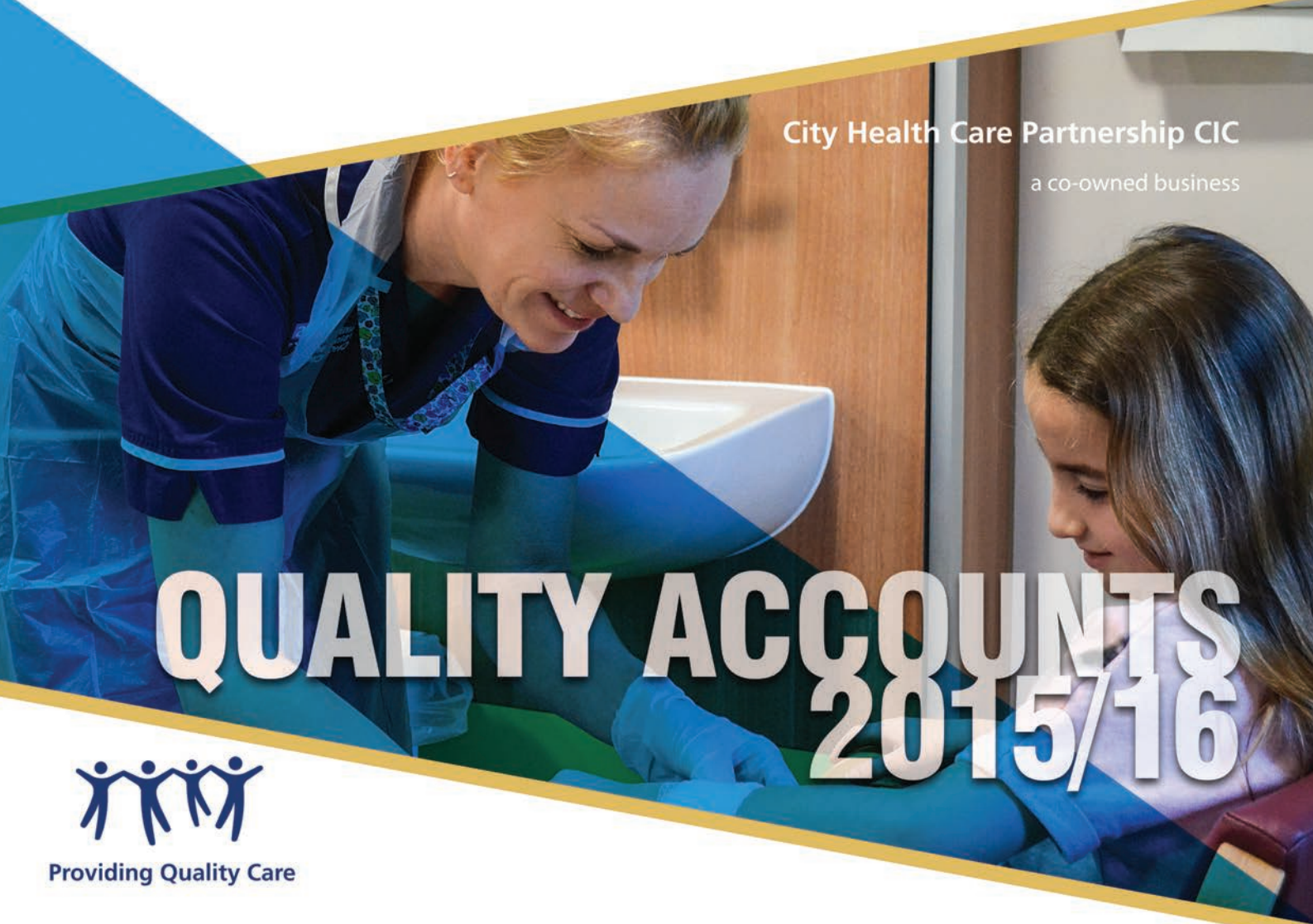
City Health Care Partnership CIC

a co-owned business



QUALITY ACCOUNTS 2015/16

Providing Quality Care

2015/16 Quality Accounts

City Health Care Partnership CIC

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Statement and Introduction from the Chief Executive

During the past 6 years, there have been many significant changes in the delivery of health care services. These have been driven by a need for high quality health care for all that has resulted in improvements in the access to services, improvements in patient safety and significant progress in the management of long-term conditions. The quality agenda and the emphasis placed upon increasing patient choice has led to a change in the way health care is delivered, moving many services out of hospital and closer to home.

The theme of our sixth set of Quality Accounts focuses on how healthcare provision in the community setting is more than a prescribed action but is instead a holistic assessment of a person's needs. This is reflected in the Care Act 2014 which requires health and social care to be considered in the context of the service user's priorities and how they can be supported in meeting the outcomes they want to achieve. The focus is on supporting people to live as independently as possible for as long as possible.

The importance on safeguarding our most vulnerable service users is, I believe reflected in this year's accounts and the commitment from our staff to deliver high quality, patient centred care is evident from the examples included in chapter 5.

As in previous years, these Quality Accounts have been produced openly and honestly to enable our service users, our commissioners and all of our partners to assist us in identifying where services are working well together, where there is a need for some improvement and where the priorities are for the future.

I firmly believe that by following our key objectives of;-

- **putting customer satisfaction at the heart of what we do**
- **being a provider of excellent health care services**
- **being an employer of choice**
- **ensuring we are able to compete in a competitive health care market**

we will always learn and strive to improve our care provision by responding to the needs of the communities we serve and our commissioner's requirements.

My sincerest thanks go out to all of our stakeholders, to those who have assisted with statements of support and those who have supported us in identifying our priorities for improvement. To the best of my knowledge all the information contained within these Quality Accounts for 2015/2016 are accurate.

Andrew Burnell
Chief Executive

Review of Our Services

Throughout 2015/2016 City Health Care Partnership CIC provided 80 health care services funded through NHS commissioning and 10 public health services commissioned by local authorities. These were originally arranged within the following business units:

• Adult Services • Children and Young People • Specialist Community Services

• Primary Care and Psychological Wellbeing Services

During the 2015/16 year City Health Care Partnership CIC has been successful in its bid to retain services as part of the national processes for health care provision and has had to review and align services into new care groups. These are now arranged as:

Care Group 1 community and urgent care services, dental services and GP out of hours

Care Group 2 paediatric services, sexual health services and public health

Care Group 3 GP surgeries, psychological wellbeing services and prison healthcare

City Health Care Partnership CIC has reviewed all the data available to them on the quality of care in all of these NHS and public health services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by City Health Care Partnership CIC for 2015/16.

The income for public health services in 2015/16 came from the Local Authorities as per the National Commissioning Framework.

National Audit and Confidential Enquiries

During 2015/16 only 1 national clinical audit and no national confidential enquiries covered the NHS services that City Health Care Partnership CIC provides.

During the period CHCP CIC participated in 100% of the national clinical audits and national confidential enquiries which it was eligible to participate on. The Long Term Conditions National Audit COPD LTC007 continued from the previous year and data was supplied with regards to pulmonary rehabilitation.

NICE Guidance

The National Institute for Health & Care Excellence (NICE) is an independent organisation that publishes evidence based guidance for health and social care practitioners.

The evidence produced by NICE assists in our quality standard developments and metrics can be used to capture, measure and compare our local service delivery. This year, we formalised the NICE triage group to include senior clinical, quality and governance staff whose remit is to review all guidance published by NICE each month and consider its applicability to CHCP CIC's services.

During 2015/2016 we reviewed 158 new NICE publications and disseminated relevant publications for consideration and action to the appropriate service within the organisation.

Additionally, we are registered as NICE stakeholders for the key service areas that we provide which means that we may be consulted to review and comment upon guidelines and quality standards being developed within one of our key clinical service areas. This has included our engagement with the following publications:

- **Oral health for adults in care homes**
- **Transition between inpatient hospital settings and community or care home settings**
- **Transition of Children's into Adult services**

Although the application of the guidance is not mandatory, implementation is considered to be an indicator of best practice and professionals are expected to take the guidance into account in their clinical practice. An example of this happened in July 2015 when NICE published guidance around Improving Anticoagulation in Arterial Fibrillation (AF): Treatment and Management. The statement 'Adults with atrial fibrillation taking a vitamin K antagonist who have poor anticoagulation control have their anticoagulation reassessed' was of particular relevance to our practitioners.

In order to measure current practice and comply with this requirement our Anticoagulation Service has commenced a project which requires reviewing all anticoagulation patients case notes and records aiming to:

1. **Identify patients with AF taking Warfarin who fit the NICE criteria for poor anticoagulation control.**

2. **Identifying factors with the potential to contribute to poor anticoagulation control as indicated in the guidance**

The first stage of this project has identified 450 patients who fit the new NICE criteria for poor anticoagulation control.

Working with local GP's measures are being put in place to address potential factors contributing to poor anticoagulation control. Each individual patient will need to be reassessed and their treatment plan revised in line with the guidance. This may result in;

- **Ensuring relevant blood samples are taken and results reviewed to establish kidney function**
- **Discussing their anticoagulation management options**
- **A switch to a new (Direct) Anticoagulant which will be taken orally**
- **Stopping anticoagulation therapy if the risks outweigh the benefits**
- **Continuing on their established current Warfarin medication**

Overall the projects aim is to ensure patients and their treating clinicians and General Practitioners are better informed about the best practice evidence around patient focused diagnosis, treatment and anticoagulation management of AF.

Clinical Audit

Clinical audit is a formal process which helps improve the quality of patient care. By analysing service delivery against specific standards such as NICE guidance, we are able to identify and measure aspects of the service which could improve. We regard clinical audits as essential to understand how we can continuously improve the quality of our services.

During 2015/2016 CHCP CIC services registered 65 clinical audits within the governance team's central database, 21 of the audits have been completed and 44 are currently on going.

Additionally we have continued to apply our Quality Monitoring Programme (QMP) to build on our previous baseline measure of the Essence of Care (2012) benchmarks. During 2015/2016 we conducted 358 QMP audits across our 45 clinical services. The information received from these audits is analysed to produce an action report for each of the specific services.

Breakdown of Service Participation

15 **Adult services**

9 **Children & Young People services**

11 **Specialist services**

10 **Primary Care services**

This, in addition to local clinical audits, has had a positive impact on our patient care for example;

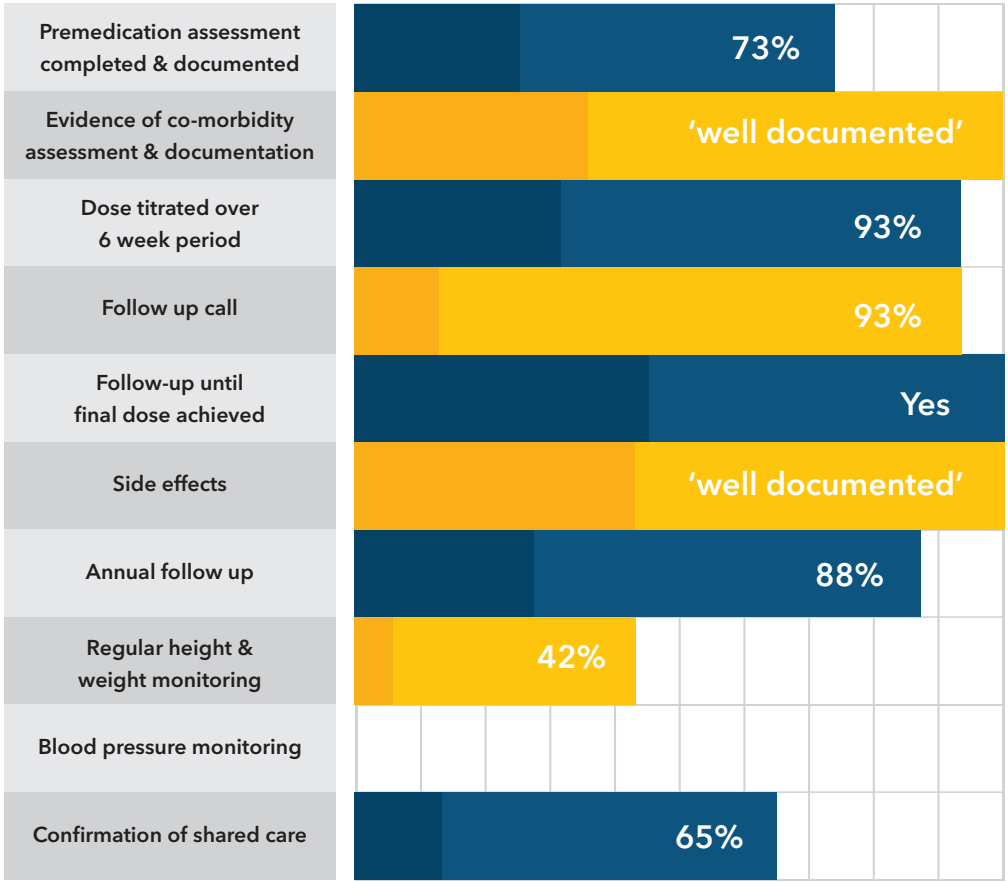
Last year we reported on an audit conducted by our therapist team which reviewed the management of people at risk of falls. The team developed an audit tool to measure

the application of best practice identified in the national and professional standards. The data captured resulted in an action plan being put in place. During 2015/2016 the team continued to monitor the application of the assessment within practice and staff reported an improvement in their falls awareness clinical assessment skills.

In another service, Dr Joanna Klejnotowska (consultant paediatrician) led a comprehensive audit of the management and compliance with clinical guidelines for children being with Attention Deficit Hyperactivity Disorder (ADHD) The team sought to identify best clinical practice and standards and captured data for the following for analysis;

- **Start date and type of medication**
- **Evidence of a full clinical assessment**
- **Documentation of any co-morbidities ie other medical problems**
- **Documented evidence that the drug dose was titrated over a 6 week period ie dosage altered to individual child's needs**
- **Timescale of first contact following drug commencement**
- **Timescale of achieving final dose**
- **Evidence that clinical assessment including height, weight, BP and heart rate monitored as well as any other medications taken**
- **Evidence that care is shared with child's GP**

In total 22 children were identified with a diagnosis of ADHD, of which 17 had commenced medication as part of their medical management. Data taken from the care records highlighted;



Following completion of the clinical audit the team were able to discuss and agree actions which included;

- Reminding practitioners of the importance of documenting their assessment findings
- Considering the use of a single assessment sheet to identify all required clinical findings
- Discuss with the multi-professional team who would be best placed to monitor growth and BP measurements
- Development of a 'prompt' within the electronic records system to remind practitioners of follow up requirements.

As part of the National Clinical Audit Awareness week led by the Health Quality Improvement Partnership (HQIP) City Health Care Partnership ran a 'reverse quiz'. Rather than ask a series of questions staff were asked to offer a question in respect of clinical audit to any of the Quality and Governance Team.

The team welcomed the challenge and managed to answer all questions posed by the staff. At the end of the week, a draw was held and a 'winner' was pulled out of the hat, which was Cheryl Malpass Occupational Therapist who asked about the access and availability of in-house clinical audits.

Research

Research is a core part of the healthcare delivery enabling progress to improve the current and future health of the people receiving care and support.

'Clinical research' means research that has received a favourable opinion from a research ethics committee within the National Research Ethics System. Information about clinical research involving patients is kept routinely as part of a patient's records and within the organisation within the central database held within the Quality and Governance Team.

During 2015/2016 City Health Care Partnership CIC participated in a wide range of research studies across our clinical services.

> **It's good to let local people talk about local issues** Service-user participant in 'What's the Urgency?' research study

> **It seems such an easy thing to be able to change to really make a difference to the care our kids get and I hope that is the case.** Parent participant in 'Perceptions of How Healthcare Plans are Communicated' research study

It felt great to be part of a study to reflect my experiences and feelings and to feel like we can be part of possibly something fundamental changing for the better to improve not only our families and daughters' quality of life but other families who have children with complex health needs. Parent participant in 'Perceptions of How Healthcare Plans are Communicated' research study

The number of patients receiving NHS services provided or sub-contracted by City Health Care Partnership CIC in 2015/2016 that were recruited during that period to participate in research approved by a research ethics committee was 124. A total of 10 studies were reviewed and approved by a research ethics committee, of which 7 were NIHR portfolio studies.

Cardiovascular Risk Profiles in Cardiac Rehabilitation programmes

Research Team: Dr Simon Nichols, Prof Lee Ingle, Prof Sean Carroll, Dr James Hobkirk, Prof Andrew Clark

CHCP CIC Site Collaborators:

Ms Toni Goodman, Mr Christy Francis

City Health Care Partnership CIC (CHCP) is an engaged partner with the University of Hull's Sport, Health and Exercise Science Department who are investigating the cardiovascular and cardiorespiratory benefits of taking part in exercise based cardiac rehabilitation (CR). This is the first contemporary UK study to investigate the fitness benefits of CR using 'gold standard' techniques. Data generated from this trial will help inform national CR exercise guidance.

The study recruits patients who have recently sustained a heart attack, a diagnosis of angina, undergone coronary artery bypass grafting or, elective angioplasty. During the study, patients attend the Academic Cardiology research laboratory at Castle Hill Hospital on three occasions and receive a sequence of clinical tests. These tests include physical examination, resting ECG, blood analysis, lung function test, arterial stiffness evaluation, ultrasound scan of the heart and carotid arteries, an X-ray scan that determines body composition (i.e. fat and muscle) and exercise testing on a treadmill.

During the exercise test the amount of oxygen breathed in by the participant is recorded allowing the research team to understand how well their heart and lungs are able to provide oxygen to the muscles during exercise. Improvements in this measure following CR indicate the effectiveness of the programme.

Dr Simon Nichols, Research Associate advises **"Although the study is ongoing and there has not been a completed analysis of the findings, patients frequently inform that participating within the study proves to be informative and enjoyable offering a valuable comprehensive health assessment not offered by the hospital following their cardiac diagnosis. Patients also report that the study provides much needed confidence following a life threatening event. Perhaps the most frequently cited comment is that patients' feel as though they have had a 'full MOT'! ".**

Parent's Perceptions of How Health Plans Communicate Health Need

Background

Children and young people with health needs may require care from multiple caregivers in addition to their family and friends. This care may be at home, in school, at leisure activities or during short breaks. Health plans (used to communicate health needs) are written by a variety of health professionals to direct the young person's care. They are written for use by parents and any additional caregivers. The aim of this study was to explore how health plans can be used to communicate the health needs of children and young people with additional/complex health needs.

Method

This was a small scale, qualitative, exploratory study, funded by NHS Hull CCG, aiming to capture rich and meaningful data to gain insight into the perceptions of parents. The study uses thematic analysis of data collected from sixteen participants, collected from three semi-structured, audio recorded focus group discussions.

Results

Analysis of the data resulted in three inter-related themes; (i) Importance of knowing the child, exploring how health plans could encompass the detailed knowledge that comes from knowing the child, alongside the struggle that parents feel when leaving their child in the care of multiple caregivers, (ii) Verbal information from parents, including the frustrations felt by parents when relaying the same information again and again to various professionals and caregivers vs the feeling of then not being listed to or having their experience and opinions valued, (iii) Using written health plans, highlighting difficulties of health plans not being read and how health plans and health information is shared. Parents also identified some possible solutions.

Conclusion

The results of the study indicate that other than emergency plans, written health plans are not always in use and when they are in use, are reportedly not always read or shared appropriately. Parents were able to leave an important message about the need for caregivers to know their children as well as knowing their health information. They also request to have their parental knowledge and experience respected and listened to, without being asked to repeat their story again and again to everyone involved.

Goals Agreed with Our Commissioners

Quality improvement and innovation is a high priority within the delivery of any healthcare service. Therefore a proportion of City Health Care Partnership CIC's payment from the commissioners in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between ourselves and any person or body that we entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. This is known as the CQuIN scheme.

CQuINS are carefully considered to establish the potential for improving patient care. There were 2 CQuIN schemes agreed at the beginning of 2015 for CHCP CIC with the commissioners from NHS Hull, NHS East Riding and NHS Vale of York CCG and North & West Yorkshire Area Teams, incorporating 11 goals. Each CQuIN contains a number of milestones that must be achieved. These all have different financial values attached to them and the value is determined by the commissioners. Each quarter a report on each of the milestones identified within the CQuIN scheme is presented to the commissioners. The CQUIN schemes and level of achievements for 2015/16 were:

CQUIN Schemes 2015/16 Summary

Hull, East Riding & Vale of York CCG's, North Yorkshire Area Team

Goal No.	Goal Title	Milestones							
		Q1		Q2		Q3		Q4	
		Number Available	% Achieved	Number Available	% Achieved	Number Available	% Achieved	Number Available	% Achieved
1	Patient Experience	3	100%	1	100%	1	100%	1	100%
2	Workforce Planning	4	100%	4	100%	2	100%	2	100%
3	Referrer Stakeholder Feedback	2	100%	2	100%	1	100%	1	100%

CQUIN Schemes 2015/16 Summary

West Yorkshire Area Team

Goal No.	Goal Title	Milestones							
		Q1		Q2		Q3		Q4	
		Number Available	% Achieved	Number Available	% Achieved	Number Available	% Achieved	Number Available	% Achieved
1	Health & Justice Safety Thermometer	1	100%	1	100%	1	100%	1	100%
2A	Care Programme Approach - Communication	1	100%	1	100%	1	100%	1	100%
2B	Care Programme Approach – Improving the health and well-being of mental health patients	1	100%	1	100%	1	100%	1	100%

3	NHS Health Checks	1	100%	1	100%	1	100%	1	100%
4	Escort & Bedwatch	0	N/A	0	N/A	1	100%	1	100%
5	Case Study	0	N/A	0	N/A	0	N/A	1	100%
6	Patient Experience	1	100%	1	100%	1	100%	1	100%
7	Assessment, Care in Custody & Teamwork	1	100%	1	100%	1	100%	1	100%

Clinical Coding

CHCP CIC was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Data Quality

To ensure our services and those elements of service delivered by sub-contractors are evidencing the high quality patient care that they deliver, City Health Care Partnership CIC collects and analyses data from across all of our contracted services.

Following the improvements reported in last year's quality accounts CHCP CIC was awarded the ISO27001 and ISO9001 international standards of good practice.City Health Care Partnership CIC will continue to take the following actions to sustain and continue to 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 for 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 at Operational and Board levels.**

Statements from the Care Quality Commission

As a provider of health care services City Health Care Partnership CIC is required to register with the Care Quality Commission (CQC) and our current status is 'Registered'. A joint visit between the CQC and Her Majesty's Inspector of Prisons has taken place during 2015/16 and we have welcomed the positive feedback as well as some suggestions for improvement.

City Health Care Partnership CIC has no conditions placed on our registration and the Care Quality Commission has not taken enforcement action against City Health Care Partnership CIC in 2015/16.

Information Governance

City Health Care Partnership CIC is committed to upholding the principles of Information Governance. As a health care provider we are required to comply with the standards defined through the Health and Social Care Information Centre's Information Governance Toolkit (IGT). We are audited against the IGT standards to provide assurance that the organisation and its employees are using, storing and processing service users' and the public's personal identifiable data in secure, confidential way.

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

In 2015/16 CHCP CIC has continued to improve the score against the Information Governance Toolkit (IGT) from previous years.

CHCP CIC Information Governance annual assessment score for 2015/16 was 78% and was graded as green. Our 2014/15 score was 75%.

The actions taken throughout the year consisted of:

- **Ensuring that at least 95% of staff were trained in Information Governance, Confidentiality and Data Protection, the actual figure attained was 96%.**

- **Developing the roles of Information Asset Owner/Administrator to assist in the embedding of Information Governance policies and procedures across the organisation.**

- **Supporting service developments through the Privacy Impact Assessments by supporting the Information Asset Owners/Administrators.**

- **Reviewing the Business Continuity Plans from an Information Governance and Data Protection perspective.**

As previously the focus for 2016/17 is to ensure that staff maintain and update their IG training annually to ensure staff are aware of any new legislative updates or changes to IG Practices.

As part of our ongoing commitment to improving information governance CHCP CIC undertakes regular audits throughout the year to ensure that practice, policy and guidance continues to be adhered to.

Comments, Concerns, Complaints and Compliments

CHCP CIC continues to review all Comments, Concerns, Complaints and Compliments received from service users or their carers in relation to our services. It is important that complaints and concerns are dealt with as quickly and efficiently by those who have been involved in delivering patient care whenever possible or appropriate.

During 2015/2016 the recorded numbers of the 4 C's (Complaints, Concerns, Comments and Compliments) are as shown below. Throughout the organisation we record when service users give us positive feedback on our care and during 2015/16 we received 1931 compliments and our service user satisfaction was rated at 98%.

Friends and Family Test

Since being implemented in October 2014, we have continued to use the Friends and Family Test (FFT) as a method for collecting feedback from our patients, clients and service users. Between 1 April 2015 and 31 March 2016, 12,252 people told us what they thought about services using FFT.

FFT asks service users how likely they would be to recommend the service that they have received to a friend or family member who needed similar care or treatment. During this period, 96.2% of those who completed the test said they would be likely or extremely likely to recommend our service, 2.2% did not know and 1.6% said they would be unlikely or extremely unlikely to recommend the service.

Genito-Urinary Medicine & Family Planning (East Riding)

You said: The clinics are not open long enough and there needs to be more of them, I think you really need to look at resources.

We did: Resources have been reviewed within the East Riding, looking at where there is a greater need for sexual health clinics. We have since opened new clinics in Hornsea and in Withernsea.

Treatment Rooms

You said: There wasn't enough dressings.

We did: Resources were reviewed across the city to ensure suitable stocks are available. Nurses now ensure patient supplies are sent with them if they are attending a different site.

Feedback from focus group with Hull and East Riding Institute for the Blind (HERIB)

You said: *Members of staff are often unaware of somebody who is visually impaired, the implications this can have on them or how to appropriately assist them.*

We did: *Many of our colleagues have since had Visual Impairment Awareness training, facilitated by HERIB.*

Let's Talk (Hull)

You said: *The service needs to be available at more times.*

We did: *Let's Talk are commencing the provision of more flexibility in their appointment times*

Parliamentary Ombudsman

In 2015/16 CHCP CIC has supported the Parliamentary Health Care Ombudsman with three investigations which have now been closed. In all instances the Ombudsman concluded that our internal investigations had been thorough and none of the complaints were upheld.

Agreed priorities for improvement 2016/2017

Within these Quality Accounts CHCP CIC is required to describe areas in which it will improve over the next year in relation to the quality of services. The areas for improvement fall within three categories:-

• Patient Experience • Patient Safety • Clinical Effectiveness

We recognise that these three areas span across all of our clinical services and therefore a major component to our aims of providing safe, effective, personalised and innovative care to the communities we serve.

Consultation Process

During the year we collected data from a range of sources such as the National Patient Opinion website, comment cards, reported incidents, complaints and concerns as well as taking into consideration the stakeholder statements from last year's Quality Accounts. This rich and varied source of information enabled us to look for the key themes and trends so that we could develop a 'long list' of potential priorities for the on coming year.

This 'long list' was shared internally with our staff who were asked to vote via the intranet for their priority in each of the three categories. Outside of the organisation we contacted health, social and patient care group and key stakeholders to ask for them to vote via an on-line survey. The top priorities for both staff and stakeholders was the same in all three areas with the above topics receiving the highest votes.

Category	Topic	% of votes
Patient Experience	Our patient journey	43%
Patient Safety	Tackling antimicrobial resistance	51%
Clinical Effectiveness	Introducing a professional lead role	62%

Patient experience - our patients' journey

Rationale

Patient experience is fundamental to the delivery of our services. We need to understand and explore the experiences that our patients and service users have and specifically what is important to them in making it as good as it can be.

We want to understand the experience that our patients and service users have of our services and specifically what is important to them in making it as good as it can be. We are proposing to undertake an in-depth review of what people want from our services to help shape our ongoing service delivery and areas for improvement.

How will we do this?

We will directly engage with our service users to determine the main drivers for their satisfaction and through using key driver analysis, we will produce a development plan for each service area under the themes of: Promotion, Maintenance, Prioritisation and Improvement. This will assist in developing service specific reports that highlight relevant trends, changes and areas for maintenance or improvement for service each area.

How will we monitor throughout the year?

We will we report findings and subsequent actions to the Community Partnership Forum throughout the year

Patient Safety - tackling antimicrobial resistance through the Introduction of an effective antimicrobial stewardship programme

Rationale

Antimicrobial resistance is defined as the resistance of a micro-organism (e.g. bacteria, fungi, viruses and parasites) to an antimicrobial drug that was originally effective for treatment of infections caused by the micro-organisms. It threatens the effective prevention and treatment of an ever-increasing range of infections and is an increasingly serious threat to global public health that requires action across all government sectors and society (WHO 2015).

It is recognised that antimicrobial resistance:

- **hampers the control of infectious diseases**
- **increases the costs of health care**
- **jeopardises health care gains to society**
- **ultimately can kill susceptible individuals**

What will we do?

Following last year's publication of the NICE Guidelines "Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use" we will utilise this to develop systems and processes for effective antimicrobial medicine use across all services provided by CHCP CIC.

We will:

- **ensure that an effective antimicrobial stewardship programme operates across all CHCP CIC provided services**
- **monitor and evaluate antimicrobial prescribing and investigate how this relates to local resistance patterns**
- **explore where required the reasons for increasing, very high or very low volumes of antimicrobial prescribing, or use of antimicrobials not recommended in local (where available) or national guidelines**
- **provide regular feedback to individual prescribers in all care settings about their antimicrobial prescribing**
- **provide education and training to health and social care practitioners about antimicrobial resistance and antimicrobial stewardship**

How will we report and monitor?

We will establish an Antimicrobial Stewardship Group as a sub-group of our Therapeutics and Pathways Group. Its remit will be to:

- **undertake the baseline audit across all services**
- **develop an action plan for implementation based on the audit findings**
- **monitor progress against the action plan**
- **carry out a re-audit across all services to measure improvements**
- **monitor antimicrobial prescribing in all services and provide feedback**
- **investigate any anomalies identified in antimicrobial prescribing**
- **provide regular feedback to the Therapeutics and Pathways Group**

Clinical Effectiveness: introducing a professional lead role and supporting framework

Rationale

CHCP's Forward Strategy: "It's Everybody's Business 2015-2020" recognises the importance of maintaining continued professional development and leadership for the workforce.

This not only recognises the need for a professional framework that addresses the intermediate and future company workforce but will also create the opportunity for new clinical leaders to recognise the emerging environments in which CHCP will be required to work.

How will we do this?

CHCP is in the process of developing a framework to support the development of professional lead roles which will be an integral part of assuring that evidence based, high quality safe care is delivered through operational services within care groups.

The core roles will have:

- **A defined description which may incorporate specific criteria**
- **Where appropriate specific hours will be allocated per month for leaders based in clinical practice**
- **The identified key pillars of working include;- leadership and management, facilitation of learning, clinical effectiveness, research and development and clinical practice**

How will we monitor throughout the year?

We will:

- **Develop the above into a combined framework**
- **Agree operational links with care groups**
- **Introduce the concept of professional lead roles**

We will measure the effectiveness via our key objectives of;-

- **Providing and enhancing the quality, safety and effectiveness of patient care on every service.**
- **Developing skills, behaviour and competence to deliver quality care and advice**
- **Building the potential of our workforce by innovating practice roles and delivering new career pathways**

Last year's priorities for improvement

We have worked hard to achieve the Priorities for Improvement that was pledged in last year's Quality Account publication. We agreed to deliver:

Patient Experience: Exploring the barriers to patient and service user engagement

Patient Safety: Implement and establish robust systems and processes to reduce harm in relation to poor transfers of care into and out of our service

Clinical Effectiveness: Implement a holistic approach that captures all aspects of safety & quality care

Priority for Improvement – Patient Experience

What we said we would do:

Rationale - the 2014 annual patient survey found that people with a disability reported a less positive experience of accessing services and similarly a less positive experience overall than those reported by people without a disability.

What we did and what we found:

Our original intention was to conduct a series of focus groups with a cross section of service users and organisations representing different disability interests from across the city.

However, upon starting this work it became quickly apparent that this approach was not suitable, with those groups approached favouring a more detailed one to one approach to discuss and explore the particular interests or barriers of importance to them.

As a result of this, the engagement with HERIB (Hull and East Riding Institute for the Blind) highlighted some requirements for improvement for people with a visual impairment. From our initial discussions with HERIB they were keen to work in partnership with us on the ways in which we could improve accessibility to services and feedback mechanisms.

They subsequently gave us access to meet with some of their user groups to discuss with them the experiences and barriers faced. From this we found that there were two key areas for improvement:

- Staff awareness and training for visually impaired service users
- Accessibility to our Friends and Family Test (FFT) for visually impaired service users

What we implemented and the impact this had:

From our findings we have developed and implemented an action plan focussing on the two key areas raised.
In respect of the FFT, we have explored and implemented the following:

- reviewed the accessibility functions that are in place on iPads for people with sight loss. These include zoom functions, voice over and colour contrast settings. We have trained reception staff on how to switch on and off these accessibility functions. The functions need to be switched off after use as they make completing the test difficult for users who are not visually impaired.
- produced a large print version of the test, printed on A4 card using a larger font of at least 20pt. This is printed on yellow card with a clear black text, following advice from HERIB that black text on a yellow background provides the clearest contrast.
- ensured that the online version of the test can be completed on a personal computer or tablet using accessibility functions that are commonly used. Although the online version of the test doesn't have functions specifically built in to assist people with sight loss, it is compatible with programmes or tools that anyone may use on their own computer.

In addition we have continued to share all the feedback received, highlighting any concerns or suggestions for improvements on a regular basis with service managers and senior staff members. We ask for input from the service and senior staff for ways we can address and rectify any issues that have arisen.

With regards to staff awareness and training, we have worked with HERIB and our colleagues in the learning resources department to facilitate the development of specialised visually impaired awareness training. This is delivered by HERIB and has been made available as part of our staff training package.

The work completed on our FFT was also recognised by NHS England in their Friends and Family Test Awards 2016 and we were successful in being a shortlisted finalist in the "accessibility initiative" category.

Priority for Improvement – Patient Safety

We stated that we would implement and establish robust systems and processes to reduce harm in relation to poor transfers of care into and out of our services. This had been identified by our service users, our staff and our commissioners as an area of concern. By creating a forum that brought together representatives from the hospital and community services it was found that meaningful discussions could be generated with regards to incidents and concerns on the issues of transfer of care and effective partnership working. The group developed terms of reference that included:-

- **To improve communication between organisations, wards and services**
- **To promote information sharing and good practice**
- **To monitor issues relating to poor discharge/transfer between service providers and obtain feedback from any poor discharge investigation carried out.**
- **To look for trends/patterns in specific areas of practice in services so that these can be monitored, supported, advice given or training provided to improve practice and care.**

Information came from a number of sources; incidents reported by our staff, issues raised by service users and their carers, and staff within partner organisations. A newly created poor transfer of care form identified clear problems which subsequently enabled actions to be put in place to prevent repetition.

Through the close monitoring of incidents and establishing the root cause of why a problem occurred a number of changes have been implemented between CHCP and partner organisations. For example; the high number of medication issues has led to a redesign of community medication charts and the methods used to notify carers or community services. This has included direct electronic communication where possible. Through the joint working group ideas and innovations are trialled and evaluated to ensure that any change benefits our service users and improves the quality of their care.

Some issues have been identified that are not confined to our local area and these have been escalated to our commissioners. Examples have also been appropriately shared through the National Institute for Clinical Excellence consultation on transfer of care to community services and with NHS England as part of a national patient safety alert.

Creation of a Percutaneously Endoscopically placed Gastrostomy tube (PEG) Passport

From our analysis of incidents and data monitoring we noticed a trend in patients being discharged into the community with little, if any details or formal 'handover' after the insertion of a PEG tube. Although the patient had undergone a surgical procedure there appeared to be no established continuity plans for their on-going care in the community with the receiving clinician reporting a lack of clinical information most importantly the date and type of the PEG tube insertion which are important elements to facilitate care planning.

Therefore, it was noticeable that a number of patients were not identified until their condition deteriorated into an emergency or urgent situation.

Very often patients would be unsure of what type of tube they had in place which created a timely / costly process to be identified which resulted in possible admission / further procedures.

What was done?

Discussion held with stakeholders to facilitate a novel approach in the ongoing management of this patient group. Small meetings and work groups were undertaken to look at transfer of care improvements and information sharing, and the Community Gastro-Enterology Specialist Nurse, created a novel approach in developing a patient passport for gastrostomy patients, recognising its importance and significance to the care of the patient following insertion of the tube. The idea was cost neutral other than printing costs for the passport, and was seen as an effective tool for the transition of care.

Impact on patient care

All patients are now provided with a Gastrostomy Passport following insertion of their tube in the hospital setting. Having a continuous record of changes assists in the early identification of potential problems, prior to the implementation of the passport there was no identification of how often and where tubes were changed.

The Passport has also become the patient's voice which improves reduced hospital stay and has resulted in less hospital admissions. All health professionals involved check that a Passport is present and that the details are correct to enable maximum communication between all involved in the patients care.

Priority for Improvement – Clinical Effectiveness

We pledged to implement a holistic approach that captures all aspects of safety and quality which will include the key domains as denoted by the Care Quality Commission (CQC) and the 6C's of nursing: Care, Compassion Courage, Commitment, Competence, & Communication.

How did we do this?

We developed and implemented a 'Deep Dive' audit process with an approach that mirrors the format of the Care Quality Committee (CQC) inspections i.e. service managers to firstly review their service provision against a detailed questionnaire and declare their compliance to the expected standards.
This declaration of compliance was then reviewed alongside data from service user and staff feedback, performance monitoring and compliments, complaints, concerns & comments received about the service. The findings guided interview schedules which were conducted by specialist staff within the organisation and broadly cover the following key domains:

- **Medicine management**
- **Information governance**
- **Complaints & concerns**
- **Infection control**
- **Clinical effectiveness**
- **Competence**
- **Supervision**
- **Documentation**

These responses, together with the findings from the '15 Step Challenge' which seeks to 'walk-through' a service area as viewed through the service user's eyes provided a comprehensive report of service delivery.

Which services undertook the Deep Dive Audit during 2015 – 2016?

We completed the process within four services and provided written reports to each area.

- **Carers Support & Information Centre, Hull**
- **Sexual Health Service, Hull & East Riding**
- **Stop Smoking Service (Knowsley)**
- **Anticoagulation Service**

What changes resulted?

Service managers were able to consider their areas report findings and develop action plans for improvements accordingly. Which has included:

- **Improved signage at clinic settings for service users**
- **Further training on the use of electronic patient records**

Influencing Care and Sharing with Others

More than a Task: Most people who access our services do so to receive a healthcare intervention. Throughout CHCP CIC's clinical services we encourage our practitioners to make the most of every opportunity when they are delivering their care to help people improve their health and wellbeing. This can be done through taking an interest in our service users' lifestyles and choices so that they can be supported to optimise their health.

One aspect of delivering more than the healthcare intervention or task is the 'Making Every Contact Count' (MECC) which was introduced nationally in 2010. CHCP CIC has adopted and embedded its principles to become part of our staffs' normal day-to-day clinical practice. Our aim is to ensure all our service-users receive the highest level of holistic care and advice.

An audit of MECC contacts conducted in May 2015 showed that since its introduction within CHCP CIC our staff have offered over 25,000 service users the opportunity to access additional assistance to support their health and wellbeing; with over 3,500 people accepting this offer and being referred to a relevant service.

However, MECC is not our only approach to delivering more than the task required. Our service user feedback has captured many examples of holistic, compassionate care which are illustrated in the following examples;

More than a task – making the link between work and health

Lymphoedema is a painful condition which presents as localised fluid retention and tissue swelling in a limb. Recently a lady was referred to the Lymphoedma service for compression bandaging to her very swollen leg. When talking to the nurse the lady told her that she was worried by her repeated absences from work due to the pain and discomfort she had been experiencing.

Understanding how people function in terms of mobility, rest and demands upon themselves is an important aspect of clinical assessment and assists in care management explains Debbie Allanson, Clinical Nurse Specialist

I asked this lady about her working day and she told me that her job entailed standing up for long hours at a time and at the end of the day her pain was unbearable and this had resulted in her having many bouts of sickness leave

Debbie continues

I knew that we could reduce the swelling, but in order to maintain this improvement and promote comfort she would need to sit down with her leg raised for a period of time each day. She told me that she was nervous about drawing further attention to herself in respect of her condition and the sickness absences that had occurred. However, with her permission I wrote to her employer explaining the impact that standing was having upon her condition in terms of exacerbating the swelling, discomfort and pain and I asked if there was anything that that they could consider which may help her

Debbie was pleased to report **In a follow up clinic when I reviewed the lady her condition had greatly improved. She told me that her employer had been grateful for the insight into how her condition affected her wellbeing and had proven helpful and supportive through changing her working arrangements to enable her to sit down for part of the shift. She was very pleased not only because she was feeling better, but that she had not had any further episodes of sickness leave**

More than a task – helping people to help themselves

Zena Scott, Tissue Viability Nurse offers one of many examples of how looking at a patients overall general well-being, over and above their presenting healthcare problem can bring the individual great rewards she says

I recall a gentleman who attended the treatment room due to a leg ulcer wound that was not healing. His doctor had referred him to the vascular consultant at the hospital and he was awaiting the hospital appointment for consideration of a surgical operation to his leg wound

When undertaking my nursing assessment I learnt that the gentleman was a heavy smoker. I know that as well as the well-publicised list of side effects people are aware that are associated with smoking, it can cause significant problems to circulation and in turn this effects ulcer healing I explained this to the gentleman and we discussed the physiological impact of smoking upon his body particularly in respect of his circulation and skin integrity

He told me that he would like to stop smoking, but did not know how to approach this. With his permission I referred him to the local Stop Smoking Service. At his next appointment he told me, with great pride that he had attended the Stop Smoking service and had stopped smoking.

Zena informs that that the nurses continued to dress his wound over the coming weeks and in around six weeks, without any surgical operation this gentleman's leg ulcer had healed.

Zena continues **Although he was so pleased with the dressing that we had done to his wound – I pointed out to him that the best approach to healing was his stopping smoking and the rewards were visible as he had undoubtedly improved not just his circulation but his overall health**

More than a task - connecting to the community

Our Tuberculosis (TB) nursing team deliver advice, support and treatment for people with a diagnosis of TB. An important additional aspect of their role is to identify and screen those people considered at risk of carrying or developing TB. Making contact with people who are at risk of TB is challenging as many may be migrants and not readily understand or connect to NHS care.

The team, through discussions with community groups heard about an 'Open Door' drop in centre in a church organised by a local multi-ethnic groups charity. The aim of the drop-in session was to offer people welfare information, practical assistance such as form filling and provide a hot meal and food parcel. The charity agreed to allow our TB nurses to attend but cautioned that this may have to be a on a short-term trial basis as the session was not aiming to deliver statutory services so they would have to see how we were received by the people who attended the session.

Diane Rudd, community staff nurse explains. **We began attending the drop-in centre some 3 years ago as a means of being able to reach out to refugees, asylum seeker and European migrants to encourage screening for TB.**

Both myself and my colleague Jane Sargent attend alternate weeks and this has helped us to develop a rapport and the trust of the groups of people that attend. We knew that in the early days we had to work at breaking down the barriers and suspicions regarding healthcare and build a trusting relationship with the people that used the drop-in session. As well as screening for TB we try to maximise out contact with the person to offer other health care opportunities ranging from assisting in registering with a local GP to making dental care referrals or referrals to other health advisory services

Diane reflects **although we initiated this aspect of our work to assist in our making contact with hard to reach groups, both myself and Jane feel that it has been a valuable opportunity for us to develop our insight and understanding of the beliefs, barriers and behaviours of different cultures. We feel very welcome at the sessions and have humbly been invited to other cultural events, festivals and open days**

More than a task – Broaching a subject

Dr Tonye Wokoma is a doctor working in CHCP CIC's Sexual Health clinics. She tells of a recent experience of seeing a shy 19 year old Somalian girl who attended the clinic requesting help due to experiencing painful periods. Tonye informs

> **the girl told me her history of suffering from what she termed as excruciating pain since she had started her periods at aged 15. She explained that she had missed school and social functions due to the frequency and intensity of the pain. During the assessment she refused to let me examine her and I respected her wishes. However my professional knowledge led me to consider whether this girl had experienced Female Genital Mutilation (FGM)**

So, I sensitively asked her whether as part of her upbringing in the Somalian culture she had experienced FGM. Quietly, she confirmed to me that she had and also her sisters and cousins had too. No-one spoke of what had happened to them, and she was unable to explain what type of FGM she had received. We gently spoke about what FGM is and I explained to her my understanding of the lasting effects upon females. I was able to prescribe treatment for her pain control, but I also asked if she would come back to see me at the clinic so that we could talk further and I could offer some specific gynaecological advice in respect of the FGM

Dr Wokoma's approach was to show understanding and compassion through developing a rapport and trust with her female patient. This enabled her to broach the subject and offer information and advice without judgement.

Tonye continues **I was so pleased to see this girl return to see me. She reported that her pain levels had greatly reduced – but most importantly she wanted to talk to me about medical treatment and support for the effects of FGM.I hope that by supporting her, she will be able to talk to her female relatives about her experience and advise of healthcare that they could receive**

Sharing and Celebrating Our Successes

Over the last year our clinical staff and their teams have been recognised for the expertise and excellence through a range of local, regional and national sharing conference and awards.

Publications have included:

Dr Jenny Brotherston (2015) Contraception meets HRT. Seeking optimal management of peri-menopause. **British Journal of General Practice.**

Dr Peter Caplin, Alan Fussey, Jane Sargent (2015) 'Bringing outpatient cardiology into the community: an alternative to hospital based clinics. **Future Hospital Journal.**

Rebecca Price (2015) Evaluating a peer support group for newly qualified health visitors. **Journal of Health Visiting.**

Karen Shaw (2015) More than child's play. **British Journal of Health Care Assistants.**

Emma Stevens (2015) How does leadership contribute to the safeguarding of vulnerable adults? A review of the literature. **The Journal of Adult Protection.**

Oral & Poster presentations at National Conferences have included:

British Dental Association
Annual Scientific Conference –
Presentations from:
Dr Gill Greenwood, Dr Chris Pollock, Jess Rowley, Sandie Eddom

Royal College of Nursing International Research Conference
Lucy Riggs

PULSE LIVE (Manchester, London & Birmingham)
Dr Jenny Brotherston

National Conference Faculty of Sexual & Reproductive Health & Public Health
Dr Kate Guthrie, Dr Ajith, Dr Alli, Rachel Potter – WINNER
of best Oral Presentation from poster presentation

National Recognition

Bev Clarke International Journal of Palliative Nursing
Nurse Educator of the Year AWARD WINNER

Equality in Diversity (silver award)

ISO Standard for quality 9001

ISO Standard for IT 27001

Quality standard for clinical skills teaching

City Health Care Partnership CIC Quality Accounts 2015-16

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

We welcome this set of quality accounts and the opportunity to comment on them. We are pleased to confirm full achievement of local CQUINs for 2015-16. We feel that the separate section in the Quality Accounts to reflect on the impact of CHCP's deep dive methodology, as supported by CQUINs, helps demonstrate both CCGs' focus with CHCP to develop as a learning organisation. These sections on patient experience and on the deep dive methodology gives some evidence on improvement to patient care and is consistent with the more detailed information shared throughout the year with commissioners.

It is positive to see the detail on research in the report and that research is viewed as a core part of the healthcare delivery. The Quality Accounts give illustrative examples of how research has been undertaken in 2015-16 with anonymised quotes from a range of stakeholders including service users and other participants. Wider recognition of how CHCP are endeavouring to build a research culture amongst staff groups and partners would be welcome. Wider recognition of how CHCP are promoting public and participant engagement (PPI) into research would also be of benefit, working with the national organisations such as National Institute for health Research (NIHR) on the "OK to Ask" campaign, would be one suggestion.

We welcome the detail NICE guidelines and guidance – the good practice to implement non-mandatory NICE guidance and the example included in the Quality Accounts is good insight in to the approach taken by the organisation.

We support the three priorities for quality selected from stakeholder engagement for 2016-17 and look forward to seeing the progress and impact of these.

We welcome the 'You Said, We Did' section and patient stories – these have a lot of impact and for a public-facing document, give more relevance to the impact on quality of care. As commissioners, we expect CHCP to continue with reflective practice on patient experience, as evidenced by the choice of patient experience as a priority for 2016-17, and look forward to continuing to work in partnership with the organisation on improving care for local patients.

The priority for clinical leadership and professional roles is particularly welcomed and believe this consistent, amongst other strategies, with the Hull and East Riding of Yorkshire Nursing Strategy, of which CHCP is a key partner. Recognising the CHCP's priority is clinical leadership throughout the organisation and not just in nursing, this approach is in keeping with national and local priorities on developing quality of care and sustainability of services and in particular supports the delivery of high quality community care and a focus on improving clinical outcomes.

We feel that the quality accounts could include more evidence on the use of qualitative data, such as incident data, and the resulting improvements made to care and to services, mirroring the section in the Quality Accounts on medications. We feel that CHCP have undertaken more work than is evident in these Quality Accounts and could provide a more robust view of patient safety in the organisation. This has been a feedback point from commissioners for the last few years and would wish to see more assurance in this area, in a well-rounded set of Quality Accounts.

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 2015-16 and look forward to working in partnership in 2016-17 to continue to improve outcomes for our patients.

Emma Latimer
Chief Officer
NHS Hull Clinical Commissioning Group

Jane Hawkard
Chief Officer
NHS East Riding of Yorkshire Clinical Commissioning Group

City Health Care Partnership CIC

Response to Statements

As with previous years we are very grateful for the feedback we have received from our commissioners and partners on these Quality Accounts for 2015/16. We wish to thank them for their supportive and constructive comments made in their statement and throughout the year during our normal working relationships.

We are pleased that the development of a culture of research has been recognised by our stakeholders as important to the improvement of our quality of care. Developing proactive evidence based care services for our patients requires a level of tenacity demonstrated by our passionate staff that at times is hard to present in the written format. We will build upon the achievements already made to continue with our service innovation and partnerships across the wider health and social care network.

We will endeavour to present stronger qualitative evidence of the positive outcomes for patients in our next set of accounts.

The very constructive comments we receive do enable us to strengthen the content of our Quality Accounts each year to reflect the diversity of the organisation and the services it provides. As the delivery of health and social care continues to change we firmly believe that the patient centred approach adopted by our commissioners, partners and staff will improve the quality and safety of patient care.

Glossary of Terms

CHCP: City Health Care Partnership
CIC: Community Interest Company
CCG: Clinical Commissioning Group
Clinical Audit: A quality improvement process that looks at improving patient care and outcomes through a reviewof care given against a set of criteria
CQUIN: Commissioning for Quality and Innovation, this is a payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets

CQC: Care Quality Commission, the organisation that regulates andmonitors standards of quality and safety in organisations delivering healthcare
GP: General Practitioner
NHS: National Health Service
NICE: National Institute for Health & Care Excellence – organisation which provides national guidance and information to improve health and social care
NiHR: National Institute of Health Research – national body whose facilities and systems represent themost integrated research system in theworld
QMP: QualityMonitoring Programme

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Polish

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Kurdish

ئەگەر ئینگلیسی زمانی تۆ نییە و دەتەوێ ئەم بەڵگەت بۆ تەرجومە بکەینەوە تکایە پەیوەندی بکە بە:

Mandarin

若 希望其他 言版本, 系：

Turkish

İngilizce ana diliniz değilse ve bu belgenin çevirisini istiyorsaniz lütfen buraya başvurun:

Farsi

اگر انگلیسی زبان نیستید و ترجمه این متن را می خواهید، لطفاً با اینجا تماس بگیرید: