Independent Clinical Services Limited

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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?	Outstanding ☆
Is the service well-led?	Good

Summary of findings

Overall summary

Independent Clinical Services trade as Thornbury Community Services, a nationwide agency providing commissioned care services with an office in the Long Ashton area of Bristol. This report focuses on the community care that TCS provides to people in their own homes. Thornbury Community Services (TCS) supply registered nurses and carers to Clinical Commissioning Groups (CCGs), case managers and private individuals providing care for clinically complex patients in their own homes. People have conditions such as acquired brain injuries, spinal injuries, paediatric and neurological conditions and require complex and high-intensity care. TCS provide community care for over 100 people around the U.K. and employ over 600 staff.

This provider was given two days' notice of this inspection. This was because they provide care in the community and we wanted to be able to speak with some people using the service. The inspection took place on 23 and 24 March and 6 April when we looked at records in the office and spoke with the registered manager. We made telephone calls to staff and people using the service around the country on 15, 19 and 20 April. We made further phone calls on 17 and 18 May.

There is a registered manager in post. 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.

There was a strong emphasis on respecting people's choices, and supporting them to achieve their wishes and ambitions. The provider ensured there were no barriers in place which would prevent people from achieving their ambitions. Relatives said the family was considered in all aspects of care planning, and they were involved in regular review meetings.

The risks of abuse to people were reduced because there was an effective recruitment and selection process in place. Staff were able to demonstrate a good understanding of how to recognise and report abuse. There were systems in place to ensure that risks to people's safety and wellbeing were identified and addressed.

People received a service that was based on their needs and wishes. A bespoke care team supported each person, which meant staff knew people very well. Care plans were personalised and contained detailed information about the support people needed. Staff were specifically trained according to the needs of the person. Staff competencies were assessed annually, or when there were any changes.

Review meetings were held regularly and people were phoned as well, to ensure the support was meeting their needs. The service was flexible and responded to people's requests where possible. Health and social care professionals were regularly involved in people's care to ensure they received the right care and treatment.

Relatives spoke highly of the quality of care given by carers. They said they trusted the carers to have the skills to keep them safe. People had positive relationships with their carers. Nobody expressed any concerns about any of the care provided. People received their medicines on time and in a safe way.

The provider learnt from accidents, incidents and complaints. They investigated these thoroughly and made changes where necessary. The provider gave us information about one instance when they did not have a complete oversight of a situation, and introduced additional training for staff and other changes to reduce the likelihood of a similar situation occurring.

Environmental risk assessments were completed for every new person using the service. This included checks to ensure the property was safe with adequate access, heating and lighting.

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.

The risks of abuse to people were reduced because there was an effective recruitment and selection process in place.

People received their medicines on time and in a safe way.

The provider had completed comprehensive risk assessments to help ensure people's safety. Staff were aware of the risks people faced.

Is the service effective?

Good

The service was very effective.

Relatives praised the care and support people received. People received highly specialised, personalised care.

Families were supported as well as the person receiving care.

Carers received specialised training which enabled them to feel confident in meeting people's needs. Staff told us their training was excellent.

Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

Is the service caring?

Good

The service was caring.

People's relationships with carers were strong, considerate and supportive.

Relatives said carers were caring and compassionate and treated people with dignity and respect.

Carers spoke confidently about people's specific needs and how they liked to be supported. They protected people's privacy and supported them sensitively with their personal care needs.

Is the service responsive?

Outstanding ☆

The service was very responsive.

Staff provided exceptional care and support which enabled people to achieve their ambitions. People told us the service was outstanding.

People's needs were assessed before their care commenced and care plans were regularly reviewed and updated as people's needs changed.

People received individualised, personalised care and support to meet their needs.

People were supported to express their views of the service they received. Most people rated the service as excellent or above average.

Relatives knew how to raise concerns and complaints. Any concerns or complaints they raised were investigated and changes were made if necessary.

Is the service well-led?

Good ●

The service was well-led.

The provider was forward-thinking and continually investing in systems which would benefit people using the service.

Carers were proud to work for the provider and had a good understanding of the values of the service.

There were effective systems in place to assure quality and identify any potential improvements to the service.

Independent Clinical Services Limited

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 over several dates in April and May 2016. We gave the provider two working days' notice because they provide community care and we wanted to be sure we could talk to the registered manager. It was carried out by an adult social care inspector over a period of two months.

Before the inspection, the provider did not complete a Provider Information Return (PIR). This was because we did not ask for one. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the previous PIR and also looked at other information we held about the service before the inspection visit.

During the inspection, we spoke with the national service manager, the registered manager, 11 members of staff and relatives of 13 people using the service. We also spoke with one healthcare professional. We saw ten care plans and associated documents from people living across the U.K. We also looked at records that related to how the service was managed, such as quality audits and seven staff files.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe using the service and with the staff who supported them. When asked if they thought their relatives were safe, relatives said, "Definitely" and "100%." Risks of abuse to people were minimised because there was an effective recruitment and selection procedure in place. Staff told us, "People are safe because staff are recruited properly and trained properly", and "They don't take on inexperienced carers. I would never leave because they look after their employees. If you have a problem they deal with it." We looked at seven staff files, including the registered managers. Pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions helps prevent unsuitable people from working with people who use care and support services.

Staff told us, and records seen confirmed that all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. Staff said, "I've done on line training and would take any concerns to the team leader" and "I would follow the policy, it's all in there." All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected. Although the computer system in use identified where safeguarding referrals should be made, staff phoned the local authority safeguarding team as well. This meant staff made referrals as soon as possible rather than waiting for the system to prompt them; this also helped to keep people safe. Staff told us, "Safeguarding is when I would have a concern about the safety of someone. I would contact my co-ordinator first. I have a booklet about safeguarding so I can look things up as I need to if necessary" and "I've read the safeguarding policy. I would report to my manager straight away, they would deal with it I'm sure. We've got phone numbers we can call if we're worried. I 100% trust them."

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. Staffing rotas showed the required numbers of staff to support individual people were allocated. Staff told us, "We have more than enough staff, we can cover everything. We know what's going on because we have bi-monthly meetings to update us, the co-ordinators will call us and update if there are any changes – straight away. We also get emails with the information so always know what's happening." Nurses and carers always had access to on call support for clinical or other needs. Staff told us they had handovers between shifts where they were able to discuss routines and any changes. For example, staff said, "We check the ventilator between us to ensure it's as prescribed. We also confirm whether we've been able to complete everything and whether anything needs to be carried over."

People's risks assessments outlined measures in place to enable them to take part in activities with minimum risk to themselves and others. In addition, health and well-being risk assessments considered the likelihood, severity and outcome of a range of emergencies, such as a chest infection for people who needed to use equipment to help them breathe. Preventative measures were also identified. Risk assessments also considered where responsibility lay. For example, where children used the service, the safeguarding of the

child was considered and the parental responsibility described. This meant, in the event of any emergency, it was clear exactly what staff should do, as well as how and when to do it. Families were considered in risk assessments too. Staff told us, "Families are very much involved, we ask them about what they think might be a risk." The risk assessments were thorough and detailed and clearly identified the resources required to manage the risks. For example, we saw where the clinical lead did not feel a ratio of one carer to one person was safe ; the staffing was increased to two.

We saw one example where processes weren't working to help parents of one child be able to identify patterns when the child's health was deteriorating, although staff had handed over small deteriorations at the end of each shift to them. This meant the child had been admitted to hospital frequently. The provider made changes which meant carers telephoned the duty desk if they identified any signs of clinical deterioration. This meant the duty person could have a conversation with the parents and encouraged them to seek a clinical review with a G.P. or similar. The introduction of this process meant the parents were able to make decisions with clinical support which meant the number of admissions to hospital was significantly reduced.

The management team completed an environmental risk assessment for every new person using the service. The assessment included a check to see if there was safe access to the premises and that heating, lighting and the power supply were working properly. Risk assessments covered all aspects of the support the person needed, such as the type of bed the person used, temperature and humidity as well as any space constraints for equipment in people's homes.

People's own medicines were stored in their own homes and administered by registered staff who had their competency assessed on an annual basis to make sure their practice was safe. All staff and families we spoke with said medicines were safely given and staff knew what they were doing. If people's needs changed staff were required to re-do their competency assessments. Analysis of accidents and incidents identified trends where medicine errors were found to be an issue. The clinical team looked at all of the data and information they had and identified where the errors were occurring. As a result, changes were made to the medicines charts and the error rate reduced.

Medicines records showed medicines entering people's homes from pharmacies were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately and clearly recorded. Regular audits of medicines took place, and where any actions were identified, we saw these were completed. Staff told us support was always available for them if needed.

We spoke with one family who discovered staff were falling asleep while on night duty. The person's care plans stated the person was unable to call for help, so it was important they were observed at all times. The family told us action was taken by the provider immediately and said, "The carers were taken off the night shift immediately." We saw the provider responded appropriately and worked with relevant agencies where needed. The registered manager told us, "Staff may be suspended while an investigation is completed, or they may work days only. There is an on-line training course which gives staff the skills to be able to prevent sleeping while on night duty." This meant the provider understood their responsibilities and had a range of options available to deal with these situations.

Good

Is the service effective?

Our findings

People using the service had complex medical and often life-threatening conditions. Some people were heavily dependent on medical interventions such as ventilators, spinal management and management of complex seizures. The registered manager told us they were proud of the success they enjoyed making sure families were happy with the staff, and the staff team for each person was right. One relative told us, "I couldn't manage without them due to my child's high level of needs" and "We have Thornbury Community Services TCS because other care providers couldn't cope." Another relative said, "[Name] gets better care at home than from nurses in hospital." This relative told us the provider liaised with ward staff and made sure all the necessary information was handed over. This was important to make sure the person could receive consistent care. Other relatives told us, "I'm really happy with the care and would be so sad to lose them", "They're really thorough" and "They touch base all the time to make sure she's happy." One relative told us, "This is the first time ever I felt supported, I know who I can turn to if I have a problem."

Relatives praised the care and support people received very highly, and told us how much they valued the staff. One relative told us how much they trusted the provider, and that they felt able to leave their child in hospital when carers were with them. They said, "I trust them, I trust their judgement. They put my child at the centre of what they do. I can leave hospital when they're there; I have peace of mind. They put the child first. We hear this from other professionals but don't see it, but with this provider we do." Another relative told us, "I absolutely, 100% trust them." One healthcare professional told us, "I would say they're outstanding across the board."

When people first considered using the service, a clinical lead identified the skills, training and qualities staff would need to be able to provide effective and appropriate support. For example, the type of support people needed included very complex procedures such as tracheostomy and ventilator management, feeding through tubes, catheter management and spinal management. A team of staff was identified with the specialist skills to be able to support that person exclusively. This meant people were able to live at home with a high level of care instead of living in care homes. Staff received the specific training needed to support the person. Relatives told us, "They feed and give medicines via a tube. They do everything", and "They're very effective and very good with [name]. When he's unsettled they're very good, there's no stress in any way with them." Staff knew how to respond to specific health and social care needs. For example, recognising changes in a person's physical health. Staff said, "If I see any changes I immediately speak with the parent, who will call the doctor or an ambulance. I have called emergency services before, and let the agency know. We have all the numbers for health advice if we need it." This meant people received effective care and support from staff who had the skills and knowledge to meet their needs.

We saw one person's care plan which showed following an incident, they were never expected to leave hospital and be able to walk. A bespoke care package was developed which meant the needs of the person and the person's family were considered together. With the support in place from the provider this person has been able to live at home with their family. The provider worked with external agencies to access additional support. For example, a range of professionals from a multi-disciplinary team were involved such as physiotherapists, and the person was able to mobilise independently. A range of additional support over

and above what the person using the service needed was put in place, to be able to support the family as well. This included obtaining further support, such as access to counselling for family members. This person is now able to stand with support, and walk with a walker, and their achievements exceeded family and clinicians expectations.

One person gave us permission to share their information. The person suffered life limiting injuries and became tetraplegic, totally dependent on ventilators and tubes for feeding. Tetraplegia is when a person has paralysis of all four limbs, due to illness or injury. This person wanted to attend university; however as they were living in a care home at the time, it was thought they would only be able to attend a university near to their home. The person wanted to attend a different university, and was successful gaining a place. The registered manager told us it was quite a challenge providing safe, competent care across two sites, the person's university and their home. The organisation funding the care for this person expected their university career to fail, due to the problems providing the complex care required across two, distant sites. The provider managed the rotas and accommodation of staff across two locations to be able to ensure staff with the skills and competencies were always available to support the person. Staff supported this person to live in the halls of residence at university, and participate in field trips. The registered manager said, "There was an immense amount of planning to enable choice and control, support social needs and maintain clinical needs, as well as facilitating trips home and holidays."

Where the provider supported children, they worked closely with parents and developed packages of care which considered the whole family. Relatives told us, "It's excellent the way they help us out as a family." Staff told us, "I've worked with the child for ten years now" and parents confirmed staff had worked with their children consistently for several years. Parents told us, "They've been with me for over ten years and we've had the same carers consistently" and "They've grown with [name] and adapted to his changing needs." Staff told us, "I feel pretty confident caring for my client, if there was anything I wasn't sure about I could ask for more training." This meant the child received care from staff who knew them well. This meant staff were involved in the growth of the child from small children and children benefitted from consistency of staffing. Parents felt comfortable leaving the care of their child to staff because they knew the staff had the skills to provide the high level of specialist care and attention needed.

Where families faced severe challenges following traumatic events we saw professional links with hospitals and various clinical teams, such as surgical, speech and language teams and physiotherapists were maintained. This meant when children were discharged from hospitals following these life changing events, staff maintained a professional relationship and had a good understanding of the challenges families faced. TCS staff worked alongside professionals in hospitals before the person was discharged, to ensure complete understanding of the clinical and other needs of the person.

Relatives told us, "They are really experienced paediatric nurses" and "They're exceptionally well qualified and very professional." People's individual needs determined the skills and competencies staff supporting them were required to have. Staff had to complete the necessary training and competency assessments before being allocated to support someone. The computer system in use would not allow a member of staff to be allocated to support someone if these were not in place. All staff and relatives we spoke with confirmed the training and competency assessments were completed. Staff said, "I have had training, it's up to date, we're not allowed to do anything if our training isn't up to date, they take us off the package" and "We have annual updates and competencies checks. If there are any changes in the client's condition or package of care, we have more training." Staff were regularly checked to ensure they maintained the skills needed to support people. This was to ensure staff were always up to date with best practice. If the person's needs changed or if they moved, staff skills were checked again before they were able to continue providing support.

Each care team was supported by a clinical lead and manager. We saw minutes of team meetings which showed the person was the focus of the meeting. Staff and parents all confirmed review meetings were held every month. Managers were able to use a meeting tracker system to check that meetings were taking place. If a member of staff failed to attend two meetings consecutively, they were withdrawn from the care team. This meant staff were kept informed of information important for the welfare and support of the person on a regular basis. Relatives told us, "They attend hospital meetings as well. I trust them 100%."

People were supported by staff who had undergone a thorough induction programme which gave them the skills to care for people safely. The registered manager told us staff were required to have a minimum level of training before they were able to work. Induction covered the requirements of the care certificate, which is a nationally recognised qualification to ensure staff had the basic skills needed to provide care. We saw induction had been updated to give staff more detailed training about record keeping following one investigation, which identified poor record keeping as one part of the areas to improve. This showed staff were made aware of changes as a result of lessons learned from the investigation. New staff were required to learn about the policies and procedures in place; these gave staff the information they needed about the processes and systems in use. Staff told us, "Training was excellent, e.g. manual handling. The training we needed was set up for us and we had to complete training before we started on shift" and "They keep track of our training and they update us when we need it. Training helps us to keep up to date with any changes, new ideas for better practice and as a reminder."

Staff had access to immediate support at any time via a rota of on-call senior staff. Staff received support and information from managers via quarterly team meetings. A senior manager said, "One of our weaknesses is staff supervision." Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. At the time of the inspection, a new supervision and appraisal process was starting. We saw there were plans for a formal supervision programme which meant carers would receive supervision four times a year. One nurse told us, "There's a lot of independent working as it is one nurse at a time, but there are regular team meetings and I've got to know the co-ordinator very well. Other staff told us, "We have regular team meetings, we can discuss if there are any issues, changes or progress" and "We have a communication book and staff write updates and changes".

Care plans reflected people's health and social care needs and demonstrated that other health and social care staff were involved. We saw health and social care professionals such as GP's and paediatricians were involved in people's individual care on an on-going and timely basis. We saw processes in place which ensured healthcare professionals and parents were involved in regular reviews. Some reviews were planned; others took place because staff recognised changes in a person's health. Reviews with healthcare professionals and staff were important to ensure people received the most appropriate care in a timely way. Staff confirmed the involvement of healthcare professionals and told us, "All paperwork has to be signed off between the clinical lead and the paediatrician. We can't make changes unless it's gone through the process" and "Other professionals come to visit, paediatrician, nutritionist, [name's] case gets reviewed regularly."

The registered manager said, "We feel we manage our client's health needs very well, because people can change dramatically."

Planning for transitions from children's services to adult services began when the child was 16 years old, ready for the actual transition when they became 18 years old. We saw this involved multi-disciplinary teams to ensure the process was as smooth as possible. Parents told us the planning was started early

enough to deal with any problems that arose. This meant the provider started the planning process early to ensure the transition from children's to adults services went smoothly.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Where people required food to be administered via tubes, controls and processes for doing this safely and effectively were in place.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. No-one was subject to a DoLS authorisation. Where people used bedrails for example, we saw assessments in place and best interest meetings had been held, which involved G.P's and parents (if appropriate.) The registered manager said, "As long as it doesn't put people in danger, if the client has capacity and understands the risks, they do what they want. Staff are aware of the processes to follow, everything is in people's care plans." We saw best interest meetings were held which involved the person and other professionals who were involved with them, such as G.P's and district nurses. We saw people with complex clinical needs had been supported to undertake activities they had chosen to do, even though these activities exposed the person to a level of risk. The activities had been risk assessed and support was put in place to minimise the risk. This meant people's choices and decisions had been respected.

Good

Is the service caring?

Our findings

People said they were supported by kind and caring staff. Parents told us, "They're great" and "I can go out and leave my child and know they're safe." One relative told us, "They really care; they know her. They deliver the care when [name's] in hospital as well and point out when she's not well." The registered manager told us, "Each family needs to feel they are the centre of your world" and "We have individuals we help to live their lives."

People's dignity and privacy was respected and all personal care was provided in private. The registered manager told us the first step towards ensuring staff respected people's privacy and dignity was to ensure they employed the right staff. We saw trigger words in care plans to remind staff to respect people's privacy and dignity throughout every process. Staff told us, "We ask for permission before doing anything, talk to them all the time and give choices where possible." Relatives confirmed this and said, "They give [name] choices and do what she wants" and "The staff are really understanding and know what she's been through; they do their best to make sure she gets what she needs." Client codes were used in communications to protect people's identities and any information stored electronically was password protected and sent securely. Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. These measures meant the provider had processes in place to maintain people's privacy and dignity.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. Relatives told us, "I would definitely recommend them, they know [name], they know her condition and how to spot any deterioration", "They're the best agency I've ever had" and "I've never had anyone so good, we have a good relationship." One healthcare professional told us, "There are no barriers, no issues, they're very patient centred" and "No-one has anything negative to say about them."

Where people were unable to vocalise their thoughts and wishes, their care plans gave staff detailed information about how the person communicated. For example, one person's care plan described smiling, frowning, crying and a range of facial expressions the person would use to let others know how they felt, and what these meant. Another care plan gave details about a range of 'swallow' and 'voice' exercises which had been devised for the person to regain and develop their voice and ability to swallow. Staff told us, "My client is able to communicate via facial expressions and body language, although she's not able to communicate verbally I know her individual communications" and another member of staff said, "Although she can't communicate I give her as much choice as possible, and we do age appropriate activities. It's important for her dignity we give her a voice and respect her wishes."

Relatives told us people were fully supported to access community activities and children were supported to attend school where possible. Relatives told us, "They're so great because I'm not tired all the time" and "[Name] is so sociable and likes to see people all they time, they make him comfortable and have a giggle." Another relative told us, "Everything they do adds to her quality of life. She wouldn't be so independent if they weren't there. They're her buddies." Staff told us, "Parents are very thankful for the help we give. The

fact they are happy to leave us with a four year old, reading stories etc. is important."

Outstanding ☆

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. Relatives' comments were positive such as, "They are absolutely fantastic, they save us hospital admissions and [name] loves them." Other comments included, "We can trust them to get it right, they really worked with me to get everything we needed" and "They listened to me, I've been with them for two years and for the first time in two years I've got a home and family environment." Most relatives we spoke with said they had recommended the provider to other people. One healthcare professional told us, "I deal with a lot of agencies and would like to see more patients using TCS. They're so much on board with everything. Everyone tells me how happy they are with them and I've never heard a patient not say the same thing."

We saw staff provided exceptional care and support which enabled people to achieve their ambitions. The family of one person were happy to share their information with us. Their relative was in hospital with a life expectancy of three days. They wanted to get their affairs in order and desperately wanted to die at home holding their spouse's ashes. As this person's clinical needs were very complex, the family were very worried about this at the time. The provider was able to assemble a specialised team with the skills to manage and support the person. Risk assessments and care planning was completed, which meant the family were happy with the support offered. The person was discharged from hospital within 24 hours. They went on to live another three weeks, and were able to say goodbye to their friends and family at home, as they wished.

People were supported to take holidays where possible. One person gave us permission to share their information. They wished to undertake a skiing holiday, despite being tetraplegic and dependent on machines for breathing and feeding. They said they "wanted to be free again." The provider completed the research into what this involved, including finding safe ski slopes, researching how temperatures will affect ventilating equipment, electricity and emergency supplies for the ventilator and various risk assessments. They also considered how to give the person respite breaks during an arduous journey. The registered manager told us, "We've completed detailed planning and risk assessments of the journey, accommodation and local hospitals during the journey and at the destination, and we're ready to go." We saw this involved detailed planning between ski organisations, instructors, the hotel and a team of support staff. At the time of the inspection, the person was too poorly to be able to go.

We saw one child lived with their family in a property not adapted for their needs. The family had struggled to gain the support needed from the property owners to make the necessary adaptations. The provider was working closely with social workers and the family to access a more suitable property.

One person had their own 'bucket list'; a list of activities they wished to completed before they died. The provider supported this person to attend an aviation museum, and arranged for a fly-past of aircraft as a surprise for them. They also supported people to visit Disneyland in Florida, and various music festivals. The registered manager said, "We try to make sure people are as socially included as possible." Another relative told us, "Staff asked what skills they needed to learn to develop my child, and offered to learn Makaton and British Sign Language. One nurse bought a Makaton app to teach herself and my daughter Makaton. They do several things with her. I would definitely say they're outstanding."

Each person had their needs assessed before they started to use the service. This was to make sure the service was appropriate to meet the person's needs and expectations. We saw there were two types of initial assessment; one was very detailed and designed to identify all care needs and risks. The other assessment was designed as a fast track assessment, for example for use when a person required care such as end of life care to be put in place quickly. The process included assessing the home, the person themselves and the equipment and staff they needed. When people had a new care package, they were contacted within the first 48 hours and asked if the support was meeting their needs in a person-centred way. This was an opportunity for people to highlight any issues or concerns they had and ensured staff were meeting people's needs, choices and wishes. Staff told us, "The care plan is a liquid document and changes regularly" and "People with complex needs may have a new care plan every two months."
We saw where one family did not want their home to be risk assessed as part of their initial needs assessment, their decision was respected.

Care plans were personalised and identified the relevant people involved in people's care, such as their G.P. They were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. For example, one person's care plan stated, "Be cautious when supporting me, if I have to stand or walk for a brief period I may experience a sudden deterioration in my mobility. Allow me to be as independent as I can but you must ensure my safety." Another care plan stated, "I have severely restricted sight. Avoid startling me by addressing me on my right hand side so I can see where you are." Care plans were presented in an orderly and easy to follow format, from initial planning through to on-going reviews of care. To be able to respond to people's changing needs more efficiently, the provider was investing in new technology. At the time of the inspection, peoples risk assessments and reviews were changing as the first stage of this process. The next stage was for clinical information to be relayed automatically to clinical teams. This meant any changes in the person's health would be immediately available to clinical teams, so they can update staff with any changes to the support necessary for the person. This meant the person's changing needs were responded to more efficiently.

Care plans contained detailed and explicit clinical information for staff. For example, in one person's care plan for maintaining their airway, the care plan gave details of the settings for the oxygen concentrator. Where people used specialised medical equipment such as a suprapubic catheter, care plans included details about which leg the bag should be strapped to, to prevent pressure ulcers. Staff were given information about situations and triggers which could cause medical emergencies, what they should look out for and how they should treat the person if this happened. Relatives told us, "[Name's] health can be an issue sometimes, but staff know what they're doing. They're excellent."

Each person had contingency plans in place which considered what the person and their families wanted. The contingency plans covered the person's clinical needs as well as operational situations such as staff sickness. This meant because staff had information and guidance available to them about a range of unlikely situations, they would be able to respond to the situation quickly and appropriately, and any risks to people would therefore be minimised. Staff told us, "We have escalation packs if people become unwell and will call 999 if people need help. There is clinical help on hand if we need it."

Nurses completed clinical reviews during a face to face meeting with the person. Depending on the level of care the person needed, these meetings were either monthly or three-monthly. Every 12 months a new care plan and risk assessment review took place. These reviews considered people's social needs as well as their clinical needs. Relatives told us, "We are always under review", "[Name] visits us regularly to go through the care plan, I see them monthly or we get a call" and "I do the care plan with them so it's what I want, they go along with us."

We saw minutes of monthly review meetings between a set of parents and staff which showed staff were proactive in identifying additional support that may be required. Relatives told us, "I'm always asked my opinion during the monthly meetings", "They always listen to me and try to work out the best for [name]" and "They listen and help where they can." Where these meetings identified any issues, for example with medicines, we saw this was followed up by clinical supervisors and medicine reviews were held. This meant staff had up to date information available and were able to respond to the person's changing needs in a timely way.

The registered manager sought people's feedback and took action to address issues raised. Surveys were undertaken every six months. The results of the previous survey and details of any changes made were sent out with each questionnaire, so people could see what changes had been made. People were given a range of options for completing the questionnaires, for example, they were offered via email, telephone call or during reviews. One person had each individual question texted to them using a mobile phone, and texted each reply back. People were able to complete questionnaires anonymously if they wished. Questionnaires asked people about their experiences using the service, and the management designed action plans to address any issues. For example, 95% of people felt they were involved in the design of their care package. In response to the 5% who had not responded positively, people were reminded they could talk to their case managers or clinical leads and reminded they could discuss any changes they wished during their monthly review meeting. 73% of people rated the provider as excellent or above average for the service they provided. Comments from people included, "The service she has received in terms of making arrangements and flexibility is nothing short of excellent", "We always feel that our opinions are listened to and any questions are answered promptly. Excellent all round – Thank you!" and "The care team are skilled, loyal and supporting. They have gone out of their way to help the family."

Each person received a copy of the complaints policy when they started using the service. The policy identified good practice and specified time frames for dealing with complaints. Everyone we spoke with knew the process for raising any concerns or complaints, and told us they were dealt with straight away. Relatives told us, "I have no complaints whatsoever, and I'm fully aware of the process" and "They listened when I wasn't happy about something and made changes." Staff said, "They try to find a solution to any problems."

All accidents and incidents were recorded electronically and were analysed to identify trends and patterns. The complaints team saw information about accidents and incidents and were able to see if there was any learning to be gained. Where complaints were received they had been responded to within the timescales required and had been dealt with to everyone's satisfaction. Incidents such as staff arriving late or been turned away from people's homes were also recorded. The provider said, and relatives confirmed they ensured people never had a stranger turn up on their doorstep. Staff and relatives confirmed new staff always went with someone who knew people well on their first visit to a person's home. All incidents were logged with the complaints team so they could be followed up, investigated and any changes made as necessary. All staff we spoke with were aware of the processes for reporting accidents and incidents. Staff told us, "The system is quite quick at dealing with things."

Good

Is the service well-led?

Our findings

The service benefitted from strong leadership and oversight at registered manager and provider level. Together they developed and sustained a positive culture that was open, inclusive and empowering. The management team had clear vision and values for the service, based on maintaining excellent care for individuals and putting them first. Staff said, "I'm sure we looked at vision and values in induction. They have a good name and they want to keep it that way. They want to be the best in the market." Relatives told us, "They're a really good company."

There were effective quality assurance systems in place to monitor care and plan ongoing improvements. We saw different types of audits which looked at all areas of the service, including care plans and staff training. The registered manager told us the clinical governance team completed audits. We saw audits of care plans which showed they had been checked to ensure clinical reviews had been completed. There were also annual audits completed by an external organisation. This is good practice because an external auditor has an independent view and this helps to give confidence in the quality of the audits. Spot checks were also completed; these included looking at everything for one person on one particular day. This meant the skills of staff were reviewed and checked they met the person's needs. A senior manager told us, "Everyone is quite passionate about their work; we want to do well."

We saw that where shortfalls in the service had been identified action had been taken to improve practice. The registered manager told us, "We know what we need to improve on." We saw where any actions were identified these were followed up immediately. The senior management team was informed if deadlines for completing actions were missed.

All accidents and incidents which occurred in the service were recorded and analysed. The information was shared with the complaints team, who investigated and made any referrals to the safeguarding team that might be necessary.

We saw an instance when the provider did not have adequate oversight of a package of care and issues were not identified in a timely manner. An investigation was completed which identified the lack of communication between the family and carers as the centre of all issues. Key lessons were learned and TCS made a number of changes to prevent any recurrence of this, or any similar situations.

The management team looked for areas for improvement and staff received incentives for achieving them. Last year the focus was clinical and social reviews because audits showed one person had not been reviewed for three months after the monthly reviews had been postponed. The provider identified this was a loophole in their processes and made changes to prevent this from happening again. As a result of these changes, people's reviews will not be postponed three months running. This meant if people's needs changed, this would be identified sooner and the appropriate support put in place.

Relatives told us the communications with the provider was very good. They said, "We have a good relationship and a nice routine where everything is covered." Staff spoke positively about the open

communications and support they received. Comments included, "Managers are very good, communications, pay, understanding, and they respect us if we say we don't want to do too many hours" and "We communicate with managers quite often."

All staff we spoke with said they felt supported, and were able to raise anything that concerned them. Staff told us, "They're very supportive", "I think they're very passionate about what they do and the org is well led. I'm supported, I get regular calls and invitations to meetings, I feel I could go to them if I needed to" and "Supported – yes, all the time."

The management team made changes to the way the service responded to new requests for care packages. These changes meant nursing staff supporting the person were observed by carers, then nurses withdrew from the care once the carers were competent. As nurses were on site they were able to observe and ensure the carers had the skills and competencies necessary to support the person. This also meant the information in the care plans was monitored by trained staff who were working with the person at the time, so the information could be reviewed and updated immediately if necessary.

There was a staffing structure in the service which provided clear lines of accountability and responsibility. The group clinical director had two clinical leads, one specialising in paediatrics and one for general clinical areas. This meant the senior management team had oversight of every region in the U.K. Each regional team had a business manager, a regional clinical lead and four or five nurses in the team. The registered manager said, "We are able to maintain a smaller business oversight by having regional meetings." This meant, although the provider was a large, national organisation, each region was supported by senior staff who in turn, were able to provide support to the teams in each area. The registered manager attended monthly community and quality meetings, which looked at any risks and complaints. Where any incidents had occurred, these were looked into thoroughly to identify the cause. Trends were monitored to see if there were any lessons to be learned.