Mrs Carole Brooke

Ancona Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

About the service
Ancona Care Home is a residential care home providing personal care to 17 people aged 65 and over at the time of the inspection. Most people were living with dementia. The service can support up to 18 people.

The home is based on two floors with an interconnecting passenger lift. All but one room has en-suite facilities.

People's experience of using this service and what we found
Infection control risks were usually managed safely. However, improvement was needed to ensure the risk of cross infection in the laundry was managed effectively.

Arrangements were in place to manage medicines safely. Some checks of staff competence were overdue, but the provider took immediate steps to address this.

People were protected from the risk of abuse and risks to people's safety were managed effectively. There was not a clear policy to ensure staff's knowledge of safeguarding remained up to date, but the provider assured us they would address this.

Staff were kind, caring and compassionate. They treated people with respect and protected their privacy at all times.

Recruitment procedures were in place and there were enough staff to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People's nutritional needs were met and they were supported to access healthcare services when needed.

Staff were skilled and knowledgeable. They supported people in a personalised way, in accordance with their individual needs.

People knew how to raise concerns and there was an accessible complaints policy in place.

People and relatives had confidence in the management and said they would recommend the home.

Quality assurance systems were in place and the provider complied with their regulatory responsibilities.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published in March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our Well-led findings below.	**Good**

Ancona Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was conducted by two inspectors.

Service and service type
Ancona is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Although a manager was employed, the service was not required to have a manager registered with the Care Quality Commission. This meant the provider had sole legal responsibility for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

During the inspection, we spoke with nine people living at the home and three visitors. We spoke with members of staff including a housekeeper, a chef, five care workers, the manager and the provider. We also spoke with two visiting healthcare professionals and a visiting activity provider.

We reviewed a range of records including four people's care records and multiple medication records. We looked at staff files in relation to recruitment and staff supervision, as well as a variety of records relating to the management of the service, including policies and procedures.

After the inspection
After the inspection, we continued to seek clarification from the provider to validate evidence found. We also received written feedback from a further healthcare professional.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection
• The home was clean, hygienic and well maintained with the exception of an area used by a hairdresser to cut people's hair, which was very dusty and cluttered, making it difficult to clean.
• The hairdressing area was located in a space between the sluice and the laundry and there was not a clear process, or a risk assessment, to prevent cross contamination between these three areas. This posed a risk of cross infection.
• We discussed these issues with the manager, who took immediate action to de-clutter and clean the area. They assured us they would complete a risk assessment to manage the risk of cross infection.
• Some measures were in place to manage the risk of Legionella in the water system and the manager told us they were arranging for a specialist to conduct a full review of the home to identify any additional measures they needed to take.
• Cleaning schedules were in place for all areas of the home and records confirmed that they were cleaned regularly.
• Personal protective equipment (PPE), including disposable gloves and aprons were available to staff throughout the home. In addition, staff were taking extra precautions when supporting a person who had a contagious skin infection.
• Staff had completed infection control training and the manager conducted regular hand hygiene audits to check staff followed their training.

Using medicines safely
• Arrangements were in place for obtaining, storing, administering, recording and disposing of medicines safely.
• Staff had been trained to administer medicines and had been assessed as competent to do so safely. However, we found some staff competence checks were overdue.
• We discussed this with the manager, who told us they would conduct competence assessments without delay for all staff who were overdue them and ensure they were done routinely in future.
• Medication administration records confirmed people had received all their medicines as prescribed.
• For people who were prescribed medicines to be administered on an 'as required' (PRN) basis, there was guidance to help staff understand when to give them and in what dose.
• There were effective systems in place to help ensure topical medicines were used as prescribed. The date creams had been opened was recorded, to help ensure they were not used beyond their 'use by' date.

Systems and processes to safeguard people from the risk of abuse
• People said they felt safe living at Ancona Care Home. For example, when asked if they felt safe, one person

told us, "Oh yes, very safe, absolutely." A family member said, "[My relative] is safe. I do not go home and worry."
• Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse. One staff member described potential signs of abuse and told us, "If I was worried, I'd go straight to the manager or [the provider], or I could also go to CQC."
• However, there was not a clear policy to ensure staff's knowledge of safeguarding remained up to date. The provider told us staff should complete refresher training every year, but we found some staff had only completed it every three years.
• The provider told us they would clarify their policy and ensure any staff who needed refresher training received it without delay.

Staffing and recruitment
• There were clear recruitment procedures in place to help ensure staff were suitable for their role. These included reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions.
• For one staff member, however, we found a reference had been supplied by an ex-colleague, rather than by the provider of the care service where they had previously worked. This meant it might not contain all relevant information.
• We discussed this with the manager, who acknowledged the oversight and assured us they would tighten their procedures in the future.
• There were enough staff available to keep people safe and to meet their needs. All the people and visitors we spoke with told us staff responded quickly to call bells.
• Staffing levels were determined by the number of people using the service and the level of care they required. The manager monitored the staffing levels by observing care and speaking with people and staff to ensure that staffing levels remained sufficient.
• People were supported by consistent staff. Short term staff absences were covered by existing staff members or a member of the management team; this helped ensure continuity of care for people.

Assessing risk, safety monitoring and management
• People were effectively protected from the risk of harm. Individual risks had been assessed and recorded, along with action staff needed to take to mitigate the risk. For example, risk assessments were in place for people at risk of developing pressure injuries. Where needed, pressure-relieving equipment was provided and staff monitored the integrity of people's skin closely.
• Other risk assessments included medicines management, nutrition, dehydration and mobility. Staff understood how to mitigate these risks.
• Lifting equipment, such as hoists, were maintained according to a strict schedule. In addition, gas and electrical appliances were checked and serviced regularly.
• Fire safety risks had been assessed by a specialist and additional action had recently being taken to reduce the risk. For example, extra fire doors had been installed to help contain any potential fire and prevent it from spreading.
• Fire detection systems were checked weekly. Personal emergency evacuation plans had been completed for each person, detailing action needed to support people to evacuate the building in an emergency. A staff member told us, "We have [information] cards to tell us where to go and have unplanned fire drills."

Learning lessons when things go wrong
• The manager described how they constantly monitored incidents, accidents and events to identify any learning which may help keep people safe.
• This enabled any trends or themes to be identified, so action could be taken to mitigate the risk and prevent reoccurrence. For example, after people had experienced falls, the provider explored ways to reduce

the risk using multi-factorial risk assessments. These considered all the factors that could potentially contribute to a fall.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has improved to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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.

At our last inspection we recommended the provider consider advice and guidance from a reputable source to enable them to properly record MCA assessments and best interest decisions. At this inspection, we found the provider had made improvements.

• Where people did not have capacity to make decisions, staff had completed MCA assessments, consulted with those close to the person and made decisions in the best interests of the person. These had all been fully documented.
• Where people had capacity to make decisions, we saw they had signed their care plans to indicate their agreement with the proposed care and support.
• Staff were clear about the need to seek verbal consent from people before providing care or support. People's right to decline care was understood; for example, one person often declined prescribed pain relief and eye drops and staff respected this decision.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

• We checked whether the service was working within the principles of the MCA and found they were. However, we also found that some DoLS renewal applications had been submitted late, and the DoLS authorisations for two people had expired.
• This oversight had already been identified by the manager, who had submitted new applications and introduced a new system to ensure renewal applications were made in good time in the future.
• Where conditions had been imposed on DoLS authorisations, we found these had been met.

Supporting people to eat and drink enough to maintain a balanced diet
• People had access to a wide choice of meals and had enough to eat and drink. Everyone told us they

enjoyed their meals. One person said the chef would "always do something different if I don't not like what's on the menu".
• Each person had a nutritional assessment to identify their dietary needs and preferences. Where needed, people were given adapted cutlery and crockery. For example, a person with impaired vision was given a plate guard to help keep the food on their plate.
• People's individual preferences were consistently accommodated, including one person who liked their meals to be pureed using a special mincer they had supplied themselves.
• Staff monitored people's weight and usually took action if people lost unplanned weight; for example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories.
• However, we identified two people whose weight records were inconsistent. We discussed this with the manager, who felt the weighing chair they used might need calibrating and arranged for this to be done.
• People were frequently offered hot and cold drinks and were encouraged to drink often. A staff member told us, "Everyone is at risk [of dehydration] as they forget to drink, so we always encourage and never walk past an empty glass."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Comprehensive assessments were completed before people moved to the home. Care plans were then developed to include people's identified needs and the choices they had made about the care and support they wished to receive.
• Staff followed best practice, which led to good outcomes for people. For example, they used recognised tools to assess the risk of malnutrition and the risk of skin breakdown. A healthcare professional praised staff for the care they had delivered to a person who was admitted with a "severe pressure wound" which had almost healed because of the effective care they had received.
• Each person had an oral care plan in place and staff supported people in accordance with the latest best practice guidance on oral care.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments. Their diverse needs were detailed in their care plans, including gender preferences for staff support.
• Staff had completed training in equality and diversity and told us they were committed to ensuring people's equality and diversity needs were met.
• Staff made appropriate use of technology to support people. An electronic system allowed people to call for assistance when needed and movement-activated alarms, linked to the system, were used to alert staff when people moved to unsafe positions.
• The system operated silently as it was linked to pagers carried by staff. This helped create the calm, peaceful atmosphere that was evident throughout the inspection. The manager told us people slept longer as a result, as they were not disturbed by audible call bells.

Staff support: induction, training, skills and experience
• People and family members told us staff were knowledgeable and competent. Comments included: "All staff are very, very good here, they are marvellous" and "Staff know how to look after [my relative] and have explained things to me".
• Staff completed a range of training to meet people's needs, which was refreshed and updated from time to time. However, we found training records were disorganised and the provider did not have a clear policy about how often staff should repeat their training.
• For example, although all staff told us they had completed practical moving and handling training within the past year, there were no records to confirm this.
• We discussed this with the provider and the manager. They assured us they would clarify their policy and explore more effective ways to monitor and record staff training.
• New staff completed a programme of induction before being allowed to work on their own. This included a

period of shadowing more experienced members of staff.
• Staff who were new to care were supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.
• Staff told us they felt supported in their roles. Comments included: "We have appraisals and staff meetings every three months", "I feel incredibly supported" and "I can contact the manager or [provider] at any time and they would always come in if needed".
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a manager to meet with staff, discuss their training needs, identify any concerns, and offer support.

Adapting service, design, decoration to meet people's needs
• Adaptations had been made to the home to meet the needs of people living there; for example, a passenger lift enabled people with limited mobility to move between the two floors of the home and corridors were fitted with handrails to provide extra support to people.
• There were sufficient toilets and bathrooms, although these were not well signed. We discussed this with the manager, who told us they intended to use a nationally recognised audit tool to help identify changes to the environment, including signage, that would better support the needs of people living with dementia.
• There was a range of communal areas available to people, including a dining area and lounges which allowed people the choice and freedom of where they spent their time.
• People also had access to a level garden with seating, which people told us they enjoyed when the weather was fine.
• There was a rolling maintenance programme in place to help ensure the building remained fit for purpose; for example, new flooring had been laid in some rooms.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People and their relatives told us their health needs were met and they were supported to access other healthcare services, including specialists, when needed. For example, people were supported to access the memory service, dentists, chiropodists, and opticians.
• A healthcare professional told us, "Any referrals I receive are always timely and appropriate."
• Changes to people's health needs and any visits from healthcare professionals were recorded in their care plans, together with any follow-up action required. This helped ensure a consistent, joined-up approach to meeting people's healthcare needs.
• The service was linked to the local GP surgery via a 'Telehealth' scheme. This allowed staff to share information, such as people's blood pressure and vital signs, with health professionals in real time. The manager told us this had resulted in quicker diagnosis and cases of sepsis, for example, being picked up earlier.
• If a person was admitted to hospital, staff used the "red bag" initiative to ensure key information about the person was sent with them. This initiative helped ensure the person's needs were understood and met. Where possible, a member of staff would also accompany the person to hospital.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People spoke positively about staff, describing them as "nice" and "lovely". One person told us, "Staff are kind and come quickly."
• A healthcare professional echoed these comments and told us, "The staff are kind and caring."
• We observed positive interactions between people and staff. Staff supported people in a friendly, calm and patient way. They consistently treated people with respect and spoke about them in an affectionate, caring way.
• During discussions with staff, they demonstrated a good understanding of people's individual needs, preferences, backgrounds and interests. They used this knowledge to engage with people in a meaningful way.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessments. Staff gave examples of how they had recognised people's diverse needs and respected their individual lifestyle choices. There were policies in place that supported this practice.
• People were supported to follow their faith. For example, staff had arranged for a religious leader to visit one person who told us, "I enjoyed seeing them and got to eat [special food] and light candles."

Supporting people to express their views and be involved in making decisions about their care
• People were involved in discussing and planning the support they received. Records confirmed that people had regular meetings with senior staff to discuss their views and make decisions about the care they received; these included decisions about their choice of activities and how they wished to be supported.
• We heard people being consulted throughout the inspection about where they wished to go and what they wished to do.
• Staff ensured that family members, and others who were important to the person, were kept updated with any changes to the person's care or health needs.

Respecting and promoting people's privacy, dignity and independence
• Staff respected people's dignity and protected their privacy at all times.
• For example, staff described how they protected people's privacy during personal care. This included listening to people, respecting their choices and closing doors and curtains.
• People told us staff always knocked before entering their rooms and we observed staff did this consistently, even if the door was already open.
• Care records were kept securely and were only accessible to staff who needed to view them. Information held on the computer was password protected.

• Staff promoted people's independence. For example, one staff member told us, "We will walk behind people [to support them] when mobilising rather than lead them, so they can decide where they want to go."
• One person wanted to manage their own medicines and had been given a secure cabinet to allow them to do this safely, with minimum support from staff.
• Care plans also encouraged staff to promote independence; for example, one said, "[The person] can wash own face, arms and upper body."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People told us their needs were met consistently and this was confirmed by family members.
• Care plans had been developed for each person and provided detailed information to enable staff to support people in a personalised way. The plans were updated monthly or when people's needs changed.
• Staff understood people's needs, wishes and preferences and could explain them to us. For example, they described in detail how they supported a person with diabetes and another person who could behave in a way that put themselves and others at risk.
• Staff responded promptly to people's needs and willingly responded to requests for support. A healthcare professional told us, "I have no concerns. They [staff] continue to work alongside us and are happy to start new initiatives if beneficial to patient care."
• People were empowered to make their own decisions and choices and people confirmed they could make choices in relation to their day to day lives; for example, what time they liked to get up or go to bed, what they ate and where they spent their time.
• For example, one person got up at 10:00am and asked if they could have a cooked breakfast. A staff member readily agreed and the chef willingly made them a full cooked breakfast, explaining that this the person's favourite meal of the day.
• Staff were clear that they were led by the person's wishes. For example, a staff member told us, "We always ask what [people] would like to do. Even if they always have tea, we still offer choice as they may change their mind." Another staff member said, "We don't stop anyone going anywhere. Everyone should be allowed to make choices. It's very flexible here."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were identified, recorded and highlighted in their care plans. For example, one person had hearing loss and there was clear information about how staff should support them with this.

• Information could be given to people in a variety of formats, including easy read, large print and pictorial. Staff also had access to pictures to help them communicate with people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
• People had access to a range of activities that encouraged social inclusion. These included exercises, arts and crafts, bingo, music and quizzes and visiting animals.
• Activities had been tailored to people's individual interests. For example, staff had arranged for a cat to visit a person who loved cats and we saw they treasured a photo staff had given them of the event.
• During an activity session we observed, people asked for alcoholic drinks. Staff prepared these for people in particular glasses that they knew each person preferred.
• As well as planned activities, staff told us they organised spontaneous activities during the day, such as games and reminiscence talks.
• Special occasions, such as people's birthdays and anniversaries were celebrated and people were encouraged to invite family members to join them. One person described the atmosphere at Ancona Care Home as a "home from home".

End of life care and support
• At the time of the inspection, no one at the home was receiving end of life care.
• However, most staff had experience of supporting people at the end of their lives and had received training in end of life care, including at a local hospice. They described the key aspects of end of life care, including comfort, symptom control, mouth care and support for the family.
• Links had been developed with community nurses and palliative care services to enable staff to seek specialist advice and support if needed.
• Information about people's end of life wishes was recorded in their care plans to help ensure they would be known and met when needed.

Improving care quality in response to complaints or concerns
• There was an accessible complaints procedure in place and people told us they would feel happy raising concerns.
• Records of complaints showed they had been investigated and dealt with thoroughly, promptly and in accordance with the provider's policy.
• The manager described how they used learning from complaints to help drive improvement and gave examples of when they had done so.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There was a clear management structure in place, consisting of the provider, the manager and senior care staff. Each had clear roles and responsibilities.
• The managers told us they felt very supported by the provider, who visited daily.
• Staff understood their roles and were provided with clear guidance of what was expected of them. Staff communicated well between themselves, for example during handover meetings, to help ensure people's needs were met.
• The provider's quality assurance system comprised of a range of audits, which had usually been effective in bringing about improvement. For example, an environmental audit had identified the need for new carpets and these had been fitted.
• Although the audits had not picked up the concerns we identified with the laundry, the manager and provider responded immediately and told us they would enhance their infection control audit to make it more robust.
• Where improvement actions had been identified, for example to update people's care plans, we saw they were monitored using an action plan.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and their relatives spoke positively about the management of the service and told us they would recommend the home to others.
• Staff had a good understanding of people's needs and demonstrated a shared commitment to treating people in an individual, person-centred way.
• The provider had clear expectations about the values staff should work to and these were set out during their induction. These included providing high-quality care in a caring and compassionate way.
• From our observations and discussions with staff, it was clear they understood these values and were committed to meeting them in their day to day work.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider consulted and engaged with people in a range of ways. These included quality assurance surveys, 'residents' meetings' and one-to-one discussions with people and their families.
• The manager acted on people's feedback; for example, in response to recent feedback from a family

member, they had made serviettes available to people at mealtimes.
• Visitors told us they were always made welcome and we saw they were offered drinks.
• Staff told us they felt listened to and that morale was good. They said they enjoyed a good working relationship with their colleagues and felt they worked well as a team.
• Staff spoke positively about the manager, describing them as "approachable" and "supportive". Comments included: "[The manager] is a good manager, her door is always open", "I'm very happy with [the manager], she won't accept second best" and "The manager definitely appreciates us".

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider was aware of their responsibilities under the duty of candour, which requires providers to be open and transparent if people come to harm. They showed us examples of when this had been followed, both verbally and in writing, as required.
• The home's previous rating was prominently displayed in the entrance lobby and the manager notified CQC of all significant incidents, as required.
• All staff were open and transparent throughout the inspection. The manager and provider were highly responsive to suggestions for improvement.

Continuous learning and improving care
• The provider and the manager had recently completed an extended course for managers, funded by the local authority, to support them in their roles.
• They were also members of a care provider's forum that shared best practice guidance and belonged to a network of homes that focused on local healthcare issues.
• The provider had also engaged with the clinical commissioning group (CCG) medicines optimisation team. They had suggested improvements to the medicines management system, all of which had been implemented.

Working in partnership with others
• The service worked in collaboration with all relevant agencies, including health and social care professionals.
• Other links had been developed with community groups, including a school whose children visited to sing to people from time to time.