HF Trust Limited

HF Trust - Leeds DCA

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 24 and 30 May 2018 and was announced.

This was the first inspection carried out by the Care Quality Commission (CQC) for this provider at this location.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to people with Learning disabilities or autistic spectrum disorder, Older People and Younger Adults.

Not everyone using HF Trust receives 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 consider any wider social care provided.

The service was divided into seven clusters and there was a manager for each cluster. Five of the seven managers were registered managers. 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 time of this inspection 71 people were receiving a service from this provider.

Systems and processes were maintained to record, evaluate and action any outcomes where safeguarding concerns had been raised which helped to keep people safe from avoidable harm and abuse.

Risks for people and for staff from the environment were assessed and managed through individual risk assessments. These provided staff with information to help keep both people and themselves safe from avoidable harm with minimal restrictions in place.

The provider ensured there were sufficient skilled and qualified staff to meet people's individual needs and preferences.

Staff had received support with their role through a regular system of supervisions and appraisals. However, staff raised their concerns regarding frequent changes in management and an associated lack of consistent support.

People confirmed they received care and support from regular staff who they knew.

Staff had completed training on the Mental Capacity Act 2005 (MCA) and were able to discuss the importance of supporting people with their independence.

Records confirmed people received assessments of their capacity to make and agree to informed decisions about their care and support. The provider was following the MCA and where people were assessed as not having capacity best interest meetings were held. However, outcomes of best interest meetings did not always robustly record the individual attendees or include copies of their input following the provider's guidance.

Procedures were in place to guide staff on the safe administration of medicines and staff had received medicines training. People confirmed, and the records we checked showed, that people had received their medicines as prescribed.

People received information in a format they could understand. Where people had communication difficulties, staff were trained to ensure their ability to communicate was enhanced.

People received at least annual reviews of their health and wellbeing.

The provider included people or their representatives in discussions regarding the use of medicines where their behaviour may at times, be challenging, and was pro-active in reducing any reliance on them favouring instead other interventions.

The provider had systems and processes in place to ensure staff were appropriately recruited into the service and had the necessary skills and personality to support individuals with their everyday needs and preferences.

Support plans included information to ensure staff were informed and respectful of people's cultural and spiritual needs.

People were supported to maintain a healthy and balanced diet. Care plans contained details of people's preferences and any specific dietary needs, they had, for example, whether they were diabetic, had any allergies or religious needs.

The provider ensured they had close working relationships with other health professionals to maintain and promote people's health.

Staff had a good understanding of people's needs and were kind and caring. They understood the importance of respecting people's dignity and upholding their right to privacy.

There was information available on how to express concerns and complaints. People were encouraged to raise their concerns and these were responded to.

There were systems of audit in place to check, monitor and improve the quality of the service. Associated outcomes and actions were recorded and these were reviewed for their effectiveness.

The provider worked effectively with external agencies and health and social care professionals to provide consistent care.

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.

Systems and processes helped to protect people from avoidable harm and abuse.

People's medicines were managed following national best practice guidance and administered as prescribed.

Sufficient skilled staff were safely recruited to meet people's individual needs.

Is the service effective?

Good

The service was effective.

Decisions made on behalf of people who lacked capacity were made in accordance with the Mental Capacity Act 2005. However, decisions made in people's best interest were not always robustly recorded.

People received information in a way they could understand and this included the use of assistive technology.

People were supported to maintain their health and wellbeing and were supported to attend at least annual G.P reviews to ensure their medicines were still required.

Is the service caring?

Good

The service was caring.

People's individual care and support needs were understood by staff and support plans included information to ensure staff were informed and respectful of people's cultural and spiritual needs.

People's privacy and dignity was respected by staff who understood when to maintain confidentiality and when to share any concerns.

People told us they were treated with compassion, dignity and respect and that they were involved in any decisions about their

care and support.

Is the service responsive?

Good

The service was responsive.

People and their relatives were encouraged to be involved in planning care and support.

Care plans recorded information about people's individual care needs and preferences.

There was a complaints procedure in place and people told us they knew who to speak with if they had a concern or complaint.

Is the service well-led?

Good

The service was well led.

There was a clear management structure in place and staff understood when to escalate their concerns. However, we received concerns from staff regarding changes to management arrangements and associated support.

The service had oversight at provider level. Quality assurance systems and processes with associated action plans were used to maintain standards and to demonstrate a commitment to continuous improvement.

People were involved in shaping the service and helped to drive improvements by attending house meetings and provider led forums.

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Detailed findings

Background to this inspection

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

This inspection took place on 24 and 30 May 2018 and was unannounced.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection process included contacting people and their relatives for feedback by telephone on the 23 and 24 May 2018. We visited the office location on 24 and 30 May 2018 to see the registered managers and office staff; and to review care records and policies and procedures. We visited people in their own homes to discuss the care and support they received and to review their records and to talk with the staff on duty on the 30 May 2018.

The inspection team included one adult social care inspector, one assistant adult social care 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. The expert-by-experience had previous experience with people with a learning disability and autism.

The registered provider had been asked to complete a provider information return (PIR) and this had been returned within required timescales. A PIR 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. We used this information to help plan this inspection.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to tell us about within required timescales.

We sought feedback from the local authority commissioning and safeguarding teams, and Healthwatch Leeds. Healthwatch is the consumer champion for health and social care.

During the inspection, we spoke with the senior regional manager, the operational manager, three registered managers, and eight staff.

We attempted to call 41 people and managed to speak with eight people in receipt of a service and eight relatives by telephone to seek their views. We visited three houses where eleven people received care and support from the provider. We spoke with six people in their own homes who provided feedback on the service they received. We spoke with four members of staff who were on duty in people's homes during our visits.

We reviewed a range of records. This included six people's care records containing care planning documentation and daily records. We also viewed the records for ten staff relating to their recruitment, supervision, appraisal and training. We viewed records relating to the management of the service and a wide variety of policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe in their homes and with the staff who supported them. One person told us, "Staff who support us help to make us feel safe; they are more like friends." Another person said, "We feel safe with all the staff who come and support us in our home, they are nice people and it gives us a good start to our day." A relative said, "I feel that my daughter is extremely safe. She has a regular team that comes in. It is hugely important to me, and to her that this is the case as they help her with all her personal care."

Staff we spoke with had received training in safeguarding adults from abuse. There was clear guidance in place to ensure people were supported to access the community; to keep them safe from harm and abuse or discrimination and to ensure they were treated equally. Staff were clear about signs of abuse to look out for and understood how to escalate any concerns. One staff member said, "If I had any concerns I would go to the manager and explain what had happened. If they didn't do anything, I would go higher. If I considered my concerns to be serious or a person could be at risk of harm I would go to safeguarding or CQC."

The provider had a safeguarding policy and procedure in place that was available for staff to follow to ensure they followed the correct process should a concern require escalation. Systems and processes were maintained that meant any concerns were robustly recorded, included a chronology of events and had clear outcomes. Actions were implemented where changes were required to keep people safe from avoidable harm and abuse. The registered manager told us, "We electronically record all concerns and we don't close them down on our systems without a full investigation and an outcome." Observations of the systems used confirmed this was the case and we saw further oversight was completed by senior management to identify any trends and maintain good practice.

People received assessments to ensure staff had up to date information to support them safely without unnecessary restrictive practices. People we spoke with confirmed their freedom was respected. Assessments identified types of, and severity of risks. For example, one care plan identified a person was unable to manage their own money and could be at risk from financial abuse. A personal protection plan recorded the measures implemented by the provider to protect the person's finances. This included staff training, lone worker assessments, management audits and a clear system and process to enable the person to make purchases and manage their bills. Other plans were in place to mitigate risks from, for example, hazards within the home, areas of risks from abuse, fire, personal care, medication, seizures, choking, mobility and accessing the community. Information was evaluated for effectiveness and updated as people's needs or circumstances changed or as a minimum every three months.

People had personal emergency evacuation plans in place so staff were aware of the level of support people who lived in the houses required should they need to be evacuated in an emergency. All the staff we spoke with were aware of these and told us where to find them. Each house we visited contained a health and safety folder; checks had been completed for the fire alarm, smoke alarm, water temperatures, first aid kit, and gas safety certificates. We saw these files were audited on a regular basis to ensure information was up to date and people's homes remained safe.

Staff had access to relevant information to support people safely. Support plans included a positive behaviour support (PBS) plan. Behaviour that challenges usually happens for a reason and maybe the person's only way of communicating an unmet need. PBS helps providers understand the reason for the behaviour so they can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen.

People received an assessment and a support plan was formulated to ensure they received appropriate levels of support to understand, and take medicines as prescribed. Some people were prescribed Psychotropic medicines because their behaviour is at times, seen as challenging. Psychotropic medicines affect how the brain works and include medicines for psychosis, depression, anxiety, sleep problems and epilepsy. The provider included people or their representatives in discussions regarding the use of these medicines and was pro-active in reducing any reliance on them favouring instead psychosocial or other interventions.

People received their medicines safely as prescribed by staff who had received training in and were deemed competent in this role. Medication Administration Records (MARs) were completed robustly and these records were checked as part of weekly medicines audits. This ensured any omissions or errors could be appropriately investigated and any learning shared to ensure people received their medicines as prescribed. One person told us, "I take lots of medicines and staff help me with them."

Accidents and incidents had been recorded and investigated in line with the provider's policy and procedures. Where required the provider had completed their duty of candour; responding to individuals to share outcomes and to apologise where necessary. There were comments about any action which had been taken to manage the risk of the situation re-occurring.

We observed there were enough staff available to meet people's needs. However, we received mixed feedback from staff we spoke with. Comments included, "We have enough staff, not always enough core staff at the house but we can rely on bank staff to help out." And, "There are enough staff but we have a high turnover." And, "I think people sign up thinking the role will be like a normal domiciliary care service; it isn't there is so much more involved so they [staff] don't stay" People and their relatives told us they received continuity of care from regular people who they knew and who understood their needs.

The provider ensured staff were selected and recruited safely and wherever possible people were involved in the process to ensure compatibility and that staff had the appropriate skills and mutual interests to meet their needs. For example, the provider told us, "If a person likes swimming then we need to ensure they are supported by somebody who also likes swimming and can swim." Checks were completed before staff began work. This included checks on previous employment by obtaining a minimum of two references, and the completion of a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Good

Is the service effective?

Our findings

People told us they were happy with the care and support they received and that staff had the appropriate skills and knowledge to meet their needs. A relative commented, "My daughter needs full help with everything unfortunately, but I do think the staff are well trained and meet her needs." Another relative said, "Staff are usually well trained. Occasionally, there is a lack of knowledge around the new staff supporting people with autism but everyone has to learn and they are usually shadowing a more experienced member of staff."

Staff were supported by the Learning and Development team to complete a three-day face to face induction with people in their homes. All staff had completed the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. This meant staff had the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

The provider ensured staff received support to maintain and update their skills and knowledge with a range of training provided. This included training the provider considered mandatory for example safeguarding, communication, personalised technology, learning disability positive behaviour support, fire and health and safety, and training specific to people's individual needs. This included dysphagia and autism awareness. Dysphagia is the medical term for swallowing difficulties. Staff told us, "Training is readily available and we are monitored to ensure we are always up to date." And, "I learned about the house and the people that live there. I did face-to-face training; that was 3 days and I completed safeguarding, and about our role. We also did the Knowledge Centre training (E-learning), lots of further face to face training, commitment to partnership and practical moving and handling."

Staff told us, and records confirmed the provider completed spot checks and observations on staff to ensure they were competent whilst they completed their role. This included observations of every day work, moving and handling and medicines administration. Outcomes were discussed as part of regular supervisions and appraisals. Where improvements were required staff were supported with further training to ensure they followed best practice and national guidance. One staff told us, "The supervisions are regular and are an opportunity for us to discuss any concerns and our progress."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The MCA applies only to people over the age of 16. Applications to deprive people of their liberty in domiciliary care services must be made to the Court of Protection. We checked and found the service was working within the principles of the MCA, and any

conditions on authorisations to deprive a person of their liberty were being met.

People's mental capacity had been assessed for some decisions. Where people were found to be unable to make decisions for themselves a best interest process had been followed. This was in line with the MCA code of practice. However, we found information to record who had attended the best interest meeting and their input was not always consistently recorded for all decisions. The provider showed us a completed form with the required information and told us they would review this practice to ensure records of individuals involvement in best interest meetings was robustly recorded to ensure any decision taken on behalf of someone who used the service was in their best interests, and was the least restrictive decision.

People were supported to maintain their health and wellbeing. Care records demonstrated people received input from health and social care professionals including, opticians, audiologists, mental health teams, occupational therapists, and palliative care nurses. People had been supported to access comprehensive annual health assessments and any follow up required.

Guidance was available for staff who accompanied people with a learning disability, autism or both to help them prepare to visit a GP or consultant appointment to talk about psychotropic medication. A staff member confirmed, "The guidance is a useful checklist to ensure we take everything we need to the review and that people understand the process." The provider confirmed their awareness in reducing reliance on psychotropic medicines to control people's behaviour and the importance of using alternative approaches. The provider told us, 'It has made a difference to [person's name] as they are more aware of what is happening in their life and they are eager to attend voluntary work again. [Person's name] retired form voluntary work but is now being supported by staff to find employment.'

Feedback had been sought to record people's religious needs to ensure they were not eating food that was against their religion. Staff confirmed an awareness of this information. One staff member told us, "[Person's name] follows a Halal diet. They make their own decisions around their meals and we support them to prepare whatever they choose."

Support plans included information to help staff provide people with healthy eating options. Where assessments identified concerns regarding people's weight; monitoring tools were used and referrals made to dieticians. Where a person had difficulty swallowing, we saw a referral had been made to a speech and language therapist and associated guidance implemented to ensure the person's food was pureed to aid swallowing. A relative told us, "Staff support [person's name] to cook and make sure that everything is safe as they do it. They also make sure that they are buying balanced dietary food items. There is a good relationship."

Good

Is the service caring?

Our findings

People told us they received a service from caring staff. Observations at people's homes we visited confirmed staff treated people with kindness and were respectful of their wishes and preferences. One person said, "I like to chat with all my staff. I find them all kind, considerate and caring." A relative confirmed, "[Person's name] has a very caring staff team. They are treated very well and they provide them with their privacy when they want it. I feel better now they are there and I have full confidence in the staff team; knowing that they are being cared for properly."

Support plans recorded information to ensure people were supported equally but accordingly with any diverse needs. Where people had religious preferences, discussions with people had been held and their associated preferences followed. People were supported to access the community, attend social events and live fulfilled lives.

Staff received training in, and understood the importance of maintaining people's dignity and privacy and ensured that where ever possible they promoted people's independence. One staff member told us, "When I support people, I am visiting them in their own homes. I always knock and wait to be invited in and I always ask if I need to use their toilet." Another staff member said, "I communicate everything I am required to do with people, to gain their understanding and acceptance and promote them to do whatever they can for themselves. For example, when providing personal care such as bathing, I make sure the door is closed, that the person washes any areas they can and that warm towels and clean clothes are available. If they want some time on their own; that's fine as long as they are safe."

People's records were stored securely and access was limited to staff who required the information to carry out their roles. Staff understood the need to maintain people's confidentiality and told us they would only share information discussed if the person was at risk of harm, abuse or required medical attention. One staff member said, "I have all sorts of conversations with people about all sorts of things; they are confidential and I would not discuss anything with anyone unless the person gives their consent to talk about it."

It was clear from care records and from talking to people that they could express their views and be actively involved in making decisions. A relative said, "Staff can only advise [person's name], they can't tell her what to do and they don't try. They do prompt and provide sensible advice." One person said, "They [staff] are good. They come in and help us. They listen to us and they are easy to talk with. I feel that I can always ask them to do a bit extra if we need them to and it has never been a problem."

Staff described how they understood that some people may need constant reassurance and told us how they responded appropriately. A member of staff said, "One person was worried about getting a filling at the dentist. They were worried about the needle. I explained that they would make it numb and that it would just take a minute. I explained if they didn't have the filling, their tooth will get sore. I always say 'is this okay with you? Please tell me if there's something that's not okay'. With this reassurance the person attended and had the filling." Another staff member told us, "I work with a person who often gets worried about going to see a psychologist, I tell them it's their choice. People can get stressed when pushed into anything so it's

important we are patient, show understanding and let the person decide."

Staff received training in effective communication and specific communication methods such as Makaton and the use of Picture Exchange Communication Systems (PECs) to enable people to communicate effectively and be understood. Support plans were in place and were specific to people's needs and abilities. We saw information for staff to follow in relation to how they should engage with people. This approach meant staff provided responsive care to people who had communication difficulties and recognised they could still be engaged in interaction and making decisions. Where people required further independent guidance and support to make informed decisions the provider engaged the use of advocates and their input and advice to enable people to make choices regarding any decisions was recorded.

The registered manager discussed how two of the people supported by the service had worked with the local 'Clinical Commissioning Group' within Leeds to create accessible documentation and documents to support providers to meet the Accessible Information Standard (AIS). AIS is a framework put in place by the National Health Service (NHS) from August 2016, making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Where people required this support care records included examples of pictorial communication methods to ensure people could understand, contribute and agree to their care and support.

Good

Is the service responsive?

Our findings

Everybody who received support and care from the provider received an assessment of their needs prior to joining the service. This was to ensure the provider could meet and respond to people's individual needs. The initial assessment formed the basis of a support plan. The support plan provided detailed information about the person, their needs and preferences, what they could do on their own and what areas they required support with. Staff told us, "Support plans are a good source of information; they enable us to formulate a picture of how we need to support someone and detail anything we need to do to make sure they are all treated equally."

The provider ensured information recorded was in an accessible format. They showed us training material that was used for staff to follow to ensure support plans were written in a format that people could understand. This meant people could contribute and improve the service they received; to focus on their abilities. We observed some care records had been completed by videoing the person. This made the experience fun and engaging for the person whilst providing informed records that included the person's likes, dislikes, medication types and how to support the person including appropriate methods of communication. One person showed us their video care plan during a visit to one house. The person also showed us how the use of assistive technology enabled them to boil a kettle and make a hot drink with limited assistance. Staff told us how technology assisted them to help people to live life the way they choose and to encourage their potential and independence.

People understood and had contributed to their support plans. Comments from people included, "I do have a care plan. It is in my support file in the office. I am happy with my care." and, "I'm not good at some things so I need the support. I have a plan for staff to follow and I have input into it." And, "I am very happy living here. "Yes, I have a care plan that's kept in the office. I can look at it when I need to and it is updated when needed." Where people were unable to discuss their backgrounds or with their agreement discussions had been held with close relatives or with friends who knew the person, their background and history. A relative told us, "We have meetings about our daughters' care and support and update the care plan every year. I can ask them [provider] anything, anytime. If we are concerned, they [staff] ring up and they do listen to our opinions on things. Communication is really very good." Another relative said, "We are involved in our sons care plan and we can add things to it if we feel it is necessary. It is reviewed every year as well. They take him shopping and the staff are very good. Nothing is too much trouble for them."

The provider supported staff to treat people as equals and ensured their care was appropriate to them as an individual. Staff received training in equality and diversity and how to support people with diverse needs. There are nine characteristics protected under the Equality Act 2010. These are: Age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. Support plans recorded information for staff to follow to ensure people with protected characteristics were supported. People were supported in following their choices be they religious, cultural or lifestyle. Examples included how staff respected people's homes and religious and cultural preferences. A relative told us, "My daughter goes to a Christian church and the staff are fully supportive of her spiritual needs. She also goes to a fellowship meeting once a month. Staff are always very respectful."

Support was given to people with disabilities to ensure they participated in a lifestyle that was meaningful and enjoyable to them. One staff said, "A lot of people we support are independent in their own way; different abilities and personalities and they all have their own personal preferences. We adjust our support to each person to ensure everybody has the best quality of life." Support plans included intervention and assistance from occupational health professionals to ensure equipment was provided that was safe and appropriate to enable people to mobilise and access the community without unnecessary restrictions.

People were supported to maintain relationships and encouraged and supported to access groups in the community, go on trips and holidays. A relative told us, "It's been brilliant recently. There have been things for [person's name] to do each evening. The only thing that stops him participating is because he runs out of money. He goes to the outdoor market, he goes to the nature reserve, which he adores. He plays darts and dominoes, and pool; he is very busy with various things. He goes to concerts and he is a member of a walking group too.

The provider had a complaints policy and procedure and guidance was available to help people raise their concerns. This was available in pictorial format and people were assisted with the process. Any complaints were recorded and evaluated electronically and included duty of candour that demonstrated the provider took any feedback seriously, acknowledging any concerns, responding, investigating and providing mutually acceptable outcomes. The provider told us complaints were evaluated monthly with outcomes and 'lessons learnt' discussed at team meetings. This helped reduce similar complaints in the future. One person said, "I did complain once, a while ago, but it was all dealt with and sorted out very much to my satisfaction."

The provider discussed the sensitive issue concerning end of life care with people. They told us in the PIR, 'End of life is a sensitive subject and where people do not wish to discuss this at present, this is evidenced and approached again at a later date.' Support plans confirmed discussions had been held and where people had agreed information regarding their wishes and preferences was recorded. Staff had access to and where appropriate had completed training in end of life care.

Good

Is the service well-led?

Our findings

The service was led by a senior regional manager who was supported by an operational manager and a team of administration assistants. Homes where people lived and received a service were individually staffed and were grouped into seven clusters. There was a registered manager for each cluster. 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.

We received mixed feedback from staff regarding the way they were managed. Staff comments included, "It feels as though the staff are on call, but managers aren't always on call. They try to be supportive as much as they can; they have a lot on their plate." And, "I've had several if not more changes of managers, we don't have the consistency. Things may be flagged up but then that managers left. The next manager, it takes them six months to get it flagged up." "My big bug bear is the management change and we don't seem to get the consistency. It's very hard if you get a new manager every year. We feel pressured. I'm very person focused." And, "The manager is very approachable and professional. She knows how to deal with individuals. She's a good manager."

The provider told us they regularly sought feedback from staff about their role and job satisfaction. They told us they held team development days to help with staff and management cohesion. We saw minutes of staff team meetings which provided staff with an opportunity to contribute to the development of the service. Because of our feedback the provider discussed other options they would consider implementing. For example, obtaining anonymous feedback using staff questionnaires and surveys, to identify areas where improvements could be made.

The provider had implemented a 'Fusin Award' to celebrate innovative thinking to overcome barriers to improve people's lives. The award was based on staff completing a nomination form and we saw submissions where staff had supported people to achieve positive outcomes. For example, promoting and supporting people to regain their independence; losing weight, returning to work and managing their own finances.

The provider communicated information and sought feedback from monthly management meetings. We looked at the minutes from the meeting held in April 2018 which recorded discussions about a Health and Safety visit, previous meetings minutes and standard agenda items for discussion and feedback. A registered manager we spoke with told us they found the meetings useful, informative and enabled them to share and implement best working practice.

People living in homes that were shared with other people held tenant's meetings. This enabled them to set up and discuss cleaning rotas, raise any concerns, discuss refurbishment and put forward their ideas for improvement. Minutes of a meeting held in March 2018 recorded feedback from people regarding a new resident to the house, activities and events people had attended and enjoyed. The information was in an

effective format that included pictorial images, photos and text in a format that people could understand. One person told us, "I enjoy the meetings; we all get together and have a good discussion."

The provider actively encouraged and supported people to shape the service. One person discussed with us their attendance and involvement in a group called, 'Voices to be Heard'. They told us this was held monthly at a central venue in Leeds which was accessible to and driven by people receiving a service from the provider. We saw these events were very well attended. The person told us they met up with friends from other houses and guest speakers attended. The previous meeting included information about diabetes. The next meeting was scheduled to include a local fire officer to have a talk about fire safety that people had asked for at the last meeting.

As part of the legal requirements of their registration, providers must notify us about certain changes, events and incidents that affect their service or the people who use it. Prior to the inspection we checked our records and we found the provider had submitted the required notifications.

The provider showed us how they maintained and improved standards and performance at each home using quality assurance checks and audits. Weekly audits were completed to check medicines management and administration followed national best practice guidance and ensured people received their medicines as prescribed. A compliance action plan assessed each home, the service provided, and staff compliance. This included fire safety, food hygiene, health and safety, and personal money, and checked staffing levels, training, supervision and appraisals.

Managers completed a further compliance tool which was linked to the CQC domains; safe, effective, caring, responsive and well-led. Each area had a traffic light colour for performance outcome ('Red for immediate action required', 'Yellow meets basic compliance' and 'Green for improving') and stages of completion of any actions. This tool had further oversight from senior management. Senior management completed checks to ensure any accidents, incidents, safeguarding, concerns or complaints were recorded, evaluated and duty of candour completed. Outcomes were monitored for trends across the wider provider area. The operational manager told us this would give them a bench mark as to how they were doing within the whole provider organisation.

The provider confirmed they ensured managers were signed up to receive regular newsletters from CQC, Skills for Care and other organizations to ensure they remained up to date on any changes in regulation, legislation and best practice.

The provider worked closely with the various local authority services and departments involved with people's care and support. This included the commissioning team, occupational health, the safeguarding team and community mental health teams. This meant people were supported with continuity of care should they need to transfer between services. For example, in and out of hospital.