Hales Group Limited

Hales Group Limited - Norwich

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

About the service: Hales Group limited- Norwich is a domiciliary care agency. It provides care and support to people living in their own homes, most of whom are older people. At the time of the inspection there were 93 people using the service.

People's experience of using this service:

The service was registered as a location on 20th April 2018. This is the first inspection since being registered.

We found most people received a good service, but some improvements made by the branch were not yet fully embedded in regard to call scheduling and staff stability.

Staff and people reported some initial difficulties with call scheduling and told us not everyone had continuity of care because they did not have regular carers. Care staff said staff responsible for planning and allocating calls did not always have sufficient information about people's needs or locations which made scheduling challenging. There had been recent changes to management and staff agreed things were improving at the service.

The service used electronic call monitoring which enabled staff to enter 'live' data at each call. This meant office staff could see if calls were being delivered as planned and in line with contractual arrangements.

Staff records were robust and demonstrated effective recruitment and support processes were in place. Staff completed an induction programme as part of their probationary period. Staff completed training considered as 'mandatory' in the care sector.

The service established people's views by sending out feedback forms throughout the year, holding regular reviews and telephoning people in between to ensure everything was satisfactory.
Staff attended training updates, team meetings quarterly and had supervisions, appraisals and spot checks on their performance. Some staff expressed frustration about the lack of communication across the organisation.

The service had policies and procedures in place and provided training to staff, so they knew how to safeguard people in their care and what actions they should take. We reviewed a number of safeguarding concerns and actions taken. These were appropriate to the level of risk, but we found the recording did not provide a clear audit trail of actions. We were provided with all the information we needed to make a judgement at the time of the inspection.

Staff supported people with medicines where required and there were systems and checks in place to help ensure people received medicines as required and at a time they needed them. Staff received training and checks on their competency. A number of errors had occurred, and the service had taken timely actions to

address the concerns.

The initial assessments, risk assessments and care plans were robust and contained good detail about people's preferences, care needs and desired outcomes. They were very individualised and gave good information about how to promote people's health and meet any health outcomes people might have.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this. There were very good assessments in place to determine if people had capacity to make decisions about all aspects of their care and welfare.

The service had audits in place to assess the effectiveness of its service. This involved listening to people using the service and acting on any feedback to improve the service. Reward systems were in place to support and encourage good staff practice and motivate the work force.

Why we inspected: This was a planned, comprehensive inspection to give the service its first rating.

Follow up: We will continue to monitor this service and plan to inspect in line with our re-inspection schedule for those services rated requires improvement.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Safe findings below.

Hales Group Limited - Norwich

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team was made up of one inspector, an inspection manager and an expert by experience who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Hales Group limited- Norwich is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit.

We inspected the registered office location on 18 April 2019. Our expert by experience made telephone calls as prearranged to people using the service and their relatives on 16 and 18 April 2019.

What we did:
Before the inspection we reviewed information already known about the service. This included reviewing notifications which are important events the service is required to tell us about. The service had sent in a provider information return when requested. This provides us with key information about their service, what

they do well, and improvements they plan to make. This information helps support our inspections.

We spoke with ten people and three relatives. On the day of our inspection we spoke with the registered manager, the branch manager, the compliance manager, the training manager, the community care manager and the regional operations manager. We spoke with six care staff, the commissioners and three health care professionals. We looked at four care plans, staff records and other records relating to the business.

Requires Improvement

Is the service safe?

Our findings

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

RI: 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.

Staffing and recruitment.

●The service had improved over recent months, primarily by introducing an electronic call monitoring system which enabled office staff to remotely monitor calls and ascertain if they were delivered according to the schedule. When calls were running late the system would show this in red which meant the office staff could take immediate steps to see why the call was held up and reallocate the call to another carer if necessary. The service had also recruited staff to oversee the planning and coordination of the service to improve its effectiveness.

●Despite these recent improvements in call scheduling and most calls being delivered on time we found there had been two missed calls in the month leading up to the inspection. We also saw that one person received calls which required two staff to deliver their care safely. Over four months there had been six occasions when only one carer had either failed to turn up or had failed to turn up on time. This meant the family member had helped to deliver the care to their relative as they could not rely on the service provided. This had a poor impact on them and the person being cared for.

●For another person a safeguard was raised by a health care professional about omissions in their care, which were immediately investigated and addressed by the service. Part of the issue for the person being supported was they did not have continuity from a team of regular carers so may not always of had the care they required.

●Information requested from the provider following the inspection showed some calls ran late but this to some extent was inevitable and were mostly delivered within half an hour of the agreed time which is permitted by the local authority. Scheduled calls were monitored, and an action log was in place for any calls not delivered as scheduled, showing reasons why, action taken, and lessons learnt.

●Staff told us there had been some difficulty with call scheduling and staff having to travel some distance to pick up care calls. There were records showing calls had run late and not everyone had continuity of care. Going forward the service now had the right staff in place who were more familiar with the needs and location of people using the service and could plan accordingly.

●We received mixed responses from people about staffing. One person said, "No it's never that late and if they're late they always apologise." When we asked another person whether carers were on time they said, "That all depends, every day it's a different time. I blend in with how they (staff) are."

●Staff agreed the situation was improving since a new care co-coordinator had come into post and a new electronic monitoring system was being used.

●The electronic system required staff to scan in and out when they arrived and left a call. The office could monitor this 'live' and so could check that staff were delivering care and support according to people's care plans. There had been some issues embedding this system and staff not always signing in and out, but staff had all received the necessary training and were more familiar with the system.

●Staff said that they mostly had regular rounds and an allowance was made for travel time. They told us that sometimes it could feel more pressurised at weekends as there were less staff working and they worked extra to cover the calls.

● We reviewed staff files. These demonstrated that there were robust recruitment procedures in place to ensure staff were recruited in line with the recruitment policy. Staff were vetted to ensure they had not committed an offence which would make them unsuitable for employment or if they had been barred from this type of employment.

Assessing risk, safety monitoring and management.

●Staff worked from leased premises which were well maintained and compliant with legislation. There were facilities for staff to meet and a training suite where staff completed their initial induction and training.

● Very detailed risk assessments were completed before offering people a service. This took into account any risks posed by the persons home, tasks to be completed and details of people's physical care needs, social needs or anything staff needed to take into account. Risk assessments were in place relating to people's medicines, manual handling needs, and day to day support needs.

●There was a central on-call system in place from 17.00pm to 09.00am and people had details of the number they should contact. Calls were automatically diverted. From 09.00 am when the office was open calls were taken by senior and administrative staff. They told us information was emailed from one on call shift to the next and each day senior management discussed anything that required action taking or any risks they had been made aware of. We reviewed the on-call folder which documented events occurring across the day, some showed clear actions taken others did not. The registered manager said actions about individuals would be recorded in their record. We suggested a clearer audit trail and cross referencing, so it was clearer what actions had been taken.
Learning lessons when things go wrong.

●Incidents, accidents and adverse events were recorded, and analysed to see if lessons could be learnt and these were discussed and shared with other managers and operational staff in their regional meetings. The registered manager said staff were aware of any policy change or concerns because they issued weekly memos and monthly newsletters.

Systems and processes to safeguard people from the risk of abuse.

●Safeguarding records were kept but did not provide a clear audit trail of actions taken and timescales. The service was however able to demonstrate that it had taken the necessary actions.

●Staff had a good understanding of what might constitute a safeguarding concern and what actions they

should take, including when to report something to an external agency. Staff received regular and updated training to help them recognise abuse.

Using medicines safely.

●Some people were supported with their medicines. Medicines were administered as prescribed, and staff confirmed they had been trained and observed. Audits were carried out to help ensure records were completed correctly and medicines had been administered as required.

● Two medicines errors had occurred in the last twelve months and no recording errors were noted. One family member told us there had been a problem with their family member getting their medicines on time which was time critical. They said however since being raised this has been sorted out.

●Assessments were undertaken which documented if people needed physical assistance or prompting with their medicines. This included details of what arrangements were in place for collecting and re ordering medicines, what medicines were taken and any other considerations such as allergies staff needed to be aware of. It also took into account any long- term conditions people had and how staff should monitor these and what actions they should take to mitigate risks.

Preventing and controlling infection.

●Staff were made aware of their responsibilities to reduce the risk of cross contamination and had training in good infection control practices. Staff confirmed personal, protective equipment was provided and there were expectations they wore gloves and aprons when assisting people with personal care tasks. Staff spot checks by managers helped to ensure they were following company policy.

●People spoken with confirmed staff did adhere to good infection control practices. For example, one person told us their carers always wore gloves and apron to empty the commode and when helping them with their personal care. Another person confirmed that staff used gloves when administering medicines.

●Care plans and risk assessments gave good information around promoting people's continence and about taking sensible precautions to promote people's dignity and reduce the risk of cross infection.

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

●The service completed a comprehensive assessment and delivered care and support in line with the persons expectations and the service level contract. The service sought advice and copies of any previous assessments undertaken.

●The service delivered care and support in line with best practice and legislation underpinning domiciliary care.

●As part of the initial assessment the service would establish if people had any additional requirements in relation to their ethnicity or culture and take into account any disability they might have which could impact on the service delivery. For example, any sensory needs. The service told us one person they supported was blind and staff knew to refer to their family but could also request literature in braille. Information was made accessible in line with accessible communication standards.

Staff support: induction, training, skills and experience

●One person told us that their care team were well trained. They said, "Generally they're (carers) good, some of them are very experienced."

● Staff received a five-day office-based induction, followed by a twelve- week probationary period. Staff completed the care certificate within their probationary period. New staff shadowed more experienced staff until they were confidence and had demonstrated the necessary competences to work unassisted.

●Staff training was up to date but not all staff said they had received specific training around people's assessed needs. They recognised it was available but said they did feel they had time to access it. Training undertaken by staff was paid for by the company and included pay for the staffs' time.

●Records provided evidence of annual staff appraisals, themed supervisions which covered specific subjects and tested staff's knowledge. For example: nutrition and hydration, medicines and moving and handling.

●Staff were supported to undertake additional qualifications. The Qualifications and Credit Framework, (QCF) In Health & Social Care Levels 2 & 3.

●Staff confirmed and we saw written evidence that regular spot checks on staff were carried out to help

ensure staff were delivering care appropriately and in line with people's plan of care.

Supporting people to eat and drink enough to maintain a balanced diet.

● People told us care staff routinely checked that they were eating and drinking and prepared them meals and snacks. One person told us about their diabetes and how staff checked on them and knew what to do if they slipped into a 'diabetic coma.' Another person said, "The carer is coming back to get me a meal and today I am having tomato soup and a ham sandwich later" she added "yesterday I had bean and a pork pie, they do whatever I want, they say "do you fancy a fry up!"

● Support with eating and drinking was included in the assessment of people's needs. The assessment considered underlying factors such as changes to people's appetite or unplanned weight loss. It also took into account if people had a good appetite or any medical condition which might impact on their dietary needs such as diabetes, food intolerances or allergies.

Staff working with other agencies to provide consistent, effective, timely care.

● People received a comprehensive assessment before being offered a service. The service took into account assessments already completed by other services and any guidance in place. The service kept the care plan under review and accessed additional support and advice when necessary from other health care professionals.

Supporting people to live healthier lives, access healthcare services and support.

● Staff knew people well but said changes in their rota meant this was not always the case. Regular carers helped to ensure they could quickly recognise when there was a change in their needs.

● People and their relatives were mostly confident in the care they received and felt staff understood their needs well. The service worked alongside other professionals as necessary to help ensure people's needs were met holistically.

● Peoples health care needs were clearly documented with detailed step by step guidance for staff to follow. This established agreed outcomes of care, the persons preferences and capacity to decide and any risks associated with the persons care.

● The service has embraced advances in technology to more effectively support people through effective electronic monitoring.

●The service had undertaken some re-enablement work and supported people to get back into physical shape or to reduce levels of social isolation by helping people access the community.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● The service worked within the principles of the Mental Capacity Act. Each person had a detailed assessment of their health and physical care needs which took into account expected outcomes of care, any risks and the persons capacity to make choices. Assessments established people's capacity for each element of care and, or support the person required and this was woven through all the care documentation with very good guidance for staff to follow. Best interest meetings would be held where a person lacked capacity to make a specific decision about their care and welfare.

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

Good: 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.

● We received good feedback from people using the service about the staff that supported them. One person said, "I would certainly recommend them and there are carers amongst them that are wonderful."

●Another person said, "They (staff) are charming and marvellous. " They said one staff, "Is literally terrific." They said, "She's a woman of my own heart, on the days she's not working the others (staff) are just as good". she added, "In the mornings she goes Woo Hoo!! and she brings the sunshine in with her!"

●A relative said carers always had a good attitude and "they're always polite." Another relative said "they (carers) are excellent, no problems with their attitude at all" they added, "The main carer puts themselves out, and when mum wasn't feeling well they popped back to make sure she was alright. They did this in their own time."

● One relative told us, "The carers are good company for him." and they said "the (main carer) reminds them to watch Vera and do the Bingo, they (carers) go the extra mile and they are all really nice." They added "I can ring them if I need to change anything and they always work around me."

● The service had an updated Equality & Diversity Policy which was in line with legislation. All staff were trained in diversity and non-discriminatory practice as part of their induction and ongoing training. This helped to ensure all staff have the knowledge and understand the need for understanding care for people with protected characteristics

Supporting people to express their views and be involved in making decisions about their care.

● Staff confirmed people were involved in their reviews.

● Family members told us they were involved in the initial assessment and review.

●The service kept in touch with people by telephone and advised people if their call was running behind, spot checks, reviews and surveys were used to gain people's feedback.

Respecting and promoting people's privacy, dignity and independence.

●People were asked about their experiences of care which were mostly positive and demonstrated that

individual carers were kind and demonstrated empathy. One person told us, "I can get myself up and dressed but I need help with my legs, if I want a shower they (carers) help with that, I've only to ask."

●A person was asked how staff upheld their dignity when providing them with personal care. They said, "They always leave me alone (on the commode) and shut the door behind them, I call them back when I am ready."

● Another person told us that carers helped to ensure they were comfortable and had their alarm close to hand. When we asked if their carers were good and kind to them they told us, "They are always exceptionally good. I have two or three of them and I am very lucky, one carer is absolutely wonderful."

● We spoke with staff about supporting people's privacy. Staff told how they would ensure a person's dignity for example by ensuring that the curtains were closed and encouraging the person to do as much as they could for themselves.

●Staff said communication plans were in place which established peoples preferred method of communication but said they would always ask people what their preferences were and what support they required.

● The registered manager told us they encouraged people to become more independent and take more control over their own lives. For example, they said staff might initially support a person to order their shopping online.

●They said they had supported people to make Skype calls as an effective way of enabling people to stay in contact with friends and family.

●Some people had used the medication support service where they will receive a reminder call to take their medicines.

Good

Is the service responsive?

Our findings

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

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

● Despite some recent issues with call scheduling people spoken with and care staff told us the service was improving and they had growing confidence in the service delivery. We saw most people had regular carers and regular times and the service was planned to enable changes to be clearly communicated. For a few people there were still some issues about continuity of care, but these were being addressed.

●Before staff visited a person they were able to view a limited amount of secure information electronically. This enabled them to safely access the persons property and know what needed to be done. Tasks had to be completed and marked off as complete and most of this was completely electronically. Staff still manually completed a medication record which was in line with the Local Authorities policy. Care plans were in situ, but the service was committed to going paperless. The documentation we reviewed was robust.

●Staff told us they did not always visit people regularly so were not always familiar with their needs over a period. Electronic records did provide staff with the information they needed but not all staff felt they had time to read it which is an integral part of safe care delivery. The service used mostly electronic records but for a few people kept paper records which could easily be shared with other professional bodies when this was appropriate to do so.

●The community care manager told us peoples' reviews were all up to date and the electronic record system would flag up when reviews were coming up or overdue. If people's needs changed between reviews additional reviews would be carried out. Senior staff confirmed the service user and next of kin would be involved in the review and advice from professionals would be sought when appropriate. Relatives confirmed their involvement with reviews.

●The service completed audits for daily records and medicines records to help identify if care was being delivered appropriately. Ongoing surveys helped to capture people's feedback and assess how people's needs are being met. This helped the service adapt and plan the persons support so it met their individual needs.
● The care plans we reviewed were in good detail and clearly described any care and support needs, risks and details of people's preferences of care.

Improving care quality in response to complaints or concerns.

● A number of complaints were viewed as part of the inspection. There were details of the complaint and

investigation, but we could not see clear outcomes and lessons learnt. The branch confirmed that the complaint had been investigated in a timely way and actions taken to ensure the immediate improvement of care. Spot checks carried out by the service identified further concerns which resulted in actions taken against individuals' members of staff.

●The registered manager said robust procedures were in place to manage complaints and the paperwork was available to inspect. We found however this was stored in different places and not all kept as part of the initial investigation making it difficult to track through. We also found that the decision- making processes around staff disciplinary lacked clear detail.

● Since our inspection the registered manager has told that their systems were robust, but they have strengthened them by introducing a monthly review of complaints by senior management. This will help ensure there is a consistent approach.

End of life care and support.

●The service provided end of life care when necessary and worked in conjunction with other agencies to help ensure the care provided was holistic. Staff received some basic training as part of their initial induction which might not be enough for less experienced carers.

Requires Improvement

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

RI: Service and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

●The service had been registered for about a year and was making continuous improvement strengthened by having the right level of management in place. This included a registered manager, care coordinator, field supervisors, care community manager, compliance administrator and apprentice administrator all whom formed part of the overall management of the service. We found however that improvements were not firmly embedded and attributed this to a number of senior staff being new to their post and still trying to get to grips with their role and the needs of the service.

●A registered manager was in post, but they were overseeing two branches. The plan was for them to move permanently to the other branch and for the branch manager to register as the manager. They had already applied to CQC and were awaiting their fit persons interview.

●People using the service were complimentary about their carers, but some mentioned about recent changes that had taken place and the unsettling effect that had. For example, one person told us when we asked about management, "If there are any criticisms from the administrative side of service then it's the lack of communication. There's been a change at the top and whilst I am sympathetic to changes they need to make, I feel they could have let me know." They said changes to the call schedule or when staff are running late were not effectively communicated. Most people however did feel that staff were responsive and let them know if calls were running late.

●We asked about contact with the office. One person said, I've got the numbers and there's always somebody there if you need them" she added "I am quite happy with them and I had a review a little while ago". Another said they had some difficulty when trying to make changes to their rotas and said they ended up talking to the carers directly.

●Staff spoke about changes that had impacted on their workload including different managers and recent changes in the organisational structure. Whilst staff recognised this had improved things they also said it had meant call scheduling had not always been effectively planned and there had been a lot of changes to their rosters which not all staff felt had been well communicated.

● Feedback from health care professionals stated their dealings with the provider had at times been difficult and they had received several concerns about the care provided. It was our understanding that over a longer

period there had been concerns but confidence in the service was growing.

●Office staff told us the branch team were good and things were working well despite being quite a new team. They were confident action was taken and there was lots of communication. They said field supervisors and the community care manager were mobile and could meet up regularly with staff to help ensure things were running smoothly.

● Opportunities for staff to meet weekly had been recently established through the community care manager and field supervisors. Some staff did not regularly attend. Quarterly staff meetings had also been set up to support staff.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

● The registered manager was passionate and clearly understood different components of the operating systems and how the aps currently used could enhance the service, make it safer and reduce the room for error.

● The registered manager was responsive to our feedback. Several people raised concern about not having a roster and one person said they did not want a male for their personal care. The registered manager told us people could request a rota, and this is then actioned. They told us they were introducing a client portal later in the year and wanted to encourage as much as possible digital interaction where appropriate. In regard to the person who prefers not to have a male carer the service took immediate action to address this.

●The branch manager was to take over as registered manager. They had relevant experience and told us they had a mentor and regular bi monthly meetings and felt well supported. They said they had a three-week induction and ongoing support and supervision.

●The registered manager told us they kept their knowledge up to date and they were expected to submit data to their manager and the local authority to show how they were complying with their service contract. Branch managers met to support each other and help ensure they were up to date with any legislative changes and best practice. There were clear policies and procedures in place at the location, staff were issued handbooks and care plans and assessments in people's homes reflected best practice.

●There was a business action plan which focussed on the service priorities and areas for development and improvement.

●The service was aiming to further develop its electronic monitoring. They had clear plans to develop its work force and expand.

● They were supporting staff growth and development.

● They had clear contingency plans in place to reduce any adverse effects on their business and ensure plans were in place to deal with any emergency and ensure they could continue to deliver a safe service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

●Peoples records were personalised with an overview of the persons needs and preferred outcomes which were specific and measurable.

● The care took into account people's preferences and staff received training to enable to provide care which was free from bias and prejudice.

Continuous learning and improving care.

●The service had different ways it monitored the service it provided and to evidence how they were compliant with legislation. They continuously strived to improve outcomes for people using the service and asked for their feedback to help them establish people's levels of satisfaction and improvements needed.

● An employee survey was completed in March 2019 which said 92.2% of respondents thought Hales was a good place to work, 84% of staff were motivated by the rewards schemes within Hales, and 71% of staff said their motivation had increased through the rewards scheme. The service had the, 'Hales Heroes' a staff rewards scheme with £1000 monthly draw for staff. There were also silver and gold badge awards in recognition of staff's performance. For example, staff were awarded for having no unplanned or unauthorised absence, staff who had 100% mandatory training in date, 85% loggings in and out of electronic system

●Annual awards were held where a member of staff could be nominated by a manager, colleague, a service user, a family member of a third party. There were different categories staff could be nominated for including having a personalised approach, maintaining professional excellence, empowering trust and championing change.

●Recruitment of new staff remained a priority and staff were given financial incentives if they referred a friend and further incentives if the person subsequently stayed and worked over a number of hours as set by the scheme.

Working in partnership with others.

● Feedback received from staff indicated that the introduction of the new app had made it easier to deliver care. It also helped ensure that evidence was readily available to the commissioners of how the service had delivered the commissioned care as specified as part of its contract with the Local Authority.

● The service said it linked in to other providers and access training and resources. For example, the service had completed 'dementia friends' through the Alzheimer's association who train people in the community about the presence and impact of dementia on individuals, their family and the community. By raising awareness, the hope was to increase tolerance and build community resilience.