Care Quality Commission

Kirklees Metropolitan Council

North Short Term & Urgent Support

Inspection report

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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?	Outstanding

Summary of findings

Overall summary

The inspection of the North Short Term Urgent Support Service took place on 18 July 2016 and was unannounced. The service has a history of compliance with all health and social care regulations. The last inspection was in February 2014.

The service provides support to people aged over 18 in three main ways. There is a re-ablement service which supports people for up to six weeks to assist them to live as independently as possible, a rapid response service for up to five days to prevent admission to hospital or support in the event of a breakdown in carer arrangements and a support worker service which provides assistance for people living with long term conditions where there may be an acute episode requiring intense, time limited input. On the day we inspected 52 people were using the service. The service operated 24 hours a day, 365 days a year and had an out of hours contact number if an issue arose outside of office working hours.

There was a registered manager in post and we spoke with them during the inspection process. 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.

People spoke very highly of the professionalism of staff, who balanced their knowledge and experience with friendliness and empathy. Staff were fully aware of the importance of gaining people's trust as this helped to build relationships and encourage people's co-operation with more personal tasks.

The service was very responsive to need, with each input specifically designed for that individual. This could include personalised therapy alongside more generic support with daily living tasks. Care records evidenced a detailed assessment and subsequent support plan identifying key objectives and the preferred method of meeting these. These were regularly reviewed, assisting people to reflect on their progress and assist for planning if ongoing support was needed.

Complaints were handled well and in a timely manner, with all resolutions recorded. Lessons learnt were shared with staff and the service used these as a mechanism to improve. The service had received many compliments from people using the service and their informal carers, emphasising how much progress people had made and the value of the service in restoring confidence.

People indicated their appreciation of the service and how supported they had felt from the start to finish. Staff worked with high morale as they felt acknowledged and could see the value of their input. We saw evidence of strong leadership with a clear vision for the service which was reflected in all aspects of service delivery and provision.

Quality assurance was robust and showed the service responded quickly to changes, had capacity to be

flexible and was keen to develop so that people had the optimum care and support possible.

People said they felt safe when working with staff as they were confident staff had the necessary knowledge to support them well. Staff knew what constituted a safeguarding concern and how to report such matters. Their knowledge showed a wide understanding of the potential areas for people living in the community.

Risks were managed well with reduction plans in place that sought to provide guidance and information to all staff. Accidents and incidents were logged appropriately with swift action taken where required. This was then absorbed into staff meetings and training so that lessons were learnt from such situations.

The service had a finite number of hours allocated and met the needs of people within this. It was flexible and responsive to people's needs, and through regular reviews ensured people received an appropriate level of service, enabling their progression through the system.

Medicine management was supported with effective policies and procedures and staff were able to explain their role and how this was managed with people they supported.

Staff received a thorough induction and ongoing supervision through regular meetings and appraisals. In addition, staff accessed all mandatory training and were able to request additional training as needed such as supporting people with alcohol dependency.

The registered manager and staff understood the requirements of the Mental Capacity Act 2005 and the importance of obtaining consent for each specific support task. This was evidenced in people's notes.

People were supported with nutrition and hydration where this was an identified need, and if concerns arose during other support tasks, staff raised this with their line managers and action was taken. Health and social care services were accessed as necessary, and there was evidence of close partnership working with the therapists attached to the team and other referral agencies.

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.

People told us they felt safe and had confidence in staff's abilities to continually re-assess risk. Staff understood how to report safeguarding concerns.

People's needs were met by regular staff and cover always arranged in the event of sickness or leave.

The service had a robust medication policy and procedure in place which staff could explain.

Is the service effective?

Good

The service was effective.

Staff had received all necessary training and were equipped to perform their roles well, having a good understanding of re-enablement.

The registered manager understood the requirements of the Mental Capacity Act 2005 and referred to other services where necessary if issues around capacity arose.

People were supported with nutrition and hydration, and the service was pro-active in referring to other health and social care agencies as required. There was good evidence of partnership working

Is the service caring?

Good

The service was caring.

People spoke highly of the staff and their professionalism.

Staff demonstrated through their discussion, records and input into service direction the importance of treating people with dignity and respect.

The service showed that consent was sought for all tasks as needed and this was recorded.

Is the service responsive?

Good

The service was responsive.

People had a person-led service that reflected and met their needs, adapting where necessary.

Care records were detailed and evidenced that the person was central to objective planning and that these were assessed on a regular basis.

Complaints were handled in a timely manner, and the service received regular compliments.

Is the service well-led?

Outstanding

The service was very well led.

People were very happy with the service they received, saying how much it had restored their confidence. Staff displayed high levels of motivation aided by regular recognition by their immediate and more senior managers.

Leadership was strong and the service had a clear purpose and focus, supported by robust quality assurance systems which aided its development and responsiveness.

Care Quality Commission

North Short Term & Urgent Support

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 18 July 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available. The inspection team consisted of one adult social care inspector.

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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with six people using the service and one of their relatives. We spoke with five staff including two carers, one occupational therapist, one physiotherapist and the registered manager.

We looked at four care records including risk assessments, three staff records including all training records, minutes of meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Good

Is the service safe?

Our findings

One person we spoke with said "Staff always turn up on time. If they are slightly late they always explain why and we appreciate that they get caught up." Another person told us "They have done their best regarding the time of calls. I really appreciate the service. As I have improved I only have one call a day and when I am due my bath, they ring me ten minutes before so I can put the plug in!" A further person, while appreciative of the service complexities, said "When it is not my usual team and cover is arranged call times are not always ideal. I have caring responsibilities and need support at specific times. They have tried to accommodate this as much as possible." This person felt the service had moved from more traditional model of home care support where tasks were completed by staff but needed to be more flexible around people's specific needs on occasion.

We asked people if they saw the same staff. One person said "I have the same four people usually unless they are on annual leave or having to cover. They always introduce themselves." Another said "It's the same people who visit but the time may vary." A further person said "It's the same few carers. They are always on time." The registered manager told us staff were organised in teams of four to reflect staff's working practices which helped to promote continuity for people receiving the service. Staff also reiterated this and one told us "If I'm running late I will always ring the service user as I know they would worry. It's just courtesy."

We asked the registered manager how they met demand for the service and they told us "We usually support around 80 people at any one time but it can vary. We do not restrict call times – staff are there as long as they need to be. Availability is managed through regular reviews of provision, as people improve they move on and we are able to take on more. At the moment there is a waiting list managed by the hospital." The registered manager advised us that the service had access to three therapists who provided occupational and physiotherapy support and expertise. This meant people could access immediate support and advice when needed, preventing the need to enter the hospital system.

We checked staff recruitment records and found the service was ensuring staff were subject to the appropriate scrutiny. References were obtained and followed up if further information was required and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

The registered manager informed us of the rigorous recruitment process which included written tests around the importance of respecting dignity in care and also a face to face interview. Staff did not start working until all checks had been processed and everything verified. Once a start date had been confirmed staff began studying for the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. The registered manager advised that if a staff member had already achieved a National Vocational Qualification (NVQ) they would complete a self-assessment tool to identify any gaps in knowledge so these could be addressed. The service had a weekly drop in for staff to get their workbooks marked and be provided with feedback.

All people we spoke with told us they felt safe while receiving support. This was due to staff being knowledgeable and also introducing themselves. One person actually said "The service has been a lifesaver. It helped me move out of hospital after a prolonged stay." Another person said "I feel safe and comfortable as all staff are very pleasant." Each person had had an assessment prior to the service starting and was presented with a welcome pack containing key information such as contact information, statement of purpose and service information, a complaints leaflet and a service questionnaire.

The registered manager had reported safeguarding concerns as appropriate and sought clarity where it was unclear. One staff member told us "I have never seen anything in relation to staff conduct that has worried me. They are all good and caring, and I would report any concerns immediately." They continued "We all realise the importance of good communication. We all ring each other and pass on any key information at the end of our shift. We accept that it is important for people to have a consistent service and so we try and maintain the same way of supporting someone if possible. We also read the care notes on every visit." This shows the service had tried to limit the effects of staff changes on the individual receiving the service as far as possible.

A different staff member told us "I would always report any concerns. I would do this in person in the office and discuss with my colleague providing support so that I made sure I wasn't jumping to any wrong conclusions." We asked staff what may constitute a concern and one told us "I would be worried if the person had no food in the house or if there were regular visitors that did not appear to have the person's best interests at heart." Another said "I would be alert for family members perhaps getting irate or raised voices." Both of these showed that staff had a wide appreciation of what may be a concern and how to deal with this.

We looked at how the service assessed risk. One person told us staff were excellent in providing support as "They suggest alternatives. I am not always able to assess risk and they see things that I can't. They suggest alternatives ways of moving to limit the risk of harm and have helped me to learn new moves." This shows the service was fulfilling its role as a re-enabling service by providing people with the skills to carry forward in managing their own care needs.

Staff were also trained to look for risks on each home visit. One staff member said "People are safe as we risk assess before we visit and all the time we are there. We may suggest a rug is moved to limit the likelihood of falls." They had all received training around supporting people with assistive technology such as carbon monoxide detectors, care alarms, fall preventers and medication dispensers. The registered manager said that staff were the eyes and ears in people's homes and were trained to see why someone could not achieve a particular task such as opening a medicine bottle. Each of these products promoted people's independence and helped to restore confidence.

The registered manager advised us that people were initially assessed and a support plan generated as a result of the identified needs. Through this process risks were identified and the service had a comprehensive risk assessment toolkit. We saw evidence of thorough home environment risk assessments looking at specific hazards such as flooring, access and equipment. Each of these was assessed against the likelihood of harm and measures put in place to reduce the risk wherever possible. If risks were not immediately resolvable then it was recorded and actions noted as to how to ensure they were minimised as much as possible. The service occasionally supported people with basic shopping and staff carried receipt books as proof of any financial transactions.

People's moving and handling needs were assessed in detail if they required assistance with personal care tasks. This was done swiftly in the event of a person being acutely unwell. The registered manager said some

people were on the re-enablement service who had had a stroke and their improvement goal was to move from a hoist to a samhall turner which maximised their potential. A comprehensive risk assessment was completed in relation to any equipment in use. This considered the task, staff capability including training requirements, the needs of the service user in regards to pain or involuntary movements and the environment. The assessment identified possible issues and suggested remedial actions. As a consequence of this assessment a specific hoisting plan was created with pictorial and written instructions as to how the hoist and sling should be used. This meant staff had clear and person specific instructions in order for them to assist someone in transferring. One staff member said "If I had any concerns about someone's condition then I would report back and an OT (occupational therapist) or physiotherapist would come and re-assess."

Few people receiving support required assistance with their medication as most of their needs focused on physical support. However, the service had detailed records for medication where required. This included the person's key details including their pharmacy. This allowed the service to make contact if there were any queries and family were unable to assist. The name of the medicine was noted alongside its location (for example, dosette box), the dosage amount, description of the medicine and the administration method (for example, orally). If a person refused their medicine this was recorded on an exemption sheet giving the reason why and followed up with the locality manager if this continued. Topical medication was recorded in the MAR chart if prescribed along with a body map. The medication policy gave clear guidelines to staff as to how to administer eye drops and the importance of infection control.

Staff had a good understanding of safe medication processes. One told us "I am only able to prompt medication. I sometimes assist with removing unrequired medication from people's houses and get a receipt when I return them to the chemist. We have a medicine administration record (MAR) which we sign if prompting people." They explained this detailed each medication if it was boxed but if the medicine was in a dosette box then the MAR details the number of tablets in each section." Another said "We check medicine is not out of date, is for the right person, is recorded properly and the dose being taken is correct. We also check stock levels and report any issues, and also the fridge for eye drops or other medicines needing to be stored in a cold environment." They also said that district nurses administered any controlled drugs such as morphine if the person was not able to do this themselves as they were not authorised to measure these out. These examples illustrate that staff had a sound awareness of their role in regards to medication and how to safely administer them.

Accidents and incidents were recorded appropriately and evidence of action taken where needed was recorded in both staff and people's files. In one specific issue a staff member had been offered further training and a risk assessment altered to reflect a change in need alongside some new equipment for a person. This showed the service was considering accidents and incidents in a timely manner and taking restorative action where required.

Good

Is the service effective?

Our findings

One person said "I feel staff know what they are doing. They are very good and have received the necessary training." Another person told us "I am confident that carers know what they are doing. I've no complaints." One relative told us "The carers are very knowledgeable and good at their job." They continued "My relative is supported with their choices such as asking which nightclothes they want to wear or if they wish to have the bed changed."

We looked at training records and found staff had received all necessary key skills training, and that if this was due for renewal this had been identified and staff booked on a course. Staff completed workbooks and e-learning, and these were assessed. Staff had gained access to a learning site in Kirklees which helped them complete training together and discuss their knowledge. Topics covered included moving and handling, safeguarding, health and safety, dignity, mental capacity, the Care Act 2014, infection control, medication awareness and support planning. Training was also practical including the use of specific pieces of assistive technology and how to best support someone on the stairs who may have lost their confidence. The registered manager advised the focus was on 'how a staff member would feel receiving the service'. One staff member said "I shadowed for six weeks before starting in the service."

Staff told us they had supervision every few months. One said "I've had one this year in addition to an appraisal." We asked staff if they felt comfortable raising any issues. One staff member told us "I'm not frightened to voice my opinion. I feel I am listened to and that we work as a team." Another staff member said "I'm very happy that I am listened to." We looked at supervision records and found they included discussion around staff's wellbeing and how they were managing their workload. It was evident there was a two-way dialogue and that staff were honest in their views. Specific knowledge was also shared with staff such as changes in policy and procedure or whether their training needed to be updated. Supervision was reflective looking at a particular issue, how this may need to be addressed and what actions needed to occur to support this. These were all signed by the manager and member of staff.

The registered manager explained that a new supervision policy had recently been implemented which aimed for all staff to receive six supervision sessions a year. This would include quarterly one-to-one sessions which their locality manager would facilitate, one community-based supervision observing their interaction with service users and their annual appraisal. We saw evidence staff were receiving supervision and appraisals. This was in addition to weekly reviews of all people receiving the service where contact was made directly with workers and team meetings which were held six-weekly. Locality managers also conducted observations of staff while they were performing tasks which showed the service was keen to ensure high standards of practice.

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.

One person said "All staff ask my preferences and do listen. We have developed a relationship as time has progressed." Another person said "They do what you want. They always ask my preference for breakfast whether it is toast or cereal." Staff were knowledgeable about to how to assess everyday capacity. One staff member said "We observe, support and prompt where needed. A person needs to be safe in their environment and we offer options to help them in this as far as possible. This could be through a dosette box or electronic medication dispenser if needed." Another staff member also advised us of the importance of checking for infections as they knew this could impact on someone's capacity. They also said "If things start moving around a person's home this could be a sign they are hiding things and it could be sign of dementia." These examples show that staff had a good understanding of capacity issues.

We asked the registered manager how staff supported people who lacked capacity. They said initially they would speak to the referrer about this, partly to judge the merit of a person receiving the service as diminishing or fluctuating capacity was a potential hindrance to the effective progress of a person's objectives. If they found there were some issues with capacity, then a best interest meeting would be held with the social worker to establish what decisions a person could make for themselves. The service sometimes worked with people who had a temporary impairment due to intoxication and staff advised us they had received specific training in this area. One told us "I know we can't cure people and we sometimes have to walk on eggshells. But we can ensure they are encouraged to eat, have food in the house and receive their medication."

The registered manager advised us that the service support people to eat and drink but that most people were encouraged to do this themselves. They said staff received training in identifying whether there may be difficulties in this area. One of the recent team meetings had included a session on 'Care to Cook' which was an initiative aimed at supporting staff to cook from scratch using basic store cupboard ingredients.

Staff also gave us examples of supporting people. One said "People can be at risk of self-neglect and will offer food to their dogs before eating themselves. We can't stop them. We offer them a choice of meals and encouragement. We always document what was offered and report back any concerns." Another staff member said "We use different techniques with people if they are reluctant to eat. We encourage them into the kitchen to make a cup of tea and then offer lunch. However, we know we can't force people."

The service worked alongside other professionals on a daily basis. Apart from the therapists attached to the team they accessed support from community matrons, GPs and district nurses. No one was currently needing pressure relief but we saw that there were records detailing the frequency and position of people if this was needed. Staff told us they were aware to report if they saw any signs of redness on people and the importance of checking if a person had diabetes as they were aware of the impact of this. We saw in people's records that other services were contacted as needed. In one record we saw "Toe nails are really long and curled under. Advised to ring GP and feedback. The GP receptionist agreed to refer to podiatrist." This showed the service ensured that all people's needs were considered rather than just those under their remit.

We met with the therapists attached to the team. They advised us communication was excellent between the service and themselves. This could be verbal, email or via meetings which discussed people's progress at regular intervals. We asked if they felt their input was requested appropriately and one therapist told us "Yes, it's appropriate and relevant. We do joint visits and work with the carers to support. This could be with personal care tasks such as showering or with more specific issues such as moving and handling although

locality managers are qualified to assess for more standard moving and handling issues."

Good

Is the service caring?

Our findings

One person said "The carers are exceptional. I have been involved in all changes to the support." Another told us "The carers are very good. My support has now reduced to two visits a day from the original three and I was in full agreement with that. They listen to me and take things at my pace. I am never rushed." A further person said "The carers were all very friendly and listened to me. I have progressed a lot faster with their help. "One relative told us "They are more than good, they do extremely well. They put themselves out to help. I can't fault them." We also read in a compliment received by the service "I've had excellent help. All carers have been very pleasant, professional, caring and encouraging. They have helped me to recover physically and to restore my self- confidence."

One person said "Staff always try to preserve my dignity. This is done through their practical and friendly approach so I am made to feel comfortable."

One person said "I was involved in a review last week where my longer term needs were discussed. This included a discussion around what help I had been receiving and what I felt I would need moving forward." We found evidence in care records of consent forms being signed by people using the service to agree to the sharing of their records with other professional agencies as required.

Staff were very aware of their role and its limitations. One member of staff said "I have to sit on my hands so that I don't do things for people. I need to be assertive but let people do as much for themselves as possible. I am constantly assessing their abilities and I need to ensure my communication skills are good so that people understand what I am asking them to do. I am always courteous and listen to people. By developing a relationship this enables them to open up." Another staff member said "It's important to gain people's trust when supporting with personal care. We learn ways of working around uncomfortable issues so we can gain their trust. This may be by mocking yourself to make them feel better. We never talk down to people." This staff member told us if they spotted someone's toe nails needing cutting, they would suggest organising a chiropodist for them. We saw evidence of issues like this being addressed in people's care records.

Staff we spoke with were also aware of cultural and religious needs of people. One told us "We're not there to condemn or comment. If we're not sure of how to respond to someone we ask. I always say 'tell me if I'm doing anything wrong' and will always follow family instructions. If there is a language barrier I will use basic signs which most people seem to follow."

The service supported people needing end of life care. There were close links with community matrons and district nurses who guided staff as to the best form of care a person could receive. All needs were documented on a person's care plan and family needs were also addressed as well. The service had a two hour response time and responded to requests from hospitals to provide support if someone wanted to die at home. Equally, if a person deteriorated suddenly the service would continue to support rather than passing the person on to a longer term service even if this meant they had exceeded their time allocation.

Staff told us that supporting people at end of life followed the more traditional method of home care. One staff member told us "It's more normal care delivery. We show empathy and are caring. All equipment will be in place and if we need it we just ask. We also support the family and encourage them to be in contact with any issue, no matter how small."

Good

Is the service responsive?

Our findings

One person said "I originally had three visits a day but this has now reduced to one as I've got better." Another person said "Some carers were a bit startled that I do not want microwave meals. It would seem that this is the norm. However, all have supported me with this as I have requested food from scratch." This person continued "Some staff are quite task focused but most are willing to let you work at your own pace. One carer said to me 'Don't worry [name] about taking a long time. I'll be here as long as you need me to be'." This person's health had deteriorated since receiving the service but they stressed that staff supported them each day depending on how they were feeling and did not pressure them to do more than they could.

At the outset of provision people set goals and objectives so their progress could be measured. If people were judged to be 'safe' then calls were reduced but equally if their needs deteriorated more calls could be provided. The registered manager explained people were reviewed on a weekly basis by feedback from the support workers and after four weeks an 'exit strategy' was planned. For people requiring ongoing support they would be assessed by the therapists in the team along with an assessor who would facilitate further assistance.

Staff were also aware of the importance of setting achievable goals. One staff member said "I could suggest someone should get out in their garden or it may be a trip to their bingo club. We would walk to the bus stop together." Another said "We take as much time as needed. This can be up to two hours a visit. People receive as little or as much time as needed." Staff were very aware of the ultimate aim of the service was to restore people's independence. One said "We are fully aware of a range of equipment to support people such as a toilet frame or grab stick. We will teach people how to use them. They may need a shoe horn or a sock aid, or may need the input of an occupational therapist. We can sort this."

Staff had access to key information from their electronic handset which outlined key tasks and these were used in conjunction with paper records kept in the person's home. The electronic device linked in with the office systems so that the locality managers could see where staff were at any given moment and it would alert them to any difficulties. This enabled the service to have a real time record which highlighted what staff were doing and where, and ensured that both staff and people using the service were safe and had current information enabling support to be provided in line with people's wishes and agreed goals.

We looked at care records and found them to be very detailed and person-centred. Each person was assessed at the outset of receiving the service and key information recorded. This included their mental health, medical needs, skin integrity, sleeping pattern, social activities and support needed for daily living tasks. In one record it stated "Sits outside on the wall on a nice day." People's needs in relation to medication was also recorded, determined by whether they were able to self-administer, needing advising or actual administering. Details were logged as to what specific assistance a person needed with the long term goal being the focus.

These support plans enabled staff to follow clear guidelines to ensure people were having their needs met in line with their objectives. Plans focused on what a person was able to do for themselves, what their outcome

was for each identified need and their preferred method of having this need met. For example we saw "Due to poor memory I need reminding and monitoring that I am completing my personal care and changing my clothes when they are dirty as I often forget to do this…..I am able to dress and will do this in the bedroom. I can choose my own clothes from the wardrobe" which indicated the need and the outcome was logged as "I like to maintain a good level of personal hygiene and to wear clothes of my own choosing." The support plan was signed by the person receiving the service.

Each record contained evidence of weekly reviews which indicated how the person was performing in relation to their agreed objectives. This was through information obtained from the care staff initially but a home visit was usually conducted by the locality manager in the fourth week. In one record we noted "Sofa appears low. Request to OT for chair raisers. Staff support with medicines and encourage [name] to eat and drink. Prompts are given for personal care and to change clothing." By the following week the person had improved that they only needed a morning call as opposed to two calls per day.

It was easy to track each person's progress as records were stored in terms of assessment, planning and review, correspondence, risk assessments and their previous referral history. All contact with the person was stored including evidence of their introduction to the service and an ongoing chronology sheet so any contact was tracked. Issues such as lack of access to a person's home were recorded and how this was resolved. It was evident that responses were timely and considered, and ensured the safety of the individual at all times. One entry noted "Forgetting to take medication so a medi-dose box was arranged."

Where people were receiving specific input from a therapy service such as assistance to walk, all attempts and successes were recorded in a chronological log providing a quick reference point for staff. Each visit had a separate entry sheet so staff could see what tasks had been carried out and any significant events. Where concerns were noted, entries showed actions been had taken to address these such as calling the GP.

One member of staff we spoke with had a sound knowledge of key local services. They told us "we can tell people about the car companion link service which will take people out to local places such as Ponderosa where people can have lunch and feed the animals." They said "I get great job satisfaction when people's quality of life improves." This shows staff were providing more than care support and were aware of the importance of social interaction in improving people's wellbeing and aiding their recovery.

One person said "I've no complaints. I'm very pleased with the service and the carers' attitude." Another said "I've had no reason to complain but would feel able to if needed." One relative said "I will be writing a letter of thanks when the service ends as they have been invaluable."

The registered manager advised us that all complaints were logged along with all compliments. Every compliment was acknowledged and sent to the specific team members so they could see how much their input had supported someone. We looked at the complaints and compliments record and also saw that senior managers in the local authority had also seen the compliments and thanked staff directly. One staff member told us "We get letters of appreciation from the manager for helping out." Another said "It's nice to receive compliments as I know I've done a good job. What counts is when people say thank you."

All complaints were logged and dealt with in a timely manner with an outcome recorded as to whether the matter was resolved. Information included the date received, nature of the complaint, summary of the outcome and whether it was upheld. The service had received fourteen complaints in 2016 all of which had been dealt with swiftly and effectively managed. Learning from such situations was then incorporated into team meetings where necessary. In the June 2016 meeting a recent safeguarding situation which has resulted in a complaint was discussed highlighting the importance of sharing communication from family

members as they were often the first point of contact.

Some compliments we read included "To you all who gave me the confidence and for your caring and professionalism at all times in the past six weeks, thank you" and "I would like to thank you all for helping mum reach back to her normal strength and filling with a confidence when clearly she felt vulnerable and intimidated when going outside." Another person said "I have met some lovely people" and another said "Every care assistant that has come to help my husband has been excellent. The male carers have helped him so much to start communicating more. They have spoken to him about things in the past which have interested him – this has made such a huge difference."

Outstanding ☆

Is the service well-led?

Our findings

One person said "The service only started a week ago but I'm very pleased. They know the routine and are 'tip top'." Another person said "The service has been brilliant. The carers were very helpful. I had them for six weeks and am now back to being independent. The advice I received was great and I progressed with everyone's help. I am now back to where I was and am totally delighted."

In some of the feedback sent into the service we read comments such as "Thank you to all who gave me confidence and for your caring and professionalism at all times in the past six weeks" and "Every care assistant that has come here to help my relative has been excellent. The carers have helped him so much to start communicating more. They have spoken about things in the past which have interested him – this has made a huge difference."

The registered manager said "We judge our success on reducing the number of calls a person receives." They regularly met with their service manager to discuss performance and assess the success of the service in terms of moving people to full or minimal assistance. We saw statistical data which showed for the period April 2015 – March 2016, 87.8% of people who had completed the re-enablement course required no further input. This was reflected in the latest month's available data for May 2016 which showed a success rate of 82.4%. Out of over 1500 referrals the previous year only 19 had been re-referred showing that the input was sustainable.

The service was keen to embrace change and was constantly re-evaluating its performance in relation to the early intervention pathway. Through its quality assurance systems which promoted listening to staff and service users it enabled it to reflect on best practice. The registered manager was keen to listen to feedback from the inspection so this could be incorporated into the service to ensure they were meeting people's needs in the best manner possible. This commitment to quality shone through from feedback from service users, staff's high morale and the high number of compliments received.

We saw in every care record evidence of a responsive service which then altered the service provision for that person, and through all these incidences, examples of which are given in the responsive domain, learning was shared if a new solution was found or staff could gain from further training such as how to effectively support people who may have alcohol dependency.

The registered and service managers discussed particular work streams such as infection control or medication to ensure they were adhering to required practice and this information was disseminated to staff via staff meetings and training. In addition, six weekly meetings were held with providers such as therapists and local hospital personnel to discuss key themes for the service such as capacity or more complex care provision.

Out of hours cover was provided through the locality managers who knew their patch well and weekend cover was available through the co-ordinators. They had access to all key information and so could support staff out in the community as needed. The registered manager also said they got access to all resources as

needed whether that was district nurses, therapists, other community care services and professional support from the social work service. They were keen to stress the partnership nature of the service and we saw this evidenced in daily records where other services were contacted as needed.

Staff felt the service was managed well. One staff member said "We can talk to anyone. The service is managed fairly. Anyone will listen to us, even if we're just after a sounding board." Another stressed the value of linking in with other professionals such as the occupational therapist, physiotherapist, district nurses, pharmacist and stroke team as all these people provided specific support and guidance when dealing with people's more complex needs.

Quality assurance systems were robust. The registered manager was part of a 'systems and process' group which regularly met to discuss the relevance of various paperwork and whether information could be documented more efficiently. The service had a series of groups which reflected on its practice and impact showing they were keen to ensure the optimum performance level for people in receipt of the service. This included analysis of compliments and complaints, feedback from staff and observational information. One of the consequences of this was staff training had been arranged in how to support people with alcohol dependency as they felt this was a skill that needed further development. Staff spoke with us about this. Other learning was around the impact of dementia on a person's mental health and how to support people through positive behaviour management.

In addition there was a care record audit system in place where a total of twenty files per month were audited by the service, regional and locality managers. This was part of the registered provider's corporate tool for assessing quality and excellence. The audit tool assessed whether all records were completed as needed, whether they were signed, dated, legible and matched other records in the file, alongside reviewing the quality of information in the assessment and planning tools. This took place for people currently receiving the service as well as those recently leaving it, ensuring that any problems could be identified swiftly and remedial action taken if necessary.

People were asked their opinion of the service at the start and at the end to provide a form of evaluation. The registered manager said the latest analysis had identified 96% of people felt they were treated with dignity at all times. Part A asked people views of their health both physically and mentally, their strengths and abilities and whether they felt in control. This was re-evaluated at the end of the service input and we saw evidence of how much people had progressed, especially in mental wellbeing as their confidence had grown. People were also asked their views of the service in regards to whether they felt involved in the process, did they feel safe, were they told which staff would be visiting and were they given appropriate time. In all the questionnaires we looked at comments were extremely positive and support mostly rated as 'excellent'.

The feedback from the people using the service referred to above in addition to staff comments was used in shaping the development of the service. This could be seen in discussions around people's individual needs such as time of calls, specialist equipment or different strategies for managing specific mobility issues. One staff member told us "We consider what the problem may be and offer solutions. It may be that someone is visually impaired or has physical dexterity problems so we can offer medication in alternative dispensers enabling them to become independent." Staff told us, and we saw from team meeting minutes that staff frequently discussed difficulties they may have encountered in an attempt to find a solution and increase people's independence. This integrated practice was embedded in the service.

If, from the feedback, a particular issue was identified this was addressed through individual staff supervision, training for all staff or consideration of alternative ways of meeting a person's needs through

generalised discussions at team meetings. This emphasised the strong culture of person-centred care through regular evaluation of effectiveness of service delivery. Staff told us that they shared knowledge of how to support people, not revealing confidences but through information and good practice. We found staff were keen to learn and develop, and not afraid of taking advice as they could see its value and benefit for the people in the service.

The registered manager was very clear of their role and the responsibilities it entailed. They said "I will always sit in the team and listen to conversations so that I know what is going on." We observed them throughout the day providing hands on guidance to staff while allowing locality managers and co-ordinators the autonomy to manage their specific patches. Staff were aware of the values of the service. One told us "Independence and safety through good quality care and signposting people to other services that may help them. This could be an access bus so they can attend church or a befriending service."

The service was divided into two main geographical areas and the registered manager attended both team meetings to share key information and to discuss how staff were feeling. Agendas showed a breadth of discussion including visits from external agencies. The minutes demonstrated that all staff had the opportunity to voice their opinion and that they were listened to. Guidance and direction given was clear and staff supported to ask for further training if needed. Discussions included topics such as confidentiality and mental capacity, emphasising that decisions may not always be the wisest for people. Guest speakers attended and shared knowledge of their services and staff worked closely with other organisations in health, social and voluntary care provision to ensure people had access to current information and support when moving on from the service.

We asked the registered manager what the key risks to the service were and they said "Capacity of the service to take new referrals." They said they were fully aware of the demands for the service but had no jurisdiction over the amount of people they could support as staffing levels were fixed. However through regular reviews of people's progress the service was extremely flexible and fluid, which meant that throughput was quick and people only received support they really needed. The mechanisms were in place for the service to assess capacity on a daily basis and we saw evidence of this through written feedback from staff who were equally aware of the demand for the service.

The registered manager advised us their key achievements were in terms of the actual number of service users supported, those who needed minimal or no support for future and that staff were involved in the development of the service. This was in a number of ways through the initial assessment and ongoing involvement with people on a daily basis, and through their input into the annual team plan. We saw how all staff had contributed to a SWOT (Strength, Weakness, Opportunity and Threat) analysis of the service and how these ideas had been taken forward in future planning.

Workshops had also occurred around the vision and culture of the team and staff had endorsed their view that honesty and good communication were the key aims. We saw evidence that the week prior to our inspection co-ordinators had discussed what was working well and not so well, what areas they would like to see improved and how could effectiveness be increased. One of their aims was to be out on the patch more so they discussed how this could be achieved. This showed staff were central to the shaping of the service and their practical knowledge was used as part of service development.