



HEMECARE SERVICE

Reablement Provider Service



Overall Outstanding

Neville Centre, Leicester General Hospital, Leicester, Leicestershire, LE5 4PW (0116) 454 5422

Provided and run by:

Leicester City Council



This service was previously registered at a different address - [see old profile](#)

Overview

Latest assessment: 5 September 2025

Report published: 6 February 2026

Safe

Outstanding 

Effective

Outstanding 

Caring

Good 

Responsive

Outstanding 

Well-led

Outstanding 

Specialisms / services

☐ Personal care

- Caring for adults over 65 yrs
- Caring for adults under 65 yrs
- Caring for children (0 - 18yrs)
- Dementia
- Eating disorders
- Learning disabilities
- Mental health conditions
- Physical disabilities
- Sensory impairments
- Substance misuse problems

Who runs this service



Reablement Provider Service is run by Leicester City Council



Mr Jagjit Singh-Bains
Registered Manager



Mrs Kate Galoppi
Nominated Individual

Similar services nearby...



Integrated Crisis Response Service

In Leicester, LE5 4PW



Macdave Services Ltd

In Leicester, LE5 4WH



Grace Care UK

In Leicester, LE5 5GE



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Report from 5 September 2025 assessment

Ratings

Overall

Outstanding 

Safe

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Effective

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Caring

Good 

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Well-led

Outstanding 

Our view of the service

Date of assessment 8 to 12 December 2025.

The Reablement Provider Service is a domiciliary care agency providing short term reablement, rehabilitation and recovery, and is part of the local authorities 'home first model', which works with established partner organisations in supporting people to remain in their own home. The service enables people to gain as much as independence as possible to facilitate their continued living at home. Not everyone who used the service received personal care. The CQC only inspect where people receive personal care. This is help with tasks relating to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our assessment 113 people were being supported.

We have assessed the service against 'Right support, right care, right culture' guidance to make judgements about whether the provider guaranteed people with a learning disability and autistic people respect, equality, dignity, choices, independence and good access to local communities that most people take for granted. However, at the time of the inspection, no person with a learning disability or autistic person was receiving care and support.

The provider, registered manager, management team and staff worked collaboratively with key partner stakeholders and agencies from both health and social care to deliver a cohesive, dynamic and responsive service. All those involved were committed to people's recovery, reablement and rehabilitation, maximising the potential of people remaining in their own home, with good quality of life outcomes. Key partner stakeholders and agencies from both health and social care were unequivocally positive about the Reablement Provider Service.

The Reablement Provider Services collaborative approach with partner stakeholders and agencies, ensured a co-ordinated transition of people's care between services. Comprehensive assessments identifying people's needs and risk were undertaken to facilitate safe and effective care, with a focus on the person and their home. Potential risks were minimised in consultation with people and a proactive approach to positive risk-taking facilitated recovery, reablement and rehabilitation.

People's care records provided a comprehensive account as to their progress in the goals identified in consultation with them, ensuring people remained at the heart of any decisions relating to their recovery, reablement and rehabilitation. Records evidenced staffs' collaborative approach, which included referrals to other services and working alongside other professionals to ensure and promote the delivery of safe, effective and responsive care.

The provider's ethos towards care was embedded across the workforce. People's recovery, reablement and rehabilitation was facilitated by staff who had undergone a safe recruitment process, and who had the training, skills and knowledge to facilitate good outcomes for people. Training for staff also considered specific areas of people's needs, which included dementia, learning disabilities and autistic people.

The provider and registered manager were committed to providing a non-discriminatory and inclusive approach within the service, both for people using the service and staff, underpinned by robust strategies, which outlined the provider's commitment to equality, diversion and inclusion.

The registered manager and management team were capable and inclusive leaders and managed a dedicated team of staff. Continuous development of the service was facilitated by a learning culture, underpinned by systems and processes which kept under review the quality and safety of the service provided. People's views, and those of staff, key stakeholders and partner agencies were central to learning and innovation.

Staff well-being was considered a high priority by the registered manager who had facilitated well-being sessions, recognising the positive outcome of people using the service, when staff were supported and valued. Staff were consistently positive of the registered manager's and management team responsiveness, support and good communication.

The collaborative approach of working with key partner stakeholders and agencies, facilitated by the registered manager, provided an overview of the wider landscape of health and social care services, enabling the service to respond to wider system pressures.

People's experience of this service

People's views were consistently positive as to the service, and its impact. A person told us, "We just want to say thank you for everything. The service helped us through a very difficult time." Whilst another said, "I was very happy with the service. It started after hospital when I had an operation and came back home. I've improved with their support." People were unequivocal in recommending the service. A person told us, "I'd absolutely recommend them, they were so good and specific to what we needed."

People's positive experiences and outcomes were in response to the services collaborative approach with key health and social care partners. This was co-ordinated by staff from the reablement service who liaised and shared information, making referrals to other services, ensuring timely responses and solutions which had a direct and positive impact on people's recovery, reablement and rehabilitation. This included the provision of equipment to promote recovery and safety.

People spoke highly of the staff, describing them as caring and respectful. People praised staff's knowledge and understanding, and the positive impact this had on their progress. People spoke of good communication between staff, which included being supported by staff who spoke the same language as them, and who understood their cultural needs. People told us they were fully involved in all decisions relating to their care, from the initial assessment and through the ongoing review as to their progress. People spoke positively about the support and care provided, when they transferred from the Reablement Provider Service to other services for longer term care and support. A person told us, "Staff arranged a review and helped sort out my long-term care before stopping. They didn't abandon me, the handover to the new company was smooth."

People told us they received regular telephone calls from office-based staff, providing them with an opportunity to share their views about the service. People were aware of how to raise concerns. People told us the service was responsive to their changing needs, which included making changes to the scheduled time of care calls. People told us they found it easy to contact and speak with office-based staff.

Similar services nearby...



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In Leicester, LE5 4PW



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✓ Medicines optimisation

Safe

Outstanding ☆

9 January 2026

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

At our last assessment we rated this key question good. At this assessment the rating has changed to outstanding. This meant people were protected by a strong and distinctive approach to safeguarding, including positive risk-taking to maximise their control over their lives. People were fully involved, and the provider was open and transparent when things went wrong.

This service scored 88 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Learning culture

Score: 3

The provider had a strong proactive and positive culture of safety, based on openness and complete honesty. Staff actively listened to concerns about safety and thoroughly investigated and reported safety events. Lessons were always learnt to continually identify and embed good practice.

People and family members we spoke with said they had not raised any concerns relating to safety and expressed confidence in the service to keep them safe. People were aware of how to raise a concern.

A collaborative approach of working with and alongside strategic health and social care partners facilitated a positive culture of safety, where potential risks both strategically and within the service were shared and understood. This enabled the registered manager to maintain the service based on staffing and the resources available, and the known needs and resources of external partners. A key stakeholder told us, "The service works constructively with system partners and commissioners to support wider system plans, including 'home first', neighbourhood working, frailty and prevention agendas. It is responsive to system pressures and demonstrates the ability to adapt quickly to changing needs, adjusting delivery models, capacity and focus where required."

Systems and processes for reporting and monitoring safety incidents and accidents were fully understood by staff. A member of staff told us, "If a person falls, we write a falls report." The provider's falls protocol and assessment tool provided clear guidance, enabling staff to assess the risk based on the person's presentation, including identifying any injuries, the initial actions they should take, and the escalation process. For example, seeking the support of a health care professional.

Records provided a clear audit trail of any incidents, including the action taken and the involvement of any other health or social care partner. For example, staff had liaised with a range of services including the manager of a housing complex and a GP in response to their identifying a decline in a person's mental health, and indicators of potential self-harm.

The registered manager evidenced their commitment to a proactive and positive culture of safety, facilitated by a robust and comprehensive analysis of concerns and incidents relating to safety. Senior managers and the provider's health and safety team investigated all incidents with all events being triaged. For example, the 3 incidents reported in the last 12 months found all to be low-harm events which had not required escalation to RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) and no repeated themes having been identified. The analysis of the individual incidents identified a combination of contributory factors, and in response an action plan was developed. All staff were reminded of the importance of footwear safety and emphasised the significance of their communicating effectively with people as to why a task could not be completed by them, when asked to do so. In addition, the action plan emphasised the importance of managerial staff supporting staff through reflective conversation, to ensure safe practices were prioritised.

Learning from concerns was an intrinsic element of the learning culture. For example, an analysis of concerns identified a theme of medication errors, which had not resulted in harm, but were identified as a potential high risk. The analysis had identified an increase in medicine anomalies when the service changed its electronic call monitoring system. The registered manager was proactive and implemented medication workshops for staff.

Safe systems, pathways and transitions

Score: 4

The provider always worked with people and healthcare partners to design, establish and maintain safe systems of care, in which safety was always well managed and monitored. They made sure there was always continuity of care, including when people moved between different services.

People spoke positively of the referral process which showed how the collaborative approach between hospital-based staff and the service worked in practice. A person told us, "They [hospital staff] asked me questions about our home at hospital, and one of the nurses referred me to the reablement service. They explained the service." The provider's analysis of data for 2025 identified 98% of referrals to the Reablement Provider Service were accepted.

The collaborative approach, supported by effective systems and processes of communication between health and social care partners facilitated the safe transfer of people between services. Social care partners had access to records via an electronic data platform, this facilitated timely and effective sharing of information. Referrals to the Reablement Provider Service were triaged by office-based staff and if accepted, several staff with identified skills and responsibilities shared information to facilitate, for example, a safe discharge from hospital. A key partner told us, "Transition planning begins at the point of referral, with clear identification of goals, risk and anticipated onward needs. This reduces delays and prevents gaps in support when people move from hospital, intermediate care or community services into reablement."

Collaborative working between agencies, ensured the appropriate equipment was sent with the person to their home, for example, a walking aid. A schedule of calls was planned, based on the person's needs as identified within their referral assessment. Assurance was sought that the person could access their home, and arrangements included the involvement of family members if appropriate, to be at the person's home for their return from hospital if required. Other factors considered were also planned for, for example, the installation of a key safe to enable staff to access the person's home, in the event the person was unable to open their door and invite staff inside. This required liaising with other departments to both request the equipment and organise its installation.

Staff from the Reablement Provider Service, along with key partner agencies, which included occupational therapists, assistive technology, social workers and the minor adaptations department, meet each working day to identify any interventions required to support people's recovery and reablement. For example, an update as to a person's progress may indicate an additional item of equipment was required, such as perching stool. This would be agreed at the meeting, ensuring timely action was taken, avoiding any unnecessary delays, and have a measurable and positive impact on the person's recovery in maximising their independence.

In circumstances where a person had reached their recovery goals, it may be necessary for the person to continue ongoing support at home. In this instance, a Care Act Assessment (an assessment undertaken by local authorities to identify a person's support needs) was completed by suitable experienced and skilled staff of the reablement service. This was then shared with partner agencies. A key partner told us, "If someone has ongoing needs following a Care Act Assessment, they [Reablement Provider Service] will make an eligibility decision and transfer the person to the long-term team to undertake a review of their needs." This example, further confirmed how staff supported smooth and timely referrals to support a safe transition to other services.

Safeguarding

Score: 3

The provider worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. Staff concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The provider shared concerns quickly and appropriately.

People and their family members expressed no concerns regarding their safety and spoke positively of the service and the kindness of staff which made them feel safe. A person told us, "Staff are lovely to have in the house, we felt secure with them. No one was abusive. They know exactly what to do and what I can do safely."

Staff demonstrated a good understanding of what would constitute a safeguarding concern, had an in-depth knowledge as to the forms of abuse, and were aware of the agencies to escalate information of concern to if required, including police and social services. Staff had undertaken training in safeguarding children and adults and was regularly updated.

Staff attended safeguarding meetings where referrals to the service for recovery and rehabilitation had been received, as part of a multi-disciplinary approach to supporting people identified as being at risk.

The provider had systems and processes for the management and escalation of safeguarding concerns. The reablement social work team recorded and progressed safeguarding alerts and incidents, their remit was not exclusive to the Reablement Provider Service.

Involving people to manage risks

Score: 4

The provider always worked well with people to fully understand and manage risks by thinking holistically. Staff provided care that fully met people's needs and was safe, supportive and enabled people to do the things that mattered to them.

People and their family members felt fully involved in the assessment of risk. A person told us, "The carer came and did a risk assessment." Potential risk was assessed, and where required equipment was provided to reduce risk and support the person in their recovery journey. A person told us, "I was provided with 2 walkers and handrails, the walker is near to my bed to help me when I get up."

Care records evidenced a dynamic risk assessment was undertaken upon commencement of the recovery package of care, this identified potential risks and barriers to a person's recovery journey. Positive risk taking was a key in enabling people to gain independence. Records showed the person was at the heart of the assessment, identifying what was important to them and the outcome they were looking to achieve. Agreed specific, measurable, achievable, relevant and time managed (S.M.A.R.T.) goals were identified to facilitate independence of daily living activities, for example preparing food and cooking, mobility, or personal care such as washing and dressing. Any associated risks were identified, and decisions made how to reduce them. For example, the provision of equipment to enable people to facilitate independence, whilst keeping them safe.

A key stakeholder told us, "The reablement service frequently contacts the care technology service for equipment and services which support people to live as independently as possible in their own homes. Referrals from the reablement service are prioritised to support hospital discharges and others who the service is supporting in the community."

Independence was not exclusively related to tasks of daily living linked to people's physical ability. Support was also provided for people whose mental health, substance or alcohol misuse impacted on their ability to care for themselves, which placed them at risk. In these circumstances staff worked alongside other health and social care professionals, with a coordinated strategy to improve people's mental health and well-being by supporting and working with them to improve their ability to self-care.

Safe environments

Score: 4

The provider was fully aware of all potential risks in the care environment and controlled them well. They made sure equipment, facilities and technology supported the delivery of safe care.

People and family members were unequivocal in their praise of the service, and the impact of collaboration between services, which resulted in timely minor adaptations to their property to support their recovery and reablement journey. A person told us, "I had a care navigator, therapy team and reablement visit to look and do an assessment of the environment. It included my mental and physical health as well as my abilities. I got 2 bath rails, 2 stair rails, a wheelie trolley, walking sticks, perching stools and toilet seats. They assessed the space in the main room with me"

A key stakeholder shared how staff went above and beyond to achieve good outcomes for people, by prioritising people's safety and well-being by acting in a way so as not to delay people's commencement of the reablement service. They told us, "The reablement service has, when needed, supported people via the collection of care technology and equipment from the care technology team and installed and demonstrated its use. This has allowed people to be supported without delay."

Measures were taken to reduce risk to remove potential barriers to people's recovery and independence This included making changes to people's home through the installation of equipment, such as grab rails or by making changes to how the person lived. A person told us, "Staff took photographs, as they were concerned about one step into the house. They advised me to clear the bedroom so that it was easy to get in and out."

Records evidenced household risks were identified as part of the dynamic risk assessment process, which included considerations as to people and staff safety. For example, parking arrangements, pets, and whether the home was fitted with a smoke or carbon monoxide alarm. The reablement service referred potential fire risk concerns to the fire and rescue service. A person told us, "We had a smoke alarm fitted."

Collaborative working with key stakeholders enabled staff to make timely referrals for equipment to promote people's safety. In addition to equipment to assist people with mobility, emergency alarms were also requested, which provide a direct link to a control centre when activated. A family member told us, "My [person] has been given a lifeline alarm around their neck and on their wrist."

Safe and effective staffing

Score: 4

The provider made sure there were always enough qualified, skilled and experienced staff, who received thorough support, supervision and strong development opportunities. They worked together well to provide safe care that met people's individual needs.

People and family members were consistent in praising the reliability of the service. A person told us, "Staff turn up at the allotted time." A family member said, "We knew which staff were coming, and at what time."

People's needs, including protected characteristics as defined by the Equality Act were considered when scheduling care calls, which included ensuring staff understood and were able to meet people's communication, religious and cultural needs. A family member told us, "The carers can speak Gujarati and Hindi, so my [person] can understand them, as [person] can't speak English."

People and family members expressed confidence in the ability of staff, they spoke of staff's knowledge and understanding of their specific needs and the impact this had on their recovery journey. For example, a person recovering from a stroke spoke of staff sharing their skills and knowledge by teaching them how to roll over in bed, using their good leg to turn themselves gently and carefully, so as they could transfer from the bed into a wheelchair or sit on the commode.

A collaborative and co-ordinated team approach facilitated the planning of care calls. The number of people requiring support continually changed, as new packages of care were accepted, people's progress resulted in a reduced number of care calls, and people's discharge from the service upon completion of their recovery journey. This meant staff had to keep a continuous oversight, adapting care call schedules as required. The service had not identified any care visits had been missed, which was confirmed by people we spoke with.

An electronic system was used to support staff in scheduling care calls and recording their arrival and departure time, which was monitored to ensure people received a timely service. Staff had access to the electronic management system known as 'OneTouch' via an app on their phones. A member of staff told us, "Rota management is completed on 'OneTouch'. We use it for electronic call monitoring, and is effective, with staff having access to it on their phones."

Records showed staff had undertaken training in a range of topics related to health, safety and welfare. In addition, staff received training in key areas specific to the role of reablement and recovery, which focused on assessing and mitigating risk, and the setting of goals through positive risk taking to facilitate people's recovery and rehabilitation journey. Training in key areas of need were undertaken by staff, which included dementia awareness and the Oliver McGowan national learning disability and autism training. Training workshops delivered comprehensive training for staff in a range of topics, including roles and responsibilities.

Staff were recruited in a safe way. Appropriate checks were carried out prior to people commencing work to enable the provider to be confident suitable staff with the right skills and experienced were employed. Staff received the support they needed to deliver safe care; this included supervisions, appraisals and support to develop and learn. Staff confirmed they had regular supervision and had their care practices checked. Staff completed the Care Certificate as part of a structured induction and were encouraged to study for vocational qualifications in care.

Infection prevention and control

Score: 3

The provider assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

People and family members confirmed staff followed infection control procedures by wearing personal protective equipment (PPE), which included gloves and aprons. A person told us, "The carers wear gloves, aprons, and masks if needed." People spoke of how staff respected people's homes in keeping them clean. A person said, "Staff wear protective covers on their shoes, and put all the dirty things in a bag, and take them out when leaving."

Staff completed training in infection prevention and control, and observations of staff competency included assurance staff adhered to the provider's infection prevention and control policy.

The registered manager informed us that infection prevention and control remained a core part of the service's working practice. There were clear expectations for all staff and regular refreshers to maintain compliance, with the principles of minimising risk, promoting hygiene, and responding emerging illness remained fully embedded in everyday practices.

Medicines optimisation

Score: 3

The provider made sure that medicines and treatments were safe and met people's needs, capacities and preferences. Staff involved people in planning, including when changes happened.

People were supported with taking their medicine if the assessment had identified this was an area of need. A person told us, "Staff give my medicines to me, and I take them whilst they are here." Supporting people to manage and take their medicines safely, for some, was an identified goal as part of their reablement and rehabilitation journey.

People's care records contained information as to people's prescribed medicines, and detailed staff's role and responsibility in supporting with medicine, where required. Where a person was returning to home from hospital, staff liaised and sought assurance medicine, where prescribed, would be dispensed by the hospital pharmacy and sent home with the person. Family members involvement in medicines was also detailed, which included where they were liaising with pharmacies and health care professionals regarding prescriptions and the packaging and delivery of medicines to their relatives' home. The reablement service made referrals for care technology, which included equipment that could be programmed to remind people it was time to take their medicine.

Staff received training and had their competency in medicine management assessed. A medicine workshop had been attended by all staff to emphasise the importance of medicine management, including recording, management of, and liaising with other health care professionals.

The registered manager maintained a medication incident matrix. Any incidents involving medicine were assessed for severity with consideration to the risk of actual or potential harm. Medicine administration records were monitored as part of the provider's quality monitoring process. The severity of the risk informed the action to be taken.

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Effective

Outstanding 

9 January 2026

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

At our last assessment we rated this key question good. At this assessment the rating has changed to outstanding. This meant people’s outcomes were consistently better than expected compared to similar services. People’s feedback described it as exceptional and distinctive.

This service scored 92 (out of 100) for this area. Find out [what we look at when we assess this area](#) and [How we calculate these scores](#).

Assessing needs

Score: 4

The provider always made sure people’s care and treatment was effective by thoroughly assessing and reviewing their health, care, wellbeing and communication needs with them.

People spoke positively of the assessment process which began whilst in hospital for some. A person told us, “I was referred to the reablement service by the doctors and nurses. They [Staff from the Reablement Provider Service] came and asked me what I needed. They told me the support was to help me recover until I was better from my operation.”

People were at the heart of the assessment process. Staff worked collaboratively with people, assessing their needs based on their home environment, their individual needs and their goals and aspirations. A person told us, “At the assessment I was asked what I wanted, they checked what I could do and what help I needed. Staff watched me and my spouse to see what both of us could do. It was excellent.”

The assessment process was comprehensive and considered protected characteristics as defined by the Equality Act. All aspects of people's needs were assessed, including general health, communication needs, age, race, religion and ethnicity. External factors were also included that may influence their recovery and reablement journey. For example, the role of family and friends in their lives, whether the person lived alone, and considered their housing and accommodation.

Staff invested significantly in keeping people's needs under continuous review to enable them to make changes to the support provided in response to people's progress. For example, by reducing the number of care call visits. A person told us, "I was absolutely involved in what I wanted from the beginning. Not only was recovery discussed but it has been regularly reviewed as my confidence improved."

People's care records comprehensively detailed their progress. A day-by-day account was documented and included information as to the involvement of any key partner agencies who had been contacted, and the action and response.

Staff escalated information in a timely manner with a member of the management team when they noted changes in people's needs. Any changes which identified the need for key partner agencies to be involved, for example, occupational therapist support, a housing need or additional equipment, the individual requirements of the person would be discussed at the daily meeting, which health and social care partners attended. A member of staff told us, "There are weekly multi-disciplinary team meetings, that involves the reablement team, supporting a joint review approach." The proactive and collaborate approach prioritised people, ensuring an effective response to their changing needs.

Delivering evidence-based care and treatment

Score: 3

The provider planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

People were supported to prepare and cook meals, where their assessment had identified this was an area where they required support as part of their recovery, rehabilitation and reablement journey. A family member told us, "The staff encourage [person] with making themselves a cup of tea or a sandwich." People's dietary requirements were documented with consideration to their religious and cultural needs, and health needs such as diabetes.

Where people did not require support from the reablement service with regards to meals, their records detailed others, such as family or friends who were supporting with grocery shopping and meals, this evidenced a robust approach to ensure all needs were both considered and met.

The provider used recognised tools in line with legislation and current evidence based good practice and standards. Staff from the reablement service would undertake joint visits to people's home with a speech and language therapy when it has been identified a person would benefit from an assessment, where people had trouble with swallowing, eating and drinking.

How staff, teams and services work together

Score: 4

The provider always worked well across teams and services to support people. They shared thorough assessments of people's needs when they moved between different services, so people only needed to tell their story once.

People benefited from robust systems and processes where information was shared by everyone involved in their care, with key partner agencies working collaboratively to achieve effective care for people.

Key partner agencies worked collaboratively at all levels, sharing information about the person so they only had to share it once. For example, people's initial referral to the reablement service contained all relevant information, including the background to the referral, health and social care professionals involved in their care, information relating to health and wellbeing, and details as to any prescribed medicines.

A multi-agency approach of key partner agencies, including community nursing therapy, care technology, mental health services, social workers, housing and care technology meant all services, facilitated by the Provider Reablement Service, worked collaboratively. This meant people received co-ordinated and timely care as they did not have to liaise with numerous agencies to secure the support and help, they required.

A key partner stakeholder told us, "The reablement service is embedded within the 'home first' model, ensuring seamless transition between hospital, community health services and adult social care in reablement, without unnecessary delay or duplication."

In the event a person required ongoing support, the reablement service forwarded to the relevant agency the Care Act Assessment they have completed. This is another example of how the Reablement Provider Service shares information, so as a person only had to share their story once.

Supporting people to live healthier lives

Score: 4

The provider always supported people to manage their health and wellbeing to fully maximise their independence, choice and control. Staff supported people to live healthier lives and where possible, reduce their future needs for care and support.

People benefited from the purpose of the service which was to facilitate, enable and encourage them to remain in their own homes. This was achieved by providing rehabilitation, reablement and recovery support, with a view to preventing people's transfer to long term care services or hospital; or by supporting people following an illness or stay in hospital. People and family members spoke of the positive impact the service had. A family member told us, "The impact of the service has been excellent, and [person] is very happy. It has given them independence, and a return of mobility."

People's care records provided a comprehensive account as to why the person had been referred to the service. There was an ongoing collaboration between people using the service and staff, to keep under review their recovery, reablement and rehabilitation journey, and setting of goals to maximise independence. A person told us, "When I had a fall and returned home from hospital, I had a lot of support. They have been amazing. I now need slightly less help, and I'm being reassessed next week, to decide what areas we will be focusing on next."

A collaborative approach with key partner agencies maximised people's opportunity to attain maximum independence, improving their quality of life, health and well-being. This included working with a range of health and social care professionals. A key partner stakeholder told us, "The reablement service is co-located with nursing and therapy staff, meaning the reablement service has access to clinical staff. People who are supported via the service typically regain a high level of independence, if not full independence, which reduces or eliminates care needs in the long term."

People's care plans explained the support people required to enable them to stay well and access healthcare services, where necessary. People with specific medical conditions, had detailed information within their care records which provided guidance for staff as to how this affected the person and how best to support them.

Monitoring and improving outcomes

Score: 4

The provider routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

People were equivocal in their praise of the service and its impact on them. A person told us, "Staff made a very difficult situation better for me. It was a traumatic and emotional time, that they made easier." People consistently experienced positive outcomes and worked collaboratively with staff to achieve these. A person told us, "The objective has been for me to get as much independence as possible, and it is progressing well. The next assessment will focus on bathing and washing, and how best to enable me to improve my abilities."

The provider's analysis of data demonstrated the positive impact of the service, which found 83% of people remained living at home at the end of their reablement, recovery and rehabilitation journey.

People's care records detailed their progress throughout their recovery, reablement and rehabilitation journey, with information as to the role of other health and social care professionals clearly documented, to ensure effective and co-ordinated care and support.

The collaborative approach between the reablement service, health and social care professionals, and key stakeholder meant outcomes were monitored, both at an individual level but also within the wider context of the health and social care system. A key stakeholder told us, "The reablement service works cohesively with health and social care through integrated pathways, a shared objective and coordinated multi-disciplinary working, ensuring people's care and support needs are met holistically within their community."

Consent to care and treatment

Score: 3

The provider told people about their rights around consent and respected these when delivering person-centred care and treatment.

People were fully involved in all decisions relating to their care and support. Assessments of people's needs considered people's capacity to make informed decisions and noted in some instances people may experience fluctuating capacity. For example, people living with dementia.

The provider understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA). The 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 MCA requires, that, as far as possible, people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests, and as least restrictive as possible.

Staff had undertaken training on the MCA and were aware that all care interactions required the consent of the person.

Similar services nearby...



Integrated Crisis Response Service

In Leicester, LE5 4PW



Macdave Services Ltd

In Leicester, LE5 4WH



Grace Care UK

In Leicester, LE5 5GE



HEMEARE SERVICE

Reablement Provider Service



Overall Outstanding

Neville Centre, Leicester General Hospital, Leicester, Leicestershire, LE5 4PW (0116) 454 5422

Provided and run by:

Leicester City Council



This service was previously registered at a different address - [see old profile](#)

Report from 5 September 2025 assessment

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Caring

Good



9 January 2026

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

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

This service scored 85 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Kindness, compassion and dignity

Score: 3

The provider always treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

People and family members spoke positively of how staff treated them with kindness and empathy and respected. A person told us, "Staff attitude is excellent. They always talk nicely to us and are always kind. They understand dementia."

The provider had collated feedback from people and their families about the service, which highlighted the professionalism and warmth of staff, and the importance of feeling listened to and involved in decisions.

Most people were supported by staff whose gender was as they preferred. However, a few people said the gender of staff was not always as they wished. A family member told us, "My [person] was supported by female carers on some occasions, and [person] is not comfortable with women carers, providing personal care" The person went onto say, "I understand, it's a temporary service, and all the carers were friendly, kind and considerate." The registered manager and staff team, where possible when scheduling calls considered people's gender preferences. However, due to the ever-changing needs of the service, this was not always possible and was explained to people during the assessment process.

People's care records were written by staff with consideration as to people's dignity. Staff detailed the care provided, and any issues were recorded sensitively without bias or judgement. A workshop for staff had been delivered which focused on recording and reporting.

Staff had received training on equality and diversity. A member of staff said, "I have received training on dignity and respect, it's very important in the work we do in the community." The registered manager informed us, which was confirmed by records, that staff received regular training on equality, dignity, human rights and unconscious bias.

The reablement service provided food parcels to those who used the service where required, which included circumstances where a person had returned to their home, following a stay in hospital.

The registered manager spoke of opportunities for reflective supervision and multi-disciplinary discussions, which provided a space to challenge assumptions, consider how to offer choice, and recognised the small adaptations that can preserve someone's dignity or autonomy in moments that matter, from dressing routines to medication decisions or cultural observance.

Treating people as individuals

Score: 3

The provider treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. They took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

People were supported by a diverse staff team, which enabled them to meet people's cultural and religious needs. A person told us, "Staff were all nice and knew how to help me. All were lady carers and that's what I wanted. They understood my culture, all of them were Hindu, and respected my traditions."

Assessments of people's needs identified people's abilities, and the areas in which rehabilitation was required to maximise people's independence, to strengthen their abilities, in support of good quality of life outcomes.

The assessment process included identifying any specific needs based on people's culture, religion or language requirements. A member of the management team spoke of a person who had been referred to the service who was deaf. The member of staff had liaised with several key partner agencies with the person, and on their behalf. They told us this had given them greater insight to the challenges faced. This had resulted in a discussion amongst the management team, as to how they could improve their service. In response, to enhance communication, transparent PPE masks would be made available to staff to make it easier for people to read lips and recognise and respond to staff facial expressions. The registered manager confirmed training for staff in supporting people with a hearing impairment would be provided over the next year.

Independence, choice and control

Score: 4

The provider was exceptional at promoting people's independence, so people knew their rights and had choice and control over their own care, treatment and wellbeing.

People spoke of the collaborative approach between themselves and staff by identifying goals based on what was important for them to achieve, promoting and maximising independence. A person told us, "I discussed using a sock applicator with staff, and spoke with them about learning how to get into and out of the bath safely. We spent 2 days practicing getting my socks on. We discussed my progress together." A family member told us, "Staff encourage [person] to be independent, like getting cups out of the cupboard and putting sugar in the tea. They are encouraging [person] to dress themselves."

Staff were highly motivated and committed to supporting people on their recovery and rehabilitation journey. All our interactions and conversations with staff at all levels within the service evidenced they understood the importance of their role, both for the person themselves and their family.

A wide range of key stakeholder partners were unequivocal in their praise of the service, and its impact on those who the service supported. A key partner told us, "The support the service offers to people is tailored to their needs. Working with people to develop their skills and confidence rather than de-enabling them by doing tasks for them."

Responding to people's immediate needs

Score: 3

The provider listened to and understood people's needs, views and wishes. Staff responded to people's needs in the moment and acted to minimise any discomfort, concern or distress.

People were involved in decisions regarding their day-to-day life, for example, what they wanted to wear and worked collaboratively with staff on achieving their rehabilitation and recovery goals. People spoke of the responsiveness of the service. A person told us, "Normally staff come at 10am, however today I asked them for an 8am call on a Sunday so I could go to Church. They have been very accommodating."

People's care records detailed their day-to-day needs, which included any choices they made. This included people's choice not to engage with staff, as well as agreeing to the accepting of new goals. Where people chose not to engage with staff, records were kept of the actions taken by staff to encourage the person, and any follow up actions taken to improve people's engagement. In some instances, people's choices not to engage were temporary, however, in some instances where the person decided not to engage, then the reablement service withdrew their support, in a co-ordinated and measured approach, liaising with other agencies to ensure a safe referral or transfer to other services if required.

People's care plans detailed their day-to-day needs and preferences. Care records reflected how people were to be given choices and have these respected. Communication with staff was effective in sharing information as to any changes in people's needs through a range of forums, which included electronic care records and meetings. Robust and timely sharing of information with key partner agencies, ensured a responsive service that was able to meet people's needs.

Workforce wellbeing and enablement

Score: 4

The provider always cared about and promoted the wellbeing of their staff and was exceptional at supporting and enabling staff to always deliver person-centred care.

The registered manager was committed to recognising and valuing the cultural and religious diversity of both people who used the service and staff. Personal beliefs, traditions and practices were supported. Language and gender preferences were considered, including when scheduling care calls.

Realistic staff rota schedules were developed to ensure sufficient travel time for staff between care visits. Rotas were developed with consideration to the cultural and religious needs of staff. Staff workforce diversity was monitored to ensure the team was reflective of people's demographic and needs.

The registered manager demonstrated their commitment to the well-being of staff. All staff were proactively encouraged to participate in workshops facilitated by an external organisation, whose aim was to encourage staff to explore their own spirituality, learning skills of reflection and meditation in support of well-being. Staff were asked to complete a survey as part of the workshop, which focused on specific aspects of their work. For example, manageable workloads, travelling time between care calls, support when dealing with complex and challenging situations, their perception of personal safety, the support they received from the management team, and an indicator as to their level of stress.

Staff spoke enthusiastically of the well-being workshop and demonstrated a keenness to engage and embrace the information given by the facilitators of the workshop. The registered manager informed us, the feedback from the completed surveys would be used to identify any specific themes and trends, as well as looking as to how further well-being events could be planned and implemented based on staff feedback.

Staff spoke positively of the support they received from their line manager. A member of staff told us, "I am always able to ring managers, I've never had an issue with not getting support, I've had nothing but outstanding support."

The provider's policies further underpinned staff well-being, including well-being passports for staff. A staff member spoke of the reasonable adjustments made, which included flexible working patterns, based on their caring responsibilities. An employee assistance programme, and an occupational health team further supported staff where required. A reward scheme acknowledged individual achievement and recognition. Information around human resources, including all forms of leave and safety were underpinned by the provider's policies and procedures.

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Similar services nearby...



Integrated Crisis Response Service

In Leicester, LE5 4PW



Macdave Services Ltd

In Leicester, LE5 4WH



Grace Care UK

In Leicester, LE5 5GE



HEMECARE SERVICE

Reablement Provider Service



Overall Outstanding

Neville Centre, Leicester General Hospital, Leicester, Leicestershire, LE5 4PW (0116) 454 5422

Provided and run by:

Leicester City Council



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9 January 2026

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

At our last assessment we rated this key question good. At this assessment the rating has changed to outstanding. This meant services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

This service scored 89 (out of 100) for this area. Find out [what we look at when we assess this area](#) and [How we calculate these scores](#).

Person-centred Care

Score: 4

The provider was exceptional at making sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

People were at the heart of all decisions and were involved throughout their recovery, rehabilitation and reablement journey, and fully understood the service was short term. People's involvement started with the initial referral to the service, the assessment of their needs within their home, the identifying of goals, and the ongoing review as to their progress. A person told us, "I have been fully involved from the beginning and continue to make decisions around my progress." People's recovery pathway in some instances required them to agree to changes in how they lived. For example, moving their sleeping arrangements to the ground floor. A person told us, "I was asked about moving downstairs, which I agreed to as I knew it would be safer for me and help in my recovery, and I was provided with a hospital bed."

People told us the service was responsive to requests they made regarding the timing of their care calls in response to changes in their circumstances, which demonstrated a person-centred approach to care. A person told us, "There was an appointment with the G.P. so, the office rearranged to come later, they were easy to get through to."

People's care records included information as to their social history, including their living arrangements, and how this related to their recovery, rehabilitation and reablement journey. People's care records provided clear and detailed information as to people's progress and their involvement in all decisions, which included the cessation of the service once the person had attained their goals. In some circumstances people required ongoing support with their day-to-day life, or staff had identified they may benefit from the involvement of other agencies. People's records evidenced their consent in such circumstances.

The provider's processes facilitated and encouraged an inclusive and person-centred approach to care, underpinned by collaborative working with key stakeholders and partner organisations, which placed people at the heart of the service. A key stakeholder partner told us, "Having a reablement, rehabilitation and recovery approach aligns both the social and medical models of social work, recognising the impact of a fall, change in health need or crisis, can have on a person and allowing them time, space and support to return to their baseline abilities via a multi-agency, person-centred approach to care."

Care provision, Integration and continuity

Score: 4

The provider had an exceptional understanding of the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

People received support from staff who had a good understanding of their local community, which included supporting people with protected characteristics as defined by the Equality Act. Staff fully understood people's cultural and religious needs and had the necessary training and skills to understand and support people's health care needs. For example, staff's understanding of people's culture and the considerations required when supporting with personal care.

Staff liaised with health and social care professionals as part of people's recovery journey, to achieve the best outcomes for people. A key stakeholder partner told us, "Having a co-ordinated approach avoids duplication for the person and their family, is an opportunity to ensure holistic needs are met and ensures people receive responsive and effective support from both health and social care services."

The registered manager facilitated weekly meetings with key stakeholders and partner agencies, which included sharing information as to the individual pressures specific to each partner and service type, and how they were to be individually managed. The reablement service was able to respond to these changes in the wider health and social care landscape, as the registered manager and management team through robust planning and managerial oversight fully understood the resources available to ensure the service was able to respond effectively.

People benefited from a service which fully understood the wider landscape of health and social care services. The registered manager, management team and staff facilitated and worked collaboratively with key partners and agencies from both health and social care services to meet the diverse health and care needs of people within their community. A key stakeholder partner told us, "The service works in a joined-up way with partners to align development activity with wider system priorities, including 'home first', neighbourhood working, frailty and prevention, ensuring reablement remains a core enabler within the integrated care system."

Providing Information

Score: 4

The provider supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

People's care records, including information as to their progress were accessible to the person and others involved in their care, including their family members. A family member told us, "I have power of attorney, the staff write things down in [person's] file about their progress."

People had access to key information in formats which met their communication needs, which included protected characteristics as defined by the Equality Act. For example, information about the service, including contact details, details about social care fees, and surveys requesting people's evaluation of the service they were available in a range of languages, along with an easy read and large print version. The colour contrast, layout and font were also considered to support people with dyslexia or visual impairments.

People were supported by staff who were able to communicate effectively with them in their preferred language. However, in unexpected or unplanned situations, staff had access to an on-line translate and text-to-speech tool. Flashcards, pictorial guides and communication boards were available to support people with cognitive or speech challenges. Tactile stickers and visual cues were sometimes added to items such as kettles or microwaves to support safe use.

All information generated by the Reablement Provider Service, which was accessible to people using the service, was reviewed by an independent group of people, who looked at the quality of the information, whether the information was easy to understand and was free from jargon. This independent review helped the provider meet the accessible information standard. The accessible information standards ensure people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with services.

The registered manager informed us staff had received training on communication best practices, particularly in relation to non-verbal communication and working with people who were neurodivergent or had fluctuating capacity. They advised every interaction was treated as an opportunity to revisit people's communication needs, with staff being encouraged to adapt not only the material they used, but also their tone, pace and language based on people's engagement with them.

The provider and staff worked with health and social care providers and shared necessary information in support of people's health and welfare. All personal information was managed consistent with the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

Listening to and involving people

Score: 3

The provider made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. Staff involved people in decisions about their care and told them what had changed as a result.

People and family members were knowledgeable as to how they could provide feedback about their experiences or the care and support they received, including how to raise concerns. A family member told us, "I have no complaints whatsoever. I'd have addressed them directly if there were any, I have a direct line to them." A person told us, "I have a phone number to contact the office on the front of the folder."

People and family members were provided with the opportunity to provide feedback throughout their recovery journey and at the time the service was ended. This was facilitated through regular phone calls, and a survey upon completion of their recovery journey. A person told us, "The staff from the office call, to check everything is okay." The provider's analysis of surveys found 97% of people were positive about the service.

Staff ensured people were listened to by involving them in decisions, and the setting and reviewing of their goals throughout their recovery journey. A person told us, "I've always been asked for my input about my care." People told us the service listened and acted upon their requests for changes in their care visits. A person told us, "I called the office to cancel a weekend call and to stop evening calls. Staff were nicely spoken and helpful, and they did what we asked."

The provider had a robust complaint policy and procedure. Records showed where concerns had been raised, these had been investigated and responded to, which included the adherence to other policies relating to staff, including disciplinary concerns. Duty of Candour requirements were met, with letters of apology being sent where appropriate when something went wrong during care. The outcome of complaints or concerns were used to support the learning culture of the service.

Equity in access

Score: 4

The provider was exceptional at ensuring people could access the care, support and treatment they needed when they needed it.

The provider recognised and understood the potential barriers which some people may face in accessing services. The collaborative approach of the reablement service in working with and alongside key stakeholders and partners, reduced those barriers, by facilitating people's access to services.

The reablement service facilitated daily meetings throughout the working week, involving health and social care professionals from a range of disciplines and specialist areas. This meant any requests for the involvement of other services were discussed and agreed, without delay to the person, by removing lengthy referral processes. A key stakeholder told us, "Attending multi-disciplinary meetings means we can discuss people and find a solution."

The timely referral and involvement of other services and agencies had a positive impact on people's day to day lives. A key stakeholder told us, "The reablement service is a key component of the local integrated care system, playing a critical role in supporting people to regain independence and avoid unnecessary long-term care or hospital use."

People's care records provided clear evidence of the involvement of health and social care professionals in their recovery journey and its positive impact on the individual. The multi-agency approach, co-ordinated by the Reablement Provider Service, ensured referrals to other services such as technology, housing, occupational therapy or nursing were made in a timely manner to ensure the reablement service was able to effectively respond in support of people's recovery, rehabilitation and reablement journey. For example, people who experienced domestic abuse or who lived within temporary housing had referrals made, with their consent to other services, and staff from the reablement service liaised and worked with staff from those other services in a joined-up way, to enable a positive outcome in an individual's recovery.

Equity in experiences and outcomes

Score: 3

Staff and leaders actively listened to information about people who are most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

People benefited from the approach of the registered manager, management team and staff in their understanding of the services key role within the wider landscape of health and social care services, in achieving good outcomes, whilst recognising the potential barriers faced by some who used the service.

The registered manager facilitated weekly meetings with key stakeholders and partner agencies across the health and social care landscape. Challenges to all key stakeholder and partner agencies were discussed, and responses to system challenges were shared. A key stakeholder told us, "Our inclusive approach has remained consistent, welcoming people regardless of disability, cultural background, mental health history, or any other protected characteristic. The referral process avoids unnecessary thresholds and instead focuses on strengths and outcomes: ensuring that people aren't excluded due to medical labels or assumptions about potential."

Planning for the future

Score: 3

People were supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

Occasionally, people referred to the reablement service experienced a decline in their health and well-being. Staff from the service liaised with health and social care professionals to source the best support and care for the person. Staff had received training in end of life care and provided the support and care when required.

As part of the assessment and referral process, information was shared as to any known wishes expressed by the person regarding treatment in the event their health deteriorated, which had been recorded on a ReSPECT document or DNACPR (a document which records people's advanced wishes should they stop breathing).

Similar services nearby...



Integrated Crisis Response Service

In Leicester, LE5 4PW



Macdave Services Ltd

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On this page

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9 January 2026

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

At our last assessment we rated this key question good. At this assessment the rating has changed to outstanding. This meant service leadership was exceptional and distinctive. Leaders and the culture they created drove and improved high-quality, person-centred care.

This service scored 93 (out of 100) for this area. Find out [what we look at when we assess this area](#) and [How we calculate these scores](#).

Shared direction and culture

Score: 4

The provider had a very clear shared vision, strategy and culture. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and an exceptional understanding of the challenges and the needs of people and their communities.

The provider, registered manager, management team and staffs' commitment of a shared vision, strategy and culture were measured by the positive outcomes people experienced, which was evidenced, in part by data. The provider's analysis of data for 2025 identified the reablement service supported 1,673 people of which, 74% required no ongoing care and support. Key stakeholders shared their views as to the success of the reablement service in achieving good outcomes for people. A key stakeholder told us, "The reablement service appears to achieve a high percentage of success in supporting people to remain at home after their short-term involvement."

The reablement service was part of the local authorities 'home first model', working with key stakeholders and partner agencies. The service provided was bespoke and tailored, facilitated through a cohesive and co-ordinated system wide approach, which enabled staff to provide individualised support to people in their recovery, reablement and rehabilitation journey.

The key values and strategic goals of the service were fully understood by the management team and staff, who worked continuously with partner agencies and services to deliver a good quality service. The culture of the service was positive, and the staff team's commitment to the delivery of the visions and values was tangible in their conversations and discussions. Key stakeholders were equally positive about the culture of the service, and the delivery of its values. A key stakeholder told us, "Frequent engagement with other partners ensures a considered continuity of support being offered by the reablement service."

Staff spoke passionately about their role and demonstrated commitment in delivering high quality care and good outcomes for people. A member of staff told us, "I love my job, I love to help people, to encourage in maximising their independence."

Equality and diversity were actively promoted across the service and embedded into everyday practices, which included staff recruitment and training. Assessments of people's needs considered protected characteristics as defined by the Equality Act, and were considered as part of staff rostering, to ensure for example, that staff were able to converse with people in their preferred language and understood their cultural needs. Key information was available in a range of languages, and formats and reviewed independently with consideration to people's communication needs.

The registered manager and management teams' oversight and monitoring ensured any risks to the delivery of the strategy, including local factors were understood and planned for as documented within the provider's contingency scenarios and response plans, and through meetings with key stakeholders and partner agencies to plan and respond to wider system pressures.

Capable, compassionate and inclusive leaders

Score: 4

The provider had exceptionally inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They always did so with integrity, openness and honesty.

The reablement service was led by a registered manager who had been in post for nearly a decade, evidencing sustained leadership. The registered manager kept up to date with good practice and the changing landscape of health and social care through ongoing learning and development, and engagement with key stakeholders. The registered manager had kept under review the requirements of the service and had made changes to the structure of the management team, which included the creating of new managerial roles, which had been successfully appointed to.

The registered manager and management team were highly visible and led by example, modelling inclusive behaviours. They had the experience, capacity and capability to ensure that the organisations visions were delivered, and risks were managed well. The registered manager was proactive in responding to information which could be indicative of a poor culture and potentially affect the quality of people's care or have a detrimental impact on staff. This was facilitated by responding to concerns, incidents or feedback, and by taking appropriate action where required, through the implementation of the provider's policies and procedures.

Staff were consistent in their praise of the registered manager and management team, of their support and availability. A member of staff told us, "The managers support us a lot, there is always someone on duty to provide support, they are available until we finish all our care visits." Another member of staff said, "Managers are always on site. We have 100% support. Managers are always available on MS teams or e-mail, they reply straight away."

Key stakeholder and partner agencies recognised the skills and credibility of the management team to work collaboratively with them, embodying the culture and values of the service, and the context in which care and support was provided. A key stakeholder told us, "Having regular multi-disciplinary meetings, alongside weekly operational meetings, enables open, honest communication across all services, identifying areas for service improvements and developments."

Freedom to speak up

Score: 3

The provider fostered a positive culture where people felt they could speak up and their voice would be heard.

The provider and registered manager acted with openness, honesty and transparency. They promoted staff empowerment and encouraged staff to raise concerns. This was facilitated through staff supervision, meetings and the availability and approachability of the management team. Staff's views were sought in relation to people's care and progress, which enabled them to directly affect and improve the quality of care people received.

We noted a culture of openness, evidenced by staff's demeanour and confidence in speaking with and sharing their views and opinions with the management team. A member of staff told us, "The service is always keen to get feedback. I do tell them how things are going. They want to know how the people I see are getting on."

The provider had a whistle-blower policy, which staff could use to share information of concern, which was accessible to staff.

Workforce equality, diversity and inclusion

Score: 4

The provider strongly valued diversity in their workforce. They had an inclusive and fair culture which had improved equality and equity for people who worked for them.

The provider had a corporate equality and diversity strategy, which focused and reviewed the culture of the organisation, in the context of equality, diversity and inclusion. Policies and procedures relating to the work force which included employment and ongoing accountability were written with consideration to equality, diversity and inclusion and the protected characteristics as defined by the Equality Act. For example, an external speaker had attended the service to talk about the impact and effects of the menopause, and a support group within the reablement service had been established for women experiencing the menopause.

The registered manager celebrated the diversity of the workforce recognising the value and importance of a diverse team in enabling the service to achieve positive outcomes for people, facilitated through staffs understanding knowledge and understanding of the diversity of the population it supported. A member of staff told us, "I work within a diverse team of staff, supporting and meeting the needs of the communities we serve."

The registered manager shared how staff rotas and working patterns were adjusted to respect religious observance, such as Ramadan and Diwali. Wherever possible, duties were redistributed or adapted to ensure staff were not placed in conflict between their work and their beliefs. They advised these adjustments had minimal impact on service delivery but had strengthened trust and staff retention.

Staff who required additional support due to disability, health, neurodivergence or personal circumstances were supported by tailored wellbeing plans, and where required, included referrals to occupational health or mental health resources. A member of staff we spoke with confirmed they were supported through flexible working arrangements.

Wellbeing was considered to be of significant importance by the registered manager, with many staff having attended a workshop recently facilitated by an external organisation. The registered manager spoke of this being the beginning of a process and journey, and as part of the wellbeing workshops had asked staff what it was, they wanted to happen next.

Governance, management and sustainability

Score: 3

The provider had clear responsibilities, roles, systems of accountability and good governance. They used these to manage and deliver good quality, sustainable care, treatment and support. They acted on the best information about risk, performance and outcomes, and shared this securely with others when appropriate.

The provider had clear and effective governance, management and accountability arrangements in place. This was achieved through ongoing monitoring across all areas of service delivery. For example, feedback from key stakeholders and partner agencies, people who used the service, and its staff. Ongoing monitoring of systems and processes, which included the auditing of records, systems and processes, enabled the registered manager to monitor the safety and quality of the service provided.

Staff understood their roles and responsibilities, with managers being able to account for the actions, behaviours and performance of staff. This was achieved by supporting and monitoring staff, through observation, supervision and training and development.

The performance of the service was kept under continuous review, working collaboratively on an ongoing basis with key stakeholders and partner agencies to deliver a service which focused on quality, the mitigation of risk and continuous improvement. A key stakeholder told us, "The reablement service collaborates closely with commissioners, providers and partner through shared governance, co-production and continuous improvement, ensuring service development is informed by operational insight, population need and system priorities."

Partnerships and communities

Score: 4

The provider clearly understood and carried out their duty to collaborate and worked in partnership, and services worked seamlessly for people. They always shared information and learning with partners and collaborated for improvement.

Key stakeholders and partner agencies comments were unequivocal in acknowledging the significance of collaborative working, and of the positive impact on people as they moved between services. A key stakeholder said, "The reablement service supports safe and effective transitions through early planning, coordinated multi-agency working and a strong focus on individual outcomes, ensuring people experience timely, well-managed moves between services."

The registered manager and management team engaged with people, communities and key stakeholders and partner agencies to share learning with each other, leading to continuous improvements in the service. For example, a key stakeholder was aware of the implementation of events designed to improve the effectiveness and efficiency of the service. A key stakeholder told us, "The reablement service is currently supporting the staff via a series of events. These sessions having included the focus on obtaining and recording information, staff wellbeing and positive thinking. Overall, these sessions were designed to improve the outcome of people being supported."

Learning, improvement and innovation

Score: 4

The provider focused on continuous learning, innovation and improvement across the organisation and local system. They encouraged creative ways of delivering equality of experience, outcome and quality of life for people. They actively contributed to safe, effective practice and research.

The registered manager and management team were committed to ongoing monitoring to measure the outcomes and impact of the service provided. Systems and processes were in place to learn from events when things went wrong and worked in collaboration with key stakeholders and partner agencies to review the effectiveness of the reablement service in the context of the wider health and social care landscape. A key stakeholder told us, "The service demonstrates a strong commitment to continuous improvement, using learning from practice, feedback and system insight to refine how support is delivered for the people it serves. This includes a willingness to test and adopt new approaches that improve outcomes, experience and flow across the system."

The registered manager shared how the service in recent years had implemented the triple R model, of rehabilitation, reablement and recovery, which was now fully embedded. The service by working with the provider's Integrated Crisis Response Service, was now able to provide support to people with more complex needs, which included those requiring 2 staff, which facilitated people's discharge from hospital, improving both the outcomes for the person, and by reducing pressures on the wider health care system.

As part of the provider's commitment to the development of an enhanced management structure to better support staff and improve internal accountability, plans were in motion to introduce dedicated quality assurance, absence management, safeguarding and complaints leads. The aim being to strengthen learning, oversight, and responsiveness across the service.

The provider had introduced the 'OneTouch electronic care monitoring system, which provided accessible electronic data and information as to people's care needs, which could be accessed by key partner and agencies within the social care sector. This had contributed to effective sharing of information, improved communication, directly affecting the service people received as it facilitated timely referrals, including requests for additional resources and equipment.

Similar services nearby...



Integrated Crisis Response Service

In Leicester, LE5 4PW



Macdave Services Ltd

In Leicester, LE5 4WH



Grace Care UK

In Leicester, LE5 5GE
