Nottingham Citycare Partnership CIC

Quality Report

1 Standard Court
Park Row
Nottingham
Nottinghamshire
NG1 6GN
Tel: 0115 8839600
Website: tracy.tyrrell@nottinghamcitycare.nhs.uk

Date of inspection visit: 28, 29, 30 November 2016, 01 December 2016
Date of publication: 08/03/2017

Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Headquarters	1-298791257
Community health services for children, young people and families	Headquarters	1-298791257
Community end of life care	Headquarters	1-298791257
Urgent care services	NHS Urgent Care	1-216720327

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of Hospitals

Nottingham CityCare Partnership are a community social enterprise caring for patients across a wide range of services, in home settings or close to home in community settings such as health centres, schools and GP surgeries and in an urgent care centre. It covers the city of Nottingham and also provides a school age immunisations programme in the city of Derby. The organisation employs approximately 1800 staff and serves a population of almost 312,000.

This was the organisation's first inspection using our comprehensive inspection methodology.

We carried out this comprehensive inspection between the 28 November and 1 December 2016. We also carried out an unannounced inspection of the Urgent Care Centre on the 7 December 2016.

Nottingham CityCare Partnership CIC provides the following core services:

- Community health services for adults
- Community health services for children, young people and families
- Community end of life care
- Urgent care services

Nottingham CityCare Partnership has not been inspected since registration in March 2011.

Headquarters has been inspected on two occasions since registration. There were no previous breaches of regulations against this location.

The NHS Urgent Care Centre was previously inspected on 12 May 2016 in response to concerns. We found that the service provided at the centre was not meeting legal requirements and we set two requirement notices in relation to:

- Regulation 17 HSCA (RA) Regulations 2014 good governance, as the provider did not have effective systems in place to monitor and manage risk by having sufficient cover to enable staff to triage and see patients in a timely manner.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing, as the provider did not have effective oversight of staffing requirements in order to deploy sufficient numbers to meet demand and have a systematic approach to determine the correct number of staff and range of skills to meet patients' needs.

Following this inspection of the NHS Urgent Care Centre by our Primary Medical Services and Integrated Care team it was found the service provided at the centre was now meeting legal requirements and as a result, both requirement notices were closed.

We inspected four core services; the end of life care service was rated as outstanding and the remaining three services were rated as good. When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence. On this occasion we found that the provider was working at a level which was consistently good with some elements of outstanding; the provider's leadership was judged to be outstanding. Therefore, overall we found the provider was performing at a level which led to the judgement of outstanding.

Our key findings were as follows:

- The organisation had a strong focus on quality and safety and providing services that met the local needs of patients. Throughout the inspection we saw how patient safety was at the forefront of the agenda.
- Staffing levels were generally able to meet the needs of patients, although there were some vacancies in the community adults and children, young people and families services. In the urgent care service there had been significant investment in agency staff to temporarily increase staffing levels to a safe level to meet demand in a more timely way. This had made a positive difference on meeting demand and managing workload.
- Patient's needs were met through the way services were organised and delivered with minimal waiting times across the services. In the end of life care service 100% of patients had died in their preferred place of care. In adult services, between April 2016 and December 2016, the organisation responded to 90% of acute requests within three hours of referral. For

Summary of findings

referrals that were classed as urgent and requiring a visit within 72 hours their overall performance for the same period was 90%. In the urgent care service there had been a steady improvement in the assessment time of patients since May 2016 with a 17% reduction in the number of patients waiting longer than the 30 minute target time set by the clinical commissioning group (CCG).

- The individual needs of patients were taken into account when planning and delivering services. In the children, young people and families service staff offered home immunisations for hard to reach vulnerable children to ensure they completed their immunisation programme. In adult services a reablement team provided care for patients who required a social care package in order to prevent hospital admission or to facilitate an earlier discharge from hospital. Specialist dementia nurses were available across the organisation to give practical, clinical and emotional support to families living with dementia. The NHS urgent care centre identified carers and those that cared for patients during consultations and were able to signpost support if required.
- The provider had an up-to-date infection control policy, which provided guidance for staff on the prevention and control of infection. Throughout the organisation we observed staff to be compliant with best practice guidelines to prevent and reduce the risk of spreading infection.
- There had been three cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and 23 cases of Clostridium difficile (C.difficile) infection between April and October 2016. Of these, no risk factors or significant lapses in the quality of care provided had been identified.
- Without exception patients were treated with kindness, compassion, dignity and respect throughout all of the services we inspected and feedback from patients, families and carers was consistently positive about the way staff treated them.

We saw several areas of outstanding practice including:

- A medicines compliance review service was available on referral by a health or social care professional for patients who were finding it difficult to manage their medicines due to poor memory, lack of dexterity or swallowing difficulties.
- In addition to the Macmillan specialist palliative care team (SPCT), there was a Macmillan support team. The Macmillan support team was part of a two year pilot which had been brought about because of a lack of provision for patients whose needs were not complex enough to warrant support from the Macmillan SPCT. This enabled patients with cancer to access Macmillan support.
- The end of life service had three virtual hospice beds within the provider's nursing home. This enabled patients to access respite care 24 hours a day, seven days a week.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The Macmillan support team had a 'sparkling moments' book, in which they recorded their positive experiences of palliative and end of life care. Although they used this to evidence where they had met their key evaluation points set by the clinical commissioning group (CCG) they also found this a useful exercise to provide positive reflection for the team.
- Nottingham CityCare Partnership along with Nottingham City CCG and Nottingham City Council had won the Health Service Journal 'Improved Partnerships between health and local government' award in November 2016. The provider had been recognised for their work in the city's integrated care programme which aims to provide seamless care for people as well as keeping more people healthier in the community and out of hospital.
- In the NHS urgent care centre the medical director had developed an application which allowed staff to review an anonymised patient record, reflect on the notes and automatically produced a scoring system to highlight areas of good practice. This provided clinical staff with an effective way to self and peer review their decision making, treatment plans and record keeping. This application had been introduced over the last six months and had been utilised voluntarily 42 times by staff (by some staff multiple times) and the final scoring could also be used in appraisals, for development and good practice was celebrated.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Overall, we rated the safety of the services as good.

Our key findings were:

- Openness and transparency about safety was encouraged across the organisation. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Staff we spoke with across the organisation had a good understanding about duty of candour. Staff talked of being open and honest when things went wrong and were able to give example of where duty of candour had been applied appropriately.
- There was a good understanding of safeguarding children and adults amongst staff. Staff were proactive in their approach to safeguarding and were focussed on early identification. However, not all staff had received training in safeguarding children and vulnerable adults at a level appropriate for their role.
- Staffing levels were generally able to meet the needs of patients, although there were some vacancies in the community adults and children, young people and families services. In the urgent care service there had been significant investment in agency staff to temporarily increase staffing levels to a safe level to meet demand in a more timely way. This had made a positive difference on meeting demand and managing workload.
- Systems, processes and standard operating procedures in infection prevention and control were reliable and appropriate to keep patient's safe. Staff demonstrated a good understanding of infection prevention and control and throughout the organisation we observed staff to be compliant with best practice guidelines to prevent and reduce the risk of spreading infection.

Are services effective?

Good

Overall, we rated the effectiveness of the services as good.

Our key findings were:

Summary of findings

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Multidisciplinary (MDT) working was well established across the organisation. We noted MDT and partnership working with external providers and stakeholders was particularly good.
- With the exception of the end of life care service, information about care and treatment, and outcomes, was routinely collected and monitored and information was used to improve care. Outcomes for patients were mostly positive, consistent and met expectations.
- Staff had a good understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Are services caring?

Outstanding 

Overall we rated the caring for the services in the organisation as outstanding.

Our key findings were as follows:

- Feedback from patients, relatives, carers, children, young people and their families was consistently positive about the service they had received from CityCare staff.
- There was a strong, visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity.
- Patients were treated with dignity, respect and kindness during all interaction with staff. Patients felt supported and told us staff cared about them.
- In the NHS Friends and Family Test (FFT), 93% of patients said that they were likely or extremely likely to recommend the service they had used to their family and friends

Are services responsive to people's needs?

Good 

Overall we rated responsive for the services in the organisation as good.

Our key findings were as follows:

- Services were planned around the needs of individual patients.
- The urgent care centre was providing a responsive service. Between July and November 2016 it met targets in respect of patients being seen and having their treatment completed within four hours.

Summary of findings

- There were a range of services offered to vulnerable groups. These included for example, specialist dementia nurses and a medicines compliance review service.
- Patients were supported to raise concerns, complaints and compliments.

Are services well-led?

Outstanding ☆

Overall we rated the leadership in the service as outstanding.

Our key findings were as follows:

- There was a clear vision and set of values which staff understood.
- The organisation had a strong focus on quality and safety and providing services that met the local needs of patients. Throughout the inspection we saw how patient safety was at the forefront of the agenda.
- There was a robust governance structure in place which included the board taking overall responsibility for the strategic direction, governance and performance of the organisation.
- The executive team were aware of the key quality and performance issues the organisation faced.
- Risks to quality were considered, monitored and managed at every level of the organisation. Organisational and service risks were reviewed quarterly at board and at regular intervals at its delegated committees and groups in various formats. We found risks were identified and mitigating actions were in place.
- We found examples of good leadership at all levels of the organisation. Staff felt supported and well led.
- The organisation had different methods in place to obtain feedback from patients and we saw examples of how they had changed services to meet the needs of local populations.
- The organisation was committed to being part of the health and social care system within Nottingham and worked effectively with other partners to support the effective use of resources across the system.

Summary of findings

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection.

Team Leader: Michelle Dunna, Inspector, Care Quality Commission

The team included CQC inspectors, members of the CQC medicines team and a variety of specialists including:

A Resuscitation and Clinical Skills Manager, Physiotherapist, Community Matron, Equality and Diversity Lead, Health Visitor and Director of Nursing.

The NHS Urgent Care Centre was inspected as part of this inspection by our Primary Medical Services and Integrated Care team. The team included two CQC inspectors, a GP specialist adviser, and a practice nurse specialist adviser.

Why we carried out this inspection

We carried out an announced inspection of Nottingham CityCare Partnership as part of our programme of comprehensive inspections of independent community health services.

How we carried out this inspection

We inspected this service in November and December 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We met with the organisations executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades. Prior to the visit, we held six focus groups and during the inspection a further focus group with a range of staff who worked within the service. We visited many clinical areas and observed direct patient care and treatment including in patient's own homes. We talked with people who use services. We observed how people were cared for, talked with carers and family members, and reviewed care or treatment records of people who used services.

Information about the provider

Nottingham CityCare Partnership are a community social enterprise caring for patients across a wide range of services, in home settings or close to home in community settings such as health centres, schools and GP surgeries and in an urgent care centre. It covers the city of Nottingham and also provides a school age immunisations programme in the city of Derby. The organisation employs approximately 1800 staff and serves a population of almost 312,000.

Summary of findings

A social enterprise is a business that trades to tackle social problems improve communities, people's life chances, or the environment. Social enterprises reinvest their profits back into the business or the local community.

Nottingham CityCare Partnership deliver approximately 60 Commissioned NHS, Local Authority Public Health services including, community nursing and home-based rehabilitation services for older people, long term conditions management, an urgent care service, falls and bone health, reablement and specialist teams including an integrated respiratory service, diabetes, end of life, stroke and speech and language therapy (SALT). Services for children, young people and families include education for young families, health visiting, the community public health 5-19 service (formerly known as school nursing service), the behavioural emotional health team and family nurse partnership.

Nottingham CityCare Partnership was formed in March 2011 and has two registered locations: Headquarters and NHS Urgent Care Centre. The NHS Urgent Care Centre was inspected as part of this inspection by our Primary Medical Services and Integrated Care team.

The organisation is in receipt of an annual income of approximately £66.5 million, with the main purchaser of services being NHS Nottingham City clinical commissioning group (CCG).

What people who use the provider's services say

The NHS Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Between November 2015 and October 2016 Nottingham CityCare Partnership scored an average of 93% for patients who said that they were likely or extremely likely to recommend the service they had used to their family and friends. Scores were slightly worse than the England average of 95%.

Nottingham CityCare Partnership carried out two main surveys that were used to gather feedback from patients and services users. The neighbourhood team survey and the main satisfaction survey, which was used to gather feedback from people experiencing other CityCare services. For July to September 2016, overall satisfaction within the main satisfaction survey was rated at 94%. This was based on people selecting 'excellent' or 'good' in response to the question on the survey and exceeded the satisfaction target of 85%.

The neighbourhood team survey gathered feedback from people that had experienced community nursing, community matrons, community rehabilitation and falls and bone health, community beds and community urgent care services. The survey had been agreed with commissioners to enable people to feedback on a general experience of health and social care rather than on each specific service. This resulted in the satisfaction levels being lower than for specific service feedback. For July to September 2016, overall satisfaction within the neighbourhood team survey was rated at 82%. This was based on people selecting 'excellent' or 'good' in response to the question on the survey and was slightly worse than the satisfaction target of 85%.

In the urgent care centre results from the satisfaction survey for July to September 2016, showed that patients were satisfied with their care, for example, 97% of patients felt involved in decision about their care, 96% of patients felt their particular needs had been met and 95% of patients felt they had been treated with dignity and respect during their visit to the centre.

We received 12 completed comments cards from patients as part of our inspection of the urgent care centre. All of the comment cards were positive about the service provided by the centre. Patients said that staff were polite, professional, understanding and helpful. Patients also said they felt listened to by staff and treated with dignity and respect.

Summary of findings

Good practice

- A medicines compliance review service was available on referral by a health or social care professional for patients who were finding it difficult to manage their medicines due to poor memory, lack of dexterity or swallowing difficulties.
- In addition to the Macmillan specialist palliative care team (SPCT), there was a Macmillan support team. The Macmillan support team was part of a two year pilot which had been brought about because of a lack of provision for patients whose needs were not complex enough to warrant support from the Macmillan SPCT. This enabled patients with cancer to access Macmillan support.
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- Nottingham CityCare Partnership along with Nottingham City CCG and Nottingham City Council had won the Health Service Journal 'Improved Partnerships between health and local government' award in November 2016. The provider had been recognised for their work in the city's integrated care programme which aims to provide seamless care for people as well as keeping more people healthier in the community and out of hospital.
- In the NHS urgent care centre the medical director had developed an application which allowed staff to review an anonymised patient record, reflect on the notes and automatically produced a scoring system to highlight areas of good practice. This provided clinical staff with an effective way to self and peer review their decision making, treatment plans and record keeping. This application had been introduced over the last six months and had been utilised voluntarily 42 times by staff (by some staff multiple times) and the final scoring could also be used in appraisals, for development and good practice was celebrated.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure all staff receive training in safeguarding children and vulnerable adults. The training must be at an appropriate level for the role and responsibilities of individual staff.
- The provider should ensure there is an audit trail of blank prescriptions in line with national guidance (NHS Protect Security of prescription forms August 2013).
- The provider should ensure they continue the development and publication of the strategy and strategic objectives for end of life services.
- The provider should ensure community 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms are audited in order to provide assurance they are being appropriately completed and monitored.
- The provider should ensure minutes are maintained to provide an audit trail of the discussions and outcomes of strategic meetings in the end of life care service.
- The provider should ensure staff in the community health services for adults service understand why processes have changed to improve patient care.
- The provider should ensure staff in the community health services for adults service adhere to best practice guidelines in regard to code of dress when undertaking any clinical duty.
- The provider should ensure essential training for staff in the community health services for adult's service meets its own compliance level of 90%.

Summary of findings

- The provider should ensure self-management plans in the community health services for adults service are reviewed on a regular basis for patients with chronic diseases to ensure they reflect current guidance.
- The provider should ensure patient pathways in the community health services for adults service do not experience avoidable delays.
- The provider should ensure staff in the children, young people and families service receive an annual appraisal.
- The provider should consider the use of a safety performance dashboard related to end of life care in order to capture safety outcomes for patients receiving end of life care.
- The provider should consider the risks associated with the lack of service level agreement between the provider and the specialist palliative care unit for providing out of hours advice and guidance about symptom control.
- The provider should consider standardising systems used to resolve issues across adult community care delivery groups.
- The provider should consider reducing the number of multiple paper records for patients receiving care from more than one adult community team.

Nottingham Citycare Partnership CIC

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Overall, we rated the safety of the services as good.

Our key findings were:

- Openness and transparency about safety was encouraged across the organisation. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- Staff we spoke with across the organisation had a good understanding about duty of candour. Staff talked of being open and honest when things went wrong and were able to give example of where duty of candour had been applied appropriately.
- There was a good understanding of safeguarding children and adults amongst staff. Staff were proactive in their approach to safeguarding and were focussed on early identification. However, not all staff had received training in safeguarding children and vulnerable adults at a level appropriate for their role.
- Staffing levels were generally able to meet the needs of patients, although there were some vacancies in the community adults and children, young people and families services. In the urgent care service there had been significant investment in agency staff to temporarily increase staffing levels to a safe level to meet demand in a more timely way. This had made a positive difference on meeting demand and managing workload.
- Systems, processes and standard operating procedures in infection prevention and control were reliable and appropriate to keep patient's safe. Staff demonstrated a good understanding of infection prevention and control and throughout the organisation we observed staff to be compliant with best practice guidelines to prevent and reduce the risk of spreading infection.

Our findings

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- CityCare had a duty of candour policy in place to improve the quality and consistency of communication when incidents involving patients, staff or visitors occurred and/or in situations which gave rise to complaints. The policy provided guidance on ensuring the requirements of the duty were met. The organisation's electronic incident reporting system incorporated a duty of candour element and prompted staff to offer an open and honest explanation to patients if an incident had affected patient care.
- Training for staff was provided at induction and for existing teams through the quality and safety team trainer.
- Staff we spoke with, across the organisation, had a good understanding about duty of candour. Staff talked of being open and honest when things went wrong. Staff were able to give examples of where duty of candour had been applied. In the end of life care service staff told us that it had recently been applied to a serious incident that was being investigated at the time of our inspection.
- Ten pressure ulcer related incidents were identified as meeting the duty of candour criteria between 1 April 2016 and 30 June 2016. An audit of these showed verbal apologies had been recorded in most instances although in some cases there was evidence of the patient being informed but no direct reference to a verbal apology being made. Direct action was taken to rectify this.
- The organisation recognised the duty of candour was a statutory requirement and had identified it as a risk on their corporate risk register with a series of controls to mitigate risk in place.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse. Safeguarding policies were available for all staff and the director of nursing and allied health professionals was the professional lead for safeguarding within the organisation.
- All staff we spoke with had an understanding of how to protect patients from avoidable harm. We spoke with staff who could describe what safeguarding was and the process for referring concerns. Staff were able to give examples of where they would raise safeguarding concerns and were able to tell us about concerns they had raised in the past.
- Safeguarding training was mandatory for all staff and included as part of their essential training. The required level of safeguarding training had been clearly identified for the different staff groups across the organisation. Data, received following our inspection, indicated compliance was low, with performance worse than the organisations own target of 90%. For example, the percentage number of staff in date with safeguarding training as of November 2016 was as follows: safeguarding children (level two) 60% and safeguarding adults (level two) 48%. However, 97% of staff had attended a safeguarding adults awareness course.
- The organisation had recognised compliance with safeguarding training across the workforce was not being achieved in some areas and had identified it as a risk on their corporate risk register with a series of controls to mitigate risk in place. Controls included for example, regular meetings with workforce departments to review compliance and attendance, reporting to the executive board all essential safeguarding training, establishing a task and finish group to review training and an increase in training sessions.
- In addition to this safeguarding compliance had been raised through the organisation's quality and safety group and was an agenda item at executive board meetings. A safeguarding training compliance action plan was in place and demonstrated a month on month improvement in compliance figures. For example, between September and November 2016 there had been a 11% increase in the number of staff up to date with level two safeguarding adults training.
- The organisation's policy was that health visitors received safeguarding supervision which was undertaken with a member of the safeguarding team. Between April 2016 and September 2016 100% of health visitors received appropriate safeguarding supervision. However the number of support staff who received safeguarding supervision was not compliant at 60%.
- The safeguarding team provided safeguarding supervision. In addition to this the organisation provided restorative supervision.

Good

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Incidents

- An incident reporting and learning policy and procedure was in place. The policy and procedure provided a framework for reporting and managing all incidents and near misses which affected patients, staff, visitors, students and contractors. The policy and procedure provided clear guidance for staff on the processes and expectations in relation to incident reporting and learning and included; the process for reporting incidents, the process for investigating incidents, open and honest communication including duty of candour requirements and the process for shared learning.
- The organisation had an electronic incident reporting system. During the period, 1 November 2015 to 31 October 2016, CityCare reported 1470 clinical and 239 non-clinical incidents through the electronic reporting system. Of the clinical incidents 38.4% resulted in no harm, 50.7% resulted in low harm and 10.7% in moderate harm. Incidents resulting in death accounted for 0.2% of all incidents.
- Openness and transparency about safety was encouraged across the organisation. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and where incidents had been raised actions were taken to improve processes.
- During the period July 2015 and July 2016 CityCare reported 198 serious incidents requiring investigation, as defined by the NHS Commission Board Serious Incident Framework 2013. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Of these, two occurred in children, young people and families services and the remainder in adult services. The majority of serious incidents related to pressure damage.
- CityCare had not had any never events for the year preceding our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There was a system in place for investigating serious incidents using root cause analysis methodology. Incident reports that we examined were detailed and demonstrated a robust investigation had taken place. All incident investigations outlined areas for learning. Our inspection teams saw examples of changes that had been introduced as a result of learning from incidents. However, we saw little evidence of how lessons learned would be disseminated wider than the immediate team except through team meetings.
- There was a clear governance structure for monitoring incidents. Incidents were reported through the quality and safety group chaired by the director of nursing and allied health professionals. A monthly incident report was submitted to the board and incidents were reviewed quarterly to identify themes and trends.
- The organisation had signed up to the Sign up to Safety campaign. This is a national patient safety initiative designed to help the NHS, and organisations delivering NHS care, and their staff improve the safety of patient care.

Medicines management

- Arrangements for managing medicines kept patient's safe.
- Departments could order medicines from an agreed list. They were supplied by an external pharmacy. We saw that the medicines management team had recently carried out audits in clinics and departments, and the results had been used to improve the safe and secure storage of medicines. The medicines we checked were securely stored and in date.
- Independent nurse prescribers were supported by a regular review of their prescribing data and attendance at a quarterly non-medical prescribers forum. A recent forum had focussed on antibiotics to encourage prescribing in line with local antimicrobial guidelines.
- The provider used a range of Patient Group Directions (PGDs). A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. We saw that many of the PGDs were out of date and were not in use. The provider told us that the PGDs were developed in conjunction with other local healthcare organisations and they could not review and reissue them in isolation.

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

The main impact was in the urgent care centre; however staff told us that this did not affect patient care as there was always someone available to issue a prescription to people who needed a medicine.

- There was a system for receiving, distributing and acting on medicines safety alerts. Medicines incidents and near misses were recorded and refresher training was provided where necessary.
- Blank prescriptions for use by the services were stored securely and staff signed for their prescription pads. However, in the urgent care centre and continence service there was no system to track prescription forms throughout the centre. Staff told us that they were in the process of developing a system.
- Patients who were identified as being at risk of readmission to hospital due to a problem with their medicines could be referred to a pharmacist for a telephone consultation. The pharmacist checked that the person understood which medicines they should be taking, for example they would make sure that the person had not re-started taking a medicine which had been discontinued by the hospital doctors. The pharmacist could also check that the patient's GP had current information on what they should be prescribing for the patient.
- Prescribing guidelines were reviewed and approved by the Clinical Effectiveness Group.

Safety of equipment and facilities

- We found electrical testing and equipment maintenance was up to date in the areas we inspected. Equipment had visible safety tested stickers to inform staff when it was last maintained according to manufacturers' instructions which ensured it was safe to use.
- CityCare had a contract with an external provider for the ordering and provision of equipment and staff confirmed equipment was usually readily available. In the end of life care service staff told us they were able to arrange for same day and urgent delivery of equipment for patients who were being discharged home for their end of life care.
- The provider used syringe drivers for patients who required a continuous infusion to control their symptoms and those met the current NHS Patient Safety guidance.
- In the urgent care centre there were up to date fire risk assessments and we saw regular fire alarm checks had been carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The centre had other risk assessments in place to monitor safety of the premises such as legionella.

Records management

- Individual care records were written and managed in a way that kept patients safe. Our inspection team found patient records were accurate, complete, legible, up to date and stored securely.
- Nottingham CityCare Partnership had reported one Level two information governance incident to the Strategic Executive Information System (STEIS). The incident occurred in October 2016 and involved patient identifiable information of approximately 40 patients being stolen from the boot of a staff member's car. We saw, the incident was appropriately investigated using root cause analysis methodology, all patients visited by the staff member since January 2016 were contacted by letter stating the details of the incident providing an apology and contact details if any of the patients affected wanted to ask any further questions and lessons learned and future recommendations had been agreed.
- Information governance training was mandatory and we reviewed training information, which demonstrated 81% of staff across the organisation were in date with information governance training against a target of 90%.
- The NHS Information Governance Toolkit measures organisation's performance against 39 requirements relating to overall information governance, and on confidentiality, information security, data quality and records management. CityCare's information governance assessment report overall score for 2015/16 was 77% and was graded green (satisfactory).

Cleanliness and infection control

- Nottingham CityCare Partnership had a five-year infection prevention and control (IPC) strategy to assist the organisation in meeting their commitment to delivering high quality safe care and prevent patients suffering avoidable harm as a result of IPC related issues. The strategy outlined how, over a period of five years, IPC risks would be managed and considered in relation to other areas of risk across the organisation. The strategy comprised of three strategic aims and three strategic objectives and detailed the actions required to ensure objectives were met by 2020.

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- The organisation had an IPC team who were committed to improving the quality of care for patients to ensure better outcomes. In line with the organisation's infection prevention and control strategy, the aim was for no individual to develop a preventable infection. The infection prevention and control programme of work included antibiotic stewardship, clean safe environments and having a zero tolerance to avoidable infections. The head of IPC was part of the organisations quality and safety group and reported directly to the director of nursing and allied health professionals.
- IPC was included within the director of nursing and allied health professionals monthly board reports as well as a quarterly healthcare-associated infection (HCAI) report submitted to the board and inclusion in the organisation's annual infection prevention control report that was submitted to the board.
- The IPC service was a jointly commissioned service by the local authority and Nottingham City clinical commissioning group (CCG) and provided advice and support to CityCare and to independent contractors working within Nottingham City.
- A population based target of zero tolerance to avoidable infection had been set nationally for Nottingham City CCG. There had been no cases of MRSA bacteraemia for the reporting period April 2015 to March 2016 and three cases between April and October 2016. All MRSA bacteraemia were provisionally assigned to Nottingham City CCG. CityCare's IPC service worked collaboratively with Nottingham City CCG to complete a mandatory post infection review (PIR) of all three cases. The outcomes of two PIR's identified no lapses in care by CityCare and both MRSA bacteraemia had been deemed 'unavoidable'. The third PIR was currently in progress at the time of our inspection.
- A population based target of no more than 51 cases for Clostridium Difficile (c.difficile) infection had been set nationally for Nottingham City CCG for April 2015 to March 2016 and remained the target for 2016/17. During 2015/16 there had been 38 c.difficile cases assigned to Nottingham City CCG. Following PIRs of all cases 34 were deemed unavoidable and of the four 'avoidable cases none had identified a lapse in care by CityCare. Between April and October 2016 there were 26 cases assigned to the CCG and 23 case reviews undertaken. The reason for less case reviews was that root cause analysis investigations had been completed for two of the cases and at the time of our inspection one case review hadn't been completed as the IPC Team were awaiting information from the GP about the case.
- In order to gain assurance of IPC practice across the organisation CityCare had revised their process of auditing IPC practice and integrated it within the organisation's existing programme of clinical peer review visits to enhance observation of clinical practice. Latest audit findings highlighted that staff required additional support and clarity around the appropriate use of gloves and cleansing of hands. The IPC lead told us this process was to continue during 2016/17.
- As part of the national 'sign up to safety campaign' sepsis had been identified as one of the key areas on which to focus patient safety efforts, in particular in patients with chronic wounds and those with long term in-dwelling catheters. The organisation's aim was to ensure all patients with chronic wounds and those with in-dwelling catheters had their risk factors for severe infection identified and actions put in place to mitigate the risks by 2018. Recent collaborative work with a local NHS trust had identified areas in which the organisation needed to focus in order to meet their aim. For example, increased education for staff across the organisation and neighbouring independent healthcare providers.
- There were infection prevention and control policies in place to provide clear guidance and standards in IPC for all CityCare staff. Throughout the organisation we observed staff to be compliant with best practice guidelines to prevent and reduce the risk of spreading infection.

Mandatory training

- All staff were required to complete elements of statutory and essential learning when they started working for Nottingham CityCare Partnership. Training was completed annually or every three years thereafter dependent upon the subject.
- The organisation overall compliance rate for statutory and essential learning was 88% and in line with their target of 90%.

Staffing

- The organisation had a two-year workforce strategy setting out the steps that CityCare would take over the next few years to ensure its workforce were equipped to deliver CityCare's vision. The workforce strategy was

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

supported by a workforce plan overseen by the human resources (HR) department. The workforce plan focussed on six priority areas including for example, recruitment and retention. We looked at the workforce plan and found it to contain depth and rigour.

- Organisation wide staff turnover for the period January 2016 to December 2016 was 14.8%. Staff sickness levels for the same period were 4.8%.
- As of December 2016 staff vacancy rates across the organisation were 29.8 whole time equivalent (WTE) vacancies for qualified nurses, 19.3 WTE for allied health professionals (AHP) and 18.4 WTE vacancies for support staff. Vacancies for qualified staff had reduced by 40% since August 2016 where there had been 50 WTE vacancies.
- Most staff across the organisation told our inspection team they felt their caseloads were manageable and were able to deliver the standard of care they wanted to. However, some felt they got stressed sometimes because of the increasing number of visits they had to undertake but had developed personal time management plans to deal with this. All staff acknowledged they were busy at times. We did not receive feedback relating to concerns about staffing levels from patients, relatives or carers.
- Managers had oversight of health visitor's caseloads and all staff we spoke with told us their caseloads were manageable. Team coordinators held weekly meetings to ensure staff were supported and work was shared.
- In the urgent care centre there had been investment in agency staff to temporarily increase the staffing levels to a safe level to meet demand in a more timely way. For example; prior to May 2016 there had been a monthly average of 128 hours of advanced nurse practitioner cover allocated. From May until September 2016 there had been an average of 607 hours. Staff told us this had made a positive difference in meeting demand and managing workload. Longer term plans included the recruitment of eight nurse practitioners whose start dates had been staggered, with a full complement of staff due to be in place by February 2017.
- The organisation had developed innovative and varied recruitment methods which included the use of social media, the introduction of nursing associate posts as part of pilot led by a local NHS trust and involvement in regional work to look at rotational posts with local NHS trusts.

Major incident awareness and training

- The organisation had comprehensive business continuity plans which were available to staff electronically. There was also a major incident plan with clearly defined roles, responsibilities, and actions to be taken by the managers and staff at CityCare Partnership that were used to ensure an effective response to a major emergency.
- In June 2016 CityCare undertook a pandemic flu table top exercise which was attended by the chief executive, all directors, all assistant directors and a number of their integrated health and social care managers. In addition to this CityCare also took part in a six-monthly communications exercise run by NHS England to ensure their on-call communications and arrangements were working effectively.
- Staff attended prevent training once (this is awareness training and early identification of potential terrorist attacks). As of November 2016, 77% of staff were in date with this training which was worse than the organisation target of 90%.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Overall, we rated the effectiveness of the services as good.

Our key findings were:

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Multidisciplinary (MDT) working was well established across the organisation. We noted MDT and partnership working with external providers and stakeholders was particularly good.
- With the exception of the end of life care service, information about care and treatment, and outcomes, was routinely collected and monitored and information was used to improve care. Outcomes for patients were mostly positive, consistent and met expectations.
- Staff had a good understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Our findings

Evidence based care and treatment

- Evidence based practice was embedded throughout CityCare. Services followed national guidance and standards such as National Institute of Health and Care Excellence (NICE).
- A NICE guidance policy was available specifically aimed at team managers, heads of service and clinical leads to provide guidance on the arrangements for monitoring the implementation of NICE guidance within the organisation.
- There were a range of clinical policies and procedures in place for staff to follow which reflected current guidance. For example, NICE guidance on Pressure Ulcers (CG029), lipid modification ((CG181) and end of life care (NG31). Staff knew how to access policies and guidelines and they were readily available.
- NICE guidance and quality standards were reviewed by CityCare teams to ensure the care provided was based on the most current evidence to be safe and effective. By reviewing guidance teams could identify and communicate any changes to staff, ensure policies reflected current recommended practice, and make any required changes. The reviews were completed within three months of publication and this was monitored by the commissioners of the organisation as part of their contract monitoring.
- There was an organisation wide governance process to ensure policies and procedures were up to date and in line with best practice. We reviewed minutes from the integrated governance committee that demonstrated where national guidance and standards had been discussed.
- Nottingham CityCare Partnership had been involved in the development of the Nottinghamshire guidelines for care in the last year of life and this provided guidance for professionals employed by them. The guidance was based on national guidance such as the Leadership Alliance for the Care of Dying People (LACDP).

Nutrition and hydration

- The provider had achieved full accreditation under the Unicef Baby Friendly Initiative (BFI) in December 2014.
- Throughout community services, a national assessment tool was used to assess patient's nutritional status and identify when interventions were required.

Patient outcomes

- The provider had 12 Commissioning for Quality and Innovation (CQUIN) measures in place for 2016/17. CQUIN's are quality indicators agreed with commissioners and are designed to improve services. For 2015/16 and the first half of the year, April to September 2016, the provider achieved all of their CQUIN targets.
- In addition to externally agreed performance targets the provider had developed five priorities for quality improvement for 2016/17. Progress was monitored against these five areas and was reported through the governance process.
- The End of Life Care Audit: Dying in Hospital is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians, with additional funding provided

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by Marie Curie to assist with the sharing and usage of audit results for quality improvement purposes. As Nottingham CityCare Partnership was a Community provider, it was not required to contribute to this audit.

- The end of life care service collected data on the number of patients who achieved death in their preferred place. Between April 2016 and October 2016, 100% of patients who died, achieved death in their preferred place of care.
- The provider had completed 29 clinical audit projects between February and August 2016 and was undertaking approximately 95 clinical audit projects for adults at the time of our inspection. This included four national projects; cardiac rehabilitation, stroke, falls and fractured hips. A fifth was to be commenced in January 2017 for chronic obstructive pulmonary disease (COPD).
- An infection prevention audit in children's services had just commenced at the time of our inspection.
- There was a programme of clinical audit within the urgent care centre. The audits undertaken demonstrated improvements in quality and future audits were being planned following the first full year as an urgent care centre.
- In our inspection of the various services we found evidence that teams had acted upon audit findings to further improve patient's outcomes. However, in the end of life services we found the service had not participated in any national audits or benchmarking exercises. For example, there was no programme of audit in place for 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.
- The provider's falls team had been identified nationally as an example of good practice. Data from the falls and bone health service 2015/2016 showed a clear positive effect on falls and fracture reduction with a reduction of hospital admissions and attendances at the local accident and emergency department of 83%.
- There were a number of patient outcomes in the children, young people and families service which were monitored as part of national outcome measures and mostly met provider and commissioning targets.
- The urgent care service produced monthly monitoring reports of the activity undertaken and service delivered, which were shared with the Clinical Commissioning Group (CCG) who had agreed key performance indicators.
- Performance on meeting agreed targets had improved following an inspection of this service in May 2016 when we found the provider was regularly not meeting their targets for initial clinical assessment times and the completion of patients' treatment in four hours. However, as of November 2016 performance remained below an agreed target of 98% for triaging adults within 30 minutes of arrival (91%) and triaging children within 15 minutes of arrival (62%).
- The provider was actively involved in research. CityCare had recruited 52 portfolio study participants and 61 non-portfolio study participants to research studies during 2015/16. The 2015/16 research activity report presented by CityCare to the CCG, demonstrated; 21 projects had received approval.

Competent staff

- There were arrangements in place for supporting and managing staff. The learning needs of staff were identified through a system of appraisals, meetings and reviews of development needs. As of January 2017, 64.7% of staff had received an appraisal this figure was comparable to the same time the previous year. The provider told us this figure was expected to rise significantly in the three months following our inspection as there was a number of staff with appraisals expiring during this period.
- Staff had access to training to meet their learning needs and to cover the scope of their work. This included ongoing support, meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating doctors and nurses.
- From April 2016, all registered nurses were required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue to practice. The provider had a professional registration policy and procedure in place which was being updated to reflect the introduction of revalidation. The document was being completed during our inspection. Nurses we spoke with could demonstrate an understanding of the requirements needed for revalidation. Monthly training sessions provided by Nottingham CityCare Partnership were available for all nurses, bookable through a specific area on the provider's intranet. Monthly training sessions were also available for all managers of nurses as they needed to be confirmers for the process. Space had been created on the provider's intranet where documents relevant to revalidation were kept; this included a link to the NMC web site.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The end of life care team delivered a comprehensive rolling programme of end of life care training to the generalist district and community nurses. They also delivered training free of charge to general nursing and care staff working in care and nursing homes.
- Members of the medicines management team provided training on medicines administration for local care home staff which was available to all local care homes on an annual basis.

Multidisciplinary working

- The providers quality strategy 2016-2019 set out how the provider would use an integrated approach to healthcare based around the needs of patients. By working in partnership with commissioners, local acute and community NHS trusts, private providers, clinicians and the voluntary sector the provider aimed to 'join up' health and social care to meet the needs of an ageing population and transform the way that care was provided for people with long-term conditions, enabling people with complex needs to live healthier, fulfilling and independent lives.
- There were integrated community health teams in place in all services which brought together different disciplines of staff to meet patient's needs.
- During our inspection we saw an effective multidisciplinary team (MDT) approach to assessing, planning and delivering patient care and treatment; with involvement from all staff across the organisation.
- Staff worked in partnership with external healthcare providers, staff and agencies on a daily basis in order to improve patient care and outcomes.

Referral, transfer, discharge and transition

- There were processes for transferring children from health visitors to specialist community public health nurses. Transfer summaries were documented for children who were diagnosed with a medical condition, had safeguarding concerns or child in need concerns.
- There was good liaison between the community matrons who looked after patients with long-term conditions and end of life care services. These services worked together to ensure that patients were referred to end of life care services in a timely way.
- The provider worked closely with the local acute NHS Trust and worked collaboratively to assess and plan ongoing care and treatment in a timely way and to ensure appropriate plans were in place when people were being discharged from hospital to the community.
- The urgent care centre shared relevant information with other services in a timely way. For example, when patients were regularly attending the centre, or were referred to other services their GP would be informed to allow for additional support and continuation of care.

Availability of information

- Staff could access the provider's intranet which contained links to guidelines, policies and standard operating procedures and contact details for colleagues within the organisation.
- Information needed to plan and deliver care was available to staff in a timely and accessible way through an electronic patient record system. This included care and risk assessments, care plans, medical records and investigation and test results. Staff were very positive about its use because it created a single patient record that was accessible by all staff and aided communication between different professions including patients GPs.
- An electronic palliative care coordination system (EPaCCS) was used in the end of life service. This is an electronic computerised information system which contains essential information about patients who have been identified as being in the last year of life. All health care professionals involved in the patient's care could access the information including the local NHS ambulance trust. The EPaCCS provided information regarding the 'do not attempt cardiopulmonary resuscitation' (DNACPR) form, as well as the patient's wishes regarding being admitted to hospital and this information was available to the local emergency ambulance service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Mental Capacity Act policy in place in addition to consent to treatment and restraint policies. Staff across the organisation, demonstrated to us an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The electronic patient record system contained a prompt for staff to gain consent from a patient to share their records with other professions. Unless this was undertaken staff were not able to share records.
- Where relevant patients had access to independent support and advocacy services.
- Mental capacity and consent to treatment training was delivered as part of the mandatory training programme across the organisation. This was completed three-yearly and, as of September 2016, 76% of staff were in-date with this training.
- We reviewed a total of nine Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms and found eight of these to be fully completed. All but one DNACPR form had a documented assessment of the patient's capacity to make decisions.
- Staff working with children demonstrated a good understanding of Gillick competency and Fraser Guidelines. There are nationally recognised guidelines relating to the taking of consent from children.
- As a priority for quality improvement for 2016/17 the provider was developing a mental health strategy in recognition of the need to address both the mental and physical health of the local population. At the time of our inspection considerable work was underway with for example, developing a primary care mental health service (PCMHS) and training, strategy development and partnership working with the local authority and CCG.

Outstanding ☆

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Overall we rated the caring for the services in the organisation as outstanding.

Our key findings were as follows:

- Feedback from patients, relatives, carers, children, young people and their families was consistently positive about the service they had received from CityCare staff.
- There was a strong, visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity.
- Patients were treated with dignity, respect and kindness during all interaction with staff. Patients felt supported and told us staff cared about them.
- In the NHS Friends and Family Test (FFT), 93% of patients said that they were likely or extremely likely to recommend the service they had used to their family and friends.

Our findings

Compassionate care

- Without exception feedback from patients, relatives, carers, children, young people and their families was consistently positive about the service they had received from CityCare staff.
- Our inspection teams carried out a number of observations to monitor staff and patient interactions.
- Without exception, interactions were very positive and staff treated patients with kindness, dignity, respect and compassion.
- All staff we spoke with or observed in practice demonstrated that patient's; including, children and young people were at the heart of what they did.
- The NHS Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Between November 2015 and October 2016 Nottingham City care Partnership CIC scored an average of 93% for patients who said that they were likely or extremely likely to recommend the service they had used to their family and friends. Scores were slightly worse than the England average of 95%.
- Nottingham CityCare Partnership carried out two main surveys that were used to gather feedback from patients and services users. The neighbourhood team survey and the main satisfaction survey, which was used to gather feedback from people experiencing other CityCare services. For July to September 2016, overall satisfaction within the main satisfaction survey was rated at 94%. This was based on people selecting 'excellent' or 'good' in response to the question on the survey and exceeded the satisfaction target of 85%.
- The neighbourhood team survey gathered feedback from people that had experienced community nursing, community matrons, community rehabilitation and falls and bone health, community beds and community urgent care services The survey had been agreed with commissioners to enable people to feedback on a general experience of health and social care rather than on each specific service. This resulted in the satisfaction levels being lower than for specific service feedback. For July to September 2016, overall satisfaction within the neighbourhood team survey was rated at 82%. This was based on people selecting 'excellent' or 'good' in response to the question on the survey and was slightly worse than the satisfaction target of 85%.
- In the urgent care centre results from the satisfaction survey for July to September 2016, showed that patients were satisfied with their care, for example, 97% of patients felt involved in decision about their care, 96% of patients felt their particular needs had been met and 95% of patients felt they had been treated with dignity and respect during their visit to the centre.
- We received 12 completed comments cards from patients as part of our inspection of the urgent care centre and four in the adult service. All of the comment cards were positive about the services provided. Patients said that staff were polite, professional, understanding and helpful. Patients also said they felt listened to by staff and treated with dignity and respect.

Understanding and involvement of patients and those close to them

- Overall, patients understood and were involved in their care. We saw some excellent examples of how staff took time to communicate in a sensitive and unhurried way

Are services caring?

Outstanding ☆

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

to ensure patients could understand the information being given to them. Clear and simple language was used to explain the care to make sure patients understood what was happening and why.

- In the end of life care service patients who were approaching the end of life were offered the opportunity to create an advance care plan, including preferred priorities for care and an advance decision.
- In the children, young people and families service staff worked in partnership with children and young people to find ways to provide care that they would engage in. We observed a member of staff sensitively encouraging a young mother who had moved to England from another country to engage in a clinic or group to enable her to makes some friends.
- Feedback from patients, across the services, demonstrated that they felt involved in decision making about the care and treatment they received. Patients told us they felt listened to, were made to feel at ease and were well supported by all staff.

Emotional support

- Without exception, across the organisation, patients who used services and those close to them received the support they needed to cope emotionally with their care, treatment or condition. Emotional support was tailored to each patient's individual set of circumstances and we saw that appropriate emotional support was provided.
- Young people in schools received timely emotional support, the specialist community public health nurses (SCPHNs) ran drop in sessions where young people could have support on any issues that were causing them to worry.
- In the end of life care service emotional support was provided to patients and their families through a variety of services, such as the end of life care team and in more complex cases, the Macmillan team. Bereavement support was also provided through a local day hospice and the service had the support of organisations from the voluntary sector.
- The urgent care centre identified carers and those that cared for patients during consultations and were able to signpost support if required. Clinicians were able to extend consultations if further time was required for emotional support.
- The urgent care centre was working collaboratively with the carers federation to deliver the 'you're welcome' and the 'first 15 steps' accreditation standards to enhance the patient experience.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Overall we rated responsive for the services in the organisation as good.

Our key findings were as follows:

- Services were planned around the needs of individual patients.
- The urgent care centre was providing a responsive service. Between July and November 2016 it met targets in respect of patients being seen and having their treatment completed within four hours.
- There were a range of services offered to vulnerable groups. These included for example, specialist dementia nurses and a medicines compliance review service.
- Patients were supported to raise concerns, complaints and compliments.

Our findings

Service planning and delivery to meet the needs of local people

- Services were planned around the needs of individual patients.
- The provider's diabetes team delivered a structured diabetes education programme for adults with type two diabetes (diabetics not on insulin) called 'Juggle'. This was tailored to the needs of individual communities in different settings including those with a hearing loss, people with a learning difficulty and those whose first language was not English.
- The provider worked with local service commissioners, including local authorities, GPs and other providers to co-ordinate care and integrate care pathways.
- Care was provided at a variety of locations across the geographical area within the urgent care centre, patient's own homes, doctor's surgeries, medical centres, and schools.
- CityCare were committed to building a healthier community through their 'make every second count' programme. This included a range of adult healthy lifestyle services designed to support adults when they had decided to make a change. Programmes included; smoking cessation, healthy eating and physical activity.

Meeting needs of people in vulnerable circumstances

- From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the accessible information standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services. CityCare had taken steps to address and embed this standard. An AIS task and finish Group made up of staff representatives from across the organisation was in place to lead developments for this standard. Accessible requirements were recorded to electronic systems in order that all staff were able to communicate in a way that was appropriate to each individual patient. Information leaflets were also available in an 'easy read' format.
- An accessible information and communication policy and standard operating procedure was in place to ensure that every individual receiving services from CityCare received the information they needed to access services in a format that was accessible to them and to have appropriate communication with CityCare staff to enable them to make informed decisions about their care and treatment.
- Nottingham had been recognised as a culturally diverse city. Interpreting services were readily available when required either by telephone or in person. The provider informed us they had 19 patient surveys from physiotherapy and occupational therapy services for adults from April 2016 to November 2016 returned where it had been definitely known that interpreters had helped patients to complete them. Data showed that a total of ten different languages had been spoken and the overall satisfaction had been 98%. No specific comments had been made for areas for improvement. The results had shown it was very similar to the English speaking patient survey results.
- Patient's with a learning disability would be assessed on individual needs and referred to other agencies if required to ensure support was allocated to the patient and family.
- Specialist dementia nurses were available across the organisation to give practical, clinical and emotional support to families living with dementia.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- The urgent care centre engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified, for example significant building work had been undertaken to the premises to ensure it was fit for purpose and had the capacity and layout to meet future demand.
- A medicines compliance review service was available on referral by a health or social care professional for patients who were finding it difficult to manage their medicines due to poor memory, lack of dexterity or swallowing difficulties. A pharmacy technician would visit the patient in their home and carry out a review to make sure the patient was getting the most from their medicines. The visit lasted 45 minutes during which the technician talked to the patient about their medicines, provided advice and support, and where appropriate offered aids to help the person manage their medicines. These could include devices to help instil eye drops, boxes to organise medicines into daily or weekly doses, and electronic displays which the team could programme to prompt a patient when it was time to take their medicines. Some of these devices were provided by the local authority. The team also worked in conjunction with the local authority to identify patients who would benefit from electronic medicine dispensers. Following the visit, the technician would prepare a report for the patient's GP to summarise their recommendations, for example asking them to prescribe liquid formulations for a patient with swallowing difficulties. A member of the team would telephone the patient after a few days to make sure they were able to use any equipment provided. One technician told us that during the consultation patients would mention other problems, so they would send them information on other services that were available to them.
- A prescription service for continence products such as catheters was available at a local health centre. A nurse would carry out an initial assessment and an annual review, and patients could request repeat prescriptions as needed. A nurse was available for advice, and the team had developed a range of information leaflets on relevant topics including constipation and wind.

Access to right care at the right time

- The urgent care centre was open every day from 7am to 9pm. Any member of the public who had an urgent, unplanned non-life threatening health need could access the service regardless of where they lived or where/whether they were registered as a patient.
- There was no waiting list for young people to access the youth offending team.
- Patients attending the continence advisory service were able to access advice and continence products between 8.30am and 5.30pm Monday to Friday.
- The end of life care service collected data on the number of patients who achieved death in their preferred place. Between April 2016 and October 2016, 100% of patients who died, achieved death in their preferred place of care.
- The provider monitored response times. In adult services, between April 2016 and December 2016, the organisation responded to 90% of acute requests within three hours of referral. For referrals that were classed as urgent and requiring a visit within 72 hours their overall performance for the same period was 90%.
- The urgent care service produced monthly monitoring reports of the activity undertaken and service delivered, which were shared with the Clinical Commissioning Group (CCG) who had agreed key performance indicators (KPI). From July to October 2016, 98% of patients were seen and had their treatment completed within four hours. This met their agreed KPI.

Learning from complaints and concerns

- CityCare had an up to date management of concerns and complaints policy and procedure available on their intranet. The policy and procedure provided guidance and standards for the handling of informal and formal complaints relating to the organisation.
- There was a clear explanation about how to make a complaint or compliment by email or telephone about care on the provider's web site. There was also information about independent support and advice as well as links to referring complaints to the parliamentary and health service ombudsman (PHSO). Patients also had access to this information in the form of a leaflet.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- From 1 April 2015 to 31 March 2016, CityCare received 54 formal complaints in total. 23 complaints were handled by CityCare directly and 31 by other agencies, primarily Clinical Commissioning Groups (CCGs). The highest number of complaints related to the adult service.
- During our inspection of all services we saw evidence of lessons learnt and action taken to improve services.
- When a complaint was raised with a member of CityCare staff, either directly within the service or through the customer care team, the provider's aim was to resolve the issue as soon as possible in a way that was acceptable to the complainant. If the issue could be resolved quickly (usually within 2-3 days) by a telephone call from the manager of the service to the complainant this would be logged as a concern. 50 concerns were resolved in this way in 2015/16.
- A monthly summary of patient experience data, including complaints and concerns, was presented to the quality and safety group. This included any learning identified that could be shared across the organisation. A summary of complaints data was also provided quarterly to commissioners as part of the CityCare contract monitoring. A quarterly patient and public engagement report including a summary of complaints was also provided to the integrated governance committee and the board.
- We reviewed five complaints and saw they had been managed appropriately and according to the organisation's policy. In all five complaints we saw where people were treated compassionately and supported with their complaint. Complaint investigations were carried out in an open and transparent manner by a nominated 'investigating officer' and all complaint responses offered an apology. All five complaints demonstrated good practice in line with the Health and Parliamentary Services Ombudsman (PHSO) principles of good complaint handling.
- Where appropriate, complaints files included a record of actions taken as a result. For example, as a result of one complaint the organisation now documented the complainants preferred method of contact on the patient's electronic care record.
- As part of the national Health Foundation funded 'Speaking Up' project the Patients' Association developed tools aimed at improving the quality of complaints handling. They developed and piloted a peer review process to provide qualitative and quantitative feedback, highlighting areas of positive performance and areas for improvement. In 2015/16, CityCare worked with a local community NHS trust to develop a local peer review process based on the national pilot. This was now fully operational, with a peer review panel taking place quarterly.
- Patient stories were heard by the board, led by the provider's public and patient engagement officer. During the year preceding our inspection a number of patients from different services

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Summary of findings

Overall we rated the leadership in the service as outstanding.

Our key findings were as follows:

- There was a clear vision and set of values which staff understood.
- The organisation had a strong focus on quality and safety and providing services that met the local needs of patients. Throughout the inspection we saw how patient safety was at the forefront of the agenda.
- There was a robust governance structure in place which included the board taking overall responsibility for the strategic direction, governance and performance of the organisation.
- The executive team were aware of the key quality and performance issues the organisation faced.
- Risks to quality were considered, monitored and managed at every level of the organisation. Organisational and service risks were reviewed quarterly at board and at regular intervals at its delegated committees and groups in various formats. We found risks were identified and mitigating actions were in place.
- We found examples of good leadership at all levels of the organisation. Staff felt supported and well led.
- The organisation had different methods in place to obtain feedback from patients and we saw examples of how they had changed services to meet the needs of local populations.
- The organisation was committed to being part of the health and social care system within Nottingham and worked effectively with other partners to support the effective use of resources across the system.

Our findings

Vision and strategy

- Nottingham CityCare Partnership had a clear vision and a set of values which demonstrated quality and safety were their top priorities. As a community health services provider, dedicated to improving long-term health and wellbeing, their vision was to build healthier communities through the delivery of a range of healthcare services tailored to the needs of local people. Underpinning the overall vision was a three-year quality strategy and four values: Integrity, Expertise, Unity and Enterprise.
- Without exception, staff were passionate about their work and knew about the organisation's vision, values and strategy and what it meant to them. We found it was publicised across the organisation and observed staff at all levels displaying the CityCare values in their day to day work.
- CityCare's aim was to be an employer of choice and recognised as one of the best providers nationally. The organisation had recognised high quality patient centred healthcare could only be delivered if staff were committed, skilled and highly engaged, worked in effective, well-led teams and felt valued.
- The provider had a number of strategies, such as a quality, risk management, workforce and equality and diversity. In addition to the strategies, there was a business plan for 2016/17. The plan focused on five priorities for quality improvement. The providers quality strategy 2016-2019 set out how the provider would use an integrated approach to healthcare based around the needs of patients.
- The urgent care centre had been through service reconfiguration which had resulted in changes to way services were delivered. The leadership team spoke about their actions to help staff feel supported through change.
- CityCare operated within a wider health and social care economy working with clinical commissioning groups, the local authority, local NHS acute and community trusts, private providers, clinicians and the voluntary sector. Its main purchaser of care was NHS Nottingham City clinical commissioning group (CCG). Information received prior to the inspection suggested the provider was well respected by the CCG.
- The organisation was involved in the development and delivery of the Sustainability Transformation Plan (STP) for Nottinghamshire. An STP is a five-year plan for the future of health and care services in local areas. attended the board meeting and shared their story whether this was negative or positive. The board were fully engaged and considered patient stories to be an important agenda item, helping them to better understand the impact delivery of care and decision making had on the local population.

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Governance, risk management and quality measurement

- The organisation had a strong focus on quality and safety and providing services that met the local needs of patients. Throughout the inspection we saw how patient safety was at the forefront of the agenda.
- CityCare had a robust governance structure that included the board taking overall responsibility for the strategic direction, governance and performance of the organisation.
- A range of sub-groups were in place chaired by either executive, assistant or non-executive directors. Sub-groups reported regularly and had governance structures in place in order to provide assurance to the board.
- From our interviews with the senior and executive leaders within the organisation, we could see they were aware of the key quality and performance issues the organisation faced.
- There was a quality dashboard in place as a tool for the board to monitor performance. It provided a range of performance metrics for the provider board as well as giving information for individual clinical teams. The quality dashboard was developed in 2015 and the content was reviewed regularly by the quality and safety group to ensure the metrics remained relevant, linked to the risk register and could be used from service to board.
- The Board shared responsibility for leadership and challenge regarding quality improvement across the organisation and the two key areas in improving quality; Governance and Leadership.
- Risks to quality were considered, monitored and managed at every level of the organisation. The provider had a three-year risk management strategy which underpinned the quality strategy to ensure that all risks to the organisation were considered. Organisational and service risks were reviewed quarterly at board and at regular intervals at its delegated committees and groups in various formats. We found risks were identified and mitigating actions were in place.
- The Board Assurance Framework was merged within the organisations risk register. Strategic risks were identified and the board members told us they felt they were sighted on these.
- The organisation had been experiencing financial pressures and a recovery plan was in place. The executive directors told us historically the organisation had always been in a strong financial position but this had changed in the past year. They understood why these pressures had arisen and they were well sighted on the risks this presented and the importance of implementing their recovery plan.
- The board were sighted on risk and we found evidence of the non-executive directors providing challenge to the executive directors. Relationships between the non-executive directors and executive directors were described as positive and supportive.
- The provider had 12 Commissioning for Quality and Innovation (CQUIN) measures in place for 2016/17. CQUIN's are quality indicators agreed with commissioners and are designed to improve services. For 2015/16 and the first half of the year, April to September 2016, the provider achieved all of their CQUIN targets.

Leadership of the provider

- The executive team at Nottingham CityCare Partnership was made up of the chief executive (CEO), director of primary care, commercial director of finance, director of operations and transformation and the director of nursing and allied health professionals. The executive team was supported by a chair, non-executive director and staff board member.
- The executive team were responsible for strategic financial management and planning, strategic risk management, overall organisational development, staff development and the effective management and operation of all CityCare services, including compliance with required legislation and standards. The team worked collaboratively with local commissioners, strategic leaders and key healthcare and community partner organisations.
- The executive leadership team were stable. The chief executive had been in post since the formation of the community interest company.
- The executive team had a positive working relationship with the local health economy which centred on their culture of putting the patient first.
- We received many positive comments about the non-executive and executive leadership from staff at all levels in the organisation. Staff we spoke with were all encouraged by the attitude of the director of nursing

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and allied health professionals and felt they were easy to talk with and listened to what staff had to say. One staff member told us they were, "Like a breath of fresh air."

- The Chairman and Chief Executive had a good relationship and worked well together.
- The board had two vacancies for non-executive directors at the time of the inspection; however they were in the process of filling these vacancies.
- Local leadership within the core services we inspected was effective and staff felt supported by their leaders.

Culture within the provider

- The organisation described itself as a values driven, person-focused business, with a passion for excellence in care. The findings of the inspection concurred with this.
- A culture of putting the patient first was evident throughout the organisation. Generally staff spoke positively about the organisation. Executive leads described an open and transparent culture with “fantastic, amazing” staff with a “can do” attitude. Where services had been affected by service reconfiguration, such as the urgent care centre, executive leaders had ensured a high level of support and visibility. In addition the board held monthly Chief Executive briefings and monthly drop in sessions at different locations across the organisation to allow staff an opportunity to raise concerns.
- Teams, across the organisation, were supportive of each other and aware of the day-to-day challenges each other faced. In the end of life care service the Macmillan support team had a ‘sparkling moments’ book, in which they recorded their positive experiences of palliative and end of life care.
- CityCare were committed to ensuring all employees were treated with dignity and respect at work and not subjected to any form of unacceptable behaviour from colleagues. The organisation had a ‘zero tolerance’ to harassment and bullying. A dignity at work: prevention of bullying and harassment policy was in place to guide staff on the process to be followed where staff may be bullied or harassed by another CityCare employee.
- CityCare carried out a staff opinion survey between December 2015 and February 2016. The CityCare survey was advertised to all staff via an online Survey Monkey. The survey was matched to the national NHS Staff Survey which ran during the same time period and results published on the 23rd February 2016. The response rate in the staff survey was 36% (574 responses) and slightly worse than the national response rate of 41% and similar to the December 2014 to February 2015 survey where there were 589 completed surveys.
- CityCare performed similar or better than average, when compared to the scores for similar NHS Community Trusts in 15 of the 24 key findings in the NHS Staff Survey. This included communication between senior management and staff is effective, receiving regular updates on patient/service user experience feedback and my appraisal left me feeling that my work is valued by my organisation.
- Of the nine scores which were worse, when compared to the scores for similar NHS Community Trusts. There was just one area where the organisations score was significantly worse which was the percentage of staff responding; there are enough staff at this organisation for me to do my job properly. CityCare’s score was 43% with the community trust average being 50%.

Fit and proper persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. This regulation is in place to ensure senior directors are of good character and have the right qualifications and experience.
- There was a policy and procedure in place to ensure this regulation was consistently applied and adhered to.
- We looked at the files of six directors. The newer in post directors had all of the required checks in place which met with the requirements of the regulation. With the exception of the Chairman, all of the files indicated a disclosure and barring check had been undertaken.

Staff engagement

- Staff, across the organisation, told us they were encouraged to be involved in how services were delivered and were able to feedback any comments or concerns they had.
- A staff representative group; ‘CityCare Voice’ met monthly and reported directly to the board. CityCare Voice Ambassadors facilitated communication between staff and the senior management team. Voice ensured that every employee of CityCare had a voice. Voice members also supported staff experience by supporting initiatives and activities that helped create a positive working environment for staff. Examples included; a

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health and well-being package, an induction project for new staff and a webpage where staff could leave suggestions, ideas and general comments about CityCare and their services.

- Membership of the CityCare board included a 'staff board member'. Through attendance at board meetings, the staff board member represented the views of staff, provided challenge to the board on any decisions that might affect staff and reported to the board any reoccurring themes within the organisation.
- A staffside partnership committee met monthly and included directors and assistant directors. Chaired alternate months by the director of nursing and allied health professionals and staffside representatives it looked at any updates or business consultations.
- Twelve staff engagement events held between May and September 2016 ('We said we Did') were organised for all staff groups to address the results of the staff survey. A further 12 events were planned to follow results of the February 2017 staff survey.
- A training programme 'The Respect Campaign' brought together staff using group discussion and scenarios. This enabled staff to engage and understand what respect meant to staff at all levels of the organisation.
- The provider had a workforce strategy. The strategy was developed by staff across the organisation and confirmed the steps that CityCare would take from 2016-18 to ensure its workforce were equipped to deliver the vision of the organisation.
- A weekly staff newsletter 'Cascade' updated staff on organisation news including for example, patient satisfaction results, policy amendments or updates and workforce development.
- An external Employee Assistance Programmes (EAP) was readily available to all staff. EAP are intended to help employees deal with personal problems that might adversely impact their work performance, health and well-being.

Public engagement

- CityCare aimed to ensure that patient and public views and opinions were central to decision-making and evaluation of services.
- The provider gathered feedback from patient and service users in a variety of ways. For example, paper surveys, comment cards in health centres, telephone calls to the customer care team and on-line feedback. Feedback was summarised quarterly and presented to commissioners of the service and the executive board. Engagement with children and families was through the Small Steps Big Changes programme.
- CityCare had established Members Panel and Patient Experience Groups (PEG). The Patient Experience Group was chaired by a non- executive director and reported directly into the board. Feedback and opinions were used to inform service developments and ensure that patient views were considered throughout the organisation. A dedicated PEG focused on people with a learning disability.
- The PEG met six-weekly and had 15-20 members. PEG meetings included guest speakers on developments within healthcare that might influence the delivery of services at CityCare. For example the sustainability and transformation plans for Nottinghamshire. There was a dedicated board feedback session at every PEG meeting resulting in PEG members being more informed of board developments.

Equality and Diversity

- An equality, diversity and inclusion policy set out CityCare's responsibilities under the Equality Act 2010, The Human Rights Act 1998, the Public Sector Equality Duty, Equality Delivery System (EDS2) and national reporting requirements to provide staff at all levels with an understanding of the organisations and individuals responsibilities in relation to equality, diversity and inclusion.
- The leadership team at Citycare demonstrated they were meeting the objectives and promoting the values of the Workforce Race Equality Standard (WRES) with processes that promoted staff involvement and led to action plans which addressed causes of inequality. Board minutes we reviewed indicated regular discussions of the WRES were taking place and WRES requirements were embedded and reviewed appropriately.
- As part of our inspection we reviewed how well Citycare was adopting the WRES and working towards achieving workforce race equality. The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) are mandatory for NHS community providers, including those providing NHS services. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.

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- The organisation's WRES report for July 2015 was published on their website. As part of our inspection we reviewed the WRES report for May 2016 which showed 15.4% of staff employed within this organisation were from a visibly black and minority (BME) community background. This compared favourably with BME CityCare board representation at 14%. Data for May 2016 showed the organisation's workforce figure had increased slightly from 13.5% in July 2015.
- EDS2 looks at four goals (two patient focused and two workforce focused) with 18 outcomes within unfavourable treatment because of specified 'protected' characteristics. There are nine characteristics in total: Age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race including nationality and ethnicity, religion or belief, sex, and sexual orientation.
- In December 2015 CityCare held a grading event with various stakeholders in order to assess how well people from protected groups fared compared with people overall. There were 37 attendees including staff, patients, service users, carers and interested parties. The organisation performed well against the goals for most of the protected characteristic groups.
- CityCare had developed an action plan based on the goals of EDS2. The action plan was RAG rated and monitored through the equality and diversity group. Executive directors at CityCare were named for each of the EDS2 action plan goals to ensure strong leadership and clear ownership for taking actions forward. We reviewed the action plan during our inspection. Actions included for example, developing a template on the organisation's electronic patient record to improve data collection and updating the organisation's mandatory training data reporting system, to ensure equality of access to training and development opportunities for all staff with protected characteristics.
- CityCare had an equality and diversity group that reported directly to the board. The purpose of the group was to ensure compliance with the organisation's equality and diversity strategy and EDS2 action plan, share information and raise awareness of equality and diversity issues. The group was chaired by a non-executive director (NED) and included representation from 'front line' staff and team and senior managers within the organisation. A patient representative was also on the group.
- A 'clinical effectiveness' group screened and ratified all new patient information, policies and procedures to ensure they met EDS2 quality standards including the Accessible Information Standard (AIS). The AIS was implemented on 31 July 2016. The aim of the standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.
- All staff received awareness training in equality and diversity as part of their induction to the organisation.
- During our inspection we spoke with six BME staff. They all told us CityCare was a good organisation to work for and they felt the executive team demonstrated commitment to equality and diversity within the work place. Staff felt, previously, there had been limited opportunities for BME staff to progress in their career or development and BME staff often felt isolated and lacked confidence to 'speak out' about their concerns. All the BME staff felt the introduction of staff forums including a 'Race, Religion and Culture' group had given BME staff a 'voice' and the confidence to raise concerns.

Innovation, improvement and sustainability

- The organisation was involved in the development and delivery of the Sustainability Transformation Plan (STP) for Nottinghamshire. An STP is a five-year plan for the future of health and care services in local areas. The organisation was committed to being part of the health and social care system within Nottingham and working effectively with other partners to support the effective use of resources across the system.
- In the children young people and families service the senior team led the submission of an application and had been awarded a £45million Big Lottery Grant as part of a National Programme to test what works in the early years.
- In the adult service a holiday lunch club had been organised in the summer by the provider's public health nutrition team to provide physical and nutritional support as well as exercise to promote a healthier lifestyle. This had been supported by a large food supplier and feedback from the event had been very positive.

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- A medicines compliance review service was available on referral by a health or social care professional for patients who were finding it difficult to manage their medicines due to poor memory, lack of dexterity or swallowing difficulties.