Nottingham Citycare Partnership CIC

1-186610815

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-298791257	Headquarters	Community Health Services for Adults	NG1 6GN

This report describes our judgement of the quality of care provided within this core service by Nottingham CityCare Partnership CIC. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by Nottingham CityCare Partnership CIC and these are brought together to inform our overall judgement of Nottingham CityCare Partnership CIC

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Overall we rated community health services for adults as good.

We rated safe, effective, caring, responsive and well-led as good because:

- The service protected patients from avoidable harm and abuse.
- Staff understood their responsibility to report incidents and we saw evidence that actions were taken as a result of these.
- Staff anticipated and managed risks to patients who used services and had a good understanding of how to safeguard people from abuse.
- Clinic areas were visibly clean with staff demonstrating a good understanding of infection prevention and control.
- Staffing levels and caseloads were planned and reviewed on an on-going basis to ensure safe levels of care were provided.
- Care records were up to date accurate and legible.
- Care and treatment was planned and delivered in line with current evidence based guidance and standards and staff had the skills knowledge and experience to deliver effective care.
- Many referrals to the service were handled by a single point of access either by telephone or electronically.
- Most patients had a single electronic patient record which ensured all staff had access to information with multi-disciplinary and integrated care pathways in place.
- Multi-disciplinary working and integrated care pathways were in place.
- Staff demonstrated a good understanding of the Mental Capacity Act.
- Without exception feedback from patients was positive about the care and treatment they received. Staff showed consistent respect and compassion for patients and their relatives and involved them in the planning and delivery of care.
- Services were in the majority of cases planned and delivered to meet the needs of people with patients receiving 'joined up' care from different teams when appropriate.
- The provider had an overall vision with values that staff were aware of and demonstrated.
- There was positive feedback from staff about the director of nursing and allied health professionals who was visible and line managers were supportive to their staff.
- There was an effective governance structure in place and staff felt proud to work for the service.

However, we also found:

- Systems to resolve issues were not always standardised across community care delivery groups and staff did not always understand why processes had changed to improve patient care.
- In addition staff did not always adhere to best practice guidelines in regards to code of dress.
- Confusion could arise with the use of multiple paper records for patients receiving care from more than one community team.

Summary of findings

Background to the service

Nottingham CityCare Partnership CIC (community interest company) is a social enterprise which provides a range of NHS community health services for adults across Nottingham City in healthcare facilities and in peoples own homes. It is free at the point of delivery. 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. The service provision includes community nursing, diabetes, cardiac rehabilitation, acupuncture, physiotherapy clinics and treatment of leg ulcers and musculoskeletal disorders.

Community nursing teams provide care to patients from bases across Nottingham city. Clinics are held in buildings not owned by the provider such as health centres and GP surgeries.

As part of the inspection we visited:

- Community nursing teams at Strelley Health Centre, Mary Potter Health Centre
- Leg ulcer clinic and musculoskeletal clinic at Clifton Cornerstone
- Chronic Obstructive Pulmonary Disease (COPD) rehabilitation clinic at Meadows Health Centre
- Reablement team at Aspect House
- Continence advisory service at Sherwood Rise Health Centre
- St Ann's Valley Centre

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.

Why we carried out this inspection

We carried out an announced inspection of Nottingham CityCare Partnership CIC 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?

During our inspection, we spoke with members of staff including, community nurses, district nurses, community

Summary of findings

matrons, health care support workers, integrated care managers, integrated care team leaders, dieticians, physiotherapists, occupational therapists and administration staff. We observed care being provided both in clinics and in patient's homes. We spoke with 32 patients, 42 staff, and three relatives and reviewed 18 patient care records.

What people who use the provider say

All patients we spoke to in adult services in the community were very satisfied with the care and treatment they received. They said, "Lovely people", "They've been ever so good to me" and "I've had a good service."

Good practice

Nottingham CityCare Partnership along with Nottingham City clinical commissioning group (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.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should ensure staff in the community health services for adults service 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 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 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 records are kept of prescriptions issued to patients to ensure there is a robust audit trail.
- 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

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated community health services for adults as good for safe because patients were protected from avoidable harm and abuse.

We found:

- Staff understood their responsibility to report incidents; we saw evidence that actions were taken as a result of these.
- Staff had a good understanding of safeguarding and the actions they would take if a patient required safeguarding.
- Equipment was available for use in patients' homes and in clinic areas.
- Patients care records were up to date, legible, accurate and complete. They were stored securely.
- Staff anticipated and managed risks to patients who used services.
- The medicines management team provided a range of services to support people to take their medicines.
- Clinic areas were visibly clean and tidy and staff demonstrated a good understanding of infection prevention and control.
- Staffing levels and caseloads were planned and reviewed on an on-going basis to ensure safe levels of care were provided.

However, we also found:

- Systems put in place to resolve issues were not always standardised across community care delivery group and staff did not always understand why processes had changed to improve patient care.
- Staff did not always adhere to best practice guidelines in regard to code of dress when undertaking any clinical duty.
- There were no record kept of used prescriptions and therefore no audit trail.

Safety performance

- The provider's quality and safety dashboard was generated monthly and reviewed by the quality and safety group. It included clinical effectiveness, patient experience, patient safety and corporate governance.

Good

Are services safe?

Patient safety issues included medicines incidents and pressure ulcers (both avoidable and unavoidable). This was used as an improvement tool for measuring, monitoring and analysing levels of patient harm.

Incident reporting, learning and improvement

- The provider had an incident reporting policy in place which provided guidance for staff on how and when to report incidents in the service.
- Between 30 November 2015 and 2 December 2016 there were no 'never events' reported for this service. 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.
- In accordance with the Serious Incident Framework 2015, the provider reported 198 serious incidents (SIs) Between 7 July 2015 and 12 July 2016 that met the reporting criteria set by NHS England. The majority of these occurred in patients own homes and were attributed to pressure damage.
- Between July 2016 and October 2016 the provider reported an additional 16 serious incidents. Seven of which related to incidents in patients' own homes.
- We reviewed five root cause analysis (RCA) investigation reports taken at random. These were comprehensive in content and included a chronology of events, why the event occurred, reflection and actions taken to mitigate the risks.
- Two of the RCA's related to pressure area damage. A pressure ulcer learning and embedding strategy panel had been put in place to identify any learning and put actions in place to improve the care of patients at risk of developing pressure ulcers. For example better documentation and referral to the tissue viability team to assist in staging the pressure ulcer. Staff we spoke with were aware that improvements had been made and this needed to continue.
- A district nurse at the Mary Potter Health Centre showed us skin care assessments that had been undertaken on a patient with a pressure ulcer. The monthly ongoing reviews included photographs which had been uploaded onto the electronic patient record system the provider used.
- We spoke with community nurses who were aware of the possibility of pressure damage, especially for older people. Members of the senior management team including the director of nursing and allied health professionals had met with staff from clinical delivery group (CDG) three, an area which had previously recorded high levels of pressure area damage. They had felt supported by managers and were able to discuss issues with them and actions they had taken to reduce the risks. As part of the transformation plan a staff co-ordinator had been placed in each CDG. Staff were positive about the outcome which had improved care and enhanced practice.
- Community nurses told us patients did not always use the pressure relieving equipment they were supplied with, despite being encouraged to do so by family and district nursing staff. We saw evidence of this during our visits with the community teams.
- The provider produced a monthly integrated incident report for the board which highlighted concerns across the services provided. In October 2016, CDG eight reported the most incidents, reporting 11 incidents, eight of which were pressure ulcer incidents. Three of the CDGs had a medication incident during the month, all of which resulted in no harm to the patient.
- We spoke with community staff about the processes surrounding the administration of insulin which had been raised as an issue. Staff knew this had been highlighted as a concern and as a result all staff were undertaking additional training and had developed methods of ensuring diabetic patients did not miss their injections. For example a triage team leader checked a separate list of diabetic patients requiring insulin injections to ensure visits were timed appropriately and monitored. This was seen to be working well. However, three different community teams were all doing something different and the system was therefore not standardised.
- All patient safety incidents graded as moderate harm were discussed as part of the provider's Holistic Incidents Review Panel (CHIRP) which met weekly. Actions taken were documented.
- Staff told us they were informed about incidents and actions taken to reduce the risks.

Duty of candour

- Staff were aware of the duty of candour requirements. Duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of

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

- All incidents raised that could trigger a duty of candour were identified on the provider's electronic reporting system.
- There were 110 applicable DoC incidents that occurred in adult services in the previous 12 months most of which related to acquired grade three or four pressure ulcers. However, in some cases these had been removed and downgraded, for example when it was determined pressure was not the cause of a wound, or after incidents, where following investigation, it was found to be unavoidable.
- Other occasional moderate harm incidents included safeguarding issues, fractures following a fall and medication errors. The audit identified that patients were informed where there had been moderate or serious harm and a verbal apology given. However a letter had not been attached to patients records and therefore the provider could not confirm that the process had been fully completed. Actions from the audit included further training for all staff and re-auditing to ensure full compliance with the regulation.
- 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. As both audits detailed the same failing we could not be assured that written apologies were made in a timely manner.
- The pressure ulcer learning and embedding strategy panel meeting held on 20 September stated that training slides were being produced for staff on duty of candour as staff were still confused with the process.

Safeguarding

- The trust had a safeguarding policy in place and safeguarding training was included in staff's essential training. Safeguarding level two, children and adults, were undertaken on a three yearly basis. Compliance rates for the number of staff in date with this training as of November 2016 showed 45% for safeguarding adults and 60% for safeguarding children. The provider's compliance rate was 90%. 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 nine percent increase in the number of staff up to date with level two safeguarding adults training.
- Staff we spoke with had a good understanding of safeguarding and were able to explain the actions they would take if they had concerns about a patient.
- During our visit, one nurse was preparing to make a safeguarding referral following a home visit. However, after investigating the issue further this had been found not to be necessary after assurances about the patient had been gained.
- A specialist nurse had raised a safeguarding alert when they found issues relating to medication for one patient that was not in their direct care. This evidenced that staff were ensuring safe care was being delivered in the community.
- After concerns relating to hospital discharges had been raised, community staff had worked with the local acute trust and the local authority in order to improve the discharge planning for patients developing a better discharge transfer system. However, the reablement teams in Nottingham CityCare Partnership had already done this, although neither team knew the actions each other had taken.

Good

Are services safe?

Medicines

- The medicines management team at CityCare provided a range of services to support people to take their medicines.
- As part of the discharge service, people 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 the patient understood which medicines they should be taking, for example they would make sure the patient hadn't re-started taking a medicine which had been discontinued by the hospital doctors. They could also check the patient's GP had current information on the patient's current medication. The patient received one telephone call to identify possible problems, and was called back by the pharmacist if needed. The pharmacy team told us patient feedback had been 90% positive. At the time of our inspection the pharmacy team provided approximately 20 consultations per month, but was aiming to increase this. A risk score was calculated before and after the intervention, which the pharmacist stated, showed encouraging results.
- A medicine compliance review was available for any patient referred by a health or social care professional who was finding it difficult to manage their medicines due to poor memory, lack of dexterity or swallowing difficulties. A pharmacy technician visited the patient in their home to undertake a review to ensure the person was getting the most from their medicines. The visit lasted 45 minutes during which time the technician talked to the person about their medicines, provided advice and support, and where appropriate offered aids to help the person manage their medicines, for example boxes to organise doses and electronic displays which prompted the patient when it was time to take their medicine. An external provider provided some of the devices.
- The team also worked with another agency to identify patients who would benefit from an electronic medicine dispenser. Following the visit, the technician prepared a report for the patient's GP to summarise their recommendations, for example asking them to prescribe liquid medicines for people with swallowing difficulties. The team telephoned the patient after a few days to ensure they were able to use any equipment provided. One technician told us that during the consultation people may mention other problems, so information would be sent to the patient advising them of other services that were available to them. Visits were prioritised by risk, for example patients taking high risk medicines would be given a higher priority. The pharmacy technicians had received appropriate training for example speech and language therapy, which helped them with advising on swallowing difficulties. In addition, referrals could be made to the falls team or the clinical pharmacist when required.
- 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 free of charge.
- At two locations we visited, we saw that medicines were stored securely, in date and stock checks were recorded on a monthly basis.
- Medication safes were provided according to a patient's risk assessment, for example if the patient lacked capacity or if there were children in the property.
- At one location, we observed community teams checking the temperature of the dressings storage area to ensure it was acceptable. They told us the optimum temperature was 25 degrees centigrade and informed us what they would do if it was outside of this. For example, rechecking the temperature within four hours and then alerting the pharmacist for advice with regard to removal of the dressings from the area.
- At the continence advisory service, patients could contact the team via telephone or email to request products from an agreed list. The clinical commissioning group (CCG) monitored prescribing. Stock for emergency use was kept securely as were prescriptions. There were no records of prescriptions that had been used although unwanted prescription pads were shredded.

Environment and equipment

- We visited four locations where patients attended clinics. Equipment had been safety tested and stickers were in evidence to identify the date this had occurred.
- Equipment supplied for use in patients' homes was contracted through an external equipment provider and staff confirmed equipment was usually readily available. For example pressure relieving cushions and mattresses.
- Equipment for use in patients' homes was supplied through a contract with an external equipment provider;

we were able to view the website of the equipment provider which staff used to gain supplies. Staff informed us that it was not generally a problem ordering supplies although some pressure relieving cushions were sometimes in short supply. If required urgently equipment could be delivered on the same day.
- Staff could contact the company if they experienced problems. For example a patient had been delivered an alternating pressure mattress that was not set correctly for the patient concerned; a call was made to the company who gave instructions to rectify the problem.
- Chairs which could be raised up electronically were in use in leg ulcer clinics; this helped both patients and staff.

Quality of records

- Patient's records were stored securely using an electronic system. In some clinics, for example the chronic obstructive pulmonary disease (COPD) rehabilitation clinic, assessments and records were paper based. Electronic systems were password protected.
- After clinics, staff updated each patient's electronic record following their appointment. This ensured the records were up to date.
- Patient records we reviewed electronically were accurate, complete and up to date. Any connectivity issues relating to the electronic record system was addressed by saving the data at the time of inputting it which would automatically upload to the system once connectivity was resumed.
- The provider undertook an annual audit of patient records but one care delivery group we visited did this on a six monthly basis. Line managers also undertook a spot-check audit prior to staff one-to- one sessions and brought the results to the meeting to discuss any issues.
- We reviewed a spot audit check on records that had been undertaken in August 2016. For one record the audit showed the Braden score (an assessment to assess a patient's level of risk for the development of pressure ulcers) was not undertaken for the patient on a monthly basis and the moving and handling assessment had not been reviewed annually as stipulated by the provider's operating processes. Assessments could be undertaken more often if it was considered necessary or patient needs changed.

Cleanliness, infection control and hygiene

- Between April and September 2016, six cases of Clostridium Difficile (C Difficile) had been identified and treated in the community. Learning to be taken forward included all involved in the patient's care to be made aware of the need to take samples if infections were not responding to the treatments being prescribed. Clostridium Difficile is a bacterium that can infect the bowel and cause diarrhoea.
- All locations we visited were tidy and visibly clean. Clinical and domestic waste was segregated and sharps boxes were available and used appropriately.
- We observed staff during their visits to patients in their own homes, in care homes and during clinic sessions and found they demonstrated a good understanding of infection prevention and control. For example we saw aseptic non-touch techniques being used when changing wound dressings.
- Staff adhered to the provider's bare below the elbow guidelines, removing outer clothing before commencing any treatment in people's homes.
- Staff washed their hands with soap and water or hand gel both before and after care was given and protective clothing was worn when required, for example gloves and aprons.
- Staff disposed of dirty dressings and gloves and aprons appropriately.
- Two members of staff at one location were seen to be wearing necklaces, which was contrary to infection control best practice and the provider's policy.
- We observed that cleaning of chairs and trolleys took place between patient treatments in the leg ulcer clinics.
- Emollients were all identified for single patient use with patients' names and date of opening clearly displayed. Emollients are moisturising treatments applied directly to the skin that are often used to treat skin conditions such as eczema.

Mandatory training

- All staff were required to complete elements of essential learning when they started working for Nottingham CityCare Partnership and annually or every three years thereafter dependent upon the subject. For example

annual training included information governance and basic life support (BSL), the latter for clinical staff only. Three yearly training included infection prevention and control for clinical staff.

- As of November 2016, 87% of staff within community health services for adults had completed essential training, which fell slightly short of the 90% target set by the provider. Basic life support (BLS) training compliance, as of September 2016, was 90% and in line with the organisation target of 90%. In September 2016 the organisation introduced a new annual BLS course that included awareness of automated external defibrillators (AEDs) and anaphylaxis. Between October and December 2016, 49% of staff had completed this training.
- Information governance training needed to be completed annually by all staff. Data submitted by the provider showed this service was 84% compliant. Ten elements in essential training, for example equality and diversity, medicines management and conflict resolution had exceeded 90%.

Assessing and responding to patient risk

- In the community setting patient risk assessments were part of the electronic care records. We reviewed six care records and saw staff had completed a range of risk assessments such as nutrition and falls. Where staff had identified risks, appropriate care had been planned and implemented. Full assessments were undertaken of all patients every three months if they continued to require care and treatment from community staff.
- Staff caring for patients with allergies were reminded of these by an alert on the electronic record and we observed staff checking with patients about any allergies, for example prior to using a new wound dressing.
- During the first meeting with new patients staff completed a full assessment of care needs. This took place whether the patient was in a clinic or in their own home. We observed this in both settings; the process identified potential risks so these could be addressed and plans of care made.
- Many, but not all of the adult services provided could be accessed through the Nottingham Health and Care Point run in partnership by Citycare and Nottingham City Council using a single access number open from 8am to 7pm, Monday to Friday. Administration staff recorded information and calls were then directed to the appropriate local care delivery group. All calls were triaged by a clinical triage nurse ensuring patients received timely and appropriate care. Alternatively, people could use a secure online form. Patients were also able to self-refer to some clinics such as a physiotherapy clinic if they felt their health concerns were better treated by a physiotherapist rather than a GP.
- A red, amber, green (RAG) tool for prioritising visits dependent upon risk was in operation. For example during bad weather or staff sickness. A nurse co-ordinator kept patients informed about the timing of visits which enhanced their understanding and reduced patient anxiety.
- We observed two handovers between community nursing teams. Patient alerts were discussed with concerns identified and escalated appropriately to minimise any risks to patients
- Specialist nursing staff were available for support in caring for patients with, for example pressure ulcers, diabetes or respiratory diseases. Staff informed us they could always access the teams when required.
- During a visit to a falls clinic, we observed a medication review for patients who had experienced frequent falls in the past. Assessments were undertaken and discussions held with GPs if required concerning changing to their medication to reduce the risk of further falls.
- Community staff had direct access to the local acute trust's electronic information system to access scan results and the outcome of blood tests which enabled treatment to be undertaken more quickly when it was required.
- Following an incident where a patient had developed sepsis, community nursing staff carried a thermometer to enable them to monitor patient temperatures. Sepsis is also referred to as blood poisoning or septicaemia and is a potentially life-threatening condition triggered by an infection or injury. Use of the thermometer enabled staff to take a patient's temperature if they suspected they had an infection and be able to access treatment without delay. However, staff we spoke to could not inform us why they were carrying thermometers.
- The reablement team consisting of between 50 and 60 occupational therapists, physiotherapists, mental health nurses, rehabilitation support workers, assistant practitioners and care co-ordinators who worked from

an office base in Aspect House. Their focus was to prevent admission to the emergency department or to an acute bed and provide short term support for elderly people following discharge from hospital. The teams were able to attend patients within two hours, (or the following day if they were discharged after 10pm) or if they became ill but did not require admission to hospital. Referrals generally came from the acute local hospital via the provider's triage hub. Triage was undertaken by a clinician who was able to challenge discharge plans for patients in hospital if it was felt they were not appropriate or safe and could leave patients at risk.

- Prior to our inspection we had received concerns that some processes within the reablement team were not working effectively, for example care-planning, timing of visits and lack of equipment in patient's homes to support safe care. These issues had been raised as concerns to managers. We did not see such problems during our visit and staff did not raise these issues
- An assessment template was used to triage all patients requiring reablement. This included skin checks, risk of falls, medications used and a full medical history.

Staffing levels and caseload

- All staff we spoke with told us agency staff were used when the acuity (the level of severity of an illness of patients) increased or vacant posts were waiting to be filled.
- Specialist posts in the reablement team, for example physiotherapists and occupational therapists, used locums to fill their vacancies.
- We spoke to a locum health care professional who was leaving the service after our visit due to a regular member of staff returning to the post. They felt they had been able to give adequate time to their patients during consultations and home visits and had enjoyed the experience.
- The vast majority of staff across all the teams we spoke with 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.
- In the community nursing teams, patients were allocated to members of the nursing team by one of the senior staff on a daily basis. This took account of the dependency of the patients and the skills and experiences of the staff members.
- Time slots for individual community visits were designated according to the needs of patients, with every appointment 'slot' worth 20 minutes. For example a comprehensive assessment for a new patient was allocated six slots (two hours) and a simple dressing was allocated one slot (20 minutes).
- Staff in one care delivery group were either working an 8am to 6pm shift, undertaking on average, 20 appointment slots per day or an 8.30am to 5pm shift undertaking 16 slots per day. Staff had been given the choice of the shifts they worked.
- Each team in a care delivery group (CDG) usually had between 130 and 140 patients to care for. The number of visits varied depending on patient need, with some requiring daily visits and others less frequent.
- Information provided by Nottingham CityCare Partnership showed that as of 31 August 2016 there were 50 whole time equivalent (WTE) vacancies for qualified nurses and 20 WTE vacancies for nursing assistants. The information provided did not break this down into different service provision so we were unable to define vacancies for adult services.
- Agency usage to cover sickness absence or vacancies had shown a downward trend between 30 June and 31 August 2016.
- Sickness rates in the service amounted to 5% of substantive posts.
- Reablement clinical staff undertook a three shift system covering 8am to 10pm. Support workers in the team covered from 7am until 11pm. All assistant practitioners were trained to undertake assessments, however a clinician would decide which patients could receive a visit by an assistant practitioner. The caseload for the team at the time of our inspection was 58 patients; senior staff felt 60 would be the maximum number, although this would depend upon the dependency of the patient.
- As lone staff working in the community could be vulnerable, systems and processes were in place to keep staff safe. We saw an electronic fob system that staff

could use to alert others if they were at risk. However, senior managers informed us these were not always being used by staff and the continuation of use of the system was under discussion.

Managing anticipated risks

- Community nursing staff managed foreseeable risks and planned changes in demand due to seasonal fluctuation, for example adverse weather. This included identifying which staff were within walking distance of patients' homes and health centre bases. The more vulnerable and highly dependent patients were identified and prioritised using a RAG rating (red, amber, green traffic light system). Those patients identified as 'red' such as those who required time critical medication such as insulin received visits first.
- The reablement team undertook a full needs assessment for all patients and goals were set which could be adjusted each day depending upon the patient. If patients required two members of staff to visit them due to their care needs, this was enabled following individual assessment. These processes aimed to keep patients and staff safe because risks were managed.

Good

Are services effective?

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

We rated community health services for adults as good for effective because patients received effective care and treatment that met their needs.

We found:

- Care and treatment was planned and delivered in line with current evidence based guidance and standards.
- Multi-disciplinary working and integrated care pathways were in place.
- Many referrals to the service were handled by a single point of access either by telephone or electronically to ensure they were directed to the most appropriate service.
- Staff had the knowledge, skills and experience to deliver effective care and treatment and were supported to undertake further training.
- Staff demonstrated a good understanding of the Mental Capacity Act.
- Most patients had a single electronic patient record, stored securely which ensured all staff had access to information to provide effective care.

However, we also found:

- Confusion could arise with the use of multiple paper records for patients receiving care from more than one community team.
- Self-management plans for patients with chronic diseases were not always reviewed on a regular basis to ensure they reflected current guidance.

Evidence based care and treatment

- Policies and procedures were available on the provider's intranet, and staff we spoke with knew how to access them.
- The senior manager responsible for updating evidence based guidance for staff and monitoring the outcomes received monthly updates from the National Institute of Health and Care Excellence (NICE). NICE provides evidence-based guidance, advice and information services to health, public health and social care professionals. Updated guidance was provided through email to team managers to share with their staff and practice was modified accordingly.
- The provider monitored the updated practice through feedback from team leaders within three months which measured how compliant teams were. If teams reported non-compliance a review was completed on a monthly basis until the team was fully compliant. For example, updated guidance (CG181) for lipid modification (reducing fat levels in the blood) for patients with cardio-vascular disease was distributed in September 2016. In October 2016 the provider had been assured by team leaders that staff were fully compliant with the new guidance.
- We reviewed six patient care records and saw care goals had been identified and personalised care plans reflected best practice.
- Patient's assessments were completed using templates that followed national guidance, for example assessing the risk of pressure ulcers and malnutrition.
- Self-management plans for some chronic diseases had been developed to give to patients when required, which included advice for when patients felt unwell. These included heart failure, diabetes and chronic obstructive pulmonary disease (COPD). However, we noted the plans were dated 2010 and were therefore not assured they were as up-to-date as they should have been.
- In leg ulcer clinics, ultrasound tests were undertaken annually on feet and legs unless wound changes were noted or the patient's condition deteriorated; in those cases they would be undertaken more frequently. The tests use high frequency sound waves to measure the amount of blood flow through arteries and veins.
- Monthly wound photographs were taken to maintain continuity of care for patients by the staff running the clinic.

Pain relief

- On reviewing records we found patients' pain was assessed and care plans developed if patients were

experiencing pain. For example when we visited one patient we observed the nurse discussing an increase in the dosage of pain relief with a GP to alleviate their discomfort.
- Staff considered patients' pain when providing care. We observed staff checking patient's comfort levels when removing and changing wound dressings and stopping if it was causing distress.
- Therapy staff identified what factors increased or eased patients' pain, for example in a leg ulcer clinic, we witnessed patients have their pain and discomfort reassessed during wound dressings and a member of staff monitoring a patient's level of comfort during exercise. We also saw a physiotherapist monitoring patients closely whilst undertaking walking tests in the chronic obstructive pulmonary disease (COPD) rehabilitation class to prevent possible pain and distress.

Nutrition and hydration

- As part of the assessment process, staff used the malnutrition universal screening tool (MUST) to identify where patients required support to aid nutrition and hydration. The MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or overweight. It also includes management guidelines which can be used to develop a care plan if a patient is identified at risk.
- During our visit we saw a nurse ask a relative about a patient's food and fluid intake. They identified the patient was at risk and referred them to a dietitian following the visit.

Technology and telemedicine

- We did not see any telemedicine in use at the time of our inspection. However Nottingham Citycare Partnership did use this on occasions to allow patients to monitor their own health and well-being using assistive technology. Clinicians supported patients to manage their own health more effectively.
- The process helped to give patients a better understanding of their own condition and feel more confident in managing it.
- The technology used reduced the risk of unplanned visits to a GP or emergency admissions to hospital.

Patient outcomes

- Nottingham CityCare Partnership 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 going to be commenced in January 2017 for chronic obstructive pulmonary disease (COPD).
- The provider was taking part in a national osteoporosis society peer review of osteoporosis and metabolic bone health.
- Data from the Sentinel Strokes National Audit between January and March 2016 showed for the early support discharge team that patients were seen within two days against a national average of one day; and a length of stay of 21 days against a national average of 36 days.
- 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%.
- The provider's falls team had been identified nationally as an example of good practice, for example holding clinics in GP practices, which provided a holistic approach to falls prevention for patients with an increased risk of falls. This had reduced the numbers of falls experienced by patients.
- Nottingham CityCare Partnership took part in the 2012/2013 National Intermediate Care Audit but did not take part in the 2015/16 audit following discussion with the clinical commissioning group (CCG).
- Staff worked closely with care homes in order to improve care and outcomes for patients. For example the care homes team provided teaching to staff based in homes providing both nursing and residential care. The service provided care home support teams to visit local care homes through a new patient referral system to review patients and proactively check for any potential problems the home may encounter. Plans were under discussion to expand the service to include all residents in the homes. The care homes specialist nurse informed us they had made a presentation to the clinical commissioning group (CCG) to encourage the commissioners to include their service in the future.
- Reablement outcomes had shown improved figures over the past nineteen months. For example in July 2015, 71 patients had completed a reablement

programme of which, 23 had been readmitted to hospital and four had gone into long-term care. In October 2016, 45 patients had completed a reablement programme; five had been readmitted to hospital and none had gone into long-term care.

- The care homes specialist nurses undertook an annual audit of care homes that took part in the National Prevalence Measurement of Quality of Care (LPZ). It is an annual independent measurement of care quality in the healthcare sector. The LPZ is used to measure the quality of care provided by each care provider and is a reliable measuring instrument for identifying and rectifying care problems at an early stage. It is assessed under twelve domains. Feedback and the development of action plans occurred each January. This enabled the specialist nurses and care home staff to work together in identifying improvement goals and improving outcomes for patients, for example in areas such as medicines management and pressure ulcer management.
- A system was in place to ensure the correct dressings were used for wounds, for example if a tissue viability specialist nurse recommended it or it was needed for a burn. This ensured the best outcomes were available to patients.
- Patient outcomes measures were performed at the start and end of the chronic pulmonary obstructive disorder (COPD) rehabilitation programme to determine whether improvements had been made for patients.
- Commissioning for Quality and Innovation (CQUIN) was introduced in 2009 to make a proportion of healthcare providers' income from commissioners conditional on demonstrating improvements in quality and innovation in specified areas. Nottingham Citycare Partnership had a number of CQUIN's to achieve, for example in the current year (2016/2017) an indicator weighting had been placed on the number of flu vaccines taken up by patients in the integrated respiratory service. At the end of November 2016, 52% of 553 patients had received the vaccination.
- Training had commenced in November 2016 for staff to help them in recognising depression in patients who were over the age of 65. This was also a CQUIN.
- The clinical audit specialist in the organisation had produced a document for members of staff who wanted to undertake their own clinical audit and improvement project to support them to do this. They were also available for discussions if required.

Competent staff

- Staff told us there were training opportunities available and they were always supported to develop. For example an assistant practitioner told us how they had been able to access training in electrocardiography (ECG), catheterisation of both male and female named patients and administration of insulin for named patients. They had been forwarded nursing related documents as this helped with plans for them to undertake their nurse training in the future.
- Community matrons had a varied role to fulfil but felt competent to fulfil it. This included case management, care co-ordination, nurse prescribing and condition diagnosis. In addition, they also attended the local acute trust to assist in the discharge of patients with complex needs.
- Nurses in clinics were able to work autonomously in managing patients with wounds that required treatment following appropriate training. Dressings were selected dependent upon patient need and the most appropriate form of treatment.
- Assistant practitioners working in the reablement team told us of how, as a result of the appraisal process they had completed their foundation degree with three others having just started it.
- Nottingham CityCare Partnership had offered flexible working packages to staff whilst studying so they could work additional hours whilst off placement. We spoke with an occupational therapy student who confirmed this and who felt supported by the provider. They told us how they wanted to work for Nottingham CityCare Partnership after they had completed their degree.
- 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.
- Community staff received dementia training. Staff were then able to assess patients as part of the assessment process and identify patients with a form of dementia and refer them to other services when needed.
- Appraisal rates as of 28 November 2016 were 73%. The director of nursing and allied health professionals acknowledged this was below the rate they wished to achieve. People we spoke with who had received an appraisal told us they found it a useful process. Some adult community teams for example the community stroke discharge team had achieved 100%, whilst others such as the city diabetes team and the neighbourhood teams were below 60%.
- We saw and staff told us they received one to one support with their line managers on a regular basis. Most staff we spoke with told us these meetings were useful and worthwhile; they were able to discuss concerns and bring issues to the attention of their manager.

Multi-disciplinary working and coordinated care pathways

- Care delivery groups (CDGs) provided care to patients living in the community. The teams consisted of community nurses, district nurses (registered nurses who have undertaken additional training for working in the community), as well as community matrons, occupational therapists, physiotherapists speech and language therapists, dietitians assistant practitioners and support workers. Some CDG's shared the same office space with members of social care teams which further promoted communication and collaborative multidisciplinary working. For other CDGs, community nurses were based in health centres, separate to therapy staff.
- Multidisciplinary meetings (MDT) were held monthly in GP surgeries to discuss patients with complex needs. These were attended by community nurses as well as professionals from other organisations such as GP's and social care workers. Although we did not observe an MDT during our inspection, we witnessed a social worker requesting to see a district nurse to discuss a patient whose social care was being reviewed. We observed a joint discussion about this.
- Nottingham CityCare care home specialist nurses held a weekly MDT with a consultant elderly care doctor from the local acute trust who managed all new admissions to the hospital from care homes in the Nottingham area. A service level agreement (SLA) was in place between the provider and the local acute trust to continually asses and reduce admissions to the hospital. An SLA is an official contract between a service provider and a customer.
- Community matrons were attached to GP practices and had patients with more complex needs on their caseload. On occasions those staff undertook joint visits with GPs if there was concern about the patient's care or treatment. This enabled patients to receive the best care in a timely manner.
- Good working relationships were in evidence between staff and the dementia outreach team provided by another organisation. It was used when required to provide one-to-one support for patients. CityCare also had support for patients living with dementia from the Nottingham City Council's dementia service.
- Nursing and medical students were able to shadow staff from Citycare to gain experience of caring for patients in the community. Shadowing means accompanying an experienced member of staff as they perform their job.
- The reablement team undertook a multidisciplinary meeting twice a day to discuss the management of patients. In addition a daily conference call was held with other care partners regarding planned discharges from hospitals and the availability of the service to offer their care and support to them. During the meeting, poor discharges from the local acute trust had been discussed in order to facilitate improvements in the process. A better transfer of care document had been developed as part of the actions taken.

Access to information

- An electronic system was used to record assessments and provide care planning information. Community staff used laptop computers either whilst they were visiting the patient or in their office after the visit.
- Because of the availability of the electronic care record 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. In some surgeries where a different electronic system was used, community nursing teams were still able to access a patient's records and communicate with the GP.
- District and community nurses could also access the acute trust's electronic records – this enabled them to access test results in a timely manner
- Some paper based care plans were in place in patient homes if other agencies were also attending the patient. This meant all care activities could be seen by each agency and prevents confusion. However in one patient's home we saw three sets of paper Nottingham CityCare Partnership notes relating to three different visiting services; community matron, district nurse and the reablement team. This may have led to confusion for staff undertaking follow-up visits, although it enabled patients to have access to their own records.
- Patients had previously raised concerns that notes from district nurses were not able to be seen on the electronic system when attending a GP appointment. This had been resolved by the provider stating that staff should update them at the earliest opportunity or within 24 hours; we observed this in operation.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The electronic 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 which could mean a delay in appropriate care.
- We observed community and clinic nurses asking for consent before providing care.
- Staff understood the Mental Capacity Act (MCA) and informed us they would request support from colleagues or GP's when they were concerned about patients who lacked mental capacity to make important decisions.
- One district nurse, with a special interest in the MCA had organised new training for all CityCare staff with the help of the organisation's safeguarding lead. At the time of our inspection they were helping to update software to reflect MCA assessments and 'best interest' decision making to ensure it was readily available on the patient's electronic record for their care delivery group. Once it was in place and working effectively this would be rolled out across all teams in Nottingham CityCare Partnership.

Good

Are services caring?

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

Summary

We rated community health services for adults caring as good because patients were supported, treated with dignity and respect and were involved as partners in their care.

We found:

- All of the feedback from patients we spoke with was positive about the care and treatment they received.
- Patients told us they were treated with dignity, compassion and respect and were involved in the planning and delivery of care.
- Our observations between staff and patients showed consistent respect and compassionate care. Staff took time to listen, support and reassure patients and their relatives.

Compassionate care

- We observed care being delivered to patients either in their own homes or in clinics. In all cases we saw staff providing kind and compassionate care in a friendly and professional manner.
- Patients told us staff were caring and polite and we observed this during our inspection.
- Staff were gentle in their approach both before and during assessments and treatment to patients. For example an assistant practitioner undertaking exercise practice with a patient, took time to ensure the patient was comfortable and prepared before each movement.
- Staff took time to listen to patients, giving reassurance and ensuring patients understood what staff were saying to them.
- Although community staff informed us their workloads were high this was not apparent when people were visited in their own homes. Patients informed us they felt well cared for at every visit and did not feel rushed.
- We distributed comment cards prior to our inspection for patients and their relatives to use. We received four for adult services and saw all the comments were very positive about the service.

Understanding and involvement of patients and those close to them

- Care was delivered in a calm and thoughtful way involving patients and their relatives or carers when appropriate. Clear and simple language was used to explain the care to make sure patients understood what was happening and why.
- Patients in the chronic obstructive pulmonary disease rehabilitation (COPD) clinic told us how they had been constantly involved in their programme. Relatives were always welcome to accompany patients at any of the sessions they attended.
- Where it was important to have a relative or carer present during a home visit and where it was possible, these were planned for a convenient time for all parties concerned.
- We spoke with three patients who told us they felt well cared for and without the service provided they would still be in hospital.

Emotional support

- During home visits staff ensured the physical and emotional care of each patient was individualised in order to support patients and their families in the best way they could.
- During one home visit we saw a community nurse providing emotional support to a family member who was becoming concerned about their relative. They showed empathy and told them what they were going to do to help improve the situation.
- Staff informed us it was important to include emotional support otherwise patients could become very upset which could hinder them getting better.

Good

Are services responsive to people's needs?

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

Summary

We rated community health service for adults as good for responsive because patients' needs were met through the way services were organised and delivered.

We found:

- Services were planned and delivered to meet the needs of people.
- Community health services were provided by integrated community teams which ensured patients received 'joined up' care in a timely manner.
- Staff ensured care was provided for those people in vulnerable circumstances and care was available to all.
- The provider responded to complaints in a proactive way and in a timely manner, using them as a learning process.

However, we also found:

- Some patient pathways experienced delays, for example patient referral to the heart failure team instead of community matrons which delayed appropriate treatment.

Planning and delivering services which meet people's needs

- The provider worked with local service commissioners, including local authorities, GPs and other providers to co-ordinate care and integrate care pathways.
- Services were provided by integrated community teams which in the majority of cases ensured patients received care and treatment that was 'joined up'.
- 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.
- The provider's diabetes team delivered a structured diabetes education programme for adults with type two diabetes (diabetics not on insulin) called 'Juggle'. This consisted of an interactive four week programme which could be tailored to the needs of individual communities in different settings. This included workplace settings, those with a hearing loss, people with a learning difficulty and those whose first language was not English. People could be referred directly from health and social care professionals as well as referring themselves to the programme. The programme received 1000 referrals a year and had received positive feedback.

Meeting the needs of people in vulnerable circumstances

- The 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. The team responded within two hours of receiving a referral and were available between 8am and 10pm.
- The care homes team triaged newly admitted patients to local care homes; its aim was to visit the patients within 20 days. We found the timescale was generally between seven and ten days with specialist nurses undertaking the first visit and assessment. Where appropriate, assistant practitioners undertook follow-up visits.
- Staff were able to tell us and we observed, staff taking time to talk to patients who were living with dementia and their carers in an unhurried way and making adjustments.

Access to the right care at the right time

- The district nursing teams triaged newly referred patients; its aim was to visit acute referrals within three hours, urgent referrals within 72 hours and routine referrals within 20 days. Between April 2016 and December 2016 there were 42 acute referrals 38 (90%) of these were seen within 3 hours. During the same period there were 1298 urgent referrals of these 1174 were seen within 72 hours (90%). There were 4197 routine referrals of these 3011 were seen within 20 days (72%). District

nurses we spoke with confirmed they spoke with patients referred for a routine visit. This was to explain the possible delay and address anything over the phone if possible.

- Community matrons co-ordinated the care of patients with long-term conditions who required specialist input for example from the specialist palliative care team. However, senior nurses informed us that sometimes care pathways were delayed because patients were not referred to the most appropriate professional at the right time; for example the heart failure team.
- Staff were able to provide care for patients in local clinics or for those patients less mobile, care was provided in their own homes. Times were flexible dependent upon hospital appointments or if patients required additional visits from staff. For example in a leg ulcer clinic patient's dressings required to be changed daily. In order to accommodate this, nurses would visit the patient's home on alternate days and the patient visited the clinic on the other days in order to reduce the burden on the already frail patient.
- Patients attending the continence advisory service were able to access advice and continence products between 8.30am and 5.30pm Monday to Friday. Patients were reviewed annually after an original assessment of need. Telephone advice was available if necessary. Good links were available with district nurses, and the stoma and urology services at the local acute trust. Nurses had developed a range of leaflets for conditions such as constipation and pelvic organ prolapse.

Learning from complaints and concerns

- Adult community services had received 56 complaints between 16 July 2015 and 28 July 2016, 23 of which had been upheld. One had been referred to the Public Health Service Ombudsman (PHSO) The PHSO is an organisation that makes final decisions on complaints about the NHS that have not been resolved satisfactorily by the provider of the service.
- The general theme of complaints was poor or lack of communication. We reviewed one complaint and saw that it had been investigated appropriately and a telephone conversation had taken place with the complainant. The issue had been discussed with a member of staff. The letter from a director had told the complainant the complaint could be re-opened if it were required or it could be taken to the PHSO.
- One complaint went to the PHSO last year (2015/2016) and was not upheld.
- Nottingham CityCare Partnership had a customer care team which was similar to an NHS Patient Advisory Liaison Service (PALS) team. Every concern or complaint was logged on the provider's electronic data system. Managers were encouraged to log all issues raised by patients or their relatives on the system and resolve them locally.
- Complaints were acknowledged the same day as they were received and usually responded to in 25 days, unless the complaint was more complex. If this was the case, a timeline was agreed with the complainant and they were kept up to date on a regular basis.
- The outcome of formal complaints was signed off by a director but if the complainant was not satisfied with the outcome the complaint could be re-opened and reviewed again.
- We spoke with members of the nursing team in Care Delivery Group 3 (CDG 3). They informed us they had received one formal complaint since April 2016 and two informal concerns. Where appropriate, visits to patients were made to discuss concerns and if necessary an apology given and care changed when this was appropriate. Staff informed us they used the process to take issues forward, learn from them and share experiences as there was a no blame culture in the organisation.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated community health service for adults as good for well-led because the leadership, governance and culture promoted the delivery of high quality person-centred care.

We found:

- The provider had an overall vision with values that staff were aware of and demonstrated.
- There was positive feedback from staff about the director of nursing and allied health professionals who was visible.
- Line managers were supportive to their staff.
- There was an effective governance structure in place.
- Staff felt proud to work for the service.
- The provider had an open culture.

Service vision and strategy

- Nottingham CityCare Partnership was an award-winning community health services provider, dedicated to improving long-term health and wellbeing. Their vision was to build healthier communities. They were a social enterprise delivering a range of healthcare services tailored to the needs of local people and free at the point of delivery. Their values were integrity**,** expertise**,** unity and enterprise**.**
- Staff we spoke with knew of the vision and values

Governance, risk management and quality measurement

- There was a system of governance meetings in place to ensure information was escalated upwards to senior managers and the executive board and information was cascaded downwards to frontline staff. This included groups for medicines management, pressure ulcer learning and embedding, incident review and clinical effectiveness which fed into the quality and safety group.
- Review of November 2016 draft minutes of the integrated governance committee meeting showed issues such as performance, quality and safety, information governance and the risk register were discussed with key items identified for escalation to the board.
- The provider's audit programme stated record keeping was to be undertaken annually. However, we spoke with staff who informed us a spot check of records were undertaken prior to staff one to one's when the results were discussed; we saw evidence of these.
- Nottingham CityCare Partnership's risk register dated 28 August 2016 showed there were no high risks for community adult services. Risk themes had identified information technology, and mobile working as the main theme with staffing issues as the second highest. All risks showed a downward trend or had remained the same.

Leadership of this service

- Staff we spoke with were all encouraged by the attitude of the director of nursing 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."
- With one exception, all groups of staff felt very well supported by their line managers and other members of the team and would not hesitate to take problems to them. One group did not feel supported and had recently taken the issues they had to senior managers; the issue was being addressed.
- Senior managers told us the reablement team had gone through a difficult transition over recent months during the transformation programme. This had been a large challenge to manage and senior staff had attended a 'cross board management course' which had been useful in managing the change. When we spoke with staff from the team, they told us the team now worked well together following consultation and morale was improving.
- Senior staff told us of some of the areas that had led to frustrations; the national lack of home care services and fragmented patient care, for example continence care. However, they were very positive about how Nottingham CityCare Partnership had moved forward and now had a consistent approach across the organisation which had not been apparent before it had

Good

Are services well-led?

become a social enterprise. All staff we spoke with told us directors were approachable and listened to staff feedback; this had provided an effective pace of change which they welcomed.

- The February 2015 staff survey results could not be segregated into core service and therefore results were for all service provision within Nottingham CityCare Partnership. The survey attracted 574 responses; a 36% response rate. Some results showed a negative difference between the provider and NHS community providers, for example 43% of responders stated there were sufficient staff to do their job properly compared to 50% in NHS community providers. Other results showed a positive difference for example 32% of responders stated the organisation valued their work compared to 29% in NHS community providers. A detailed analysis of the results of the survey went to the senior management team to decide which areas they were going to concentrate on for improvements to be made.

Culture within this service

- Without exception, all staff demonstrated Nottingham CityCare Partnership's values (integrity, expertise, unity and enterprise) in their day-to-day work, caring for patients and their families and when interacting with colleagues at all levels.
- Staff were proud of working for Nottingham CityCare Partnership and felt they provided excellent care to all their patients.
- Staff felt able to speak up when they had concerns about for example, care provision and they told us they felt comfortable doing so.
- However, two senior nurses we spoke with felt the provider was driven by targets and money and was very business focussed. They also stated they were being asked to do more with fewer resources.

Public engagement

- A group of patients who were either using the service or who had used it previously had been set up by the provider. This patient experience group (PEG) met six weekly to discuss issues, for example pressure on groups of staff. The provider informed us it was a well-attended group but was not entirely representative of all patient groups who used the service. This had been acknowledged by the public and patient involvement lead for the organisation. As a result, the provider was working with other agencies to gain feedback from different demographic groups about their services in order to improve.
- PEG members along with staff, undertook informal inspections of the provider's services, which everyone involved had found a useful process.
- PEG members also sat on the recruitment panel for new members of staff and reviewed complaint responses.
- CityCare had two main surveys that were used to gather feedback from patients/services users. The Integrated Care Survey and the main satisfaction survey - which was used to gather feedback from people experiencing other CityCare services.
- Public involvement was sought on any change in major service provision. We were informed patients had been upset after the provider lost commissioner funding for podiatry services which had ceased in September 2016.
- This meant the provider was actively engaging with the public to improve services.

Staff engagement

- Teams within adult community services held regular team meetings and we reviewed minutes of these. This meant there were opportunities for staff to meet formally to discuss issues relevant to the running of their service.
- Staff were able to approach members of the executive team at any time and discuss issues. Staff felt empowered to do this. One member of staff we spoke with told us how they had been encouraged by the board to undertake a piece of work to improve knowledge of the Mental Capacity Act for staff.
- Nottingham CityCare Partnership stated that all their employees were instrumental in everything they did. Through an initiative called 'CityCare Voice', the purpose of which was to engage with staff and give them the opportunity to raise their thoughts and ultimately improve the working experience for staff. Issues could be raised through nominated members of staff called 'Voice Ambassadors' and taken to a staff representative, the staff board member, working with directors at board level. This meant staff could feed themes which staff didn't feel were being resolved up to the board. Any comments or resolution from the board were in turn fed down to staff through the ambassadors.

Good

Are services well-led?

- Staff we spoke with knew of the initiative although some told us there were too few ambassadors. There were plans to increase the number to make the process easier to use.
- Newly recruited staff were introduced to 'CityCare Voice' during their induction to the organisation.

Innovation, improvement and sustainability

- The medicines management team worked in conjunction with another agency to identify people who would benefit from electronic medicine dispensers. Following the visit, the technician prepared a report for the person's GP to summarise their recommendations, for example asking them to prescribe liquid medicines for people with swallowing difficulties. The team telephoned the patient after a few days to ensure they were able to use any equipment provided. One technician told us that during the consultation people may mention other problems, so information would be sent on other services that were available to them.
- 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.