Agenda Item 13

URGENT ITEM

Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 7 MARCH 2017

CARE QUALITY COMMISSION INSPECTION REPORT ON HALES GROUP AND THE ACTIONS TAKEN BY THE COUNCIL

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of Report

1. The purpose of this report is to advise the Committee of the outcome of an inspection of Hales Group (Leicester) by the Care Quality Commission (CQC), and the actions taken by the Council to improve the quality of the service for service users.

Background

2. The Committee have previously received a number of reports about the Help to Live at Home (HTLAH) Service. HTLAH was commissioned jointly with the two county Clinical Commissioning Groups. A detailed report on the roll out of the HTLAH Service and the lessons learnt will be submitted to this Committee at its meeting in June 2017.

3. The County was divided into 18 HTLAH lots, with each Borough or District area containing at least 2 lots. In addition there is more than one lead provider in each Borough or District area (as shown in Appendix A). Hales were awarded three geographical HTLAH lots for the contract which commenced on 7 November 2016. The location of these lots is shown on the map attached as Appendix B.

CQC Inspection

4. CQC visited Hales on 5, 6 and 7 December 2016. The inspection report was published on 24 February 2017 (attached as Appendix B). The report highlights that Hales were found to be inadequate in the areas of safe, effective, well led and responsive. This meant that they were found to be inadequate overall.

5. All the providers were subject to quality and financial checks prior to the award of the contracts. This required satisfactory CQC ratings, references, effective service mobilisation plans, and a robust financial assessment. Providers that had been rated as inadequate at the point of procurement in the domains well led and safe were excluded from contract award.

6. Hales has seven other domiciliary services that have been inspected and rated by CQC. Of these sites, six are rated as good and one is rated as requires improvement. This indicates that the organisation has the capability to deliver effective services and to deliver improvements to care services.

7. Hales are currently responsible for the care of 117 service users, but 63 of these people have their care provided solely by a sub-contractor (who are not subject to CQC restrictions).

8. Since the inspection in December 2016, Hales have been subject to a number of restrictions placed on them by CQC, in particular a requirement that they are unable to take on any new service users or to increase the size of any individual package by more than 3.5 hours per week without the written agreement of CQC. The lots operated by the provider are in effect closed to Leicestershire County Council for new business, and means that care is being placed with alternative providers. CQC have also requested that Hales submit to them on a fortnightly basis an update relating to actions put in place to address the issues outlined above.

9. From the Council's own contracts management, it was evident that in the period immediately after go live there were significant problems in Hales mobilising effectively to deliver the new HTLAH service. Their mobilisation plan had not been effective in making them ready to deliver the required volumes of care, principally because the provider did not have sufficient numbers of skilled and experienced staff. The local branch did not have the systems and capacity in place to quickly make the necessary improvements. The provider had also not adequately escalated the significant capacity and capability concerns with the Council in the run up to go live, meaning that urgent reactive action was required when problems with missed and late calls emerged in the first days of the service.

10. The Council agreed that evidence presented of the service in the CQC report is accurate at the time of the inspection, and reflects much of what we were aware of in the initial period in November and early December 2016.

11. CQC plan to undertake a follow up inspection within the next three months, and this will be published in due course.

Action taken by the Council

12. It was clear soon after 7 November 2016 that Hales had significant difficulty in managing the volumes of care in the Lots as they did not have enough staff available. The Council therefore immediately placed 50 cases with alternative service providers to ease the pressure on the service. It was also agreed that no new cases would be allocated to them until sufficient staff had been recruited.

13. An urgent meeting was convened with the local and regional manager on 8 November 2016 to outline our concerns and seek assurances that these were being tackled. All incidents of missed calls were escalated to the Local Manager. They remain subject to regular contract monitoring meetings and there have been two further escalation meetings with the Assistant Director (Strategy and Commissioning).

14. Since 7 November 2016, there has been one safeguarding alert concerning an individual Hales service user. In the same period CQC have forwarded more general concerns raised with them about the quality of the service provided by Hales. None of these concerns alleged abuse or neglect of specific service users and were followed up as part of contracts management.

15. The Council's Quality Improvement Team (QIT) have worked with managers at Hales to develop a Programme of Support to address the issues outlined above. QIT staff all have extensive management and operational experience in providing care services within a range of service provision. The team is well regarded across the health and care community and has a good track record of supporting providers to meet compliance and improve standards of practice.

16. Hales agreed to work with QIT and after some early teething problems have been actively engaged since January 2017. There is good engagement from the new Branch Manager and Regional Director. QIT report that progress is being made in a number of areas and the three allocated QIT officers visit approximately three days per week. The updated Programme of Support and summary visit information is shared with CQC on a weekly basis.

What improvements have been made?

17. More staff have been recruited and there is a more robust recruitment system in place. Most service users now have an appropriate care plan in place, and there are plans to complete this work soon. Audits of medication administration have been completed, and staff have been given guidance on the improvements required.

18. The number of missed and late calls has reduced very significantly. They have introduced a system where they are checking ahead by calling staff to ensure they have read rotas and will be attending all calls.

Month	Number of missed or late calls
November 2016	12
December 2016	7
January 2017	1
February 20 17	1

19. From 7 November 2016 to the end of December 2016, a total of eight formal complaints relating to Hales have been received by the Council. These related to a range of concerns about the service, with missed or late calls being a feature in most cases. Each complainant has received an individual response to the issues raised and had a follow up contact to check that the service quality has improved. No formal complaints regarding Hales have been received so far in 2017.

20. A new local manager has been appointed and she is being supported more effectively by the wider organisation. Further work will be required to ensure the sustainability of management and staffing capacity.

21. Hales are making significant efforts to work closely with the Council to address the issues raised in the CQC report. The volume of concerns raised with the Council has declined significantly over recent weeks and we have received no further formal complaints from service users or relatives for some weeks. Hales now appear to be performing much better. It should be noted, however, that Hales are delivering low volumes of care compared to the expectations within the framework contract. Discussions are planned with the provider and CQC to consider if the provider can increase provision through taking back sub contracted activity.

Background Papers

None

Circulation under the Local Issues Alert Procedure

A copy of this report has been circulated to all members via the Members News in Brief.

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List of Appendices*

Appendix A – Distribution of Lots in County Areas
Appendix B – Location of Lots
Appendix C – CQC Inspection report on Hales Group Limited - Leicester

Relevant Impact Assessments

Equality and Human Rights Implications*

22. Contained within contract documents is the requirement for the service provider to deliver all commissioned care calls to meet the assessed needs of the service user taking into account the gender, age, race, ethnicity, culture, sexuality and disability in accordance with the specified tasks on the service user's support plan, and which meet the specification and the Health and Social Care Act 2008, (Regulated Activities) Regulations 2009.

23. An updated Adults and Communities Equality and Human Rights Impact Assessment (EHRIA) was completed in August 2016 and reviewed by the Adults and Communities Departmental Equalities Group (DEG) on 6 September 2016.

APPENDIX A

District or Borough	HTLAH Contract Lot
N W Leicestershire DC	1 Castle Donington & Whitwick
N W Leicestershire DC Hinckley & Bosworth BC	2 Ibstock & Measham
N W Leicestershire DC	3 Ashby de la Zouch & Coalville
Charnwood BC	4 Loughborough East
Charnwood BC	5 Loughborough West & Shepshed
Melton BC	6 Melton Mowbray
Harborough DC	7 Market Harborough
Melton BC Charnwood BC	8 Thurnby & Syston
Oadby & Wigston BC	9 Oadby
Oadby & Wigston BC	10 Wigston & South Wigston
Hinckley & Bosworth BC	12 Hinckley & Twycross
Hinckley & Bosworth BC	13 Groby & Market Bosworth
Hinckley & Bosworth BC Blaby DC Harborough DC	14 Broughton Astley & Burbage
Blaby DC	11 Blaby & Countesthorpe
Blaby DC	15 Glenfield & Braunstone Town
Blaby DC Harborough DC	16 Narborough & Lutterworth
Charnwood BC	17 Birstall & Anstey
Charnwood BC	18 Mountsorrel & Quorn

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APPENDIX B

LOCATION OF LOTS

- Lot 11 Blaby and Countesthorpe
- Lot 16 Narborough and Lutterworth
- Lot 17 Birstall and Anstey

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APPENDIX C

Hales Group Limited

Hales Group Limited - Leicester

Inspection report

4 Brook Street
Syston
Leicester
Leicestershire
LE7 1GD

Tel: 01162602181
Website: www.halescare.co.uk

Date of inspection visit:
05 December 2016
06 December 2016
07 December 2016

Date of publication:
22 February 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Hales Group Leicester provides personal care for people aged 18 years of over who need care or support at home. At the time of the inspection there were196 people using the service. However 100 of these people were receiving support from another homecare agency through a sub-contracting arrangement. The majority of people who used the service had their care funded by the local authority.

The inspection took place on 5, 6 and 7 December 2016 and was announced. We gave the provider of the service 48 hours' notice of the inspection. This was because the location provides a domiciliary care service. We need to be sure that the manager would be available to speak with us. Prior to our visit we had received information of concern about the quality and safety of the service provided. This information prompted our visit.

The month prior to our inspection Hales Group Limited - Leicester had secured a large contract to provide care packages to people who had previously received their care from other providers. This meant that they were providing over double the care calls in the second week of November than they had the previous week. As part of this process Hales Group Limited Leicester had transferred a number of staff from other providers to be employed by the,. We had received feedback from people using the service, their relatives and staff that there were concerns about the quality of the care provided and significant disruption to people's care packages.

There was a registered manager at the service however they had submitted an application to de-register. The registered manager was on leave at the time of the inspection. There was a branch manager in post who had submitted an application to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from abuse. People told us that staff were often late for calls and that they had missed calls completely. We found that there was a high number of missed calls. The irregularity of visits meant that people did not receive care that was vital to their physical health and did not receive food or drink. This is neglectful practice but had not been recognised as such. Incidents of missed calls had not been reported or investigated appropriately. The provider had not checked on people's welfare to make sure that they were safe when they had not received their care.

Some people had been left in degrading situations, for example, not having their continence needs met.

People were not consistently protected from risks relating to their health and safety. Risks had not always been assessed. People had not had their needs assessed or plans of care put in place to enable staff to understand and meet their needs safely.

There were not enough staff to meet the needs of the people who used the service. There was a system in place to record if staff were late or missed a call however this was not being used to monitor that people were receiving the care that they required.

People were at risk of not receiving their medicines as prescribed. Due to the missed and late calls medicines were not given at the agreed times. We also found that staff had not all received training to administer medicines. People's care plans did not always give staff guidance on how people should be given their medicines.

People received care from staff that had not always undergone the appropriate pre-employment checks. Staff had not received appropriate training and support to enable them to fulfil their roles.

The service was not working within the principles of the Mental Capacity Act 2005. People had been determined to not have the capacity to make a specific decision without appropriate assessments having been carried out. Relatives were being asked to make decisions on behalf of people without the legal right to do so.

People were supported to access healthcare services.

People told us that staff were mostly caring and that they did their best. However people's experiences of care were affected in a negative way by the lack of sufficient staff to meet their needs and by the way that the management responded to concerns about their care.

People were not always treated with dignity and respect.

There was a complaints procedure in place. However people and their relatives felt that their concerns were not listened to. Where people had raised concerns these had not been recognised as a complaint, investigated or responded to.

People's views about the quality of the service had not been sought by the provider as they told us that they felt the responses would be negative. There were no effective systems and processes in place to monitor the quality of the service or the safety. The provider had failed to monitor, assess and mitigate the risks to people using the service.

The provider had taken on a new contract to deliver care to a significant number of people. They had not planned how to do this effectively. The provider did not have plans in place to manage transition. Resources were not adequate to provide a high quality service to people.

People's packages of care had been transferred to other providers as part of a sub-contracting arrangement. People had not had their needs assessed before the transition. This meant that the provider did not ensure that the new provider was able to meet people's needs. They also did not transfer people's packages of care safely.

We identified that the provider was in breach of six of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see at the end of this report the action we have asked them to take.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from abuse. They had received visits that were often late, missed or irregular. They had missed medicine, food, and drink.

Risks in relation to people's care had not been properly assessed or managed. People's needs had not been fully assessed.

The provider had not recognised that the significant number of missed calls could be neglectful practice. They had not monitored these, or reported them appropriately.

Staffing levels were not adequate to meet the needs of people who used the service. This put people at significant risk.

Staff had not always been recruited safely. Pre-employment checks had not always been completed.

People were not supported to take their medicine safely. People had missed medication and care plans did not give staff guidance on how to support people safely with their medicines.

Is the service effective?

Inadequate

The service was not effective.

Staff had not completed training that enabled them to effectively carry out their role. They had not received support or supervision to ensure their competence.

The service did not work in line with the Mental Capacity Act 2005. People were assessed as not having the capacity to make a specific decision without appropriate assessments having been carried out.

Due to the irregularity of people's visits people did not always receive food and drink when they required this. People were supported to access healthcare services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that staff were mostly caring and that they did their best. However people's experiences of care were affected in a negative way by the lack of sufficient staff to meet their needs and by the way that the management responded to concerns about their care.

People were not always treated with dignity and respect. Some people had been involved in developing their care plans. However, their wishes about their care were not always asked or followed.

Is the service responsive?

Inadequate

The service was not responsive.

People's care needs were not always assessed. Their care was not delivered at the times they wanted by carers who they had asked for.

People were not always contacted when staff were going to be late. Staff made them feel rushed and did not stay for the time they were allocated or complete all tasks.

The provider had not recognised concerns as complaints and had not investigated these or responded to them in line with the complaints procedure.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor the quality of the service were not used effectively to identify when people received a poor service. Action was no taken when people received poor care.

People felt that the communication was not always open from the registered manager or the staff based in the office.

The provider had not identified that the shortfalls in the service delivery could be abusive practice. They had not notified the local authority or CQC of these incidents so people could be protected from further potential harm.

People had not been asked for their feedback on the service as the provider thought this would be negative.

Staff felt that they were not supported in their roles.

Hales Group Limited - Leicester

Detailed findings

Background to this inspection

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

This inspection took place on 5, 6 and 7 December 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that the registered manager would be available to speak with us.

The inspection was carried out by three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for someone who used this type of service.

Before our inspection, we had received information of concern from people who used the service, their relatives and staff. We also reviewed the information we held about the service and information we had received about the service from people who had contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service. We also contacted Healthwatch (the consumer champion for health and social care) to ask them for their feedback about the service.

We reviewed a range of records about people's care and how the service was managed. This included 10 people's plans of care and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people who used the service and policies and procedures that the provider had in place. We spoke with the branch manager, the regional manager, a care co-ordinator and nine care workers.

We contacted 29 people who used the service by telephone. We spoke with eight people who used the service and four relatives of other people who used the service. This was to gather their views of the service being provided. The other people we contacted either chose not to speak with us, or were receiving care from one of the sub contracted organisations so their feedback could not be obtained. We did pass their feedback to the inspectors for the sub contracted organisations.

Inadequate

Is the service safe?

Our findings

People told us that staff had missed calls or were often late. One person told us, "I have had missed calls on occasion but I've not worried about that. I don't like to complain." Another person said, "They [Staff] do their best. On occasion I have to wait." Another person commented, "The time they come keeps drifting. One day I was sat in my pyjama's until 8am."Relative's also confirmed that calls had been missed and staff were often late. One relative said, "We should have calls at 8, 12, 4 and 8. Now it seems to have settled to something like 10, 12, 4 and 8 but we are lucky if we get someone coming 3 or 3 and a half times a day. They seem to combine the two morning calls. So they are missing one visit a day." Another relative said, "I have had to complain and get someone out to reassess but the carers were coming at all times or not coming." One relative told us, "At the start there were a lot of missed visits. We also have a lot of late visits. We had two missed calls yesterday. No one called to tell us. [Person's name] is being put at risk."

We asked the branch manager for details of how many missed calls there had been. They were not able to provide this information. We asked for details of call monitoring and analysed this information ourselves. We looked at the records for all calls that were due to take place over a three week period in November 2016. These showed that there had been a total of 131 missed calls in that time. We also found that there had been 69 calls that had been cancelled. The reasons for the cancellations were not documented. People, their relatives and staff told us that some calls had been cancelled when staff had been very late. One staff member said, "Sometimes staff turn up, sometimes they don't. Either they turn up too late or not at all. One person told me that the staff turned up at 6pm for an evening call. This was too early so [person's name] turned them away and cancelled the call." We asked the provider how calls had been monitored to ensure that people received the care that they needed. The call monitoring system that was in place did have alerts that would identify when staff had not turned up after a specified period of time but these had not been used. The branch manager told us that the alerts were now being used. The provider did not use the electronic data to track late, missed or irregular visits to mitigate any risks to people's health and welfare and ensure they received the support they needed. We found that unless people had reported missed calls or lateness as a complaint that there had not been any attempt to contact people to ensure that they were safe when they had not received a call. This placed people at risk of harm.

At the time of our inspection Hales Group Leicester had been working with people under the new contract since 7 November 2016 which meant they were in their fifth week of providing support. We found that assessments had not been completed for all people who were using the service. This meant that where people were potentially at risk of harm this had not been identified and control measures had not been put in place to reduce the risk. One staff member told us, "[Person's name] has dysphagia (Swallowing problems that meant the person required thickened fluids to ensure that they could swallow them safely), and they don't have an assessment. [Person's name] has been admitted to hospital. On the day of their admission too hospital they were given un-thickened soup." We clarified with a social care professional that this was not the reason for the admission to hospital. However this person had a specific diagnosed health condition that represented significant risk to them. The provider had not identified the risk, assessed it or put guidance in place to make sure that the person received their care safely. A relative told us, "It has taken two months to get the crucial part of any care plan in place. It would have been nice to have gone through it with

someone. I noted mistakes in the plan including key information such as their diagnosis which makes them less likely to look after themselves at all, the details of the medication are incorrect, they should mobilise as much as possible due to poor circulation and this is not included, and they are incontinent which is not recorded anywhere." We received information from a health care professional. They told us that staff had called 999 as they were unsure how to provide care to one person. The health care professional said that there was no assessment in place. The person required care in bed and had a terminal diagnosis. One person told us, "Since this company took over I haven't even got a book. They left me two loose papers. I did have a proper care plan which said what they had to do but that has all gone. No one has spoken to me about a new one." A relative said, "Things went wrong in the first week. We had to speak with the council and we went through the care plan. Someone came out last week to go through all of the medical side of things."

Staff told us that not all people had an assessment which guided staff on how to provide care for people and meet their needs safely. They told us that they either used information from the previous providers, family members or relied on their own experience, however staff did say that they were not sure what each person's needs were. One staff member commented, "No one has any swallowing problems that I am aware of. Where families have told us what to do I have left notes for other carers." Another staff member said, "Luckily the family were there so I could ask them." One staff member told us, "Some people do have care plans. Some don't. I have used my own knowledge to provide the care. I have been doing this job for a long time." Another staff member said, "Some people still don't have plans. I have followed plans that were from other providers. One person doesn't have anything at all. [Person's name] is living with dementia. I have had to ask his wife." People who had contacted us prior to the inspection told us that assessments had not been completed. During our inspection the branch manager could not tell us how many people had not had their needs assessed, they said they would need to check the records. They did tell us that as of the 28 November 2016 (the week before the inspection) there were 29 people who still needed full assessments and that since then they had started to complete assessments for these people but was not able to confirm how many had been completed.

We found that where assessments had been undertaken these had not been fully completed. For example we found one person who was identified as being at risk of falls. A falls risk assessment had not been completed. This meant that there were no control measures identified to tell staff how to help the person to avoid falls. In care records we looked at we found that two people had not had their needs assessed until the 23rd November 2016 and these assessments did not include all required areas such as moving and handling and medicine assessments where people had identified needs in these areas. We also found that four people had an assessment of their needs but a care plan to tell staff how to provide the care had not been put in place. Information that is important for staff to know to keep people safe had not been recorded. For example, where people used hoists there was not specific information about how to use this. This is very important as people have been assessed by a health professional in order to ensure that the hoist and equipment is correct for them so that the person can be moved safely. If this guidance is not followed a person can be at risk of injury.

The provider had asked other providers to support some of the packages of care they were contracted to deliver. This was because they did not have the capacity to manage all of the calls they had been asked to cover. Where packages of care had been transferred to other providers this had not been done safely. We found that assessments had not been fully completed before the information had been passed to the other provider. For example, one care assessment had been partially completed by Hales Group Leicester. This did not record the person's name. The person was taking a number of prescribed medicines and a medicine assessment had not been completed. This would help staff to know how to support the person to take their medicines safely. We found that 22 packages of care had been passed to one provider without a full

assessment having been completed. This meant that responsibility for the care and treatment of people had been transferred without timely assessments having been completed to ensure the health, safety and welfare of people.

People did not receive their medicines safely. Relatives and staff told us of times when medicines had not been administered due to the late and missed calls. One relative said, "There were two calls yesterday. [Person's name] missed his medicines last night." Another relative gave us examples when medicine had not been administered correctly. They told us, "[Person's name] was given her dementia tablet. However they did not give the rest of the medication from the dosset box. They also administered two eye drops in each eye. The notes about this were vague. However [person's name] has one drop in the morning and two in the evening. I had to walk six miles on the 27 November to give [person's name] her medication as the staff had not given it and on Saturday 3rd December staff had not recorded that they had given medication but all of Sunday's tablets were missing. I had to contact the pharmacist for advice."

The service had a policy in place which covered the administration and recording of medicines. However, this was not being followed. Staff told us that as care plans were not in place that information about medicines was not always detailed. One staff member said, "[Person's name] doesn't have a care plan. They came out of hospital and there was problems with their medicines and they did not have all that they needed. I had to leave notes for the other staff and discussed it with the family." Other staff told us that they had transferred from other providers and had been asked to use different medication administration records (MARs). They told us that these were different to what they had used previously and they had not been told how to complete them correctly. One staff member said, "The medication sheets are different. I didn't have any training. I have had to work without being told what to do." We found that staff training in handling medicines was either out of date or they were not recorded as having completed the training at all for 17 staff. Records showed that it had been identified that staff were regularly not putting people's names on MARs when they were used. This meant that records were not being completed correctly and there was a risk that people would not receive their medicines. There was also a risk that staff did not know how to give people their medicines as prescribed by their doctor.

Where people required support with medicines they had not all been assessed or had a care plan to guide staff as to how to support the person safely. We found that where people did have care plans in place these did not always provide information for staff. For example in one person's care plan it stated that they did not have capacity to take their medicines themselves and needed support with this. However, the care plan did not give staff any guidance on how to do this. This meant that staff were not told how to support the person to take their medicines safely.

These matters constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

People were not protected from abuse and improper treatment. They were put at risk of neglect due to missed and late calls. One relative told us, "[Person's name] had two missed calls on Sunday. No one attended after the lunchtime call. Therefore [Person's name] did not eat or drink from 1pm Sunday until carers came arrived at 9:30am on Monday. That is almost 20 hours without fluids." Another relative said, "On the first day of Hales starting [person's name] had no calls. No medication and no breakfast. We weren't notified until 5pm." Another relative told us that staff had missed calls and as a result they were having to administer the person's medicine and prepare food to make sure that they did not miss these. A relative told us that they had experienced a high number of missed calls. They explained that they had to provide the care for their relative including medicines and food to ensure that their needs were met. A staff member told us, "I know that some staff had struggled to access one person's flat. I had left information about how to do

this. [Person's name] missed their meds because staff couldn't get in. I reported it to the office. I report any issues such as when people have missed medicines." This meant that people were at risk of neglect and acts of omission as they were not receiving care to meet their needs and were not receiving support with taking prescribed medicines and food where they required this.

People were subject to degrading treatment and their needs were disregarded. Staff told us of examples where people had experienced late or missed calls and the impact that this had on them. One staff member told us, "[Person's name] is living with dementia. When the carers didn't go in they pressed their lifeline. As [person's name] is hard of hearing they did not realise that staff on the lifeline were responding. They went outside and were found in their nightclothes, crying by the paramedic who had been called by the company responding to the lifeline call. Another staff member said, "I found [person's name] sat in the dark late in the evening. The tea call had not been and they had not had anything to eat or their medicine. They were sat in the dark waiting for someone to come." One staff member told us, "[Person's name] did not receive their night time call. I found them the next morning still sat in their chair. They had spilt water when over themselves when they had tried to get a drink."

The provider had a policy in place for identifying and reporting potential safeguarding incidents. Staff we spoke with demonstrated an understanding of potential types of abuse and the action to take should abuse be suspected. Prior to our inspection staff had contacted us anonymously to raise concerns about the number of missed calls and the impact this had on people. This shows an understanding of staff member's rights to be able to raise concerns externally. Where people had experienced missed and late calls these incidences had not been identified by the provider. The provider had the ability to track and monitor missed and late calls as they had a system that would have alerted them to any missed and late calls. They had not used this and had not established measures to make sure that people had received their care. This put people at continued risk of neglect.

People and their relatives told us that they had contacted Hales Group Limited Leicester to tell them about missed or late calls. Staff also told us that they had reported missed calls, potential neglect and missed medicines to the office staff. When we reviewed the complaints that had been received we did not find that these had been recorded, recognised as potential safeguarding, reported or investigated. The provider had not implemented a system to identify and investigate missed or late calls and what this meant for people's health, welfare and safety. They had not reported these incidences to the Local Authority as a potential safeguarding concern. The provider has a duty to report any safeguarding concerns and to CQC in accordance with statutory notification procedures. This meant that systems and processes were not established and operated to prevent abuse.

These matters constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

We found that there were not sufficient numbers of suitably qualified, competent and experienced staff in order to meet the needs of people who used the service. One relative told us, "They don't seem to have enough staff." One staff member commented, "A lot of staff have left that has made it difficult. It is hard to cover all of the calls." The staff we spoke with told us that they had been asked to cover additional calls. One member of staff said, "I think they are short staffed. I get phone calls asking me to fit extra calls in as they are not covered. This makes me late for everything else." Another staff member told us, "I have been told I cannot have my holiday as they cannot cover it." One staff member commented, "I work for Hales in another area. I have been asked to cover as they are short staffed." One staff member told us, "I was supposed to be on a call where two staff were needed. The second person didn't turn up. I called the office and was told that someone would be an hour. The person's son did not want me waiting around so he helped me." A care co-

ordinator told us, "We do not have enough staff to cover the calls at the moment. Whenever staff have a gap we are allocating calls to them."

The branch manager and regional manager told us that three quarters of the staff who were due to transfer from other providers had chosen not to transfer very close to the date of the new contract starting and that this had a significant impact on their ability to provide staff cover. Following the transfer of the staff a further four staff resigned with immediate effect. They told us that in order to cover all calls they had asked other providers to support them and put in place sub-contracting arrangements. We found that an email was sent to one of the sub contracted providers identifying 72 calls that had not been covered for one day. This included 23 calls that should have already taken place. The branch manager told us that they were working to recruit more care staff to make sure that all vacancies were filled and this was on-going. They told us that a post had been created for a resourcer who would support the branch to recruit. The branch manager told us that this person was due to start in the week following our inspection. They also told us that on the commencement date of the new contract they did not have all office staff in post. This meant that there were not enough staff in place to co-ordinate the calls that needed to happen and to support the staff who were directly carrying out the calls. The branch manager told us that they were recruiting to these posts and that they had employed some staff who were due to be starting shortly. They told us that the staff who were in post were not sufficient to support the number of staff and people who were using the service. The branch manager explained that due to the high number of staff who had not transferred this had a detrimental impact on the branches ability to cover. In order to try and resolve this the provider had brought in staff from other areas to cover calls. However, there were still a significant number of calls that had not been covered. This meant that the provider did not deploy enough suitably qualified staff to meet the needs of people using the service at all times.

We looked at staff recruitment files and associated records. The information for one staff member who had transferred from another provider was detailed and checks had been undertaken by the previous provider to make sure that they were suitable for their role. These included obtaining references, checking people's right to work documentation and undertaking a Disclosure and Barring Service (DBS) check. The DBS check helps employers make safer recruitment decisions and aims to stop those people who are not suitable from working with people who receive care and support. We found that one staff member who had been recruited by Hales only had one reference in place and this was a personal reference from a friend. The member of staff had identified people who could be contacted for a reference on their application form and their friend was not listed on the application form. We also did not find evidence of a DBS check being completed. We asked for information about all staff member's DBS checks to ensure that these had been completed prior to staff starting work. We had to ask the branch manager to check the information as this identified 22 members of staff had started work before the provider had received a DBS Check. The branch manager did provide updated information. This was still not correct as one person had started work one year and two months before their DBS check was recorded as being completed which the branch manager told us was a recording error. We found that nine staff had started work before their DBS check had been received. This meant that the provider could not be sure that staff were suitable to work with potentially vulnerable people. The branch manager told us that a person had been employed to act as a recruitment specialist and this person would be ensuring that all checks were completed appropriately.

These matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Inadequate

Is the service effective?

Our findings

We found that staff had not received the support, training and supervision that they required to enable them to safely meet people's care and support needs. People and their relatives told us that staff did not always appear to know what they were doing or have been trained prior to visiting them. One person said, "I have one (staff member) regularly who know what they are doing. The others are haphazard." Another person said, "Some of them are on training when they are here." A relative told us, "The person who came this morning was rubbish. Even she knew she hadn't done what was needed." Another relative commented, "This weekend we had one nice but incompetent member of staff." One relative told us, "We had a lovely girl turn up one tea time. She didn't have a clue what to do. I had to train her. Not all of the staff know what to do." One relative commented, "I do worry about the apparently untrained staff." Staff told us that they had been asked to work with staff who they felt had not completed all of their training. One staff member said, "I have worked with some of the new staff. One new staff member didn't know how to use a sling, a hoist or how to put on pads. She couldn't do any of it and put a sling on all wrong. I had to step in." Another staff member told us, "I met up with another carer for a call where they needed two of us. They tried to get the person to stand up from the commode using their neck and not their waist. They didn't know how to use the basic equipment." One staff member told us, "I did my induction but have not had any other training." This meant that people were put at risk of injury. If staff do not use the correct techniques when helping people to move it can cause injury and harm to the person and the staff member.

Staff training records showed that a number of staff had not completed training in key areas, or training was out of date for them. For example, we found that staff training in safeguarding needed to be refreshed for ten staff. We also found that 20 staff were not recorded as having received this training at all. Records showed that training in moving and handling was out of date for eight staff. We found that a further 17 staff were not recorded as having completed this training. It is important that training in moving and handling is completed and up to date as techniques can change. If people are moved incorrectly it can cause injury and harm to the person and member of staff. The branch manager told us that they had identified that some training was out of date for some staff and they provided dates for when this was to be completed. However this did not include any staff where the training was not recorded as having taken place at all. This meant that we could not be sure that staff were suitably trained to meet the needs of people using the service.

Staff told us that they had not had supervision meetings for a period of time. Supervision is time where staff meet with a manager to discuss their practice and any concerns that they may have. One staff member told us, "I have not had supervision. I have had two spot checks in a year and a half." Spot checks are undertaken while staff are working to check their practice. Another staff member said, "I have only had one supervision this year." Another staff member commented, "I have not been invited to any supervisions. Spot checks haven't happened for a long time." Records showed that 19 staff were due to have supervision and this had not happened when it was due. We found that for nine of these staff their last recorded supervision meeting was in 2015. We also found that 11 staff were recorded as not having had supervision at all. We found that 18 staff were recorded as being due to have a spot check that had not taken place. For three of these staff their last check had been in 2015. Records showed that nine staff were recorded as not having had any spot checks to review their competence. This means that staff have not received on-going or periodic supervision

in their role to make sure that their competence is maintained and they understand what is expected of them in their role.

We found that where staff had transferred from another provider they had received limited support and guidance. One staff member told us, "We have not had any support or supervision. We have not been told how to do the paperwork. Some of it is so different." Another staff member said, "They had a big meeting with us before the handover. I was very excited as they seemed great. Since the actual transfer we have not had any support." One staff member commented, "They promised us everything. I have not been told what to do. They arranged a team meeting but it was cancelled. I'm sure it will get better." The branch manager told us that they had met with the staff who were transferring prior to the transfer. We saw a copy of a letter that had been sent to the staff welcoming them to Hales Group Leicester that had been sent in September 2016. The branch manager and the regional manager told us that they were aware that some of the staff who had transferred were not happy. They told us that they had arranged a meeting with them at the end of November however none of the staff had attended this. The branch manager told us that they were arranging another meeting and would put it on the rota so that staff could attend. We found that aside from the initial meeting held with staff and the letter that had been sent to them there had not been an induction process for the staff to introduce them to Hales Group Leicester to explain what was expected of them and to discuss policies, procedures and paperwork that was in place. We branch manager told us that they were trying to appoint a field care worker who could provide support to staff in one particular geographical area as that was where a number of the staff who had transferred were working. They told us that they felt this would offer them more support, however staff had transferred to Hales Group Leicester four weeks before our inspection and this support was not yet available to them.

These matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

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

We checked whether the service was working within the principles of the MCA and found that it was not. We saw that where people's needs had been assessed a form was used that identified where people had capacity and if they consented to care. This included if people had capacity to manage their medicines. We found that five people were recorded as not having capacity in one or more area where they required support. However no assessments had been completed to show that the person did not have capacity. Under the MCA if a person is believed to not have capacity to make a specific decision an assessment must be undertaken to show that the person has been given every opportunity to enable them to make the decision. This meant that whoever had completed the assessment had determined that the person did not have capacity to make a decision without recording evidence to show that this was true. We also found that one person had not signed their care plan or consented to their care. The reason for this was because they were living with dementia. Under the MCA a diagnosis of a health condition such as dementia does not mean that a person is not able to make their own decisions. The care plan identified that the person's husband would make all decisions for them. A person cannot legally make decisions on behalf of someone without a lasting power of attorney. This is a designated power and can only be agreed in a court after appropriate assessments have been completed. The care plan did not identify that the person's husband had the legal authority to make decisions on their behalf. This means that the person was not given the

opportunity to consent to their own care which they may have been able to do. We found that four people had not had their capacity to make decisions considered at all as they had not had this area of their needs assessed.

When we spoke with the staff they had limited understanding of the MCA and what it meant in practice for them. One staff member told us, "I have done MCA training. I am not involved in assessments." When we asked what would happen if someone refused care the member of staff told us, "The family would make the decision." This is not in line with the MCA where people have a right to refuse care and capacity to do so must be assumed. We looked at training records and found that 22 staff were not recorded as having training in MCA and DoLS.

Where people did have care plans these all contained a statement that 'All care will be delivered in the best interests of the service user'. This statement did not identify that the first principle of the MCA is that the person must be assumed to have capacity.

These matters constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

People told us that where they had support with preparing their food staff asked them what they wanted. One person said, "They get me a cup of tea and sometimes warm me a cup of soup. That is nice. They will get me what I want if I ask." Another person told us, "I just have something out the freezer. They ask me what I want and get it out ready." However, we found that one had been identified as having to receive fluids that were thickened to a specified consistency following an assessment by a health care professional. Staff told us that this person did not have a care plan in place. One staff member told us, "[Person's name] knows that they have to have their drinks thickened. As staff did not turn up for their call [person's name] couldn't have a drink as they cannot thicken it themselves." We spoke with a social care professional who told us that the person had been admitted to hospital with increased confusion. The social care worker also told us that it had been reported to them that the person had been given soup that had not been thickened to the required consistency. This means that the person was at risk of choking and guidelines on how they ate safely had not been followed. Relatives also told us that they had to support people to have something to eat and drink due to missed and late calls and without them people would not have received nutrition and hydration. A relative told us about times when staff had not provided food. They told us, "I visited just after the carers. They had not left a sandwich. If [person's name] refuses food they are supposed to make a sandwich for later. They do not fill in the paperwork to say if [person's name] has had any food. I have to assume they haven't given her any." This meant that people were not supported to have sufficient to eat and drink and to maintain a balanced diet.

We saw that people were supported to access healthcare. Records showed that staff had documented when someone appeared to be unwell and had contacted the office staff to ask them to contact a health care professional. Staff told us that they would support someone to contact a health professional if they felt it was needed. One staff member told us, "I called an ambulance as I felt that [person's name] was very unwell. We waited until the ambulance came."

Requires Improvement

Is the service caring?

Our findings

During our inspection we found that people's experiences of care were affected in a negative way by the lack of sufficient staff to meet their needs and by the way that the management responded to concerns about their care.

People were not made to feel that they mattered or were listened to when they were not happy about their care. One person told us, "When it was 8 o'clock and my regular staff was off I didn't know if anyone was coming. I rang the office. I did get a bit cross because no one had called up. I am not sure it made any difference." Another person said, "They don't tell me if it is going to be a different care worker. They just come." One person commented, "Certain senior staff are impolite and rude." A relative told us, "You do eventually get a response if you complain. I tried to contact Hales constantly but got no answer." Another relative said, "I phoned to speak to a senior manager and I got a phone call back to say they were too busy to speak to me. We have not had a call or anything from them to check what has happened." One relative commented, "I raised concerns with Hales about their manner of caring. I never had a call back." This demonstrated that people were not always given appropriate explanations for why their planned care was not provided as agreed or preferred.

People told us that most staff acted in a caring manner towards them. One person told us, "They are fine. Kind and helpful." Another person said, "They are very good." One person commented, "They are fine. I haven't got anything against them." However, another person said, "A few carers attitude is as though they are doing the client a favour." Relatives felt that some staff were caring in their approach. One relative said, "It varies from wonderful, please come and move in to oh dear, I hope I don't see them again." Another relative commented, "The staff are quite nice. It is not fair on them."

People told us that when they had regular staff they had built a good relationship with them. One person said, "My regular one is very good. I get different ones and they don't know me as well." Another person said, "I had one carer for a long time. We got on really well. She left because of all the changes which is a real shame." Another person commented, "The one in the morning who is regular is excellent. The others are different. Some I have never seen before." A relative said, "The existing staff know the routine. Others arrive without knowledge. They don't know why they are there or what to do. They ask [person's name]. There is no point doing this as he doesn't know." Staff told us that when they worked with people on a regular basis they had built up good relationships. One staff member told us, "I have worked with the same people for a long time. I know them well. It runs very smoothly. There is not one person who I go to see who is not happy to see me. When you go in there it is all about them."

People told us that where their needs had been assessed they had been involved in this; however, some people said that they had not been involved in making decisions about their care. One person said, "I was very involved." Another person told us, "They didn't ask me what times I wanted, or if I wanted male or female carers." Care plans did not include detailed information about a person's life history, or their likes or dislikes. Staff were able to tell us how they got to know people through working with them on a regular basis. However they told us that since the new contract start date they did not always see people who they

had cared for previously. One staff member told us, "People look forward to seeing me. Now and again I get to visit someone I worked with before. They are not happy. I went to [person's name] they were crying saying I missed you so much." Another staff member said, "I have worked with some people for nearly five years. I know what they like and don't like. I don't see most of those people regularly now. When I do see them they are down as their regular staff are not being used."

People told us that staff respected their privacy and treated them with dignity. However, one relative told us that they had asked that staff did not make unscheduled visits as the person has hallucinations of people entering their home and this made them anxious. The relative went on to tell us that staff continued to arrive at unscheduled times when the person was not expecting them and this was upsetting the person. The relative explained how they tried each week to confirm what time staff would be coming but even when times had been agreed the staff still turned up at other times. Staff told us about a person who was very upset when they woke up to find someone they did not know on their landing at 10:30pm. The staff explained that the person was meant to have a call for support to go to bed and this was late. The person's relative had helped them go to bed. When the staff member, who had not visited the person before, turned up two and a half hours late they let themselves into the property. This woke the person up and they were alarmed to find someone they did not know on their landing. This shows that staff were not always respecting people's wishes or treating them with dignity by entering their home at times that were different to planned times when people were not expecting the staff.

Staff told us that they encouraged people to be independent and to choose what they wanted. They gave us examples of encouraging people to dress themselves, wash themselves and eat independently. One person told us, "They ask me what I want. If I can do something myself they let me." This showed us that staff understood the importance of allowing a person to continue to do things for themselves and how this benefitted the person.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's confidentiality.

Inadequate

Is the service responsive?

Our findings

People told us that the staff arrived at times that were different to planned times and they did not always know which staff would be arriving. One person said, "The first two weeks it was so bad I thought we were going to have a heart attack. It is a bit better now although I don't get a rota so I don't know who is coming and the timings are terrible." Another person told us, "The staff just come. The office don't tell me it will be a different worker." Relatives confirmed that planned times for calls were not met. One relative said, "I had to take a day off work because of the timekeeping. It is terrible." Another relative said, "I had called to agree the call times. However when the weekend came there were more problems with staff turning in late and times for visits changing." Daily records we looked at showed that the times between people's call visits were erratic. For example, we looked at the records for one person over a period of five days. In that time the number of visits per day ranged from two to four visits. We also found that the timing between visits was not consistent. On one day they had a call at 5:55pm until 6:15pm, the next call was at 6:45pm leaving only 30 minutes between calls. On other days the person received a call at 9am, midday, 4:30pm and 6:45pm. Visits at irregular times meant that some people did not have their medicines at regular intervals, access to adequate nutrition or hydration and waiting for long periods for personal care. Staff confirmed that people had been left in undignified situations due to having to wait for their staff. One staff member told us, "[Person's name] was wet as they couldn't wait any longer. They are very proud."

People told us that they did not receive care at their preferred call times or from staff that they knew. One person said, "I told them I wanted 7 until 7:30am. They have put me down for 7:40am. I had had a call at 7am for all of these years. It doesn't seem fair that I've got shunted." A relative told us, "[Person's name] prefers a call at 8am. It is now more like 10am." Staff told us that people were not receiving care that met their preferences. One staff member told us, "[Person's name] needs two staff. She doesn't like male carers. One day a male and a female carer turned up. [Person's name] wouldn't let them in." The branch manager and regional manager told us people had been supported by a large number of different providers previously. They said there were a lot of people who had preferred call times that could not be met as Hales Group Leicester did not have the staff available at those specific times. They told us that they were doing what they could but it was not possible for everyone to have their care at the time they wanted it.

We found that people had not all had their needs assessed and a care plan developed when they had started to use the service as part of the new contract. They also told us that when an assessment had been completed they were not always listened to. One person told us, "They asked which staff we wanted and then didn't provide them." One relative told us, "There is still no care plan. A lot of notes have been recorded on the previous provider's documents or on plain paper by the staff." A relative told us, "The carer arrived and asked me what was for [person's name] dinner and did they have any medicines. Had there been a care plan in place she may have read through this." Staff also told us that care plans were still not in place for all people who used the service.

Care plans we looked at had little information about the person or their wishes as to how their care should be provided. Information about people's personal care needs, daily routine, nutrition and hydration needs, continence care and support required with their mobility had not been fully completed. For example we

found that two people had key safes at their properties. A key safe is a security measure so that staff can access the property without disturbing the person and the keys are kept safe. The key safe number had not been recorded within the care plan. This meant that staff did not have the number in order to use the key safe and had difficulty accessing the property to deliver care as a result. We also found that people's history and background had not been completed. This information is important for staff to help them to understand the person and to get to know them. Where people had been with the provider before the new contract we found that care plans had not been reviewed to make sure that the information was in date and still correct. For example, one care plan we looked at had last been reviewed on 29 September 2015. Reviews should be completed whenever someone's needs changed or at least annually to make sure that they care they are receiving still meets their needs. This means that people were at risk of receiving inconsistent or inappropriate care if their needs changed.

These matters constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care.

People told us that they sometimes felt that staff did not have the time to provide all of their care, complete all tasks, or read information in the care plan. One person said, "On occasion they may miss something. They are very busy." Another person told us, "The carers are not doing the chores they are meant to. They left my washing in the laundry all night and some of my clothing was lost." Relatives confirmed this. One relative said, "When it is a new care worker and they only have 20 minutes they are not going to read a care plan." Another relative told us, "[Person's name] called me to ask if he took medicine at this time of day as the carer wanted to know. The staff ask him and there is no point. He is not able to tell them. We have a care plan as we insisted on it after things went so wrong." One relative told us, "They do not complete a lot tasks. [Person's name] was wet. I asked the staff to support them to have a shower. They told me that [person's name] didn't need one. They had just put their clothes on wet. I had to insist." Another relative told us, "I visited [person's name] just after the workers had been. I found that they had a soiled pad on. This had been missed by the staff. They are regularly not washing bedclothes either even though that should be done." This meant that people were not receiving the care that was planned and that they needed.

People told us that they were not all sure how to complain. One person said, "I don't have any information on how to complain." Relatives told us that they felt that their concerns were not listened to. One relative said, "I called Hales on 12 December. This didn't seem to impact greatly. I was informed that the person on call lived in a village and does not receive good internet reception so could not have checked to see if the call had taken place anyway." Another relative told us, "We can now contact the office and speak with someone. It has not made things better. There is not a day goes by without a problem." The provider had a complaints procedure and this was available within the information given to people when they started to use the service. We looked at the complaints that had been received. We found that a number of the concerns that people had told us that they had complained about were not recorded. The provider told us that all complaints that had been received had been investigated. Three of the relatives we spoke with expressed serious concerns about the quality and reliability of the care received. All three of these people told us that they had contacted the provider to raise these concerns on more than one occasion but little had changed. There was no record that the provider had received these concerns, investigated, responded to or resolved them. We asked the provider if people reported missed or late calls, or care not being completed correctly was this was recorded as a complaint. We were told that concerns of this nature had not been recorded as complaints. This meant that the provider was not responding to people's complaints or concerns in a meaningful way.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us that they felt that the provider did not have systems and processes in place that enabled them to provide a quality service. One person told us, "I think the owners must be on holiday because the organisation is rubbish." Another person said, "I don't think that they are well organised." A relative told us, "I don't think they have any internal quality system. They seem to have dramatically increased in size without increasing the infrastructure." Staff told us that they felt that the provider had struggled to manage the increased number of people since the introduction of the new contract. One staff member said, "It is like they went in at the deep end. They are trying to sort it out but it is just a mess." Another staff member commented, "They shouldn't have taken on what they couldn't manage. They have said bear with us. The people are what is important."

The provider told us that the quality and safety of the service had been affected by the start of the new contract which was commissioned by the Local Authority to start on 7 November 2016. This involved the service working in three geographical areas and providing support to all people who received local authority funding in those areas. At the time of the inspection the number of people receiving the service was still fluctuating. This was because people had requested to stay with their previous provider and changes in funding were being implemented to accommodate this and other people were asking to not have support from Hales Group Leicester. One person told us, "We have cancelled the care and are looking for another company. They couldn't keep to the times they were saying."

We found that the branch manager and regional manager had recognised that there were significant problems with the service delivery. However, despite the contract having been in place for four weeks at the time of the inspection an action plan to identify and address the concerns had not been written until December 2016. Within this action plan some of the concerns we found during this inspection were identified. However they were not identified in detail. For example, the provider did not identify the number of missed or late calls, the number of staff who had not completed training or had supervision, or the impact that this had on people. The timescales given within the action plan did not reflect the serious nature of the concerns or the need to address these urgently.

We found that there was a significant number of missed calls. These were times when people had not received the care calls that they needed to keep them safe and provide vital care. The actual number of missed calls had not been identified or monitored by the provider until we asked for the information. As these had not been identified they had not been recognised as potentially neglectful practice and reported as a safeguarding concern. The processes that were in place to monitor this had not been used effectively. The branch manager told us that a new electronic system had been put in place prior to the new contract starting to allow staff time to get used to this prior to the increase in work. They told us that they had been trained in the use of this system. The system had the function to notify staff in the office if a carer had not turned up or was late. This was not being used until the time of our inspection. There was no other monitoring system being used to identify if people were receiving the care that they required. The provider had not taken action to ensure that people were safe. This resulted in people missing medicine, food, drinks and being left in degrading situations. People's health, safety and welfare had been put at risk. The provider

had not identified this risk and put control measures in place to minimise future reoccurrences.

The provider was awarded the contract in August 2016 with a planned start date in November 2016. As part of the tender exercise it was identified that additional staff would be required to support the branch in order to deliver the care. The recruitment for all of the required number of branch staff had not taken place at the time of our inspection. This meant that there were not enough resources in the service to support the care staff and to monitor the service delivery. As part of a transfer of services from one provider to another people should have a full assessment to ensure that the new provider could meet their needs and have enough suitably trained staff to provide the care. At the time of our inspection the service had been delivering care under the new contract for four weeks. There were still a number of people who required assessments of their needs. The provider was not able to confirm numbers at the time of the inspection. They had identified that 29 assessments were outstanding as of 28 November 2016 but were unable to confirm how many had been completed since that date. As the staff to support the office had not been recruited prior to the start date of the new contract this meant that the capacity to complete timely assessments had been reduced. The provider had not planned effectively or provided resources to ensure that people would safely transfer to Hales Group Leicester.

The provider recognised that they were unable to provide all care that was required under the new contracting arrangements. They told us that they asked the Council if they could delay the start date for the new service but this was not possible. The branch manager and regional manager told us that this was identified very close to the start date of 7 November 2016. At this time three alternative providers were identified and sub-contracting arrangements were put in place. People were not told about the change in provider. One person told us, "I'm not sure who I am having." A relative told us, "I thought Hales had passed us back. I didn't realise it was sub contracted." Another relative said, "I am not impressed with the supposedly smooth cross over. If they are sub-contracting the work who is actually delivering the care." The provider did not put in place arrangements with the sub-contracted providers to ensure that they were delivering the care that people needed. We also found that the provider was not able to tell us how many packages of care had been sub-contracted. The provider handed over packages of care without having completed their own assessments on people. They did not ensure that the provider could meet the person's needs just that they had capacity to take on the work. This meant that the provider did not have an accurate, complete or contemporaneous record in respect of each person.

We found a lack of planning to meet people's needs. Records showed that an email was sent to one of the other providers identifying 72 calls that had not been covered that day and asking for their help. This email included 23 calls that were supposed to have taken place before the email had been sent. This meant that the provider did not have a robust plan in place to enable them to manage the new increased contract. They did not have suitable processes in place to mitigate the risk to people of them not being able to provide the service. They also did not have contingency plans in place to deliver the care they were contracted to provide.

We found that communication with people had been limited and people felt that they had not been listened to. One person told us, "In September someone said they would be coming out to see me within a week. They never came." A relative told us, "I wouldn't give them 10 out of 10 for communication. They did not contact us to tell us about the problems." Another relative told us, "I was only with Hales for a week. It was diabolical. They were late every day. I rang them and they weren't bothered."

Where people had contacted the provider to raise concerns these had not been recognised as complaints and investigated or responded to. Feedback had not been sought from people following the problems that had occurred. The provider told us that they had considered sending out a quality survey to ask for

feedback, however had decided against this as the results would be negative. Staff within the office had not contacted people who had not received their care to make sure that they were safe. The provider had not kept people informed of the problems and what was being done to resolve these or to apologise.

The provider did not have an effective system in place that monitored the recruitment, training, supervision and support for staff. This meant that information we requested had to be clarified as it was out of date. It also meant that staff had not always been recruited safely, completed relevant training or been supported and supervised to ensure competence in their role.

We found that audits had been completed on Medicine Administration Records that had been returned to the office. However, the amount that had been returned was limited. We also found that the audits had not identified all areas of concern. For example, we found one signature had been crossed out and the audit noted no problems, we also found that for one person their name was on the record however the month and year were not recorded. This had not been identified as part of the audit. Records also showed that the person who completed the audits had identified that a person had refused or not taken their medicine on a number of day but had not taken any action to address this. Medication records are a legal document to record that people have received all of their medicine as prescribed. This meant that the people were at risk of not receiving their medicines safely as records that were kept were not correct or completed.

During our inspection we raised serious concerns with the provider about people's safety. We identified significant concerns about the way people received care and the management of the implementation of the new contract. We were concerned that there were immediate risks to people's health and well-being. We informed the provider of our concerns. The provider acknowledged that things had not run smoothly since the start of the new contract. They told us that they were working to address the concerns.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The provider had failed to submit statutory notifications in relation to incidents that they have a duty to report to CQC by law. For example, allegations of abuse. We found a total of 131 missed calls over a three week period. As missed calls and associated missed care is potentially neglectful these should have been notified to CQC as potential abuse. The provider did notify us that there had been a problem with the implementation of the new contract. However they did not disclose the extent of the problem or the impact this was having on care delivery and on people receiving the service. As the service was effectively stopped for the people who received missed calls the provider should have notified us of this as an event that had stopped the service. These notifications are an important safeguard for people using the service. Failure to notify CQC denies people an important level of oversight and protection.

This constituted a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: notification of other incidents.

There was a registered manager in place at the time of our inspection. However they had submitted an application to de-register. They were on leave and we were told they would not be returning to the service. The branch manager had applied to become the registered manager. The branch manager and regional manager were new to the organisation at the time of the inspection as both had started their employment within the last three months. They told us that they were supported by an operations manager however that person had left the organisation in December 2016. Following our inspection we met with the managing director of Hales who told us that they and another regional manager would be providing support to the branch.

Some staff we spoke with told us that they did not feel supported or valued by the management. One staff member told us, "I have found it very difficult I have not had anyone to ask questions. When I have rung with concerns they either argue with me or put the phone down." Another staff member said, "You have no support. One of the care co-ordinators had a go at me in front of one of the people I support. It is how it is run. We are treated badly." However, one staff member commented, "I can approach my manager." Another staff told us, "I used to be so proud to work for Hales. Now I dread it. It is how they speak to you. They are so rude. You cannot talk to anyone."

The provider told us that they were recruiting more staff to assist them with monitoring the quality of the service that was provided. This included a trainer to make sure that training was up to date and that staff were supported in their roles. The timescale for this according to the service's action plan was February 2017.

The service had up to date operational policies and procedures in place which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints and equality and diversity. Those which were relevant to staff were also contained within the staff handbook that was issued to all employees.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Commission without delay of incidents that occurred whilst services were being provided. This included incidents that are classed as abuse or allegations of abuse in relation to people using the service.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had not all had an assessment of their needs and preferences for care carried out. People did not receive care that reflected their preferences or that met their needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care of people was not provided with consent of the relevant person. Where a person had been assessed as not having capacity to make a specific decision a capacity assessment had not been completed in line with the MCA. Relatives had been asked to make decisions without the legal right to do so.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

People's care was not provided in a safe way. People had not had all risks to their health and safety assessed and the provider did not do all that is reasonably practicable to mitigate the risk.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Systems and processes were not operated effectively to prevent abuse of people. Systems and process in place were not operated effectively to investigate an allegation or evidence of abuse. Care that was provided for people was neglectful.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced person deployed in order to meet people's needs. Staff did not receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not used to assess, monitor and improve the quality and safety of the services. They did not mitigate the risks relating to the health, safety and welfare of people. The provider did maintain an accurate, complete and contemporaneous record in respect of each person when they were transferred to another provider. The provider did not seek or act on feedback from people in relation to the services that they were providing.

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we imposed a condition on the providers registration in respect of the regulated activity.
From 14 DEC 2016, the Registered Provider must not provide personal care to any new person, any current person following a hospital admission, any person who requires respite provision and must not agree to increase the level of personal care being provided by more than 3 hours, without the prior written agreement of the Commission.

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