

Kirklees Metropolitan Council

Highfields

Inspection report

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12 August 2016
19 August 2016

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 9 August 2016 and was unannounced. We contacted the carers who worked for the service on 12 and 19 August 2016.

Highfields Shared Lives is a shared lives placement service, which recruits and supports paid carers to provide family based placements for adults with learning disabilities within the carer's home. Placements can be long-term with the adult living with the carer as part of their family, or as respite care which can range from a few hours a week, overnight or longer stays. On some occasions the service can provide an emergency service offering placements to people who find themselves in a crisis situation. At the time of our inspection there were over 90 people referred to the scheme and there were 73 carers.

At the last inspection 22 November 2013 we found the registered provider had met the regulatory requirements.

At the time of our inspection the service had moved locations and was in the process of registering the new location. A new manager had been appointed and they had submitted their application to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Carers we spoke to were very positive about the service. They felt they were well supported by the Shared Lives team. We found they had undergone a robust selection procedure and had been approved by a panel before they could commence providing care for a person referred to the scheme.

People had in place Service User Plans and Risk Assessments (SUPRAs) which described their needs and how these were to be met. SUPRA's covered issues such as people's physical and mental health, people's communication styles and road safety issues. Carers were able to tell us about the content of people's plans and they demonstrated they knew people well.

Relatives and carers told us they felt safe in the service. We saw carers had received training in safeguarding issues. They were aware of the risks to people and knew what actions to take to keep people safe.

Carer were familiar with people's medicines and were able to describe to us the arrangements for giving people their medicines in line with their care plan.

We saw carers had received training in first aid. Carers told us they had also received training from a variety of other professionals to meet people's needs. The manager told us bespoke training was arranged for each carer to ensure carers were able to meet people's needs.

Carers had been given guidance and support regarding people's eating and drinking needs, food to avoid and when to encourage a healthy diet and monitor people's alcohol intake. This meant carer's were aware

of people's nutritional needs.

We saw people accessed a range of activities including day centre attendance, local swimming and leisure facilities, horse riding as well as local facilities for example parks and gardens. Carers took people on holidays.

We found the service was caring. Carers spoke to us with warmth and affection about the people they cared for. We also found carers were able to support people to try new things irrespective of their disability.

The service adhered to the Mental Capacity Act and ensured people's capacity was assessed to make decisions. We found relatives, carers and other professionals were involved in making decisions in people's best interests.

The staff team were complimentary about the manager. They felt the manager was supporting the team to make progress them in the right direction. Since coming into post the manager had made a number of changes to the service to ensure systems in place were streamlined and worked together. They had ensured they had seen people's care plans and signed them off.

The service had in place an updated Statement of Purpose which accurately described the service and the expectations of those involved in it. This meant people were clear about what was required of them.

The Registered Provider had introduced a new computerised system. The Shared Lives team were in the process of transferring information into the new system whilst ensuring records were up to date.

The Shared Lives team had a plan to recruit more carers. We saw new publicity had been developed which had included a family who used the service. Information giving meetings had been set up to give prospective carers an opportunity to look at becoming a Shared Lives carer. The service had put plans in place to utilise a new assessment approach for carers using the UK Network Shared Lives Plus approach which in turn would support the new requirement for carers to complete the Care Certificate. This is a course designed to give people new to the care workforce a chance to learn about their chosen profession to nationally agreed standards.

We saw the Shared Lives team was able to access and worked in partnership with other disability services to support carers and enable them to meet people's needs for example in providing the right equipment or activities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Safeguarding adults' policies and procedures were in place and all the carers we spoke to confirmed they had completed safeguarding training.

People had risk assessments that were regularly reviewed by staff. The carers we spoke to were aware of risks and what actions were needed to prevent accidents from occurring.

The service had appropriate recruitment procedures in place for carers.

Is the service effective?

Good ●

The service was effective.

Carers told us they felt they had appropriate training and support to carry out their role.

Carers received three monthly visits to monitor their practice and to check on their required support levels. They also had an annual review.

Carers were aware of people's dietary requirements and what was required to ensure people remained healthy

Is the service caring?

Good ●

The service was caring.

Support plans included information on people's personal history and their need. This enabled staff to understand the background of the person they were supporting.

Some of the carers told us they had supported people since they were children and they valued this scheme because it enabled them to continue to care for people who had become a part of their family.

People using the service had a voice and were able with the

support of advocates or people acting on their behalf were able to be involved in and contribute to decisions which affected them.

Is the service responsive?

The service was responsive.

The service was responsive. The support plans and risk assessments were reviewed annually or if any changes to the person's support needs or to the placement were identified.

Carers told us if they had an issue they wanted to discuss with their support worker and their worker was not available they found any member of the team was willing to offer support to them.

Carers knew how to complain but said they had not had reason to do so.

Good ●

Is the service well-led?

The service was well-led.

Since coming into post the manager had reviewed the practice of the team and put in place changes to ensure the team was better prepared going forward to make improvements.

The service had clear networks in place which supported the carers employed by the service.

Annual reviews on carers were carried out by the Shared Lives staff team to ensure they were able to meet the requirements of the service

Good ●

Highfields

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 August 2016 and was unannounced. We contacted the carers who worked for the service on 12 and 19 August 2016.

The inspection team consisted of one adult social care inspector.

During our inspection we spoke with the manager and the three members of the staff team who supported the carers in this service. We also spoke to seven carers and looked at their records including reviews and contacts they had with the service.

We reviewed the care plans in place for nine people who used the service and spoke to two of their relatives.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted the local authority commissioners and Healthwatch. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection

Is the service safe?

Our findings

One person who used the scheme reported in a carer's review, "I feel safe and comfortable." Carers also reported feeling safe and comfortable with the service. A relative told me they thought the service was, "Very Safe."

We saw that carers who applied to the service underwent a rigorous process including participation in a preparation course before they could begin to care for people referred to the Shared Lives scheme. Carers had completed applications forms and given details of two referees which had been obtained prior to them starting work. Checks were carried out on carers to assess their suitability for the work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helped employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults. We saw the registered provider had carried out DBS checks on the carers as well as other checks including health checks. This meant people who used the scheme were protected from carers who were not suitable to carry out the role.

Prior to being accepted for the scheme an assessment report was written on the prospective carers before being considered by a panel of people with professionals from multi-disciplinary backgrounds. Carer's we spoke to confirmed they had undergone this process and been approved by a panel.

We found carer's family pets had been included in assessments as well as their home environment and other family members. These were reviewed to assess if they posed a risk to people who used the service. This meant all aspects of the family were taken into account in the assessment.

We found we had received very few notifications on accidents and incidents in the service. The manager confirmed there had not been any since they came into post. The carer's we spoke with told us they knew about people and how to support them to minimise and occurrences where people using the service were injured.

Risk assessments had been carried out for each individual person who used the service. In one person's risk assessment we saw the person was agile and strong, and had limited road sense. Guidance was given to carers on what to do included vigilance when the person was out in the community. In another person's documents we saw there was an agreement that a person only used Facebook they were with their long term carers and not their respite carer to ensure the person did not accept as friends people who may go on to exploit them. We found carers were advised to ensure their home had clear walkways as one person was susceptible to falls. This meant risk assessments were in place and pertinent to each person.

People's medicines were given to them by their carers. We saw in their care plans people's conditions were described and what was used to treat them. Carer's had in place Medicine Administration Records (MAR). These were checked by their support staff. When we spoke to carers they were able to describe to us people's medicines, the prescribed amount and when they were required to be taken. We found people's care plans reflected what the carers told us including how people's medicines were dispensed by local pharmacy. Some people had specific medicine requirements for example one person found it easier to

swallow their medicines when it was in food. We saw agreements had been put in place with their GP. The carers explained to the person the medicine they were receiving each time they gave it to them. This meant carers knew what to do and the advice and agreement of the person's GP was incorporated into people's medicines plan.

The Shared Lives staff team carried out annual health and safety checks in people's homes. We saw these included the layout of the home and if it was suitable for people who used the service. These checks were recorded in people's care plans and carers confirmed to us they had been carried out.

The service had in place the local authority safeguarding policy. Staff and carers had been trained in and understood safeguarding how to report any concerns. We found any safeguarding issues including the stability of placements were reviewed when people's care plans were reviewed. One relative told us how a Shared Lives staff member shared with carers about how a person got a bruise and made the relative aware. They told us, "That way everyone is kept safe." This meant people's safety and well-being were constantly monitored by the service.

The staff in the scheme recognised the increasing demand for new carers to ensure they had a plentiful supply of carers to meet the needs of new people referred to the scheme. We found they had taken action through a new publicity campaign to increase the numbers of carers and had plans in place for their next recruitment phase. This meant the service was addressing the need for additional staff. We saw that new staff members had been bought into the team to support the demand for the service.

The service had in place carer agreements which stated the expectations of carers in their dealings with the scheme and people who used it. This meant the service had in place a framework for ensuring people were kept safe whilst using the service.

We saw people's human rights were protected by the scheme. For example Article 8 – the right to family life was embedded in the service. Carer's provided support to people to access and spend time with family members who were important to them. We found carers promoted Article 5 – the right to liberty and security when they worked with other professionals to decide if people needed their liberty restricted to keep them safe. This meant the shared lives scheme adhered to the requirements of the Human Rights Act.

Is the service effective?

Our findings

The carers we spoke to told us about their backgrounds to us and demonstrated they brought to the scheme a wide range of skills and knowledge. Some carers spoke to us about working in other roles where they had gained learning and expertise to support them as a carer. We saw staff had invited carers to relevant training opportunities. Each carer had a minimum of first aid training and safeguarding training. Carers told us they felt they had sufficient training to meet their needs. Going forward we noted carers had been told new carers would need to complete the Care Certificate in line with government guidance. The Care Certificate is a nationally recognised qualification for people new to care work. It sets out minimum requirements to be covered in induction and training before people in the care profession can work without direct supervision.

The manager told us when carers required bespoke training this could be accessed via the learning disabilities team. We found carers had been given specific guidance and training to care for people. For example, they had been taught to use equipment for people to assist in moving and handling by other professionals. We saw this was not recorded in the carer's on-line files. We spoke with the manager about this issue during our feedback and discussed the scheme being able to demonstrate carers had received the required training to be able to care for people with severely complex needs. The manager agreed to address the issue.

We saw staff in the service received regular support through supervision with the manager. The service staff held three monthly reviews with carers to look at their support needs and how they were managing each placement. Carers confirmed to us these took place but also pointed out that if there any additional needs or concerns they received the support as and when it was required. One carer told us if they contact the service a member of staff, "Gets straight back to them." One person told us they were able to tell the service anything without fear and they felt they would always get a positive response. We found carers felt they were well supported by the service. One carer told us they had been doing the work for 15 years and praised their support staff. They told us they had, "Never felt any different."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the Shared Lives staff and carers understood the issues of capacity and had received training on the issues. People whose capacity varied due to mental health issues were monitored by their carers.

We saw the Share Lives staff team had agreed that before a person is referred to the scheme they need to have undergone a capacity assessment to determine if they have the capacity to decide if they wished to be cared for in a family setting. We found consent was a key theme of the service. People's care plans reflected when people were able to consent and how people communicated their consent.

Guidance had been given to each staff member which gave information on the principles of Mental Capacity Act and specific information appertaining to shared lives schemes sourced from the Law Society. These included potentially liberty restricting measures which may apply to such a scheme and included vary levels of supervision and guidance with activities of daily living, preventing the person from leaving unaccompanied for their immediate safety and addressing challenging behaviour. We saw these measures had been considered in people's care planning. Where people's capacity to make decisions had been questioned we saw best interests' decisions had been initiated and assessments undertaken before decisions had been made. For example one person had been assessed about using public transport. They were found unsafe to manage these arrangements and plans were drawn up in their best interests to access supervised transport.

We saw that people had in place plans support to their nutrition and hydration. These included people's preferred eating habits and when required carers were to encourage and support healthier eating. One person was reported to like to regularly eat snack food and their carers were to encourage a healthier lifestyle. Another person preferred to stand to eat their meals. We found in people's care plans some people had food to avoid due to the impact they were known to have on their behaviour. We saw that where people liked to drink alcohol they were supported by carers to do this in moderation. This meant people were supported to have appropriate food and drink.

We saw in people's physical health section of their care planning document carers were responsible for ensuring people attended medical appointments including unplanned emergency visits to the GP and planned hospital appointments. We saw family members had also arranged appointments for people and carers supported them to attend. Carers we spoke to told us about people's medical appointment and confirmed their support to people. We found carers had been involved in monitoring people's symptoms before reporting these to medical staff. This meant carers monitored people's health needs and supported people to sustain good health.

People's relatives told us they found the communication with the service to be good. They described regular communication with the Shared Lives staff and praised them for making sure actions were carried out. During our inspection we heard staff communicating with people with respect. One carer said the team were good at communicating with the carers. This meant people were happy with the levels of communication with the service.

Is the service caring?

Our findings

Carers we spoke to who had looked after people since they were children were happy that the Shared Lives schemes existed. One person said, "Another carer told us they found the scheme, "Very rewarding." Carers told us about their personal past experiences which had motivated them to join the Shared Lives scheme. For one carer it was important that people were, "Never on their own", and they always had someone for them.

Carer took a positive approach about the people they cared for. One carer said, "He's a treat to have." We saw carer's promoted people's well-being. This was either carried out by the range of activities people undertook but also the inclusion in their family life. We saw people had been included in family holidays and taken to places they enjoyed.

Relatives we spoke to told us carers were committed to their roles. They told us they, "Got along well with the carers." Carers talked to us about people with warmth and affection. One relative told us, "They are part of the family". This sentiment was echoed by other carers who reported to us that they had cared for people in excess of ten years. This meant people using the scheme were an accepted part of people's families and relationship networks.

Written into people's care planning documents we found descriptions were given to carers about providing information and explanations. This included carer's explaining about people's medicines or explaining to people about what was going to happen next. We found carers explained to people about medical appointments to reduce their anxiety. One carer went to the person's medical appointment on their own to get the person's results as they were too anxious to go with them. This meant the carer had supported the person to understand their health needs.

New publicity information for new carers had just been completed by the service. We found carers with their family members and the person they provided care for were the focus of the new publicity to promote the scheme. The manager provided reassurances that appropriate consents had been obtained. This meant the service had involved people in promoting their own scheme.

We found the service had adapted national factsheets to give carer's information about the service, what it is designed to do and what is required of carers. A newsletter provided additional information and updated carers on recent events including changes to the staff team.

We found the service encouraged and support people's relationships with their family and friends by flexible arrangements for visiting and arrangements for stays at home. We spoke with family members who confirmed the service worked with them.

Staff in the Shared Lives service praised the carers for their support and dedication to people in their care. They described to us how carers managed people with very complex needs, often supported by their other family members.

We saw in people's care plans arrangements for end of life care had been put in place. This included consultation with family members and GP's as well as people's having put in place end of life expenses. Suggestions were made in the care plans as to how end of life discussions could be held tactfully involving the carers as and when the opportunity arose. We found the service was willing to engage in end of life discussions with people giving them a choice about how they wanted to end their life.

We saw people had been supported by advocates to help them make decisions and contribute to carer reviews. Family members had also acted as natural advocates and worked with carers to support carers to work with their family members. One staff member told us about one carer who had advocated on behalf of the person they were caring for with the medical profession. We spoke with the carer who confirmed they had acted in this role to give the person using the service a break from continued attempts to reduce their medicines. This meant people using the service were encouraged to have a voice and be supported in matters which affected them.

Carers spoke to us about promoting people's independence. We saw in people's care plans discussions had taken place about each person's need for independence. For example one person was able to dress themselves, another person was able to go and use their mobile phone. Other people were able to access public transport. One person was able to go to the local shop without crossing roads to buy chocolate, another person was able to have a key to their carer's home. We found the service had adapted to each person's needs to promote their independence.

In our discussions with carers we found they had a positive approach to disability and an acceptance of people with additional learning needs. One carer described a person as noticeably, "Slowing down" and added, "But we all do that don't we." We found carers supported people to try new things including holidays abroad. In one person's care plans we read a carer felt that a person whilst restricted by their disability were not restricted in what they do because of the involvement of the family. This meant despite their disability the family for example supported them to go on holiday and visit new places. In our conversations with carers we found they had developed ways of ensuring people were not restricted by their disability.

People each had their own bedrooms where they could seek out privacy if they wished. One carer reported a person preferred to, "Sit in the garden." Carer's recognised the need for people to have privacy.

Is the service responsive?

Our findings

One relative told us they could not do without the carers and said they had "No Concerns." Another relative told us they found the carers, "Easy to get along with." A carer told us the Shared Lives team were "Fantastic", this was partly due to the response they gave carers including positive feedback. One carer felt the staff team, "Took care of the carers." Another carer told us, "The service is wonderful" and described their support worker as, "Amazing." Members of the team we spoke with recognised that the carers do a demanding job and if they ask for support they need to respond quickly

We looked at seven people's support plans and risk assessments and found that these were person centred. This meant that the plans were specific to each person and described their individual needs. We saw the plans gave detailed information pertinent to each person likes, dislikes and their individual needs. For example one person had an allergic response to make up, another person required a particular shampoo to treat their scalp and another person required a specific wheelchair. This meant people were treated as individuals and their plans reflected their individual needs.

The scheme had in place Service User Plans and Risk Assessments (SUPRAs). SUPRAs were divided into Physical health, Mental Health, Mobility, Personal Care, Community and Road Safety, Communication and Accommodation, Animals/Pets, Daily Living Skills, Leisure/ Lifestyles and Consideration for Holidays. We found there was up to date information recorded in each section including what had and had not worked with each person. We saw additional information on events which had taken place between reviews was also recorded. For example these included, family bereavement, and any best interests' decisions. The carers told us they were in possession of sufficient information to be able to care for people and had access to specialist advice when required. We discussed various aspects of people's care with carers and they were able to tell us the contents of the plans. This meant carers were familiar with the care needs of the people who used the service.

Each of the care plans identified the person responsible for meeting a person's needs. This could be the carers, their respite carers and their family members. The SUPRA listed the people who had been consulted in the review and other sources of information used. We saw people using the service had all been consulted together with family members, care managers, Shared Lives staff and staff from other services used by the person. This meant the care plans used by the service were informed by the person and other professionals with whom they came into contact.

Additional information was also provided in the SUPRA around safeguarding issues and where there were issues happening in the carer's own family how these were being managed. This meant that support was provided to people where there may be difficulties in their placement.

From the SUPRA's and our discussions with carers we found people were enabled to enjoy active lives. Some people attended day centres. One person liked to go for a walk every day, another person went swimming. We found people were engaged in a variety of activities including attendance at a leisure centre, horse riding, shopping and services provided by a beautician. People using the service were also supported

to volunteer; for example one person helped in a charity shop.

We saw the service had in place a complaints procedure. The manager told us there had been no complaints in the last year. We spoke to relatives and carers who knew of the complaints procedure but told us they had never felt the need to use it.

People had in place arrangements for respite care with either that care being provided by the Shared Lives scheme or provided by other care staff, or family members sometimes under a direct payment scheme. We spoke to some carers who were transporting people to their respite placements and to a relative who was expecting their family member to be dropped off for the weekend. We found the transfers between people's care placements were managed positively by people involved in the scheme.

We saw in the newsletter the shared lives scheme had planned two coffee mornings to celebrate and acknowledge National Shared Lives. The newsletter said, "We look forward to seeing you there and it will be an opportunity for you to meet and catch up with other Shared Lives Carers." This meant in addition to celebrations carers were given the opportunity to meet up with other carers and avoid social isolation.

The service had in place clear community links with other services and professionals who supported people. We found carers and support staff linked with GP's, community nurses, occupational therapists, physiotherapists and community based psychological services.

Is the service well-led?

Our findings

At the time of our inspection the registered manager had left the service and a new manager had recently been appointed. The new manager had applied to become registered and submitted applications to advise us of the change the location. This meant the service had taken all reasonable steps to meet the regulatory requirements.

Staff told us they felt confident in the new manager and said they were taking the right actions to move the service forward. The carers described feeling well supported and cared for by their respective workers.

The manager was able to give us a good account of the service. They provided us with all of the information we needed to conduct the inspection and explained their future plans to improve the service. For example the new manager told us they had put in place a monitoring process to measure numbers of prospective carers attending an introductory meeting and then converting their interest to applying to become a carer. They believed the rate to be low and wanted to examine the issue in more detail.

The service had an up to date statement of purpose, this is a document which tells people and their relatives what they can expect from the service. We saw the statement of purpose explained the process new carers were expected to go through and there were clear expectations of people referring to the service about the amount and type of information required from them to be able to match people with prospective carers.

We saw the service had in place a team business plan. The plan reviewed where the team were currently at and included actions for the forthcoming year. The plan included a Strengths, Weakness, Opportunities and Threats (SWOT) analysis. This included ongoing recruitment, training and approval of new Shared Lives carers. We saw this action had been taken forward, new publicity material and information sessions for members of the public had been set up. This meant the plans were being translated into actions.

The registered provider had introduced a new computer system to record people's information. We found the staff were in the process of transferring new information across from their old system. Both systems had security measures in place and were password protected. This meant people's information was stored confidentially. Staff told us they were making progress in the transfer to the new system and recognised further work was required to bring the new system up to date whilst they continued to maintain up to date records in the old system. In speaking to carers we found people's SUPRA's were up to date and accurate.

We saw there were annual reviews of carers to monitor their progress and check if they were able to meet the requirements of the Shared Lives Schemes. Arrangements had been put in place to enable people who used the service to contribute to the review. One carer told us the person in the household was 'Always present at the review.' This meant in the continuous assessment of the carers the professionals perspective was not the only view taken into account.

Carers were asked for feedback on the service. We found carers had made positive comments about the service. The service had put in place a new carer feedback form. The manager explained the form was

simpler and would enable them to be able to aggregate the results and better measure the service.

The manager chaired a staff meeting and from the minutes of the meetings and discussions with staff and carers we found they had brought and number of oversight changes to the services. This included the development of a communications strategy to the wider public to recruit more carers. The service was also moving to adopt the best practice assessment of new carer's guidance from the UK network service of Shared Lives Plus as this dovetailed with the new carer's requirement to complete the Care Certificate. The manager also required that they had signed off people's SUPRA's We found the manager had made a number of changes to the service which indicated they had questioned the practices of the team and were willing to be accountable and responsible for the service.

The service had recently moved and was co-located on the same floor of the Civic Centre in Kirklees with other disability services. The manager explained this had led to improved communication with partners in other learning disability teams. We saw the service worked in partnership with the care managers of the other teams on the same floor, but also had similar working in partnership arrangements with health care colleagues for example specialist epilepsy nurses. Carers were also supported to develop community links including access to local leisure facilities, and volunteer opportunities for people using the service. We found each person we looked at who was using the service at the time of our inspection had a different community network in place and different partnership working arrangements to support their care.