restart in line with NHS recovery plans and health care providers were expected to review their capacity to recommence or defer data collection.

NICE SHARED LEARNING PUBLICATION – ABSTRACT TAKEN FROM NICE WEBSITE
www.nice.org.uk

National clinical audits participated in by CHCP

Professional Body	Audit Title	Audit Methods	Audit Update
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	National Audit of Care at the End of Life (NACEL)	Measures the experience of care at the end of life for dying people and those important to them.	NACEL suspended the audit in 2020 due to the COVID-19 pandemic.
Parkinson's UK	UK Parkinson's Audit	Quality improvement tool allowing measurement of practice against evidence-based standards and patient feedback in a continuous cycle of improvement.	The next round of the UK Parkinson's Audit will take place in 2022. Advising that 'adding a year to the audit cycle will allow services to recover from the impact of COVID-19 and dedicate 2021 to service improvement.'
British Heart Foundation (BHF)	National Audit of Cardiac Rehabilitation	Collects service level information about staffing and performance.	HQIP advised the continuation of data collection 'where and when possible.'
National Diabetes Audit (NDA) & National Clinical Audit and Patient Outcomes Programme (NCAPOP)	National Diabetic Foot Care Audit (NDFA)	Measures performance against NICE guidance.	NDA informed that they will not be publishing Best Practice Tariff reports due to the disruption in data collection.
Royal College of Physicians (RCP)	National Asthma and COPD Audit Programme (NACAP)	Collects service level information around admissions, staffing, resources and performance.	RCP informed that they will not be publishing Best Practice Tariff reports due to the disruption in data collection.
Royal College of Physicians (RCP)	National Audit for Pulmonary Rehabilitation	Collects service level information about staffing and performance.	Data collection paused throughout 2020–2021 in line with recovery plan priorities in the service. Sought direction from RCP who advised that there were 'no consequences of not participating as the instruction from NHS England is that services should only participate in national audits if they are able to.'
British HIV Association (BHIVA)	British HIV Association (BHIVA) 2020 National Clinical	Collects service level information of the management of individuals with HIV and seropositive for hepatitis C to measure against guidelines (case note audit) and engagement in care (survey of clinic policy and practice)	Postponed 2020–2021 due to COVID-19 pandemic. Study of COVID-19 among adults with HIV commenced engagement from October 2020.
King's College London	Sentinel Stroke National Audit Programme (SSNAP)	Collects service level information around admissions, staffing, resources, and performance.	HQIP advised the continuation of data collection 'where and when possible.'

CHCP Staff-Led Clinical Audit

Clinical care delivery was prioritised by practitioners during 2020–2021 and thus the organisation's cross-service record keeping audit was postponed. However, during 2020–2021:

20
Services registered at least one clinical audit

18
Clinical audits were completed

41
Audits are ongoing

One of our GPs working in our primary care service completed the following clinical audit:

An audit of patients on contra-indicated medications, Clopidogrel and Omeprazole or Esomeprazole – Dr Borisade, General Practitioner

Aims

The audit sought to examine whether Clopidogrel, an anti-clotting medication and Omeprazole or Esomeprazole, drugs to reduce gastric acid or PPI - proton pump inhibitor, were being prescribed for patients at the same time.

Background

These medications are commonly used in general practice and are contra-indicated for concurrent use due to the potential interaction where the PPI may reduce the effectiveness of the anti-clotting medication. A Drug Safety Update from the MHRA (Medicines and Healthcare Products Regulatory Agency) was issued highlighting this potential interaction in 2010 and updated December 2014.

However as the medications are commonly prescribed and both Omeprazole and Esomperazole are available to purchase from pharmacies Dr Boraside wished to review current compliance with the drug safety alert. It was noted the concomitant use of these medications should be discouraged unless deemed essential.

Methodology

A search through the patients' electronic healthcare records identified patients who had historically been prescribed both medications.

A detailed record review was undertaken of each set of records.

Results

A total of 65 patients were identified within the electronic patient record system as being historically prescribed Clopidogrel and Omeprazole or Esomeprazole. 59 patients were identified as having a clinical diagnosis and medication prescribed accordingly but no overlapping prescribing intervals or inappropriate combination of the drugs.
A further 6 patients were identified as receiving treatment with both drugs presently.

Outcome

All 6 patients had treatment reviews to determine a clear rationale for medication prescribing and following discussion with their doctor, where appropriate alternative medications were prescribed in line with their clinical diagnosis.

Learning from the clinical audit

Initial audit findings and further advice to healthcare professional colleagues was shared within the primary care service to act as re-enforcement of the MHRA Drug Safety Update which included:

- The use of Clopidogrel and Omeprazole or Esomeprazole should be discouraged unless clinical assessed and considered essential
- Doctors should check whether patients who are taking Clopidogrel are also buying Omeprazole or Esomeprazole from a pharmacy, and discuss the consideration of the suitability of alternative gastrointestinal medications.

A follow-up re-audit showed no patients having both medications prescribed at the same time.

Audit Telephone Triaging During the COVID-19 Pandemic - Lucy Slater, Dental Core Training Student

Aim

The aim of the audit was to ascertain compliance with standards and best practice for telephone triage at this difficult time.

Lucy tells us: 'The COVID-19 pandemic has changed dental practice and new national, regional and local guidelines have been quickly introduced. CHCP Dental clinicians adapted swiftly to telephone triaging to reduce face to face appointments at Urgent Dental Care centres, whilst striving to ensure safe, effective practice.'

A baseline audit demonstrated wide variation in the documentation of the telephone assessment so a triaging pathway was developed for dentists to follow and provide a framework to improve compliance with required standards.

This included:

- Amalgamating current guidance on record keeping and telephone triaging during the COVID-19 pandemic
- Streamlining the process of asking for photographs and encouraging patients to do this prior to consultation with the dentist, with consent collected and recorded at the same time
- Streamlining process of asking for the pharmacy and pharmacy nhs.net email address
- Enabling best practice whilst limited to telephone triages and to re-establish safety measures we take for granted in normal practice. Including confirmation of:
  - The identity of the person on the phone
  - The patient details to ensure you can call back if required and to ensure details are correct in case the patient requires a prescription
  - The patient's COVID-19 status
  - COVID-19 risk of the patient
  - Full medical history taken
  - Red flag screening tool, for example, to help rule out sepsis
  - Previous notes and radiographs have been reviewed if available
  - Discussion regarding the patient's ideal management pre-COVID-19. This may be a face-to-face consultation and assessment, or removal of source of infection rather than antibiotics
- If considering a face-to-face appointment, a full COVID-19 risk assessment should be completed, and the patient should be discussed with the clinical lead.

Learning from the audit

Lucy offered the following insight: 'On reflection, this audit cycle has made a significant improvement to our service and the safety and efficiency of the telephone triaging. It has allowed us to learn quickly and adapt to the changes imposed upon us by the pandemic. The Dentist Form created was very long and did take a while to complete. However, this was supported by our triaging dentists and was generally embraced. The audit's aim was not to verify compliance of the Dentist form but to help ensure best practice.'

	Standard	1st Cycle	2nd Cycle
Confirmation of identity of person on the phone			
Person on the phone	90%	88%	100%
Patient details confirmed (date of birth)	90%	19%	94%
Contact details confirmed (telephone number and first line of address)	90%	19%	94%
Medical history confirmation			
'Checked, no changes' written (or summary)	N/A	75%	40%
Systematic review/full medical history taken	90%	13%	63%
COVID-19 status	90%	25%	91%
Clinical history, virtual exam and investigations			
Patient complaint	90%	94%	100%
PDH - records reviewed. Radiographs reviews	90%	44%	95%
Photograph consent documented if obtained	90%	41%	100%
Diagnostic impression	90%	75%	94%
Management plan			
Ideal management prior to COVID-19	90%		91%
Advice given	90%	94%	100%

Audit of the Hull and East Riding Speech and Language Therapy Services Waiting Time and Clinical Waiting Priorities – Anna Ray, Professional Lead Speech and Language Therapy.

Aim of audit

The aim of the audit was to determine if the current standard operating procedure enables prompt, safe and equitable triage of patients with swallowing difficulties across the Hull and East Riding Speech and Language Therapy service.

The following standards were identified and audited against:

- Referrals are checked to ensure they meet service criteria
- All swallowing referrals have a telephone assessment completed on them
- All Hull patients had a completed integrated care assessment done on the telephone
- Referrals are prioritised according to the prioritisation triage matrix
- Priority referrals are seen within 10 working days of registration
- Triage letter is sent out to the patient and GP on completion of triage.
  - COVID-19 risk of the patient
  - Full medical history taken

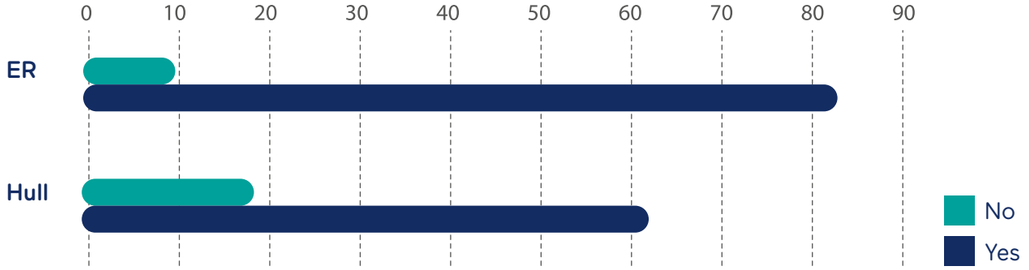
Findings

143 patients met the referral criteria and, in each case, their electronic health care records were examined for compliance with the standards.

82% of dysphagia referrals who were referred met the criteria to have a telephone assessment undertaken.

Overall, 74% of patients were prioritised in accordance with the guidelines and all dysphagia referrals triaged as priority on telephone assessment were seen within 10 working days.

Did the patient meet the service criteria? (By area)



	Number of priority referrals	Mean number of working days between referral and visit	Median number of working days between referral and visit	Mode number of working days between referral and visit
Hull	9	5.2	6	6
ER	6	6.7	7	9

Learning from the audit

Anna tells us: *'In 2019 a standard operating procedure was ratified to increase the standardisation of the triage process of new referrals into the Speech and Language Therapy service. The service receives referrals for both communication and swallowing difficulties (dysphagia) which undergo differing triage processes. The triaging of dysphagia referrals is challenging as staff need to determine which of those patients are at high risk of deteriorating health and potential hospital admissions as a result of their dysphagia and therefore need seeing within the agreed priority key performance indicator (KPI) of 10 working days.'*

Consideration of the findings for each of the audit questions generated a focused discussion across the team with a raised awareness of the importance of documenting compliance with key standards and has supported them to review their triage guidelines, update the telephone assessment template, ensure priority slots are highlighted in the work-planner and update their record keeping standard operating procedure.

NICE Guidance

The National Institute for Health and Care Excellence (NICE) is an independent organisation that publishes guidance, standards and indicators for clinical care and service delivery provision.

Whilst at the beginning of the year many NICE publications were paused due to the impact of the COVID-19 pandemic, NICE prioritised the publication of COVID-19 rapid review guidelines to support clinicians in their clinical practice. Within CHCP a process was established to ensure the rapid escalation of such guidance once received to the COVID-19 Tactical group for their immediate actioning.

During 2020-2021 233 publications from NICE were received and reviewed by CHCP.

Of these, 53 were either newly published or updated COVID-19 rapid guidelines.

CHCP's established NICE Triage Group agreed to meet virtually via MS Teams each month in order to continue their responsibility to receive, review and disseminate all published NICE guidance.

In addition to our triage group and compliance processes, during 2020-2021 our staff participated in the NICE National Stakeholder review and development of the following guidance:

- NG88 Heavy menstrual bleeding: assessment and management
- NG182 Insect bites and stings: antimicrobial rescribing
- NG183 Behaviour change: digital and mobile health interventions
- NG184 Human and animal bites: antimicrobial prescribing
- NG185 Acute coronary syndromes
- QS194 Decision making and mental capacity
- QS196 Community pharmacies: promoting health and wellbeing
- QS47 Heavy menstrual bleeding

Implementing point-of-care D-dimer tests for deep vein thrombosis (DVT) – Adam King, Nurse Practitioner

Following the publication of NICE Guidance (NG158) the DVT service sought to examine their compliance with the required standards.

People who present with suspected deep vein thrombosis should have all diagnostic investigations completed as soon as possible. This includes a D-dimer test to detect the presence of a blood clot. This is an important part of the diagnostic pathway and typically, this would be obtained via laboratory testing.

If a D-dimer test result is not received within four hours of the patient presenting at the service, interim anti-coagulant medication must be given.

NG158 stated the requirement to consider the use of an alternative point-of-care (POC testing is an alternative to sending in blood to the lab) diagnostic test to sending a blood sample for laboratory testing and thus shorten the diagnosis process.

As a community-based DVT service without a dedicated laboratory service, the service would have to utilise hospital-based laboratory facilities to send their blood samples which might result in delays in obtaining the result, so we have been utilising a POC D-dimer test since 2013.

Whilst for many services around the country this may have been a new standard, CHCP sought to evaluate the care provision and share their experiences with NICE.

Key Findings

CHCP see approximately 1500-2000 people a year with suspected DVT. With POC D-dimer tests in place, the average time from a person presenting to diagnosis and treatment is approximately 1 hour. This compares favourably with the average 4-6 hours previously taken when waiting for the laboratory results.

This reduction in time to diagnosis means the patient's journey through the service is more efficient and time-to-treatment, when required, is reduced.

Those with a low likelihood of DVT and a negative D-dimer test no longer undergo unnecessary scans, resulting in a cost saving. More importantly for the patient, very few people receive interim therapeutic anticoagulation, as this is only required if the test result is going to take longer than four hours. Only those who attend late may require this if investigations cannot be completed and they have to return the following day. As well as the cost savings, this reduces the risks involved with exposing people to anticoagulation, potentially unnecessarily.

Key Learning Points

Implementation of POC D-dimer tests within our dedicated community DVT service was easy; once the cost difference between the POC tests and laboratory tests were shown to be insignificant, all stakeholders immediately saw the benefit to patients and were supportive of using them. However, we can also see the benefit of other non-dedicated services using these tests and should other organisations across the country be considering purchasing such a machine, our experience would suggest considering the following:

- Consider the number of machines required. As our service is a dedicated DVT service, it made sense to invest in more than one machine to accommodate each clinic room. However, as the tests are quick, many services may find one machine adequate for sharing across clinical rooms.
- Consideration could be given to purchasing a machine and sharing the cost and its use between a group of GPs or as part of a primary care network.
- Time is of the essence when diagnosing DVT and interim anticoagulation therapy is necessary if diagnosis is delayed. If you are in a location where laboratory testing cannot be done within four hours, use of POC D-dimer tests may reduce your use of anticoagulation therapy. This avoids people being exposed unnecessarily to anticoagulation and the risks that are associated with this.

Since implementing the tests, the main advantage is the reduction in time from the person presenting to diagnosis and receiving treatment. Other advantages include a reduction in unnecessary interim anticoagulant treatment (reducing risk of potential adverse effects), avoiding unnecessary investigations such as ultrasound scans and consequently saving money.

Research

CHCP is committed to ensuring that people who use our services receive high quality, effective care. We recognise the important purpose that research plays in improving health outcomes and quality of care. Research studies enable our practitioners to examine new treatments and resolve uncertainty about existing treatments.

In common with all healthcare providers, our research activities were seriously curbed during 2020–2021 due to the COVID-19 pandemic. Taking our direction from the National Institute of Health Research (NIHR) we were informed of 'the suspension of non-urgent research including all studies requiring healthcare access or resources. All NHS Trusts, health and care providers are expected to prioritise support for Urgent Public Health studies.'

Thus, our main priority was to support our NHS Trust partners to recruit to their COVID-19 related studies to assist with potential participant identification. During the year we established a process for escalating and responding to all COVID-19 related research enquiries to the organisation to CHCP's Tactical group for their review and actioning.

One such study, 'Investigating a vaccine against COVID-19' sought to examine the efficacy, safety, and tolerability of a newly developed vaccine in preventing COVID-19 in healthy adult volunteers. CHCP agreed to assist in the recruitment of this study and shared the request for research participant volunteers with our staff.

Over the 12-month study timescale participants were asked to:

- Receive one or two doses of either the licensed vaccine or a 'control vaccine' for comparison. None of the volunteers, or research staff knew which vaccine was given to whom
- Agree to have between 6 and 12 blood tests taken to check if there are any problems and to look at immune responses to the vaccine
- Complete a diary for up to 28 days following vaccination
- Complete a weekly questionnaire that monitors the members of their household's exposure to COVID-19
- Be willing to perform a weekly nasal swabs or saliva collection

Some of our staff that volunteered to participate in this research have told us:

I was motivated to take part as I felt it was necessary for volunteers to do this and I am generally fit and well. I thought it would be a small part to help develop a much-needed vaccine, so that the whole world could be offered some hope of help in getting over the pandemic. - Mark, Urgent Care Practitioner

I felt that I needed to do something to help with this COVID-19 pandemic and I felt that I was well enough to participate and that the risks to myself were minimal. I feel proud to be part of this pioneering treatment and now as a vaccinator giving the Oxford AstraZeneca vaccine, I am seeing the benefits of my participation to protect the population. - Kay, Senior Sexual Health Nurse

I decided to volunteer for it last year as I consider myself fairly fit and well and strongly believed that a vaccine was of the utmost necessity to help curb the virus. As a health care worker seeing 30-40 patients a day my chances of coming into contact with the virus were and still are fairly high. I am still taking weekly swabs which are now being processed to look for variants and still have monitoring blood tests. I feel happy to continue to do so as the more information the scientists get, the better chance we have of learning how the virus mutates. - Debbie, Staff Nurse

The number of patients receiving NHS services provided or sub-contracted by City Health Care Partnership in 2020 - 2021 who were recruited during that period to participate in research approved by a research ethics committee was 78. Please be aware that we do not collate figures for people that we do not directly recruit such as those studies which we support and are conducted by our NHS Trust partners.

Another study, PHOSP-COVID was conducted in collaboration with Hull University Teaching Hospital and our Integrated Care Centre. The research is seeking to understand the longer-term health problems of COVID-19 for those patients who had previously been admitted to hospital with the virus.

The researchers want to understand:

- why some people experience more severe COVID-19 than others
- why some people recover more quickly than others
- why some patients later develop other health problems
- which treatments or interventions that patients received in hospital or afterwards were helpful
- how we can improve the care of patients after they have been discharged from hospital.

Dr Dan Harman, Medical Consultant, tells us why this research is important: 'Our clinical team at the Jean Bishop Integrated Care Centre are recruiting patients to this study, the results of which will hopefully provide further insights into this new and debilitating disease'.

BE PART OF RESEARCH

Goals Agreed With Our Commissioners

In line with published guidance on the NHS response to COVID-19, the operation of Commissioning for Quality and Innovation scheme (CQUIN) remained suspended for all providers until 31 March 2021; there was no requirement to implement CQUIN schemes, carry out CQUIN audits nor submit CQUIN performance data. Commissioners continued to make CQUIN payments at the full applicable rate.

As a healthcare provider, CHCP is required to register with the Care Quality Commissioner (CQC) and we are compliant with this requirement. As part of the CQC registration, the CQC is required to inspect our services and service delivery on a regular basis. Throughout 2020-2021, the majority of CQC inspections have taken place remotely, for example across our GP practices, with a focus on COVID-19 response. Feedback from all such virtual interactions is that the CQC was assured with our management during the pandemic, and we have welcomed and responded promptly to all feedback from such reviews.

Other services are also subject to inspection via other organisations; for example, school nursing is involved in Ofsted inspections and our Offender Health Care service is subject to regulation via Her Majesty's Inspector of Prisons and Ofsted.

Feedback the CQC received following a two-part inspection of the healthcare services within HMP Hull highlighted some areas for development in relation to the management of long-term conditions within the service and clinical oversight with regards to safe care and good governance. This prompted remedial actions to be taken by the Senior Management Team. With the support of the Medical Director, Chief Operating Officer and Executive Nurse, processes and procedures for the identification, review, and management of patients with long-term health care conditions was reviewed. CQC monitoring of our plans and progress has resulted in assurances being given.

Data Quality

To ensure our services deliver quality patient treatment and care, CHCP collects and analyses data. Good quality data is the essential ingredient for reliable performance information and has been recognised as everyone's responsibility within the organisation. By making it part of the day-to-day business CHCP has created an integrated approach across operational, performance management and quality assurance functions. We have taken the following actions to assure and improve data quality:

Assessment

Data is assessed against the six key dimensions of Accuracy, Validity, Reliability, Timeliness, Relevance and Completeness

Reporting

The outcome of data assessment is used to inform the Data Quality Audit priorities and enable an informed selection of areas for data quality improvement

Action

The development of our Data Quality Improvement Plans and the regular review of progress against these plans are assessed across Operational and Board levels

Clinical Coding

CHCP was not subject to the Payment by Results clinical coding audit during 2020–2021 by the Audit Commission.

Information Governance

The organisation is required to comply with the Data Security and Protection Toolkit (DSPT) which is a self-assessment tool. The DSPT provides assurance that the organisation is practicing good data security and personal information is handled correctly.

The DSPT does not include any levels and instead requires compliance with up to 40 assertions and 100 evidence items to demonstrate that an organisation is working towards or meeting the standards for Data Security and Protection for health and social care.

The annual assessment is intended to enable organisations to maintain and improve compliance of those standards contained within the toolkit.

CHCP has met the standards required by the Data Security and Protection Toolkit and is comparable with other local health care providers.

The actions taken throughout the year consisted of:

- A review and update as per the new General Data Protection Regulations and Data Protection Act 2018 of all policies and procedures
- Successful submission of the toolkit to a compliant level
- Maintained accreditation to ISO90001 / ISO270001
- Provision of staff training in a range of areas including Information Asset Owner, subject access and data security training
- Privacy Impact Assessment process updated, improved, and embedded within the project management process
- Achievement of data security training to 99%
- Reviewed data flows within each of the existing services and conducted risk assessments to identify and enhance security and technical measures
- Reviewed and updated the Business Contingency Processes in relation to business and cyber activities
- The Business Contingency Plans have been tested in some services to give additional assurances of the measures in place to protect data.

ACHIEVEMENT OF DATA SECURITY TRAINING TO

99%

Parliamentary Ombudsman

During 2020-2021 there were no complaints referred to the Ombudsman.

Comments, Complaints, Compliments and Concerns

All Comments, Concerns, Complaints and Compliments, known as the 4Cs, are reviewed daily from across CHCP's services. Our aim is to deal with complaints and concerns as quickly and efficiently as possible by those who have been involved in delivering patient care to seek a resolution to the complainant's satisfaction.

Comments, Concerns, Compliments and Concerns received during 2020-2021

Comments	Complaints	Compliments	Concerns
2017 - 2018	2017 - 2018	2017 - 2018	2017 - 2018
51	137	448	1629
2018 - 2019	2018 - 2019	2018 - 2019	2018 - 2019
44	124	421	1504
2019 - 2020	2019 - 2020	2019 - 2020	2019 - 2020
57	130	758	1590
2020 - 2021	2020 - 2021	2020 - 2021	2020 - 2021
42	115	479	1511

During 2020-2021 we have noted a slight decrease in the overall number of comments, concerns, compliments and complaints and we welcome the work being done by our engagement and marketing team to promote alternative ways of enabling feedback.

We continue to welcome and learn from our service user feedback and offer some brief examples of how we have listened and acted upon feedback.

Friends and Family Test

The Friends and Family Test (FFT) is an important feedback tool where people who use our services have the opportunity to provide feedback on their experience.

Following the outbreak of the COVID-19 pandemic the collection of FFT feedback forms was paused to ensure that national infection control guidelines were maintained to prevent the spread of the disease.

The submission of FFT data to NHS England and NHS Improvement was suspended throughout the year, however patients could still provide feedback via the FFT website.

DURING 2020-2021 A TOTAL OF 6,887 Responses

Responses to the question: 'Overall, how was your experience of our service?'

Very good	Good
88.78%	7.94%
Amount **6,114**	Amount 547
Neither good nor poor	Poor
1.22%	0.46%
Amount **84**	Amount **32**
Very poor	Do not know
1.05%	0.55%
Amount **72**	Amount **38**

Recommendation

Very good and good	Very poor and poor	Neutral or do not know
96.72%	1.51%	1.77%

You said – We did

We value feedback from people who use our services and offer the following as examples of how we have responded to such comments and made appropriate changes.

You said:

"I attend the hospital 3 times a week for dialysis – why can't I have my foot care done at the same time?".

We did

We trialled a podiatrist attending the dialysis unit during the pandemic to reduce the amount of clinic attendance by patients. This was very well received and we will continue to provide this service.

You said:

"I really enjoyed the rehabilitation session – but wanted to ask additional questions. How can this be accommodated?".

We did

We now factor in an additional timeslot at the end of each session for open questions.

You said:

"How can I exercise when I must remain at home during the pandemic?

How would I know what would be most beneficial exercise for me and my health problems?".

We did

We purchased an exercise prescription software programme designed by physiotherapists. We are now able to provide bespoke programmes emailed to our patients following their telephone consultation.

You said:

"I am a carer and doing the shopping for my relative with health problems. It is very challenging during the pandemic i.e., waiting and queuing to get in shops etc. I am finding it stressful – can you help?".

We did

Our Carers Information Service worked with the City Council and agreed to produce a Carer Priority letter to support people who are shopping on behalf of a vulnerable person.

You said:

"I'm sorry but I missed your telephone call as it was inconvenient for me to talk to you. Can you help prevent this happening again?".

We did

Our sexual health service now books all telephone slots so that the patient has an agreed date and time for their telephone consultation.

CHCP VOICE

Priorities for Improvement 2021 - 2022

Within these Quality Accounts we are required to describe areas in which we will improve over the next year in relation to the quality of our services. The areas we are required to look at fall within three categories:

- Patient Experience
- Patient Safety
- Clinical Effectiveness

These three areas span all of our clinical services and therefore support a major component of our aims of providing safe, effective, personalised and innovative care to the communities we serve.

Last year, understandably, our response to the demands of the COVID-19 pandemic made a substantial impact upon our services and commanded a significant amount of our time and resources and hence, affected our ability to complete each pledge (please see Chapter 4).

However, we recognise the importance of our pledges from last year and following discussions held at the Integrated Quality Forum we have agreed that we will extend the three pledges throughout 2021–2022.

Patient Safety

Preventing urinary tract infections and the prescribing of unnecessary antibiotics by promoting hydration and preventing dehydration.

Rationale

Urinary tract infections are a leading indication for antibiotic prescribing and are often diagnosed following a urinary dipstick test, despite their poor positive predictive value or without specific considerations of the patient's clinical symptoms.

How will we monitor throughout the year?

We will report through the Infection Prevention Committee and the Integrated Quality Forum.

How will we do this?

We plan to progress our initial work around this clinical challenge by embedding new ways of working and enabling informed, educated care management choices.

We want to ensure that we introduce a consistent approach to care, making sure that all we do is based on national evidence and by working with internal and external partners. We have a range of initiatives that we plan to deliver, including:

01 Undertaking an audit to determine a baseline of practitioners' knowledge.

02 Delivering training and producing educational resources.

03 Following up on those who have attended the educational sessions to capture their learning.

04 Setting a launch date for June 2021 with a marketing drive to raise awareness of the topic.

Patient Engagement

Expanding our approach to capturing service user feedback.

Rationale

It is important that we and those who commission our services understand the experiences and perceptions of our service users.

We would like to progress the opportunities for online service user feedback. This will be a more efficient manner of collating feedback and will reduce our paper consumption.

How we will do this?

Working with our Service User Voice group we will establish and embed the work that has begun during the previous year.

We plan to continue to reduce our carbon footprint through reducing the requirement to attend groups and meetings in person and we will cease to routinely collect feedback using paper-based materials.

How we will monitor throughout the year?

We plan to monitor monthly and to feedback directly to each service area. Promoting quality improvement initiatives led by front-line staff rests on the understanding that those directly involved in giving and receiving a service are best placed to improve it, provided they are given the right tools and support to do so.

Clinical Effectiveness

Rationale

The promotion of quality improvement initiatives led by front-line staff rests on the understanding that those directly involved in giving the service are best placed to improve it, provided they are given the right tools and support to do so.

How will we do this?

Our pledge remains for 2021 – 2022 and we will work with practitioners as and when they have the capacity to engage in line with each service's recovery plans.

During the past year, we have witnessed the value of accessing virtual eLearning educational sessions and it is our ambition to offer a more blended approach to complement our established quality improvement training, by providing a range of eLearning, virtual support sessions and additional assistance to staff wishing to begin a quality improvement initiative in their clinical area – this may be through offering one-to-one support, coaching, training or project management support.

How will we monitor throughout the year?

Through CHCP's Integrated Quality Forum.

Last Year's Priorities for Improvement 2019 – 2020

Last year's priorities for improvement across CHCP were published in our Quality Accounts 2019 – 2020 and within this chapter we are required to report the progress made in each of the pledges. We would usually present a summary of our completed work, outputs and achievements within this section. However, as indicated in Chapter 3, to varying degrees our work in these pledges has been affected by competing service-delivery pressures.

Thus in all instances we have extended these pledges and will continue their progress throughout 2021 – 2022.

Patient Safety:

Preventing urinary tract infections and the prescribing of unnecessary antibiotics through promoting hydration and preventing dehydration.

Rationale

In last year's Quality Accounts we advised that urinary tract infections are a leading indication for antibiotic prescribing, often diagnosed following a urinary dipstick test despite their poor positive predictive value or without specific considerations of the patient's clinical symptoms.

We had planned to progress our initial work around this clinical challenge and embed new ways of working through preventing urinary tract infections and enabling informed, educated care management choices.

We firmly believe that this is an important area of clinical care and want to ensure that we introduce a consistent approach to care management so will make sure all that we do is based on national evidence.

In 2020 we started our work by introducing new clinical guidance around 'to dip or not to dip' principles. Within the guidance we discussed:

- The importance of accurate diagnosis and management
- Symptoms of urinary tract infections
- Clarification of the signs of uro-sepsis and sepsis
- Correct method of obtaining urine samples
- Treatment options
- Dehydration

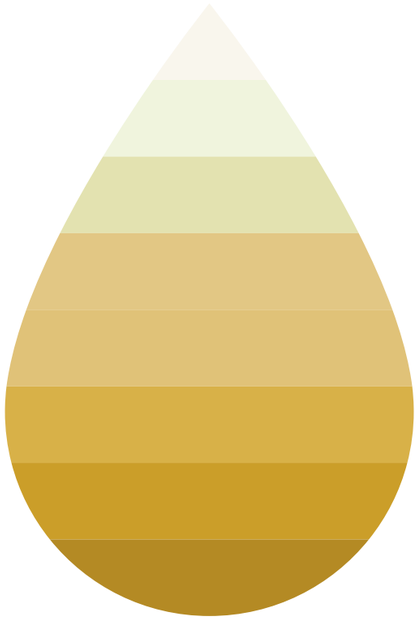
The guidance was reviewed and ratified at the Integrated Quality Forum. Within the guidance, we have produced clear flowcharts for quick reference and developed visual prompts and tools for clinical staff.

Whilst the work was paused we have not lost our drive and ambition to progress – please see Chapter 3 for our plans to carry this work forward.

Let's talk hydration levels

How hydrated is your patient?

Healthy pee is 1-3, 4-8 you must hydrate!



1
2
3

Hydrated

If your patient's urine matches 1, 2 or 3, they are properly hydrated

4
5
6

Dehydrated

If the colour of your patient's urine matches 4, 5 or 6, they need to drink more.

Start a care plan to ensure regular drinks and ensure an allocated member of staff helps the patient for the rest of the day.

7
8

Severely Dehydrated

If the colour of your patient's urine matches 7 or 8 - the patient needs to be rehydrated.

Urgent fluids needed, commence fluid chart, hourly fluids, observe for other signs of deterioration and contact the doctor if necessary.

Note: some foods, vitamins and some medication can change the colour of urine. Also, be aware if your patient is on a fluid restriction for heart failure.

Patient Engagement

Expanding our approach to capturing service user feedback.

Last year we pledged to progress our engagement work with people who use our services to ensure that we are able to listen and act on their experiences. Due to the COVID-19 pandemic, our Service User Voice Group (SUV) was postponed from April 2020 until November 2020. We are now pleased to report that this has been reinstated and we have recruited more members:

- SUV Group currently has 12 members
- CHCP Voice, our virtual SUV Group, has 42 members.

Since November 2020, we have held five virtual meetings and now plan to continue meeting monthly.

We have seen the benefits of adopting online service user feedback introduced during the pandemic and it has shown to be a more efficient manner of collating larger volumes of feedback. To reduce our paper consumption and in agreement with our SUV members, all our documents and reading materials that we circulate to our members are shared electronically. Additionally, online and email communication is being favourably received and we will continue to work in this way for this group; whilst recognising that this may not suit everyone we will continue to meet the challenge of the needs of others and maintain other means of feedback such as verbal, written etc.

When we introduced the Hull City Hall Vaccination Centre, we piloted other means of capturing feedback through a small-scale media campaign using methods such as social media platforms, the CHCP Website, QR codes and devices displayed at the centre.

This has proven to be successful as we have been receiving feedback from members of the public and those who attended the Vaccination Centre.

Our SUV members are beginning to play an integral part in contributing their experience to shape service improvements and in 2021 they will be working with an external audit company to examine how CHCP's services have responded during the pandemic.

We welcome their unique perspective through offering a 'fresh set of eyes' and a shared desire to 'get things right'.

Clinical Effectiveness

In last year's Priority for Improvement pledge we stated that promoting quality improvement initiatives led by front-line staff rests on the understanding that those directly involved in delivering a service are best placed to improve it, provided they are given the right tools and support to do so.

Our pledge was to extend our quality improvement training through offering a range of additional support to staff wishing to progress a quality improvement initiative in their clinical area – this could include one-to-one support, coaching, training and project management support.

Understandably, all clinical services had increased demands throughout the year and staff prioritised patient care provision. Thus, the Quality Improvement team shifted their focus from front-line staff to those who manage the services with the aim of assisting them to develop bespoke support relevant to their team or service area.

Starting in the summer and continuing bi-monthly, all meetings were held remotely and conducted via MS Teams on computers.

Through these discussions with senior managers and leaders, a Quality Improvement Programme was developed, concentrating on improvement initiatives in the following areas:

- Development and assurances of policies, protocols, procedures and guidance (PPPGs) produced and used within the team
- Service or teams bespoke record keeping audit tool
- Clinical audit prioritisation, process and outputs
- Patient information publication and compliance with accessible information standards.

A theme throughout this work has been supporting and developing the expert skills and knowledge that colleagues require in order to 'make it easy to do the right thing'. Encouraging discussion, practice and continued support when developing PPPGs and Patient Information promotes confidence and expertise in delivering a complex message in a way that is easy to understand and follow, whilst meeting agreed evidence-based standards.

Staff have been supported to appreciate clinical audit, from the evidence base required to identify standards to meaningful data collection and analysis.

Integrated Community Services	Health & Wellbeing Services
33 meetings	31 meetings
53 attendees	60 attendees

A total of 64 meetings have been held with 113 attendees.

"Identifying areas for improvement through individual and group discussions and training has enhanced the connections being made between quality, quality assurance and quality improvement. Our discussions have been beneficial in identifying and promoting the priority improvement areas within their teams or services and assisted in developing and embedding systems to promote sustainable learning and improvement."

- Lucy Riggs, Quality Improvement Practitioner

Our vision is to lead and inspire through excellence, compassion and expertise in all that we do and we are proud of the achievements and recognition of our staff.

Within this section we would like to share some of the examples of service delivery, care and excellence that has been delivered by our colleagues during the year.

COVID-19 Mass Vaccination Centre – Accessible Information Standards

In February 2021 we introduced a new vaccination centre within Hull City Hall. People over the age of 70 or those working within health or social care were amongst the first people to attend for their COVID-19 vaccination.

In recognition that we would be soon vaccinating up to 1000 people a day we were keen to ensure that we made the process and associated information as accessible to all as possible.

Therefore, we began by developing a pathway to support the front-of-house and reception staff to follow and assist them in identifying a vulnerable or high-risk patient who was attending for vaccination.

This includes patients who may have:

- Chronic illness or fragility
- Anxiety
- Needle-phobia
- Communication difficulties
- Learning disability or difficulty
- Autism
- Sensory loss
- Severe mental illness
- Other vulnerabilities

The pathway involves the Senior Manager being informed as soon as it is identified that there is someone on site who is differently abled to ensure reasonable adjustments are quickly made to support the person's experience in the vaccination centre.

The manager will request that the patient is chaperoned to the administration station and supported to book in. We appreciate that for some people waiting in the communal waiting area with others may cause undue anxiety.

The patient will be escorted to a private bay where they are assessed by a skilled clinician using communication tools or sign language user as required.

Once vaccinated, the clinician will support the patient to the recovery area before escorted them to exit off site.

We have actively recruited volunteers with additional skills such as using sign language or with experience of supporting people with additional needs, all of whom are supported by our Accessible Information Officer; they have been invaluable in shaping our processes.

The feedback we have received form those who have used the service has been overwhelmingly positive including:

'The entire process (which took around 7 minutes from being greeted at the door) was superbly organised, thorough and brilliantly managed. Everyone I met was friendly, professional, and reassuring. Many thanks to all involved in the process of developing and delivering the vaccine - an astounding achievement.'

'I'd like to thank the entire team of volunteers and professionals on a job well done. From the check-in procedure to the delivery of the vaccination I felt completely secure and in the best hands. Well done!'

Do you need information in a different way? How do you communicate?

Pictures

Easy Read Documents

British Sign Language

Other Communication

Makaton

Email/Text

Large Print

Braille

Audio

Do you need extra support?

If you would like documents or information in a different format, such as audio tape, large print or Braille please tell us.

01482 347649 | chcp.makeitclear@nhs.net

#MakeItClear

Fit Testing Improvement Programme City Health Care Partnership CIC

Meeting the challenge of supplying and using correct Fit-tested face masks during the pandemic.

During 2020 CHCP was one of five healthcare providers chosen to engage with a rapid improvement project led by NHS England and NHS Improvement (NHSEI); the findings captured within this storyboard were shared nationally and used to shape future national strategy.

Rapid improvement cycle

- Improve face fit test pass rate to 100%
- Capture staff experience of face fit testing in order to provide qualitative diagnostic data to use to identify change ideas to improve staff experience

Data Collection and analysis

As an organisation we realised there was a large amount of informal expression and sharing of clinician and leaders' experiences, feelings and challenges associated with FFP3 Mask Fit Testing which was not being formally captured.

We created two SurveyMonkey questionnaires to capture rich data relating to some of these experiences both of clinical staff, as well as the leaders supporting services across the organisation. We collated trends and themes from the completed questionnaires as well as identifying what's working /what's not. This data was used to explore and implement change ideas to enable improved support. Existing fit test data was used for baseline and weekly data collected and analysed for the rapid improvement project.

Tests/change ideas tried during the rapid improvement cycle:

- Full time Infection, Prevention and Control staff commitment to face fit testing and increased operational face fit testers trained to face fit test out in practice areas.
- Development and recruitment of four full time face fit tester/ PPE champions
- Introduction of test type information to be sent to staff with appointment details
- Process changes including sharing fit test results data with managers including DNA and reasons if not tested.

Staff survey

Out of 75 clinical staff responding to the survey, 55 had undergone at least one FFP3 face fit tests. 43% of clinical staff said wearing the FFP3 mask had implications in their clinical practice. 17 managers also responded to the survey, both groups provided free text as well as quantitative data.

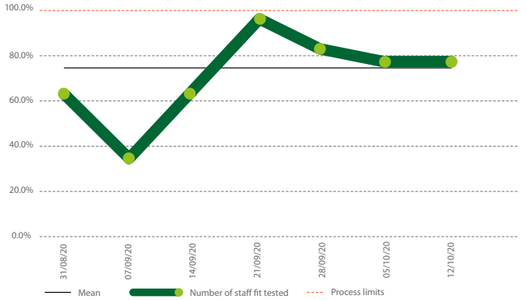
The following key themes were identified :

1 Eligibility for fit testing
2 Individual mask preference single use/reusable
3 Experience of qualitative test
4 Manager's challenge to keep abreast of who has been tested and outcome
5 Effects of wearing an FFP3 mask
6 Fit test location
7 Desire to choose/wear alternative mask
8 Waiting time for fit test
9 Prioritisation of who to test
10 Challenge of managing staffing levels/demands.

The rapid improvement project group used the feedback from clinical staff and managers to help prioritise the change ideas. The free text from staff gave insight into the lived experience of both attending a face fit test and what happens after the fit test. This helped the group to focus on the importance of not only test/pass rates but also what happens next. This included the staff journey if they were unable to find a mask that passes a fit test and those staff who leave a fit test with a mask pass and experience implications of its use in clinical practice.

Percentage of face fit test mask passes per week

City Health Care Partnership CIC - Starting 31/08/20



What have we learnt?

- Collaboration with other organisations and NHSEI has enabled sharing of change ideas/experience and knowledge – vital for rapid improvement. We have discovered that we share similar challenges and can help each other with change ideas and improvements
- Staff experience is as important as fit test pass rates and that it is not just the fit test but the experience of wearing FFP3 masks that we need to understand more fully
- Appropriate data collection is essential to provide baselines and diagnostic information to begin to develop change ideas
- Data analysis, considering not just number of staff passing fit tests, is required to ensure that the complexities of fit testing are accurately reflected in the data eg. mask types, fit test type, number of appointments required
- Sharing up to date information regarding staff fit test status and mask availability with all managers and service leads is essential for workforce planning and service delivery.

The tests we are planning next:

- Increase use of quantitative testing with the aim to reduce number of fit test appointments needed, to test maximum number of masks to achieve a face fit test pass
- Collect real time staff experience feedback at every fit test
- Process change to include increased pre fit test information and learning materials (including fit checking)
- Face fit tester induction, training and competency development and evaluation.

Thank you for taking part in NHS England and NHS Improvement's fit testing quality improvement programme.

We have been impressed by the professionalism of all staff involved. They have been candid, with a positive approach to the current situation that we all face. My team has been impressed by the commitment that teams have expressed towards ensuring that all staff are able to access appropriate FFP3 masks. This dedication can only benefit patient care too.

Sue Tranka, Deputy Chief Nursing Officer
NHS England and NHS Improvement

Promoting Carers' Champions during the Pandemic

A carer is someone who provides unpaid support to family or friends who could not manage without their help. This could be caring for a relative, friend or partner who is frail, disabled or may have mental health problems. There are estimated to be over 6.5 million carers across the UK with predictions that 3 out of 5 of us will be a carer at some point in our lives. This means that the majority of adults will care for a family member or friend at some point in their lives. Many carers do not see their role as separate from the relationship they have with the person for whom they care, whether that relationship is as a parent, child, sibling, partner or friend.

Julie Bahn, Service Manager advises, 'We know that in 2020 there had never been a more important time to 'think carer', as throughout the COVID-19 pandemic unpaid carers had to provide more and more care in such challenging times. This was often without the crucial face-to-face support services of day centres and support groups, which were closed due to infection control measures, and for many coping with a feeling of isolation as the usual support or visits from friends and family and local services were curtailed. In addition, we heard through the media the plight of many unpaid carers with a message that some felt that they were being pushed to the limit through providing evermore care for others with fast diminishing support due to the pandemic restrictions.'

We had been planning to deliver a short 'Carers Champion' educational session to our CHCP staff to enable attendees to 'think carer' and recognise unpaid carers and be able to refer a carer for support.

However, the pandemic prompted us to seek alternative means of getting this message out and CHCP's Carers' Information and Support Service, in partnership with Learning and Development, created an online training Carers Champion Training resource. Within this resource a brief training session, which takes around 30 minutes, can be easily accessed.

The session is hosted through our CHCP training department and is also available through the Hull Connect to Support website. The session includes videos of 'real' people who share their stories and experiences and aims to enable Carers Champions to be able to understand the role, impact and needs of an unpaid carer and spread the word of where resources and support can be accessed.

Once introduced, the interest of other local and regional stakeholders was generated who were keen to adopt the training resource for other staff, volunteers and members of the public to use. This includes: Hull City Council, East Riding Council, Hull University Teaching Hospitals and Clinical Commissioning Groups in Hull, East Riding and Scarborough, Whitby and Ryedale.

The training is now freely accessible to any professional, volunteer or member of the public across Hull, East Riding, Scarborough, Whitby and Ryedale and offers consistent information to all whilst tailoring the support and resource advice to the person's specific geographical area.

Since the launch of the training session on Carers Right Day on 26 November 2020 we now have 131 Carers Champions across the geographical area who have undertaken the training session. Once the person has completed the session we remain in contact with them via a quarterly Champions Newsletter that keeps champions informed with up-to-date information about the support from healthcare, social care and the local authority and services, resources and latest news to support and maintain health and wellbeing that is available to unpaid carers. **http://www.nwyhelearning.nhs.uk/elearning/yorksandhumber/CityHealthcare_Hull/CarersChampionTraining/*

Driving Forward CHCP's People Plan

Our people are by far our biggest asset. They are critical to the sustainability of our business and the transformation of the local healthcare economy.

The national NHS People Plan sets out actions for all NHS organisations to work towards to improve staff experience and wellbeing. The plan is bound together by the common threads of compassion and care; we must look after each other and foster a culture of inclusion and belonging.

From this we have developed our own bespoke CHCP People Plan, which is relevant to our environment and ensures we can make a real difference to the employment experience for all of our colleagues and strive to make CHCP the best place to work.

In the first instance we identified five clear workstreams:

- Equality, Diversity and Inclusion
- Leadership
- Recruitment and Retention
- Learning and Development
- Wellbeing

All our people plan workstreams continued throughout the pandemic and are running with a new rigour to review our internal developments during the pandemic and focus on key activities to support our workforce as we move forward.

The restrictions, pressures and challenges of the pandemic have really highlighted the need to focus on the wellbeing of our colleagues and ensure the experience at work is positive.

Prioritising staff health and wellbeing is at the forefront of the plan as we move forward, from helping staff to deal with changes outside of work that are impacting on their work-life balance to looking after their mental and physical health wellbeing. Throughout this time, we have been offering access to support and encouraging conversations to enable all colleagues from across the organisation to be able to seek and access the assistance that they may need.

We recognise that every staff member, colleague, practitioner and volunteer has had to make significant adjustments to their working during 2020-2021. Whilst adapting and adopting new ways of working became the 'norm', the agility of the organisation was called upon to respond and introduce transformational changes.

Rebecca Scarr, HR Projects and Business Manager tells us, *'Our Plan is for the whole of our workforce; whilst understandably much of the media attention has focused upon front-line staff during the pandemic we recognise the invaluable support needed by all our staff to enable our patient-facing colleagues to function. The pandemic did not stop progress; rather it focused our minds on how we ensure we create a healthy, inclusive and compassionate culture.'*

This will not stop us progressing and we recognise that this is a first step on a longer journey. To continue on this journey, we are committed to ensuring we hear from our colleagues on a regular basis to understand any particular themes or pressure points with regards to wellbeing and to enable us to identify and implement relevant supportive measures as a result.

Results from a wellbeing pulse survey in the midst of the pandemic gave us the following insights:

85%

of staff felt that CHCP had kept them as safe as possible during the pandemic

95%

of staff felt that CHCP had communicated effectively

Protecting our patients and our staff through an automated symptom checker system

Managing and maintaining the delivery of essential healthcare has been one of the biggest challenges to all care providers during the COVID-19 pandemic. Whilst government advice was to adhere to social distancing and minimise face-to-face contact, it was recognised that many aspects of health and supportive care needed to be continued, most often to the housebound and vulnerable patients in their homes.

This included the requirement for all patients to be screened for symptoms to be able to safely visit and undertake care with the necessary protective equipment. Whilst in some areas of the country this was undertaken by community health care staff making a telephone call themselves and asking about key COVID-19 symptoms, at CHCP we were keen to protect our practitioner time and sought a technological solution to assist.

Working with a computer technology company, software was developed for 'remote monitoring' of possible COVID symptoms. This meant that patients who were due to receive a home visit from our staff received an automated telephone call or text in the morning to screen for key symptoms such as asking whether anyone in their home had a raised temperature, a new and continuous cough, shortness of breath or loss of appetite, taste or smell.

The patients' responses to the questions are analysed by the software and any warning signs flagged up and alerted to the practitioner in order to follow up and take appropriate actions.

Patient records are automatically updated and non-responders are sent additional alerts and reminders.

Mike Cosgrove, project manager said, "*The symptom checker service has been invaluable during the pandemic. It has reduced anxiety among patients and professionals, cut the number of missed appointments and enabled our frontline staff to prepare for meeting patients in person. The balance between automation and individual input has reduced the demand on our clinical staff and provided us with real-time information to help manage the health and wellbeing of our patients.*"

As the system has been embedded into daily use we have extended its functions to also include additional updates on government advice and severe weather alerts.

"As a digital health company, we will do everything we can to protect our brave NHS staff as they carry on with their vital jobs of providing care to people in the community. We have been inspired by the collective efforts of everyone involved in setting up this new service so quickly during a time of crisis.

"It is a simple and scalable solution to a difficult challenge faced by CHCP in common with all healthcare providers and will ease pressure on the staff at a time when every single resource is needed in the battle against coronavirus.' Bryn Sage, Chief Executive InHealthcare.

The feedback from our patients has been very positive and highlighted that the symptom checker served as a source of reassurance that healthcare staff were taking measures to protect themselves and those that they visited.

IN THE FIRST EIGHT MONTHS

350,000

phone calls were made to patients who were due to receive a home visit by a member of CHCP staff.

'I feel that I am being protected from the impact of the pandemic'

'Doing this protects us and the nurses coming to see us. It helps prevent further spread of the virus'

'I am grateful that people are checking on us before my nurse comes to visit me'

Providing an Urgent Specialist Advice and Guidance Telephone Line

The Hull and East Riding Frailty Team have been exceptional this year in being creative and innovative. Before the COVID-19 outbreak, the team regularly visited care homes and saw patients face to face at the Integrated Care Centre. However, during the first wave of the pandemic a more reactive and responsive approach was required to manage the surge in demand in the community for frail patients, both for COVID-19 and non-COVID related concerns from patients and their cares at home, those being cared for within residential care and the expanding community rehabilitation service.

Marie Serajuddy, Senior Operational Manager, explains, *'We had a robust team with exceptional skills and knowledge in the care of frail patients and the team had to rapidly consider different ways of working. Within an extremely short timeframe the whole service remodelled to become an agile and reactive service.'*

This has included introducing an 'Urgent Specialist Advice and Guidance Telephone Line' being developed as a priority, which was provided by specialist GPs and medical consultants to offer clinical advice and support for GPs, paramedics and care home staff for frail patients in care homes and their own homes to provide specialist support when needed.

The Advice line sought to provide:

- A rapid frailty response model, seven days a week 8am to 8pm for Hull and the East Riding
- Response to any clinical COVID-19 and non-COVID clinical queries
- Virtual clinical triage, advice, support and care planning for frail patients including advanced care planning where required
- Triage undertaken by Community Geriatricians and GPs with an Extended Role in Older People's Care
- Aligned operational arrangements between frailty services, Yorkshire Ambulance Service, primary care, local authority and community services to enable efficient access and communication
- Access electronically to primary care records and mobilising plans to ensure timely flow of information across healthcare services.

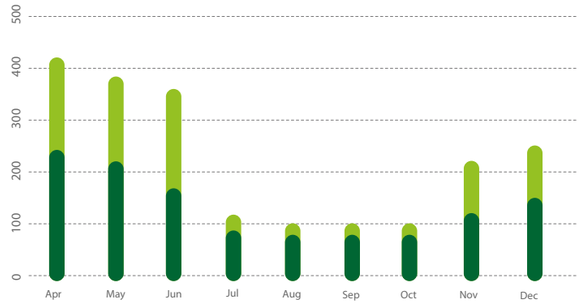
The Advice line proved effective and popular with a total of 2078 patients registered with the service and 3457 telephone calls undertaken during the first eight months.

Marie continues, *'The feedback has been exceptional from all who have used the service as well as our local clinical commissioning groups, who have indicated that they will continue to this element of care provision in the future. Our aims in terms of preventing hospital admissions, providing high quality end of life care and rapid 'step up' to community beds was achieved as in the first eight months we believe that we prevented over 300 hospital emergency department visits and potential hospital admissions.'*

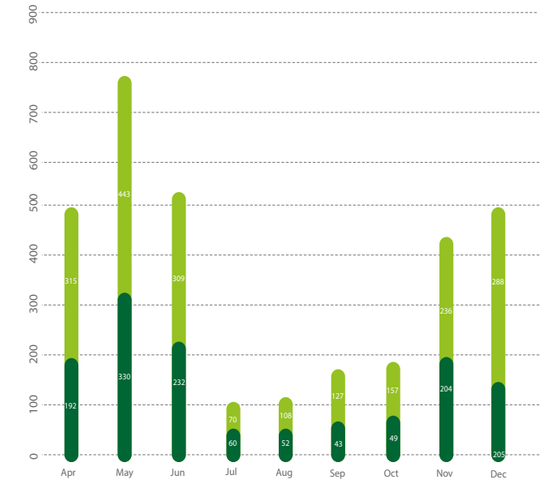
'Our rate of conveying patients to hospital after being attended by a paramedic is currently at its lowest ever point and it looks like this service is likely to be playing a positive part in enabling that in this area.'
- Dep. Director Yorkshire Ambulance Service

Advice and Guidance telephone line New patient referrals

01.04.20 - 31.12.20



Advice and Guidance Telephone Line calls 01.04.20 -31.03.20



Sharing, celebrating and recognition of our success

Throughout the year staff from across our services have been recognised for their excellence, compassion and expertise.

Here we highlight a small selection of their achievements.

Previously, each year we have held a celebration event shortly before Christmas which brings together staff from across all of our services who deserve a special 'shout out'.

This year, due to social distancing restrictions we held our first virtual awards ceremony.

As part of the celebratory event staff and teams are nominated by their colleagues for consideration within six award categories. In total 119 nominations were received and our judging panel of colleagues from across the business found it quite a challenge to shortlist the winners and finalists for each award.

Awards

- Lucy Slater, Community and Special Care Dentistry Team - Finalist for The British Society of Paediatric Dentistry (BSPD) – Clinical Governance Award
- Jessica Talbot, Lucy Slater and Elizabeth O'Sullivan, Dental Services - Winner of the Clinical Case Poster Presentation Award of the 12th European Academy of Paediatric Dentistry (EAPD) Interim Virtual Seminar

2021

Publications, Presentations and Posters

- Pramod Subbaraman, Dental Associate - We will have a lot to do when this is over (COVID-19 related); British Dental Journal (2020)
- Minnie Lyons-Coleman, Dentist - Obstructive sleep apnoea and the role of the dental team; British Dental Journal (2020)
- Adam King, Nurse Practitioner, Community DVT Service - Implementing point-of-care D-dimer tests for deep vein thrombosis (DVT); National Institute of Health and Care Excellence (NICE) shared learning publication (2020)
- Lucy Slater, DCT 2 in Community and Special Care Dentistry - Poster presentation – 'Telephone Triaging During the COVID-19 Pandemic: An Audit'; Yorkshire and Humber Health Education England - First prize winner
- Andrew Burnell, Group Chief Executive - CHCP - 'CICs have played a key role in the pandemic response and must be empowered in the reset'; NHS Providers (2020)

Team of the year

Winner: Hull and East Riding Intermediate Care Team

Finalists:
- Integrated Community Care Frailty Team
- Hull Macmillan Specialist Palliative Care Team, East Riding Macmillan Team, Health and Social Care Team, Palliative Liaison Nurses and Specialist Palliative Care Administrative Team

Inspirational Leader

Winner: Harriett Ottaway, Intermediate Care Team

Finalists:
- Jayne Booth, Sunshine House
- Ian Grout, Information Systems Manager

Creativity and Innovation

Winner: Joanne Deighton, Learning Resource Team

Finalists:
- East Riding Pulmonary Rehabilitation Service
- Hull and East Riding Bladder and Bowel Health Team

10 Year Star

Winner: Rebecca Scarr, Human Resource Team

Runner up: Karen Dexter, Pulmonary Rehabilitation Team

Volunteer of the Year

Winner: Rebecca Donnelly Bate

Finalists:
- Neil Birch
- Peter McClellan

Unsung Hero

Winner: Zoe Wainwright, Bladder and Bowel Health Care Team

Finalists:
- Ellie Thompson, Learning Resource Team
- Jo Burden, Intermediate Care Team

Feedback on City Health Care Partnership CIC Quality Accounts 2020/2021

Joint statement for publication – NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group

Firstly, NHS Hull and East Riding of Yorkshire Clinical Commissioning Groups would like to take this opportunity to thank all the staff at City Health Care Partnership CIC for their hard work and dedication during the COVID19 pandemic that has been ongoing for a significant period of time. The efforts taken in responding to this global health crisis have been truly impressive across the health system. We would like to extend our gratitude and appreciation to you all, for your part in the local NHS response and the wider system response.

NHS Hull and NHS East Riding of Yorkshire Clinical Commissioning Groups welcome the opportunity to review and comment on the City Health Care Partnership CIC Quality Accounts for 2020/21. The report illustrates a focus and commitment to continuous improvement in the quality of patient care in 2020/21, with a particular focus on how services have changed how they operate in order to continue to provide services that are of a high quality despite the pandemic.

Commissioners were pleased to see the Quality Account reflect upon the different ways of working that CHCP has implemented since the beginning of the Covid pandemic, including the telephone triage for dental care and in providing urgent specialist advice and guidance as part of the frailty service; thus, ensuring services can continue to be delivered in a safe and effective way. Commissioners also note the continued commitment to their staff through improved FFP3 fit testing, and the drive to push forward the people's plan.

Commissioners would like to congratulate CHCP CIC and their staff on successes this year in the winning of the national awards including Lucy Slater being a finalist in "The British Society of Paediatric Dentistry award – Clinical Governance" and Jessica Talbot for being the winner of "Clinical Case Presentation Award of the 12th European Academy of Paediatric Dentistry." We also note the continuation of the staff awards, we recognise the need to applaud success within an organisation, this has been especially important in this difficult year.

Despite the pandemic CHCP have committed to continue to be involved in both local and national audits. Commissioners note the implementation of NICE guidance and how this is managed within CHCP, in particular the implementation of point of care D-dimer for Deep Vein Thrombosis which significantly improves patient experience, in having test results within the hour when a DVT is suspected and the decreased need for scans upon a negative test result.

Commissioners note the increased number of audits that have been shared within the Quality Accounts this year and are pleased to see the results of the primary care clinical audit which focussed on the dual prescribing of Clopidogrel and Omeprazole or Esomeprazole. Commissioners also note the audit undertaken to look at Telephone triage within dental care, this having resulted in some positive quality improvement work to ensure that there has been a significant improvement in the delivery of the service.

Commissioners note the positive response to patients concerns and the "You said, we did" initiative that demonstrates the ways in which patients/carers can raise their concerns. Commissioners would have welcomed a summary of any themes and trends from complaints and the further learning and improvements made to services that have resulted from patient complaints.

Commissioners were pleased to read about CHCP's commitment to the Covid-19 research over the last year, especially in staff being encouraged to participate in the research into the Covid vaccine. We are pleased to see this the joint working with other NHS organisations in participating in Covid related research. Commissioners would have welcomed a quality priority focusing on the recovery phase post the Covid-19 pandemic and how some of the patient safety and clinical effectiveness initiatives delivered during the pandemic can be further developed and embedded.

The commissioners note that the Covid Pandemic has had a significant impact on achieving the quality priorities that CHCP identified for 2020-21 and we recognise the limitations of the progress that has been made. We note that CHCP have made the decision to use the same quality priorities for 2021/22 and we look forward to receiving updates on the work undertaken in these priorities.

Commissioners note that CHCP have not added any further quality improvement for 2021/2022. Whilst we acknowledge that the number of Serious Incidents (SIs) reported during 2020/2021 are low, Commissioners would have welcomed hearing more about how the learning from incidents has been embedded to improve the quality, safety and patient experience of services.

Commissioners recognise the importance of the work on preventing urinary tract infections and the prescribing of unnecessary antibiotics by promoting hydration and preventing dehydration. We were pleased to see that progress has begun again with the development of clinical guidance around the dip or no dip process, and further work is planned in the upcoming year to ensure that there is a consistent approach to care for UTI's.

Commissioners acknowledge the ongoing work to enhance patient engagement, that in response to pandemic CHCP hosted patient engagement meetings through a virtual forum. Commissioners note the increase this has seen in membership of the virtual group, and we look forward to seeing how the use of different medias will allow for more patient engagement about service provision.

Commissioners were pleased to read about the way that the Quality Improvement team have promoted initiative led by front line staff and look forward to reading about quality improvement initiatives in next year's report.

We can confirm the accuracy of the Quality Accounts, to the best of our knowledge, based on the information shared through contract management arrangements in 2020-21 and look forward to working in partnership in 2021-22 to continue to improve outcomes for our patients.

Emma Latimer

Accountable Officer
NHS Hull Clinical Commissioning Group

City Health Care Partnership CIC Response to Our Commissioners Statement

We would like to thank Hull Clinical Commissioning Group and East Riding of Yorkshire Clinical Commissioning Group (CCG) for reviewing this Quality Account publication and providing a joint statement for inclusion. We welcome the acknowledgement of the hard work and dedication of all our staff over this historical year and our ability to respond, change and innovate to continue to deliver high quality care across our services.

We welcome the acknowledgement of individual practitioners and team achievements, alongside our continued commitment to proactively engage in local and national audits to improve our patient experience and measurable quality improvements in service delivery

We are pleased that the positive response to patients concerns and the "You said, we did" by the organisation has been noted, and will summarise any themes, trends and learning from complaints and patient feedback in our future quality accounts in more depth. We will continue to monitor the effectiveness of different medias will allow for more patient engagement about our service provision.

We acknowledge the recovery phase to the Covid-19 pandemic is in progress at a local, regional and national level. We are actively collating our learning from the challenges, collaborations, and innovations throughout the last year with an aim of continuing, embedding and enhancing service delivery for our patients, alongside our improvement plans.

We appreciate the comments that the number of Serious Incidents (SIs) reported during 2020/2021 are low, and we will report in the future on our increased engagement with patients to improve their experiences overall of our services, and the impact of the emerging Patient Safety Incident Response Framework.

We are thankful for the considerations, comments and praise received and look forward to our future partnership working to deliver the quality expectations from all our stakeholders.

City Health Care Partnership will, on request, provide this document in braille, audio or large print.

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City Health Care Partnership CIC

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Quality Accounts 2020/21