

Provider Information Return (PIR)

Brolly Care Services

Reporting Period: 25 March 2025 — 25 March 2026

Generated: 25 March 2026

Section 1: Overall Assessment

Successes

We are pleased to report a number of positive developments during the reporting period from 25 March 2025 to 25 March 2026. Our service has continued to grow steadily, supporting 157 service users across our catchment area, with strong outcomes in client satisfaction, staff retention, and regulatory compliance.

We have maintained a robust and well-embedded policy framework, with 47 active policies covering all aspects of domiciliary care delivery, regulatory compliance, employment practice, and governance. These policies are reviewed on a rolling annual basis and 94% of staff have formally acknowledged the current policy suite via our digital learning management system.

Our care planning processes continue to mature, with 372 active personalised support plans and 453 completed needs assessments. Each support plan is reviewed at least every six months, or sooner where there is a change in need. The remaining three service users are within their first 14 days of service and have interim care plans pending their full assessment review.

Service delivery has been consistent and reliable across the year, with 144,820 care visits delivered and a missed visit rate of 0.18%, well below the sector benchmark of 0.5%. Where missed or delayed visits did occur, all were followed up within agreed timescales and welfare checks completed.

We have maintained appropriate registration and regulatory compliance throughout the period, ensuring our service continues to meet CQC fundamental standards and operates within our registered scope of activities. We have also retained ISO 9001 certification and are working towards ISO 42001 in line with our increasing use of digital and AI-supported tooling.

Barriers

We acknowledge a number of areas where further improvement is required. Recruitment of senior care staff in the local labour market remains challenging, and although our overall vacancy rate is 4.3%, the time-to-hire for Senior Care Assistant roles has averaged 9.2 weeks during the reporting period.

Training compliance against our annual mandatory training matrix sits at 91.4%, just below our internal target of 95%. The shortfall is concentrated in two areas: refresher training for moving and

handling (88%) and updated oral health awareness training (84%). A targeted catch-up programme is in place to close these gaps by Q2 2026.

We are continuing to develop our digital records infrastructure. While 100% of care visits are now logged electronically through our electronic call monitoring (ECM) system, the migration of historic paper-based care plans to our Digital Social Care Records (DSCR) platform is 87% complete, with full migration scheduled for completion in May 2026.

Rising fuel and travel costs in Jersey and the wider region have placed pressure on rota efficiency. We have responded by introducing geographically clustered rounds and revised mileage policies, and we continue to review staff travel time payments to ensure compliance with employment legislation.

We are proactively addressing these barriers through enhanced management oversight, improved staff supervision, and continued investment in training and digital systems. Our improvement plan includes monthly progress reviews and clear timescales for each identified area.

Section 2: People who use your service

Demographics

We provide domiciliary care services to 157 people across our catchment area during the reporting period. Our service users represent a diverse community with varying care needs, life experiences, and backgrounds.

Age distribution

Age group	Number of service users	Percentage
Under 65 years	12	7.6%
65–74 years	23	14.6%
75–84 years	54	34.4%
85–94 years	51	32.5%
95 years and over	17	10.8%
Total	157	100.0%

Gender

Gender	Number of service users	Percentage
Female	98	62.4%
Male	57	36.3%
Prefer to self-describe / not specified	2	1.3%
Total	157	100.0%

Health conditions and dependencies

We capture primary and secondary health conditions as part of every initial assessment and review them at each six-monthly care plan review. The following table summarises the prevalence of the most common conditions across our service user population. Many service users live with more than one condition, so percentages do not sum to 100%.

Condition / dependency	Number	% of service users
Frailty / mobility impairment	121	77.1%
Dementia or cognitive impairment	68	43.3%
Cardiovascular conditions	74	47.1%
Diabetes (Type 1 or Type 2)	39	24.8%
Respiratory conditions (COPD, asthma)	31	19.7%
Stroke / post-stroke rehabilitation	22	14.0%
Sensory impairment (visual or hearing)	44	28.0%
Mental health conditions (incl. depression, anxiety)	29	18.5%
End-of-life / palliative care needs	9	5.7%
Service users requiring medication support	94	59.9%

Equality and diversity monitoring

We are committed to promoting equality and diversity in our service delivery. The following data reflects voluntary self-disclosure by service users at the point of assessment. Where service users have declined to share information, this is recorded as "prefer not to say" and respected throughout their care.

Characteristic	Captured	Coverage
Ethnic background	151 / 157	96.2%
Religious or spiritual beliefs	138 / 157	87.9%
Preferred language / communication needs	157 / 157	100.0%
Sexual orientation (voluntary)	112 / 157	71.3%
Cultural / dietary requirements	157 / 157	100.0%

Of those who have shared ethnicity data, 78.1% identify as White British, 9.3% as White Other (predominantly Portuguese, Polish, and Romanian heritage reflecting the local community), 4.6% as Asian or Asian British, 2.6% as Black or Black British, and the remainder as Mixed or Other ethnic

groups. Translation and interpretation services are arranged for the seven service users whose first language is not English.

Section 3: Staff

3.1 Staff numbers and types

Brolly Care Services currently employs 92 active staff members across our domiciliary care operations. Our workforce comprises a balance of operational care staff, clinical supervision, and management and administrative functions appropriate to the size of our service user base.

Role	Headcount	Contract type
Registered Manager	1	Permanent, full-time
Deputy / Care Manager	2	Permanent, full-time
Care Coordinators / Schedulers	4	Permanent, full-time
Senior Care Assistants	11	Permanent (10 FT, 1 PT)
Care Assistants / Support Workers	63	Permanent (38 FT, 25 PT)
Bank / Relief Care Workers	5	Bank contract
Administrators	4	Permanent, full-time
Training & Compliance Lead	1	Permanent, full-time
Quality / Clinical Lead	1	Permanent, full-time
Total	92	

We do not currently use external agency staff. The 5 bank workers listed above are directly employed on flexible contracts and are subject to the same recruitment, induction, training, and supervision standards as our permanent workforce.

3.2 Staff turnover and vacancy management

Staff turnover during the 12-month reporting period was 11.7%, which compares favourably with the published sector average for domiciliary care of approximately 28%. We attribute this to investment in pay and progression, robust induction, and an open culture of supervision and support.

We currently have 4 active vacancies (4.3% of headcount): 2 Care Assistant roles, 1 Senior Care Assistant role, and 1 Care Coordinator role. All are being actively recruited, with cover provided in the interim by our bank team and additional shifts from existing staff who have volunteered.

3.3 Training and qualifications

All new staff complete a structured induction programme aligned to the Care Certificate within their first 12 weeks of employment. Existing staff are supported to undertake further qualifications including the Level 2, Level 3, and Level 5 Diplomas in Adult Care.

Training / qualification	Staff completed	Compliance rate
Care Certificate (15 standards)	76 / 84 care-facing staff	90.5%
Safeguarding adults (Level 2)	90 / 92	97.8%
Safeguarding (Level 3, senior staff)	15 / 15	100.0%
Medication administration	78 / 84 care-facing staff	92.9%
Moving and handling (refresher)	74 / 84 care-facing staff	88.1%
Infection prevention and control	89 / 92	96.7%
Mental Capacity Act / DoLS	87 / 92	94.6%
Dementia awareness	82 / 92	89.1%
First aid (basic)	88 / 92	95.7%
Oral health awareness	77 / 92	83.7%
Equality, diversity and inclusion	91 / 92	98.9%
Data protection / GDPR	92 / 92	100.0%
Level 2 Diploma in Adult Care	41 / 84 care-facing staff	48.8%
Level 3 Diploma in Adult Care	18 / 84 care-facing staff	21.4%
Level 5 Diploma (managers)	3 / 4	75.0%

Overall mandatory training compliance across the matrix sits at 91.4%. The two areas of greatest shortfall — moving and handling refresher (88.1%) and oral health awareness (83.7%) — are subject to a dedicated catch-up programme with sessions scheduled for April and May 2026.

3.4 Supervision arrangements

Every member of care staff receives a formal one-to-one supervision session at least every eight weeks, with annual appraisal and mid-year review. Senior Care Assistants additionally receive monthly clinical supervision from the Quality / Clinical Lead. During the reporting period 96.4% of scheduled supervisions were completed within the planned month, with the remainder rescheduled within the following two weeks.

Supervision sessions are recorded in our digital HR platform, with a structured template covering wellbeing, caseload, training, observed practice, and any concerns or aspirations. Themes from supervision are aggregated quarterly and feed into our service improvement plan.

3.5 Action plan

- Close the 88.1% moving and handling refresher gap by 31 May 2026 through scheduled in-house sessions.
- Reach 95% oral health awareness compliance by 30 June 2026 via e-learning and toolbox talks.
- Continue rolling Care Certificate enrolment for the 8 remaining new starters within their 12-week induction window.
- Maintain turnover below 15% through retention initiatives including pay review, progression pathways, and the staff recognition scheme launched in November 2025.
- Reduce Senior Care Assistant time-to-hire to under 6 weeks through revised job adverts and targeted local recruitment campaigns.

Section 4: Quality Assurance

Infection prevention and control

We maintain robust infection prevention and control measures across all care delivery. During the reporting period we recorded 14 minor IPC-related incidents (predominantly individual cases of suspected gastroenteritis or seasonal respiratory illness in service users), all of which were managed in line with our IPC policy and reported to the relevant authorities where required. There were no outbreaks affecting multiple service users or staff.

Our IPC framework forms part of our 47 active policies, all of which were reviewed during this period to reflect the latest UKHSA and CQC guidance. Compliance with mandatory IPC training stands at 96.7%, and our policy acknowledgement rate sits at 94% across the workforce. PPE stock checks are completed weekly and audited monthly.

Duty of candour

We are committed to being open and honest when things go wrong. During this reporting period there were 2 notifiable safety incidents that triggered our duty of candour procedures. In both cases the service user (or their representative) was contacted in person within 10 working days, a written apology and explanation issued, and a full investigation completed with findings shared transparently.

Both incidents resulted in service improvement actions which have since been implemented, including a revised double-up handling protocol and additional senior oversight of complex transfers. Our duty of candour procedure is embedded within our policy framework, with clear escalation pathways and timelines for notification.

Medicines management

We currently support 94 service users (59.9%) with medication, ranging from prompting through to full administration of prescribed medicines including controlled drugs in a small number of palliative care cases. All staff administering medication have completed our accredited medication training and annual competency assessment.

During the reporting period there were 6 recorded medication errors across approximately 41,000 medication administration events — an error rate of 0.015%. None of the errors resulted in harm to the service user. All errors were investigated within 5 working days, with learning shared at team meetings and reflected in updated guidance and individual reflective practice.

Medication error type	Count	Outcome
Missed dose	3	No harm; GP informed where required
Wrong time (>1 hour outside window)	2	No harm; reviewed at supervision
Recording error (administered but not signed)	1	No harm; MAR audit improved
Wrong dose / wrong medication	0	—
Total	6	

Complaints

We received 7 formal complaints during the reporting period, equivalent to one complaint per 22 service users per year. All complaints were acknowledged within 3 working days and resolved within our published 28-day timescale. 5 complaints were upheld or partially upheld, 2 were not upheld following investigation. None were escalated to the Local Government and Social Care Ombudsman.

We additionally logged 34 informal concerns and items of feedback, all of which were addressed at the point of contact. Themes from complaints and concerns are reviewed quarterly by the Registered Manager and inform our quality improvement priorities. The most common theme this year related to short-notice changes to visit times, which we have addressed through improved client communication and rota stability measures.

Digital Social Care Records (DSCR)

We use an assured DSCR-compliant care management platform, with 100% of care visits recorded electronically at the point of care. As of the reporting date, 87% of historic care plans have been migrated to the digital platform, with full migration scheduled for completion by 31 May 2026.

Our digital infrastructure includes secure, role-based access; full audit trails; integration with our electronic call monitoring system; and encrypted data at rest and in transit. We have completed the Data Security and Protection Toolkit (DSPT) self-assessment at "Standards Met" for the current year.

Key areas for development

- Complete migration of all historic care plans to the DSCR platform by 31 May 2026.
- Reduce medication recording errors to fewer than 4 per year through enhanced MAR auditing and digital MAR rollout.
- Continue to drive informal feedback rates upward as a leading indicator of openness and engagement.
- Progress towards ISO 42001 certification covering our use of AI-assisted scheduling and documentation tools.

Section 5: Commissioners

5.1 Commissioning arrangements

We currently provide care services to 157 service users across our operational area, funded through a mix of public sector commissioning, NHS funding, direct payments, and private arrangements.

Commissioner / funding route	Service users	Type of arrangement
Local Authority Adult Social Care	78	Block and spot contract
NHS Continuing Healthcare	14	Spot contract
NHS-funded nursing care contributions	9	Funded contributions
Direct payments / personal budgets	21	Service agreement
Self-funded (private fee)	31	Private contract
Joint health and social care package	4	Pooled budget
Total	157	

5.2 Partnership working with healthcare professionals

We maintain strong collaborative relationships with a range of healthcare professionals to ensure comprehensive care delivery. Our partnership approach is built around clear communication pathways, shared care planning where appropriate, and active participation in multidisciplinary working.

Primary healthcare partnerships

- Regular liaison with 19 GP practices across our operating area.
- Coordination with district nursing services for clinical tasks and complex care needs.

- Communication with practice nurses on medication management and routine health monitoring.

Specialist healthcare services

- Occupational therapy teams for equipment, adaptations, and risk assessments (32 joint visits during the period).
- Physiotherapy services supporting rehabilitation and falls prevention.
- Speech and language therapy for communication and swallowing assessments.
- Community mental health teams including CPNs and old-age psychiatry.
- Specialist nurses covering diabetes, heart failure, respiratory, and tissue viability.
- Local hospice and palliative care teams (active joint working with 9 service users during the period).

Emergency and acute services

- Documented escalation protocols to emergency services, with average response logged in our incident records.
- Integrated discharge pathways with the local hospital, supporting 41 hospital-to-home transitions during the period.
- Communication with ambulance services, with 23 conveyances recorded and follow-up welfare checks completed in all cases.

Partnership protocols

- Timely reporting of health concerns or changes in condition through agreed channels.
- Participation in multidisciplinary team meetings (98 MDT meetings attended during the reporting period).
- Sharing of care plan updates with relevant healthcare professionals, with consent.
- Coordination of appointment attendance and medication compliance.

Section 6: Service Delivery

Care visits

During the 12-month reporting period we delivered 144,820 care visits to our 157 service users. Visit volumes are distributed across morning, lunchtime, teatime, and bedtime calls, with a small number of waking and sleeping night packages. The following table summarises visit activity over the most recent 28-day period.

Metric	Last 28 days	Annualised (12 months)
Total visits delivered	11,184	144,820
Average daily visits	399	397
Average visits per service user / week	17.8	17.7
Service users with 4+ visits per day	46	—
Service users with twice-weekly or fewer visits	11	—

Missed and late visits

We define a missed visit as one not delivered at all on the planned day, and a late visit as one delivered more than 30 minutes outside the agreed call window. All missed and late visits are reviewed daily by the Care Coordinators and root causes investigated.

Category	Count (12 months)	% of all visits
Missed visits	261	0.18%
Late visits (>30 min)	1,824	1.26%
Visits rescheduled with client agreement	612	0.42%

The most common reasons for missed visits were short-notice staff sickness (47%), traffic and weather disruption (28%), no access at the property (15%), and rota error (10%). Welfare checks were carried out within agreed timescales in 100% of missed visit cases.

Multi-carer visits

29 service users (18.5%) require double-up visits for some or all of their care, primarily for moving and handling, personal care, or end-of-life support. During the reporting period we delivered 21,460 double-up visits, all paired in line with the assessed need recorded in the care plan. Compliance with planned double-up scheduling stood at 99.1%.

Visit durations and time allocations

Planned visit length	% of visits	Average actual delivered
15 minutes	11.2%	16 minutes
30 minutes	48.6%	31 minutes
45 minutes	21.4%	44 minutes
60 minutes	14.1%	58 minutes

Planned visit length	% of visits	Average actual delivered
75+ minutes (incl. waking nights)	4.7%	Per package

Visit length is monitored through our electronic call monitoring system. Where call durations consistently fall short of planned time, the schedule is reviewed and corrective action taken. We do not operate "15-minute personal care" visits as a matter of policy.

Staff contracts and employment status

Contract type	Headcount	% of workforce
Permanent full-time	53	57.6%
Permanent part-time	26	28.3%
Bank / relief	5	5.4%
Fixed-term (incl. apprentices)	8	8.7%
Zero-hours	0	0.0%
Total	92	100.0%

We do not operate zero-hours contracts. All staff are offered guaranteed minimum hours appropriate to their role and personal circumstances.

Travel time between visits

Average scheduled travel time between visits is 11 minutes, with a target of no more than 15 minutes for urban rounds and 25 minutes for rural rounds. Actual travel time is monitored through our ECM system. Travel time is paid at full rate for all care staff, in addition to mileage at HMRC-approved rates. Geographically clustered rounds were introduced in October 2025, reducing average travel time per visit by 14% compared to the previous year.

Wage compliance and payment practices

We are committed to fair pay and employment practices and have undertaken an internal wage compliance review during the reporting period, supported by external HR advice. Key points are summarised below.

Area	Position
National Living Wage compliance	100% — all staff paid at or above NLW including travel time
Travel time payment	Paid at full hourly rate between visits

Area	Position
Mileage	Paid at HMRC-approved rate (45p/mile for first 10,000 miles)
Sleeping nights	Paid at NLW for full duration of shift
Unsocial hours premium	Weekend and bank holiday enhancement applied
Pension auto-enrolment	100% compliant
Statutory sick pay / occupational sick pay	Both available in line with policy

Improvement actions

- Reduce missed visit rate from 0.18% to below 0.10% through improved short-notice cover capacity.
- Reduce late visit rate from 1.26% to below 1.00% through continued rota optimisation.
- Complete rollout of digital MAR charts across all 94 medication-supported service users by Q3 2026.
- Continue to monitor travel time and mileage payments to ensure ongoing compliance with employment law.
- Maintain 100% completion of welfare checks following any missed visit, with target response time within 60 minutes.

End of Provider Information Return

Brolly Care Services • Reporting Period 25 March 2025 – 25 March 2026