Kent County Council

Kent Shared Lives

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 05 December 2014, and was an announced inspection. The manager was given 48 hours notice of the inspection as we needed to be sure that the office was open and staff would be available to speak with us.

Kent Shared Lives provides a service for adults who need support and who want to live as part of a family or household. It is an alternative to residential care for people who want to live or stay in a homely environment, but cannot manage on their own. It provides services for people with learning, physical or sensory disabilities, and people with mental health problems. The service provides long term placements and respite care. It is responsible for co-ordination between the people who use the service and the carers with whom people live.

Kent Shared Lives staff liaise with social workers, who oversee the processes and care management of the people who need support. The staff are responsible for recruiting carers who will provide the care and support that people need within the carers' own families or

Summary of findings

households. For the purposes of this report we will refer to those who provide support as 'carers'. At the time of our inspection, the service had 123 carers, and was providing support to 164 people, of whom 142 were receiving long term care, and others were receiving respite care. 58 of these were receiving personal care as well as other support. Our inspection process included the recruitment of carers to support people, how they were matched to people needing support, how well they were trained and supported themselves; and how people who were being supported felt about their placements. We obtained people's views about their placements.

The service is run by a registered manager, who was present throughout the day of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The service ensured that staff and carers were trained in safeguarding people, and in how to recognise and report different forms of abuse. Staff and carers were confident that they could raise any matters of concern with the registered manager or directly with the local authority safeguarding team. People who received support told us that they felt safe now that they were living with a family, and could raise any concerns with their carers.

An assessment of different risks was carried out before placements were agreed, and these were updated on an on-going basis. Risk assessments included checking that carers' houses had sufficient space to take people for placements, and a suitable single bedroom, and met health and safety requirements. These included comprehensive risk assessments for the property such as gas, electrical and fire safety; and checks that the property was safe for any equipment used such as wheelchairs. The assessments explored if the carers' homes were suitable for any necessary adaptations, such as ramps, and if the person needing support could use steps and stairs. Other assessments checked that carers had a stable home life; that family members agreed with taking people into their home; the carers' financial stability; and if they were in good health.

People receiving support had individual risk assessments, such as if they were safe to access the community on their own; if they could safely use public transport; if they smoked; if they needed support with their finances; and if they had health needs where they might require support, such as epilepsy.

The service carried out thorough recruitment procedures for their own staff and for recruiting carers. These included Disclosure and Barring Service (DBS) checks; checks for personal identity; and written references. The staff had specific areas of responsibility, and had their own caseloads. This enabled them to develop an on-going knowledge of the carers' needs and abilities. They supported the carers through monitoring visits, and worked with social workers in regards to changes in the circumstances of the people they were supporting. The staff said that the size of their caseloads enabled them to have sufficient time to carry out effective monitoring.

Staff ensured that carers had received relevant training so that they could support people with all of their needs, such as support with taking any medicines. Training in assisting people with their medicines was given to all carers; and additional training was put in place for people with specific health needs where carers may need to support them, such as insulin for people with diabetes, or medicines to give to people with epilepsy in the event of seizures. There were clear procedures for assisting people with medicines in accordance with the Mental Capacity Act 2005, where people may not be able to make decisions about whether or not to take their medicines.

The manager ensured that staff kept up to date with training requirements and were able to develop their knowledge and pursue career development. The staff ensured that carers were trained in all required areas to support the people in their care. Staff and carers received regular monitoring, individual supervision, and yearly appraisals. Staff followed detailed processes to match people needing support with the right carers, so that they could be quickly accepted into family life, and become a part of each carer's household.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other

Summary of findings

way to look after the person safely. In 'Shared Lives' services the process involves the court of protection. However, there was no-one receiving support who needed to be deprived of their liberty, and so no applications for the court of protection had been made.

Carers assisted people needing support with all aspects of their day to day living, including their nutrition, personal hygiene care, health needs, education and employment, travelling, social lifestyle, and keeping in touch with friends and family. They supported people in making decisions about their own care and lifestyles, and promoted their independence as much as possible. Feedback from people receiving support showed that they felt they were given choices in what they did and where they went.

Carers and people receiving support were given comprehensive information to help them to discuss situations and make decisions. The information was provided in different formats such as easy-read format, or with photographs for people receiving support, if this aided their understanding. Advocacy services were sourced and made available if needed, including Independent Mental Capacity Advocates (IMCAs), if people who lacked mental capacity needed support to make complex decisions about their care.

Carers and people receiving support were informed about how to raise concerns or complaints, and who would help them through these processes.

Kent Shared Lives staff showed they had a clear understanding of the service's vision and values, and worked together to provide opportunities for on-going improvements and expansion of the service. There had been a recent inclusion in the service for giving advice and support for people living with dementia. One of the staff was specifically allocated to this area of support; and was also arranging the commencement of using telecare in this capacity. (Telecare is a system of using equipment such as pendant alarms and pressure mats to alert carers that their support is needed).

The manager was creative in developing the service, and took projects on board which studied ways to make the service even better, and expand the knowledge of Shared Lives' services nationally. She was exploring the possibility of starting day care service provision, as well as expanding the service for people who needed long term care and people needing respite care.

Health and social care professionals told us that this was a very professional service, which was constantly seeking ways to meet people's needs in a way that was as normal for people as possible, entering into family life, and feeling accepted and supported. They said that the service had very high standards of recruitment and service provision.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Carers and people receiving support felt safe because of the detailed checks and assessments that were carried out.

Staff and carers understood their roles in regards to safeguarding people from abuse, and knew how to raise any concerns of abuse with the manager or safeguarding authorities.

Carers and people receiving support had detailed risk assessments in place. These provided a framework for staff and carers to minimise the risks and take appropriate action to protect people. People's medicines were managed in accordance with professional guidance, and in ways that supported them.

Is the service effective?

Good

The service was effective. Staff and carers were appropriately trained and supported to understand their responsibilities and provide the support that people needed.

The manager, staff and carers understood the requirements of the Mental Capacity Act 2005, and ensured that people were appropriately supported by their next of kin or advocate in making difficult decisions.

Staff ensured that carers had sufficient knowledge and competence to support people with having a healthy diet. Staff provided carers with support in assisting people with their health needs, and monitoring people's on-going health.

Is the service caring?

Good

The service was caring. Carers and the people they supported spoke positively about the care and support they were given.

Staff and carers enabled people to take part in their own care planning and to make their own decisions about their care and support. The staff contacted advocacy services to support people when this was needed.

Carers protected people's privacy and ensured they were treated with respect.

Is the service responsive?

Good

The service was responsive. People took part in their care planning and received support that was tailored to their individual needs.

People were supported in following their preferred lifestyles, activities, education and interests.

Carers and people receiving support were confident that they could raise any concerns, and that they would be listened to and dealt with appropriately.

Is the service well-led?

Good

The service was well-led. The staff had a clear understanding of the service's vision and values and worked with the manager to bring about on-going improvements.

Summary of findings

The manager and staff were looking creatively at different ways in which they could expand the service and assess the quality of care for people receiving support.

The manager maintained quality assurance and monitoring procedures in order to provide an on-going assessment of how the service was functioning; and act on the results to bring about better services.

Kent Shared Lives

Detailed findings

Background to this inspection

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

This inspection took place on 05 December 2014 and was announced. The manager was given 48 hours notice of the inspection as we needed to be sure that the office was open and staff would be available to speak with us. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service; and the expert by experience who assisted us had experience of working with young adults with learning difficulties.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was sent out before the inspection and was completed by the registered manager within the required timeframe. We reviewed this information, and we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). (A notification is information about important events which the provider is required to tell us about by law).

We obtained feedback from 18 carers; from 57 people receiving support; and from seven social workers who were case managers for people receiving support. Some of the professionals and people we spoke with permitted us to share their comments in our report. Feedback was obtained through questionnaires sent out by CQC before the inspection visit; and through the service's own questionnaire results for 2014. We also carried out telephone calls and e-mails with carers and health and social care professionals. Some of these people gave us permission to quote their comments.

We visited the service's offices and talked with five staff who were present on the day of the inspection, as well as the manager. After visiting the offices, we visited one of the carers who supported three people in their own home. We also met one of the people receiving support.

During the inspection visit, we reviewed a variety of documents. These included records and recruitment files for five carers, which included their pre-assessment documentation; assessment processes; care agreements and panel meetings. (A decision-making panel meets to go through all of the recruitment and assessment processes and decide if people are suitable to be carers).

We also looked at four care files for people receiving support; accident and incidents reporting; the complaints log and complaints management; monitoring visits for carers; staff recruitment and training files; staff training records; the staff handbook; staff supervision records; some of the policies and procedures; and minutes of staff meetings. We viewed the questionnaire results for 2014, which included responses and comments from 57 people receiving support, 5 relatives and friends, and 53 carers providing support.

We talked with the manager and one of the staff about the projects they were involved in and how these were being developed.

Good

Is the service safe?

Our findings

People who received support told us that they felt safe in their placements. One person told us "I have no worries now and I feel safe"; and "I'm not lonely any more as I have family and friends". Responses to the Shared Lives 2014 questionnaire showed that people felt they were treated equally and fairly by their carers and host families. Carers providing the placements told us that that they had received training which supported them, such as health and safety and lone working. All of the carers that we talked to praised the level of support they were given in caring for people, and one said they knew that they "Only had to pick up the phone" if they required advice or help.

All of the staff and carers were trained in safeguarding adults and knew about the different types of abuse that people could experience. They knew the action to take if they should have any suspicions of abuse, and knew the processes to follow if any abuse was suspected. They were familiar with the Kent safeguarding protocols and how to contact the Kent County Council's safeguarding team.

Carers' files showed that the staff carried out very detailed risk assessments for all aspects of carers' personal, family, social life and health to determine if they were suitable to care for people in their own homes; and risk assessments for their own safety. The staff assessed the risks for every person in the carers' household to determine their suitability for having people who needed support to live in their home with them. This included assessments for the main carer's husband/wife/partner and children. The assessments provided information about their ethnicity, length of current partnerships/relationships; financial management and arrangements; health status; and the facilities provided in the home.

Detailed risk assessments for the carers' homes were carried out before a decision was made about their suitability as carers. These checked the fire safety and emergency procedures in the home, such as smoke and carbon monoxide detectors; exit doors; ventilation; domestic safety; steps and stairs; lighting; noise levels; quality of furniture and furnishings; any out of bounds areas; and any rules about locked doors or gates. Carers were required to have a fire plan in place, which provided details of access to the property and who lived there; escape routes, assembly point, and what to do in the event of a fire day or night.

People receiving support had risk assessments put in place by their social workers. These were appropriate to each individual person, and included risk assessments such as physical limitations within the home such as steps or stairs; wheelchair use; travelling unaccompanied on buses or trains; and support for people with their families and friendships. The risk assessments were reviewed each month by their allocated carer or more frequently if needed, so as to ensure their safety in every aspect of their lives. Any accidents or incidents were reported to the staff by the person's main carer; and there were systems in place to monitor these and check their frequency and why they had occurred.

Kent Shared Lives followed detailed recruitment procedures for their own staff, using an on-line system for the application form. Applicants had checks for their personal identity, a Disclosure and Barring System (DBS) check, written references, and a medical check. They provided proof of their qualifications. Successful applicants were invited for an interview with the manager and two other staff. Where possible, the interview process included a person receiving support, so that they could give their views on the applicant's friendliness and empathy, and how they related to people.

Shared Lives' staff were assigned to specific geographical areas, so that carers and people receiving support were clear about who was maintaining the links with them, and who to go to for help and advice. Staff told us that their caseloads were within levels that enabled them to become well acquainted with the carers and people receiving support; and to carry out meetings and monitoring visits and reviews. Computer spreadsheets showed the details of when review dates were due and when they had been carried out. Reviews were carried out at least annually where there were long term established placements; but more frequently for new placements or for people with changing needs. Carers had three monthly support sessions in their own homes to talk through on-going developments and any learning needs.

Carers were all given training in medicines management before they could have a person to live with them in their own home. The training ensured that they understood how to support people who could manage their own medicines (for example checking if they had taken them, or prompting them to take them); and people who needed physical support with opening packets, or checks that they had

Good

Is the service safe?

been able to swallow them. Carers were trained in the use of 'as necessary' (PRN) medicines, and supporting people with purchasing and taking over the counter medicines where this was appropriate for them. Where people had specific health care needs such as epilepsy, carers were given additional training and competency checks to ensure they could support them effectively with emergency medicines.

Good

Is the service effective?

Our findings

People said they were very happy with the service they received. Some of their comments included, “The service is very good”; “I am happy with it all”; and “ I think it is lovely, I enjoy my life here. Our carers are lovely to all of us”.

Staff told us that they had gone through a two month induction process after receiving confirmation of their employment. This included shadowing other colleagues and working through all the processes for recruiting, allocating and supporting carers for providing care in their own homes. A new staff member told us they had studied the Skills for Care ‘Common Induction Standards’ when they started working with the service, as carers were required to do this training, and it was important that the staff understood the contents of it. (The ‘Common Induction Standards’ are the standards people working in adult social care need to meet before they can safely work unsupervised). The staff member added that going with colleagues for visits to people was the most useful and helpful part of the induction and initial training, as it helped them to see how the different aspects of the service fitted together.

Staff had completed relevant formal qualifications before they were eligible to apply for work with Shared Lives, and were required to carry out additional training where this was needed. Staff files showed they were trained in all of the subjects that carers were required to complete. One staff member said “We need to know everything that the carers are trained in and more, so that we can give them knowledgeable help and advice.” Training subjects included first aid; medicines; infection control; valuing diversity; Mental Capacity Act level 2; and safeguarding adults up to level 5 training. This included knowledge of legislation for safeguarding, and an understanding of the legal processes for restriction and restraint of people. This ensured that staff were suitably equipped to provide advice and support for carers.

The staff carried out training in other additional subjects such as dementia care, end of life care, epilepsy, and sensory impairment. Administrative office staff told us that they also carried out all of this training, so that when people phoned the office for support or advice, the office staff understood their questions and concerns.

Carers were required to carry out training before they were permitted to have people who needed support going to live in their homes. Their training included knowledge and skills in caring, health and safety, safe storage of chemicals, first aid, safeguarding adults, and medicines management. Staff assessed the carers’ ability to communicate clearly, and their understanding of universal precautions in hygiene. They used the ‘Common Induction Standards’ as part of the assessment processes, unless carers had already completed formal training such as a National Vocational Qualification (NVQ) or diploma in health and social care at level 3. (To achieve an NVQ, candidates must prove that they have the ability competence to carry out their job to the required standard).

Carers were required to understand and respect people’s confidentiality, keep clear and accurate records, protect people from discrimination, and support people with their finances. All of the carers that we talked with thought that their training needs were being met. Training events were held regularly and some subjects were accessible online. They said they really appreciated this, as it did not take time out of being at home. One carer praised the service’s thoroughness in new training for carers to support people with dementia, which they said had involved further training being offered to the carers and families, and adding extra information to the documentation.

Staff and carers had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. In Shared Lives services the process involves the court of protection. The registered manager told us that she had asked the providers for additional training in response to the Care Act 2014, to be sure that the service would be following current guidance. Some people receiving support lacked the mental capacity to make informed choices for difficult decisions about their care and welfare. These people were supported through ‘best interest’ meetings with their next of kin, health and social care professionals, and advocates, for any decisions for which they needed support.

Staff carried out detailed processes to find out about carers’ own preferences, so that they could consider all the aspects of people’s lives when matching them to the carers who would be the best for them. This ensured that people

Good

Is the service effective?

who liked activities such as outdoor pursuits, sports, gardening, craft activities, films, cinema and different types of music would be matched as far as possible to carers who had the same type of lifestyles and preferences. This made it easier for people to understand one another and enter into each other's activities and general life. Staff also assessed the lifestyles and preferences of other family members to see if the person receiving support would be compatible with other family members; and checked if people liked pets if this was applicable.

Carers had three monthly support and supervision sessions, which took place in their own homes. These meetings included checks and assessments for their own health needs, family concerns and day to day living; as well as assessments for how well they were supporting people in their care. One carer told us, "The monitoring is good and there is a good network of people giving support"; and another said, "The support from staff is absolutely wonderful". Staff also carried out in-depth annual reviews, when all aspects of care and support were reviewed and discussed.

Carers were required to show their understanding of supporting people with their nutritional needs, and this was discussed as part of their initial assessments. We saw that one carer's file stated, "Cooks mostly with fresh ingredients, and uses fresh vegetables". Discussions took place about the specific needs of people receiving support, to ensure that their carers would provide them with a varied diet suitable for their needs. Carers told us that "The people we have live as part of the family; and we usually all eat dinner together at about 6.30pm". People receiving support had care plan files which showed if they could help to prepare their food, and how much support they needed in the kitchen. Some people had lunch out when they attended college or day centres; and some had individual life goals to increase their knowledge, ability and confidence in choosing and preparing food. One person's file showed that they had been advised by a doctor to lose weight, and had come to a place of understanding of their need to eat smaller portions, to eat healthy foods, and not to have unhealthy snacks between meals. People who received support showed by their questionnaire responses that they liked the food they received and had a choice of meals.

Carers were assessed for their own health needs, and informed staff if they had health scares or health concerns that might entail life changes. Many carers had other people within their family units or friendships who acted as 'support carers' to the people who lived with them, and who had the same checks carried out as the main carers. These people could provide support for people if the main carer became ill or needed some respite from their usual caring responsibilities.

Each person receiving support had a health action plan in place. Carers supported people with attending health appointments such as to doctors, dentists, opticians and chiropodists. Some people required support to attend out-patient appointment at hospitals, or with mental health services. Carers checked with people's doctors and community nurses if they needed on-going health support such as blood pressure checks, blood tests, wound care dressings and flu vaccinations.

Good

Is the service caring?

Our findings

People who received support gave positive feedback about their placements. This included comments such as, "The service I have regarding going to my host family is excellent, fantastic, friendly and fun"; "It is really good"; and "My carer is a very caring person. She understands me better than anyone else, and therefore I can't see how the service can be improved."

Results from CQC sending out questionnaires showed that 100% of people receiving services who responded agreed that "My carer knows how to give me the care and support I need"; and, "The support and care I get helps me to be as independent as I can be." The questionnaires included additional comments such as "My carer has made my life better because she has always been there for me. She always backs me up if I have trouble at work or with somebody at home; she has always been a really kind carer, we have a good relationship." Another person said, "I am very happy, the transition has worked out superbly."

All of the people that we talked with or received information from about Kent Shared Lives gave us positive feedback. Carers said that they felt very well supported and could access support or advice easily, usually instantly by phone or by email in the first instance. One said "The scheme is an absolute success and there are no complaints or concerns". It was evident through our conversations that they cared very much about the person or people who lived with them. One person said "I just want the best possible quality of life for them" and this ethos came through very strongly from others. Another carer said, "She is part of the family". Other comments included, "We enjoy it very much and we have every support"; "If I need advice I just ring them"; and, "Yes we are definitely well supported". Another carer said, "They are absolutely brilliant - I only have to pick up the phone".

We had positive feedback from health and social care community professionals. They said that staff had "An excellent ethos to provide satisfactory care", and that staff often went the 'extra mile' to ensure that carers and people receiving care were properly supported. Another person stated "The staff and managers I have dealt with are very knowledgeable, responsible and most professional in my dealings with them. They seem to genuinely care about the people they work with, and I feel they go over and above their duties in maintaining and improving their services".

Carers were fully informed about the people they were supporting so that they could be effective in their care. This included people's previous life history, their likes and dislikes, and their preferred methods of communication. People's care plan files included details such as 'Likes dance classes, keep-fit and shopping'; 'Likes computer games, playing cards and watching television'; and 'Becomes anxious easily, and needs a calm atmosphere.' This helped to ensure that carers were appropriately matched to people so that they felt comfortable with their carers, and could build up trusting relationships together.

People were encouraged to take part in decisions about all aspects of their care. They were enabled by their social workers to look at details of prospective carers on a computer system, so that they could see what the carer looked like, what the home was like, if it was in the town or country, and if they thought they would get on well with this person. The social worker then arranged meetings to take place, for example, visiting for tea, for an activity, for an evening, or to stay overnight. This enabled the person and the carer to discuss the person's care and support needs and identify if the carer might be the correct person for them. Some people's care plans showed that they needed support to discuss their preferences, and what they hoped for from sharing in family life with others. One of the care plans we viewed stated "I have choice in what I do; my clothes, my food, and where I go."

Support plans included details of people's ability to communicate. For example, a care plan stated that a person needed time to come to a decision and should not be rushed. Another stated that the person could communicate clearly, and could use a mobile phone to contact their carer when they went out. There were processes in place to access advocacy services if people needed support with making decisions, and did not have anyone suitable to help them. The service contacted other services of health care professionals as appropriate for people to have the support they needed. This included services such as 'Advocacy for All', and professionals such as learning disability nurses.

Carers protected people's confidentiality and made sure that people received support with their personal care in private. We talked with a carer who was providing support for three people; and she explained how she supported one person early in the morning to carry out personal care, such as a shower and shave while others were still in bed,

Good

Is the service caring?

as this person went to work early. The other people received personal support one at a time, depending on who was ready to get up first. Support was always given discreetly and individually, so that people's privacy would be respected, and their dignity would not be compromised.

People were encouraged to maintain or improve their independence, depending on their individual care plan. For example, some people had small goals such as putting toothpaste on the brush, changing bed linen, or taking washing downstairs; and they were supported in gradually developing further independence.

Good

Is the service responsive?

Our findings

People told us about the positive changes in their lives through questionnaires, for example, "I can come and go any time before 7pm. I have a choice of stopping out in the afternoon"; and, "I have given up smoking. I eat healthy food. I go on lots of holidays. I am happier". People said they had choice about the time they got up and went to bed, were involved in their care planning, and felt able to say 'no' if they did not agree with something. Carers told us that they supported people to maintain relationships with their family and friends, for example, one said the person visited their mother on Sundays; another visited their family several times a year.

People were supported by their carers and social workers to develop their care plans and to identify the activities and the life style that they preferred. People's care plans had different sections to help them to think about different aspects of their lives. These included a 'My Life' support plan that was written in a style relevant to the person receiving support, and might include, pictures, photographs or an easy-read format. These included a pen picture of a person's 'typical' day, such as the time they preferred to get up; the support that they needed during the day; if they attended a work placement or college; the meals that they liked; their preferred hobbies and leisure; and the time they liked to go to bed at night. Care plans showed if people had a set daily routine, or if this differed, for example, at weekends. Preferences were highlighted, such as if the person preferred a bath or a shower; if they liked to visit family or friends at weekends; if they liked to visit support groups and day centres; and if they liked to be mostly on their own or in company.

Care plans showed that some people had work placements, and provided details of the work they carried out, how they travelled to work and if they needed support out in the community. Some people went to college to learn life skills and other subjects; and some attended clubs and day centres such as Mencap. There were specific details to remind carers of their needs. For example, 'I can communicate verbally but need time to think'; 'I need lots of help with my hygiene and doing my hair'; 'I can make a sandwich but need help with other food'; and 'I can travel locally on buses'. Care plans showed details such as 'Things that make me anxious or upset' and how carers should deal with those situations. Another plan showed that a person could appear 'over-friendly' in the community and be a target for abuse by others, and how this should be avoided. People's preferred hobbies and activities were included, such as 'Likes ten-pin bowling'; 'I like to do art and craft activities'; and 'I need support with my College work'. Social workers and carers worked together with people to decide on new goals and achievements. These might include budgeting and taking more control of their own finances; collecting their prescriptions; and practical skills such as washing up, making their bed and helping in the kitchen.

Carers supported people with maintaining family relationships and contacting their friends. Some people received respite care when their usual carers were unwell or taking a holiday. People were supported in phoning or e-mailing family members and in visiting them. Shared Lives staff completed regular visits to each home, and these monitoring visits included looking at records such as the person's finances, medicines management and daily records; and checks in the home, which included the person's bedroom and a discussion with the person receiving care.

Carers and people receiving support were encouraged to raise any concerns or complaints at any time. People using services were given a guide about Shared Lives which included how to report concerns and the complaints process. This was in an easy-read format for people where this applied. Carers were given a copy of the Kent County Council complaints procedure which showed who they could go to apart from the registered manager and Shared Lives staff. However, carers who responded to our questionnaires and who we spoke to said they would not have any difficulty in raising concerns with the Shared Lives staff, and knew they could contact the office staff or the manager at any time.

The Shared Lives complaints file showed that there had been three complaints dealt with by the staff during the last year, but these were not directly related to the Shared Lives service, and were more to do with helping carers or people receiving support with payment issues and similar situations. The records showed that there were reliable processes in place to support people who raised concerns or complaints, and that these were properly investigated and followed up by the registered manager or other allocated staff.

Good

Is the service well-led?

Our findings

People receiving support, carers, and health and social care professionals, told us that Kent Shared Lives was a professional and caring service. People who received support confirmed that they had received appropriate help in being placed with the right carers, who provided them with the support they needed. One person said "It is an excellent service, I should have done this some years ago."

The feedback we received from carers included, "I have always found this service to be professional, with very knowledgeable and experienced staff, and the service works in a very person-centred way. The service is extremely well organised and the team all work together to provide the best possible lifestyles for service users." Feedback from health and social care professionals included these comments: "There have been some incredible success stories which are really heart warming and show how good person centred support and care can really change people's lives." "It's potential to continue to meet people's growing needs is excellent"; and "Their standards of employment and service provision are a 'gold standard'. The management have good, professional relationships with the team. They are thorough in their assessment and matching service provision process and demonstrate a real purpose and responsibility towards their carers and service users alike."

Staff told us that they had a clear understanding of the service's vision and values, and worked together to provide opportunities for on-going improvements and expansion of the service. This was carried out through monthly team meetings, and structured supervision, enabling staff to discuss topics as individuals and as a group. The manager set the main agenda for team meetings, but staff were invited to add items to this so that they were fully involved in developing the service.

A staff member said that the manager was "Very creative, and can think outside the box." There had been a recent inclusion in the service for enabling people living with dementia to access Shared Lives' services, and giving them advice and support. One of the staff was specifically allocated to this area of support; and was also exploring the use of telecare in this capacity. Discussions about telecare included the piloting of equipment such as pressure alarms and pendant alarms. For example, an alarm could be set for 10-15 minutes for when a person got out of bed during the night and did not return to their bed, indicating there might be a problem. This meant that if a person got out of bed to use the toilet or to get a drink and returned to bed within the set period of time, the person's carer could sleep without being disturbed; but the carer would be alerted if there may be a problem. Some carers had more than one person living with them who was receiving support, and this use of technology prevented them from being disturbed unnecessarily. The manager and allocated staff were looking forward to attending 'Telecare assessor training' as part of this process.

Another new initiative was to look at developing day care service provision for people who needed extra support during the day. This could be used by people in long term placements, those receiving respite care, and people being assessed for future placements. The service was taking action to develop this.

The manager was supporting one of the staff in taking part as a liaison person for a new project, evaluating the value of Shared Lives schemes for older people with dementia. This would be in conjunction with the local authority, looking at outcomes for people receiving support. The project would provide results which could be used through Shared Lives Plus, which is a nationwide network that connects Shared Lives' services. A second phase would be to look at capturing information from carers and people receiving support, in order to provide an effective measure for identifying people's quality of life in relation to others in the general population.

The service had strong links with the local community, including working with learning disability community services, occupational therapy, mental health services, Shared Lives Plus, and advocacy services. This provided a network of care for people receiving support, ensuring that they were assisted in every aspect of their lives.

There was a system in place for obtaining feedback from people through the use of annual questionnaires. These were sent out to a total of 95 people, including social workers, staff, carers, people receiving support, and people's family and friends. The results were analysed and used to bring about further improvements. The responses to the 2014-5 questionnaires were very positive in every section. People receiving support were asked if they were given choice about their lifestyles and activities; if they were supported with being independent and making choices; if they were involved in their support planning, and

Good

Is the service well-led?

if their carers helped them with any problems. Carers were asked if their training needs were being met and if their monitoring visits were helpful. Health professionals were asked questions such as “Are service users/parents consulted about the service they access?” and “Do you have regular meetings or contact with the providers?” The registered manager also asked people to complete an ‘exit’ questionnaire if they left the service, so that their views could be obtained and any relevant action could be taken.

The manager carried out auditing processes as a means of monitoring the service and its effectiveness. This included checks for accidents and incidents to assess if any action could be taken to prevent further issues; and checks to see that staff’s monitoring visits for carers were correctly completed and kept up to date. People receiving support had annual reviews with their social workers, when people had the opportunity to give their feedback about their carer and the service generally.

Carers were invited to quarterly meetings so that they could encourage and learn from one another; and carers were also sent a regular newsletter to keep them up to date with any changes in the service.