Blackburn with Darwen Borough Council

Shared Lives Scheme

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

Summary of findings

Overall summary

This inspection took place on the 13 and 14 March 2018 and was announced.

The Shared Lives Scheme is run by Blackburn with Darwen Borough Council. The purpose of the Shared Lives Scheme is to provide a service that extends the range and quality of support available to vulnerable adults who may have a learning disability or mental health problem, disability and older people. The scheme currently has a portfolio of approved households which provide a range of long-term, respite and day support and currently have 20 people who use the service. There are four staff who manage the shared lives carers. Shared lives carers look after people in their own homes and are responsible for their day to day care.

Not everyone using the Shared Lives Scheme receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection, the service was rated Good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection .

People who used the service told us they felt safe. We saw safeguarding and whistleblowing (reporting of poor practice) policies and procedures were in place to guide staff and carers. All the staff and carers we spoke with told us they understood their responsibilities in relation to safeguarding.

Robust recruitment and selection processes were in place for both staff and carers. We saw the service had undertaken all the necessary checks when recruiting new staff and carers.

Risk assessments had been completed associated with people's health and well-being such as mobility, medicines and personal care. These were designed to keep people safe and not restrict them. Operational risk assessments were also in place to keep staff safe in the office environment. Risk assessments were reviewed on a regular basis.

People were supported to have maximum choice and control of their lives and carers supported them in the least restrictive way possible. The service had made an application to the court of protection for one person.

Prior to commencing employment staff and carers completed an induction. This gave them an overview of the service and an opportunity to undertake mandatory courses (courses the provider had deemed necessary for their roles). Training such as equality and diversity was not a mandatory course, although all the staff we spoke with were aware of the diverse needs of people they were supporting. The registered manager informed us they were addressing training during our inspection and were adding further courses to the mandatory ones..

All the people we spoke with told us they enjoyed living with their carer. People and their carer were comfortable around each other and they were laughing and joking with each other. All the carers were aware of the diverse needs and wishes of people they were supporting. We saw cultural, spiritual and religious needs were discussed and planned for if there was a need.

Support plans in place were person centred. These were very detailed and gave carers and staff a clear picture of the person, their needs and how best to support them. We saw support plans were reviewed on a regular basis with the person.

We saw evidence that people who used the service undertook a broad range of activities such as swimming, bingo and walking. Some people attended college and others attended a day centre if this was what they wanted to do. We also saw that people went on holidays; one person told us they were going on a cruise.

The service had a complaints policy and procedure in place. All the staff we spoke with were aware of this policy and procedure and carers told us if they had any complaints they would approach the staff or management. The registered manager told us they encouraged people to raise complaints if they had any and to be open and transparent.

All the staff and carers we spoke with told us the registered manager was approachable and they felt supported in their roles. The registered manager talked of having an 'open door' policy so that they could be approached at any time.

The registered manager sought feedback from people who used the service, staff, carers and external professionals in order to monitor and improve the service. Surveys were sent out on an annual basis.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained Good.	**Good**
Is the service effective? The service remained Good.	**Good**
Is the service caring? The service remained Good.	**Good**
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

Shared Lives Scheme

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 was a comprehensive inspection which took place on the 13 and 14 March 2018. This inspection was announced. The provider was given 48 hours' notice because the location provides a shared lives service and we needed to speak to people; arrangements needed to be made for people to attend the office during our inspection.

The inspection team consisted of one inspector and one assistant inspector on the first day and one inspector on the second day.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We obtained the views of the local authority safeguarding and contract monitoring team and local commissioning teams. We also contacted Healthwatch to see if they had any feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. No concerns were raised with us prior to the inspection.

During the inspection, we used a number of different methods to help us understand the experiences of people who used the service and their carers. We spoke with three carers and two service users. We also spoke with the registered manager, team leader and two support officers (staff). The role of support officers is to manage the carer's and oversee the package of care.

We looked at a sample of records including three people's care plans and other associated documentation,

two staff recruitment and induction records, two shared lives carers recruitment/induction and monitoring records, training and supervision records, minutes from meetings, complaints and compliments records, policies and procedures and quality assurance audits.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. We asked the registered manager how they ensured staff and carers were aware of their responsibilities in relation to safeguarding. They told us, "Through training and team meetings; safeguarding is on the agenda as it is very high profile. We are always talking to carers to ask if there have been any problems or concerns. The carers come straight to us as they are very protective."

Records we looked at showed staff and carers had received training in safeguarding. One carer told us if they had a safeguarding concern they would speak to the team leader in the first instance. Another carer we spoke with told us they had needed to raise safeguarding concerns in the past, describing the process they followed to keep the person safe. All the carers we spoke with were aware of their responsibilities to report any concerns. Safeguarding and whistleblowing (reporting of poor practice) policies and procedures were in place for staff and carers to refer to if they needed guidance. The registered manager and staff had close links with the safeguarding team within the council.

We checked the procedures in place in relation to medicines. We saw that shared lives carers and staff were trained in the administration of medicines, although none of the carers we spoke with were administering medicines. Records showed that during monitoring visits staff audited medicines to ensure these were being administered, stored and managed safely by carers. The team leader audited these and passed the information on to the registered manager. However, most people within the service were encouraged and supported to self-medicate to maintain their independence. The registered manager had oversight of the monitoring visits and undertook an audit on medicines on a regular basis to ensure they were managed safely.

We asked the registered manager how they ensured recruitment processes were robust. They told us, "We have our equality and recruitment policies which we follow. We have a criteria to shortlist people and ensure it is fair." We looked at two staff and two carer's recruitment files. Both staff and carers had to complete an application form, provide at least two references, attend an interview (and for carers a panel had to approve the decision to recruit), provide identification and go through related security checks such as Disclosure and Barring Service (DBS). DBS checks let the service know if someone had a criminal record or been judged as unfit to work with vulnerable adults. Robust recruitment processes were in place when employing staff and carers.

Risks associated with people's health and well-being had been assessed. We saw risks assessed included personal care, mobility, medicines, fire, finances, falls and food preparation. Risk assessments that were in place were designed to keep people safe and not restrict them. There were also risk assessments in place to keep staff safe in the office environment such as display screen equipment, electrical, fire, noise at work and fall from heights. Again these were in place to keep staff safe whilst at work. On an annual basis, staff undertook basic health and safety checks in carer's homes to assess for general hazards such as slips, trips and falls or fire safety. Whilst some staff did not feel they were fully trained to do this, the registered manager assured us these checks were basic and did not require any specialist training.

Records we looked at showed that some carers supported people with their finances. This was audited by Shared Lives Scheme staff during the three monthly monitoring visits to ensure it was being managed safely and accurately.

Accidents and incidents were managed safely in the service. We saw any accident, incident or near miss had been recorded with clear evidence of the action taken. The registered manager told us, and records we looked at confirmed, accidents and incidents were audited to look for trends or patterns so that action could be taken to reduce them.

The service had an infection control policy and procedure in place. Training was also available through e-learning for both staff and shared lives carers.

Good

Is the service effective?

Our findings

People's needs were assessed by a social worker prior to being referred to Shared Lives Scheme. The service also assessed people to ensure that the matching process was effective and people's needs were met by appropriate carers. One carer told us, "The matching process has worked well for me." Another carer told us, "I feel the matching process is quite long, but it is phased which is a good thing." The matching process consisted of the person's needs wishes, likes and dislikes compared to the carer's considerations; for example if they would consider caring for someone with a physical disability. The person was then introduced to the carer and they were given time to decide if the move was suitable for both of them. This may have consisted of going for a meal at the house a few times, then progressing to overnight stays until such time both parties were ready for the move. This promoted a smooth transition.

Staff and carers both received an induction prior to commencing with Shared Lives Scheme. The care certificate was being used with new carers joining the scheme. The care certificate is considered best practice in health and social care. Carers that had joined the service previous to the care certificate were able to attend any sessions they felt were suitable for them.

Training was done either on a face to face basis or as e-learning. One carer told us, "The training has been relevant and helpful." We saw some training was classed as mandatory (the provider had deemed these must be completed), some which the service recommended to carers dependent on the person they were supporting and some which both staff and carers could do (a choice of 132 courses online). However; training such as equality and diversity, was not a mandatory course and all the carers we spoke with told us they had not undertaken this training. We discussed this with the registered manager who immediately began to review the training, went to see colleagues in the training department and assured us that training as a whole would be looked at and more mandatory courses added.

Staff told us they received regular supervisions and appraisals. They told us these were regular, usually once per month and they were able to discuss any part of their role. Appraisals were held on an annual basis and looked at training and continuing professional development for staff. Records we looked at confirmed what staff had told us. Carers had monthly monitoring visits; these enabled them to discuss the package and any concerns they had.

People were supported to attend appointments such as GP, opticians, podiatrists and dentists. People's health checks were audited during monitoring visits by staff to ensure they had regular reviews with healthcare professionals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The process in shared lives placements is to apply to the Court of Protection to place a restriction on a person.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions under an Order from the Court of Protection were being met. Records we looked at showed an application to the court of protection to authorise restrictions deemed necessary to ensure the person using the service received the care they needed. These applications are made by the person's social worker rather than the service. They were awaiting the outcome of this application; in the meantime care and treatment was being delivered in the persons' best interests.

We saw people's capacity had been assessed and evidence of this was in their care records. We saw for one person it was noted, "[Name of person] is not able to consent to treatment, therefore his GP prescribes in his best interests." We saw social workers had been involved in assessing people's capacity to consent. For those people that were able to consent we saw they had signed documentation within their care records, such as support plans. One carer told us, "I support [name of person] by listening to her as she has capacity to make choices."

All the people we spoke with told us they could eat what they wanted. One person told us, "Last night I had chicken and rice and this morning I had Weetabix." Support plans we looked at showed people's preferences in relation to the food and drink they had. These were very detailed including information such as the amount of support a person required to make a meal or if they could manage certain aspects of cooking. We saw cultural and religious preferences were catered for; for example halal foods.

Good

Is the service caring?

Our findings

All the people we spoke with told us they enjoyed living with their carer. One person told us, "Yes I am happy with [name of carer]." Not all the people we spoke with were able to give us detailed responses but we were able to observe interactions when they came into the office to speak with us. We asked the registered manager how they ensured people who used the service felt they mattered and that carers listened to them. They told us, "By our monitoring visits and in particular our out of placement visits (visits for people away from the home with a staff member) as this is a one to one with the person and any issues they will bring to our attention. Everyone has their own delegated support officer (staff)."

We saw people laughing and joking with each other, talking about what they had planned for the day or week ahead and people were very comfortable in their body language. It was clear that people were happy and carers genuinely cared about the people they were supporting. All the carers we spoke with talked about people they were supporting in a kind, sincere and compassionate manner.

Whilst equality and diversity training was not a mandatory course in the service at the time of our inspection, all the carers were aware of the diverse needs and wishes of people they were supporting. The new care certificate covered equality and diversity for new carers. Support plans were detailed in how best to communicate with a person, for example one person was hard of hearing in one ear so it directed people to speak to them in their other ear. We saw good evidence of people's history and backgrounds in their care records. We saw cultural, spiritual and religious needs were discussed and planned for if there was a need.

We looked if the sexual orientation of people was discussed in order to ensure they were appropriately matched with carers. We saw it was briefly discussed during the assessment stage with the person and it was asked of carers in the matching tool. The registered manager and team leader informed us that if they had a person who came under such protected characteristics they would utilise the community learning disability team as they provided support to people in areas such as sexual orientation, sexual health and sexual awareness. We discussed this with the registered manager who informed us that they would ensure staff documented people's sexual preferences better on the forms and that relevant training was sourced for staff and carers.

Records we looked at showed that people were supported to be as independent as possible. Support plans clearly showed what people were able to do for themselves to promote their independence and what things they required support with. For example if a person could make a meal for themselves or if they could partially make a meal.

All the people we spoke with and carers confirmed that they had their own bedrooms. This was their own private and personal space which they could choose to have decorated however they wished. Carers respected people's privacy and dignity.

Good

Is the service responsive?

Our findings

Support plans we looked at contained a lot of detailed information about the person and were person centred. These looked at the person holistically, for example, in one persons plan it looked at drinking. This showed the person was not able to make hot drinks and required full support, it detailed the person liked tea or coffee and did not need sugar or sweetener. It went on to detail if they liked their coffee/tea strong, medium or weak and if they liked an alcoholic drink. This level of information was maintained throughout the support plans and would support carers and staff to meet the needs of people using the service.

Records we looked at showed that support plans were reviewed on a regular basis between the person, the carer and a staff member. We saw that people had signed their review forms to demonstrate their agreement with the content and any changes made.

We saw support plans also detailed what people liked to do to keep stimulated and prevent them from becoming bored. Records showed that some people attended college during the week or a day centre. Some people attended groups/activities such as craft groups, swimming, bingo, theatre, walking, cinema, gym and beauty salons. One person we spoke with told us they were going on a cruise with their carer; they appeared very excited as they had never been on a cruise before. We saw some people went on regular holidays to Ireland in a cottage. People were very much involved in social activities of their choice within the local community.

We looked at how complaints were managed in the service. We asked the registered manager how they ensured that people who used the service and their carers knew how to make a complaint. They told us, "They are given that information right from the start at recruitment. If they air a concern staff will ask if they want to make a complaint. We are open and transparent because that is how we learn. Everyone is encouraged to use the compliments, concerns and complaints procedure." The service had a complaints file; we noted no complaints had been raised since our last inspection. All of the carers confirmed they had never needed to make a complaint and the person they were supporting had not raised any complaints that they were aware of. People using the service were given the complaints procedure when moving in with a carer. All the staff we spoke with were aware of the complaints policy and procedure and carers told us if they had any complaints they would approach the staff or management.

We checked if the provider was following the Accessible Information Standard. The standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We noted that paperwork was in a format designed for people with a learning disability to be able to understand, for example, the use of pictures and lack of jargon. The registered manager told us they could do any paperwork in this format if needed.

Records we looked at also showed if people had communication difficulties such as loss of hearing. If this had been recorded the plan clearly stated how the carer and staff were to best communicate with the person. The registered manager also told us they had good links with the assistive technology team and if

anyone needed anything at all to support them or to increase their understanding they would be able to seek support from them.

End of life was discussed with people who used the service. This was done in many different ways, for example, very slowly and discreetly with those people who did not like to discuss it. One carer told us, "Some service users don't want to talk about it and some do. Sometimes a family member will talk about it. Sometimes it will be a carer or shared lives staff." Two people who used the service already had funeral plans in place. Staff and some carers had received training in end of life care and were aware of current best practice guidance around ensuring people have a dignified, pain free death. At the time of our inspection there was no one receiving end of life care.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff and carers all told us the registered manager was approachable. The registered manager was a visible presence in the service on a daily basis, although the day to day running of the service was managed by the team leader. One staff member told us, "[Name of registered manager] is always in and out of the office, but she is always contactable." Another comment we received was, "[Name of registered manager] is proactive." The registered manager told us, "I have an 'open door' policy. The staff don't just come to me, I go to them. I ask them if they ok and what they have done for the day." All the staff told us they felt supported in their roles and that communication was good in the team.

The registered manager undertook regular audits of the service to monitor and improve the service. We saw audits included care plans and care records, medicines, accidents and incidents, safeguarding and risk assessments. The registered manager told us audits allowed them to spot themes and trends and highlight any issues quickly. Senior managers also audited the service and the health and safety department also undertook an audit; this further ensured quality was maintained and improved.

Staff undertook a monthly monitoring of the scheme which gave them a clear picture of how placements were progressing and if there were any issues or concerns. Monitoring visits looked at the person as a whole; their health and social needs. For example, they looked to see when people had last seen a GP or an optician and also looked at opportunities to undertake activities. The service also conducted 'out of placement' visits; these were with the person anywhere away from the home, so could be in a coffee shop or a meeting point of their choice. These visits enabled people to speak freely about the placement and if they had any worries or concerns.

Records we looked at showed staff meetings were held on a regular basis. We looked at the minutes of the last meeting and saw discussions had taken place around topics such as training, quality monitoring visits, service users, DBS checks and sharing good news stories. Staff told us they were able to raise things in staff meetings.

Workshops were being held for carers to attend. These were focussing on the care certificate but the registered manager told us once they had completed this the workshops would continue with the focus of being informative and educational for carers.

We saw surveys were sent out to people who used the service, carers and external professionals in order to gain feedback about the service so improvements could be made. We saw the service user survey was in an easy read format so people could understand it and asked questions around their placement. Records we looked at showed nine surveys had been returned and the results of these had been analysed; people's

feedback was positive. Carer's surveys asked questions around the support they received from the service, training and if they felt valued. We saw five surveys had been returned and the results had been analysed; in the main carer's feedback was positive. Surveys to external professionals had been sent out and they were awaiting these being returned.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the registered manager had appropriately submitted notifications to CQC and other agencies.