HF Trust Limited

HF Trust - South Oxfordshire & Berks 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

The inspection took place on 11 and 18 April 2016 and was announced with 48 hours' notice.

HF Trust – South Oxfordshire and Berkshire Domiciliary Care Agency (DCA) is registered to provide personal care. The agency office is based in Milton Heights in Oxfordshire. The service provides support to adults living in eight shared living accommodations in South Oxfordshire and Berkshire. Support can range from a few hours each week based around provision of activities, to twenty four hour support for all aspects of personal care and daily living. At the time of this inspection 25 people were supported by the agency.

The service had 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.

People felt safe and their relatives also felt their family member was safe in the service. Processes were in place to make sure people received their medicines safely. Staff recruitment procedures were thorough and ensured people of good character were employed. Staff were provided with relevant induction and training to make sure they had the right skills and knowledge for their role.

Risks associated with people's care and support had been assessed. Clear guidance was in place for staff to ensure people remained safe and were supported to be as independent as possible and participate in household tasks and access the community safely. The service had safeguarding procedures in place and staff had received training in these. Staff demonstrated an understanding of what abuse was and how to report any concerns in order to keep people safe.

Staff were knowledgeable about the people they supported and had access to development opportunities to improve their skills. Staff received support they needed to carry out their jobs safely and effectively. Staff were confident in the way the service was managed.

The service followed the requirements of the Mental Capacity Act 2005 (MCA) and the principles of the Deprivation of Liberty Safeguards (DoLS). This helped protect the rights of people who may not be able to make important decisions themselves.

The service was highly responsive to people's changing needs. People's preferences were sought and respected throughout the whole planning process. We saw all people had a comprehensive person centred plan which they reviewed with staff support at regular intervals. People told us staff provided consistent personalised care and support. We noted care records were focused on empowering people to have control of their lives. People had been involved in developing their support to ensure it was person centred and flexible to suit their individual needs. People had opportunities to express what they wanted out of their lives and staff ensured that where possible, these aspirations were achieved. These included who they wanted to

live with and to celebrate significant events in their lives, such as attending family events and going on holidays they had expressed a desire to do. People were encouraged to retain and gain skills to ensure they had as much independence as possible. There were opportunities for people to gain work skills and attain a qualification to use for securing work. People were promoted to live full and active lives and were supported to go out and use local transport and facilities. People were involved in groups to ensure their views were taken account of at a local and national level. People had also had the opportunity to discuss their care on a one to one basis.

People were involved in regular reviews of their care and support where they were able to discuss any changes they wanted in their care or support. We spoke with people and their relatives who said they could speak with staff if they had any worries or concerns and they would be listened to.

There were effective systems in place to monitor and improve the quality of the service provided. Regular checks and audits were undertaken to make sure full and safe procedures were adhered to. People using the service and their relatives had been asked their opinion via surveys, the results of these had been compiled in an action plan if improvements were identified.

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. People told us they felt safe.

Staff knew how to keep people safe from the risk of abuse and harm.

People were supported to take their medicines when they needed them.

People had up to date risk assessments and regular reviews to ensure information was relevant to keep them safe.

Is the service effective?

Good

The service was effective. People were supported by staff that had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff supported people to maintain good health by assisting them to access healthcare professionals when needed.
Is the service caring?

Is the service caring?

Good

The service was caring. People reported that staff were kind and caring and they were treated with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

The service was good. People and their relatives were involved in developing care plans which provided clear guidance for staff on how to support people in the way they wanted.

People received care that was individually tailored to their specific needs and helped to achieve their wishes and hopes.

The service was striving to make people's experience of care as

positive as possible by engaging them in all processes.

People knew how to raise concerns and were confident action would be taken.

Is the service well-led?

Good

The service was well led.

The registered manager had systems in place to monitor the quality of service. Learning was used to make improvements.

The service had a culture of openness and honesty. Staff felt communication from their managers was clear and were positive about the leadership.

HF Trust - South Oxfordshire & Berks DCA

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 11 and 18 April 2016 and was announced. We told the registered manager two days before our visit that we would be coming. We did this because we needed to be sure that they would be available to show us the records.

This inspection was undertaken by one inspector and an Expert by Experience who telephoned people who used the service and their relatives to obtain their views. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received about the service and notifications submitted by the service. We asked the provider to complete 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 returned as requested.

This information was reviewed and used to assist with our inspection. We visited the office and spoke with the registered manager, an area manager, two service managers, two senior support workers and two support workers. We also sought feedback from external professionals. As part of this inspection we met with three people supported by the service at the office. We visited two shared living locations and spoke with three people at their premises. We also spoke with 11 relatives. We spent time looking at records, which included five people's support plans, four staff recruitment and training records and other records relating to the management of the service, such as quality assurance audits and reports.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments included, "Yes I do" and "I feel safe". We spoke with relatives of people in the service and we received comments including, "My [relative] does feel safe. They have had the same carer for many years and the continuity makes them feel safe" and "Yes, the same staff have been there for years and that makes me feel he is safe".

People were supported by sufficient numbers of staff. Most people were living in shared housing and received 24 hour support. Staffing levels were determined by a person's needs and the rota was then devised to meet their needs. This was reviewed annually, and if support needs changed, re-assessments were carried out. For example, one person's health needs had declined due to epilepsy, so extra hours were agreed to ensure their safety.

The registered manager was familiar with the process required to follow if any abuse was suspected. The provider also had an internal safeguarding log, which was audited to see if any trends or patterns were present. The log was person centred and people were asked what they wanted to achieve following an incident. People were asked again at conclusion if they were happy with the outcome. The training record showed staff received regular safeguarding training and the staff confirmed they had an understanding of their responsibilities how to protect people from harm.

The service had an organisational policy on safeguarding people that reflected the local authority's procedures. This gave a clear guidance to staff about how to report to the safeguarding team, including relevant contact numbers. This was read by all staff to ensure they knew how to keep people safe and take appropriate action if concerns about a person's safety had been identified. Staff could describe the different types of abuse and were clear of the actions they should take if they suspected abuse or if an allegation was made.

The service had a whistleblowing procedure. Whistleblowing is a way in which a worker can report concerns, by telling their manager or someone they trust. This meant staff knew how to report any unsafe practice which may harm people. Staff said they would always report any concerns to the most senior person on duty at the shared living locations or to the manager at the office. All staff felt confident that senior staff and management would listen to them, take them seriously, and take appropriate action to help keep people safe. Staff knew they could contact other external organisations, such as the Care Quality Commission (CQC) if they felt their concerns were not been acted upon.

People were kept safe by staff employed with thorough recruitment procedures. We looked at four staff records which all contained a completed application form detailing employment history, proof of identify, two references and interview notes. All records contained evidence of a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the service. Staff confirmed they had been requested to provide references and a DBS check was completed prior to them working alone with people.

People were protected from the risk of financial abuse by systems that were in place to monitor the management of their finances, where applicable. Risk assessments were completed to keep monies safe and to assess if people could have total control over their finances with no input from staff. Monthly reconciliations were completed by managers not involved in the individuals support. People had signed consent forms to show that they agreed to staff supporting them with their money.

People received their medicines safely. A relative commented: "They do give the medication safely. They have a log book and it is signed each day". There was an up to date medicines policy in place with guidance on administering and recording medication including non-prescribed 'as required' medication. Training records showed staff that administered medicines had been provided with training to make sure they knew the safe procedures to follow. Staff were knowledgeable on the correct procedures on managing and administering medicines. This showed that staff had understood their training and kept people safe. The registered manager and service managers said that Medication Administration Records (MAR) were completed for each administration. We saw MAR charts provided from two shared living locations and found they had been fully completed. The medicines stock corresponded with the details on MAR charts. People had signed consent forms to show that they agreed to staff supporting them with their medicines. Some people had been assessed to allow them to administer their own medication. Medicines were checked independently by an independent pharmacist every 18 months.

People were protected in the event of an accident or incident. Accidents, incidents and near misses were recorded on an electronic system so that patterns could be monitored and action taken. The accident and incident policy had clear guidelines about procedures for staff to follow. We saw an example of a potential incident because of slippery steps going into a house. We saw that this had been actioned by having non slip treads fitted to the steps to reduce risks to people. A health and safety report was completed quarterly and went to the provider's health and safety executive board who monitored all the reports and the outcomes. We saw the last audit was completed in February 2016.

People's individual risks to their health and safety were assessed. The records identified the risk and actions needed to manage these. For example, we saw a risk assessment for a person who had epilepsy which stated when out in the community, they must always have their 'crash bag' which contained emergency medication with them. We also saw that a person who had a skin condition had advice on their risk assessment to ensure it was monitored and reported if deterioration occurred.

All premises had a 'disaster plan'. This explained what would happen in the event of an emergency, such as no electricity or fire. Premises also had regular safety checks including hazardous chemicals, electrics, first aid equipment and fire checks and these had been regularly audited.

Good

Is the service effective?

Our findings

People spoke positively about the staff ability to meet their needs. Comments included, "[Name] helps me with my medication" and "I was helped with bus training". All of the family members we spoke with said the carers seemed well trained and skilled to meet their relative's needs. A relative told us, "Yes, they seem to know what they are doing. They are well trained".

Staff received a comprehensive induction before they started work with people in the service. Most staff had been trained to deliver Person-Centred Active Support (PCAS). This focussed on engaging people in all aspects of their lives, promoting independence and choice. The provider had also developed a model of support called 'Fusion'. This model ensured that people were at the centre of everything the service carried out and included what support was given. Staff said the training was very in depth and helpful. The training was followed up four weeks later with an observation and feedback session. The training staff undertook reflected the Care Certificate's requirements. The Care Certificate is an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

People were supported by staff that had good knowledge and received training appropriate to their roles. Staff received regular training, which included safeguarding, manual handling, food hygiene and fire safety. A staff member told us, 'If needs are identified, then training is arranged. I've had diabetes and pressure area care training recently'. A relative commented, "My [relative] needs the hoist and I have seen them use it in a safe manner and with skill". A system was in place to identify when refresher training was due so that staff skills were kept up to date. A member of staff commented "I feel the training is good and I have received all the ones I need to do the role".

Staff told us they felt supported by their managers. Managers attended leadership training tailored to their roles including supervision skills and managing poor performance. They exchanged relevant information about the service and other changes to keep staff updated. We saw most staff had regular supervision meetings. A staff member said "Yes I have regular supervisions and we discuss the people we support but also personal development and health and safety". A couple of service managers acknowledged that they were behind slightly on supervision meetings, but had scheduled these in. This had not impacted on the staff as they said they could approach management at any time and there was an 'open door' policy. Staff had appraisals annually, which gave them the opportunity to reflect on practice and development and set targets.

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 application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had reviewed everyone to see if any needed DoLS applications. Two people had been considered as needing applications and these had been applied for

The registered manager and the staff had a good understanding of the (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had received training on the MCA and DoLS. This meant they were able to ensure people had choices and their rights were protected. Information on how the MCA affected other areas of care such as medication and safeguarding were embedded into the policies. Staff we spoke with were able to explain clearly how they used the MCA in their work with people to ensure they could make their own decisions where possible. We saw examples of where people were supported around decisions. One record stated a decision specific assessment around choice of a holiday. It detailed that the person had looked at holiday brochures, had discussed verbally and was shown pictures to enable them to make a decision about where to go. We also saw an example of capacity assessment around moving to new accommodation for one person and also a best interest decision about using photographs to enable staff to monitor a person's skin condition.

We observed staff interacting with people and we noted they sought permission before giving support. For example, a person whose speech was difficult to interpret was asked by the staff member if they wanted them to assist with answering. When we visited people in their home, permission had been sought from them prior to us visiting. People had been consulted about their care and treatment needs and had agreed to the support provided.

People were involved in planning their meals and some helped with the shopping. A relative told us, "On a Sunday evening all of the lads in the house meet up with the carer and discuss their menu for the week". People were encouraged to eat healthily and have a balanced diet, but also had the option to have foods they chose. For example, one person was keen on having the same sandwich each day and staff were aware to make adjustments elsewhere to ensure the person received all the nutrients needed. People were encouraged to make their own lunch and take part in cooking. Comments included, "I make my sandwiches". People who needed support with their feeding were well supported. A relative commented, "My [relative] cannot feed herself but they are very good at feeding her. They take their time in doing so".

People's health care needs were documented in the support plan and a hospital passport. Health action plans showed people were supported to access professionals such as GPs, dentists and opticians. We saw referrals to specialists around changes in behaviour and we noted the advice from this appointment with suggestions around supporting the person was incorporated into the care plan. We also saw referrals were made for people to access services such as neurology, psychiatry or dermatology. This meant the service had made appropriate arrangements to assist people to manage their health conditions when required.

The support plans contained guidance for staff on how best to monitor and support people's health. Staff were aware of people's healthcare needs and knew how to recognise any early warning signs of deterioration in health. Personalised information on specific health conditions was included, along with the actions required of staff to support the person. For example, we saw that one person had a family history of bowel cancer and it stressed the need for regular screening for the person to monitor this. Each person had a communication passport that described, in detail, how the person needed to be supported with communication and what was important to them. The passport reflected any health professional's input and potential hospital visits.

Good

Is the service caring?

Our findings

People told us and we observed staff were caring. One person commented, "I'm happy". Another person said, "They are very nice". Throughout the day of the inspection, people came into the service office to make themselves a hot drink and have a chat with the registered manager. One person sat at a table in the office looking through photographs and told us that they liked to do this each day. Interactions we witnessed were respectful and warm.

Staff knew people well and their description of people they support matched what was detailed in the support plans. Relatives we spoke with were positive about the caring staff. Comments included "My [relative] has a good team who care for her. She likes to know her carers so when one is off they supply a good back up who knows her well". Another said "My [relative] is in a house with two others he tells me the carers are very kind to him they take him to snooker and to church".

People's records included information about their personal circumstances and preferences and goals, and how they would like their care and support to be delivered. The plans also focussed on promoting independence and encouraging involvement safely.

People's communication needs were considered. For example, how they expressed wishes and made choices and any issues around capacity. If assistance was needed with communication, speech and language advice was sought. People were encouraged to take an active part in shaping their support. This was through one to one support with staff, through person centred planning, involvement in recruitment and meeting people they live with to discuss 'house issues' including decoration.

People's independence was promoted and people's opinion was sought. Where possible, people were encouraged to do as much as possible. A relative confirmed, "The carers do prepare it [meals] but my [relative] helps. He has chores such as helping to peel the potatoes". Another relative said, "They encourage my [relative] to do things for herself like her laundry". This meant the staff were aware to promote people's independence and to retain and improve their skills whenever possible. We saw people's independence was further enhanced by having risk assessments so that people could go unsupported when safe. For example, we saw a risk assessment for a person to use public transport and to attend church unsupported.

People were treated with dignity and respect. Relatives confirmed this. Comments included, "They are superb they absolutely do respect his privacy and dignity". Staff respected people's right to confidentiality with regards to personal records and information about them. This was handled sensitively in respect of sharing information with relatives and balancing this with the person's privacy. We did not observe any staff discussing any personal information openly or compromising privacy. Staff received training on 'Professional boundaries and decision making'. This taught staff the balance between being caring but remaining professional. Staff described how they treated people with dignity. Comments included, "It's important to treat people as individuals and with respect".

People's family relationships were promoted. A person was supported to attend a family event and

equipment required and additional staff support was put in place to ensure the person could attend. This was successful and meant the person was able to take part in a significant family occasion.

People's religious needs were met. We saw on a support plan that stated the person liked to go to church and daily notes confirmed this had happened. Another person used to like going to church but had changed their minds recently and this was noted on their support plan.

People had been given a service users' guide to the service. This had information about the service in a format that was easily understandable with appropriate use of pictures and symbols. The guide ensured people were aware of the services available from the service. The registered manager told us information on advocacy services was available should a person needed this support. An advocate is a person who would support and speak up for a person who doesn't have any family members or friends that can act on their behalf and when they are unable to do so for themselves.

All people were offered end of life planning. However, there was an understanding about how sensitive this was, so it was approached in a way that respected people's wishes if they chose not to do this. We saw a person had done a plan stating where they wanted to be buried and what they wanted people to wear and what kind of music to be played.

Good

Is the service responsive?

Our findings

People and their relatives were actively involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Speaking with a person they said, "They help me do things I enjoy" and another person said "They take me shopping to buy ingredients". People told us and we observed that staff supported people in the way they preferred. Comments from relatives we spoke with included, "They are always looking for new activities to fill his day; they are very proactive" and "There are some concerns with my [relative] at the moment but they keep me informed and the staff will chat to me when I go in".

People's care and support planning was carried out in partnership with them. This was to ensure that support was personalised and in line with what the person had chosen. People had choice about how much control they had in the process. For example, the service enabled people to choose the venue for their review meetings and decide who to involve. Some people chose to hold their person centred plan meetings in the local pub and some in their own houses. The person centred plan took into account a person's likes and dislikes, support they needed with their personal care and looking after their home and money. The support plan gave clear instructions for staff about what support was needed and how and when it should be delivered. It took into account how the person communicated, how they made choices, and whether their capacity to make decisions was limited in certain circumstances. This information was also summarised in a 'one page profile'. Therefore the summary of the most important things for the person was easily available for the staff.

Staff understood the importance of people wanting to have relationships and supported them appropriately to ensure that they could achieve their wishes, such as living together. We saw two examples where house moves had taken place to enable people in relationships to live together as they had chosen. A person commented "I'm happy – good move". The staff also worked closely with a couple who got engaged and supported them in their relationship. A staff member commented "Individuals are encouraged to have aspirations regardless of their degree of learning disability". Staff supported a person's friends and house mates as the person's health needs were changing. They described the importance of helping them to understand what was happening to their friend to explain the changes of behaviour to reduce their anxieties.

Staff had worked in the service for a number of years and demonstrated a good understanding of the support people needed with communication. For example, a person who communicated with gestures, sounds and expressions required major surgery. The person was supported by staff during this time to make sure they understood what was happening to them and the staff also assisted hospital staff in understanding what the person was expressing. Staff ensured that the person had the support and reassurance they needed during their time in hospital.

People were allocated a staff member who had the role of co-ordinating their person centred plans. This helped to develop positive relationships with staff in understanding a person's needs and wishes. The co-ordinator organised meetings to discuss if people wanted to change anything in their plans. Each person

was encouraged to set their own goals. For example, one person made a request to visit Cadbury's World. Another couple who were supported wanted to have their own flat in the community and this was achieved. The same couple celebrated a significant birthday with a trip to New York. This was achieved through planning and fundraising.

The service ensured people's support plans were always current and reflected their needs. The information recorded in care records was reviewed annually or at any time a change may be needed. The service introduced a 'Do I Need a Change' form. The form contained pictures and areas to discuss such as 'Happy about money; work; hobbies; relationships; dreams'. If a person wished to move to another service either within the same organisation or another external organisation, support plans were made accessible to ensure a smooth transition.

People were supported by the staff that knew them very well. Staff could clearly describe the history and preferences of the people they supported. The information reflected what had been recorded in people's care files. The service had commissioned an experienced member of staff to audit all of the plans to ensure they are person centred and reflect people's wishes and needs. When the audit was completed, any recommendations made were acted upon.

The service used technology where possible, to promote people's independence. The management implemented personalised technology to maximise people's choice, independence and ability to have a control in their lives. These included iPads with symbol supported communication applications. Other equipment had also been installed, such as fingerprint sensitive door locks and video cameras to show people who was outside. Most doors inside the properties had touch button opening. The management introduced a number of devices to promote people's independence, such as hot drinks makers instead of a kettle to minimise injury. People's independence was enhanced by allowing them to move around more freely, particularly as some people used wheelchairs. Being able to make a hot drink safely where risks are present, meant people could safely make their own without asking staff to do this. An electronic medication system was being implemented which meant accurate administering and recording of people's medication was done immediately. The process could not be completed until all steps had been taken which left less room for error and meant people were better protected from errors around medication.

People's relatives felt the service was very responsive to people's changing needs and that any changes were communicated immediately. Comments included, "They are very good - always at the end of the phone" and "Yes there are regular meetings".

People were supported to follow their interests and take part in social activities, education and work opportunities. For example, the service had developed an accredited hospitality and catering course. People who did this course covered practical skills to enable them to work in a professional kitchen. It was aimed to build on people's skills and help them gain the confidence. Food hygiene and health and safety were covered and an accredited qualification at the completion to help seek employment. We spoke to one person who had just achieved some work in a local café of which they were very proud and excited to have been accepted for a work placement. A relative commented, "My son is doing a cooking course and they take him shopping to buy ingredients for it".

People were supported to maintain a range of individual interests and activities, according to their personal preference. Some people attended the office base where a timetable of events took place daily. A variety of activities were offered, such as car washing, travel training, publicity group, woodwork, model making and cookery amongst many others. People from the service took part in a publicity group visited local organisations such as churches, schools and a hospice. This was primarily to raise awareness about HF Trust

and what they had to offer. We spoke with a person who was part of the publicity group and they expressed how much they enjoyed their involvement with this. They said "I like being part of the group and have visited a church to speak". This meant the service enabled people to have a role in the local community and be actively involved them in building further links.

The service actively encouraged people to give their views and people were enabled to do so in a number of ways. People gave feedback through questionnaires, discussions and through monthly 'Voices to be Heard meetings'. This was a forum for people who used HF Trust services to talk about what they were happy with and what they would like to change or develop. Anonymous surveys were sent to people to ensure people were able to provide feedback without disclosing their name if they chose to do so. People who may be nervous about being honest in their feedback were encouraged to take part without being identified. For example, a response was received from a family member as they felt they weren't receiving enough information about their relative and were concerned about choices they were making. A meeting was arranged to talk about the service's approach being to ensure that individual's choices and rights needed to be respected. The service reviewed how the person had made their holiday choice and that they had been given all the information needed to make that choice and had the capacity to make this choice. Communication between all parties was also reviewed to see if improvements could be made to reassure the family member.

People were always at the centre of the service delivery and were also involved in development of the provider's policies. People attended national meetings and contributed to how the service was developed and run. For example, when working on the smoking policy the people who used the service decided that staff should not smoke near their premises and therefore designated areas were agreed. These local meetings fed into larger divisional and national meetings across HF Trust.

People were provided with important information to promote their rights and choices. There was a clear complaints procedure in place. Relatives said they knew how to make a complaint. Staff told us that they would always pass any complaints to their service manager or the registered manager, who would take these seriously. An easy read version of the complaints procedure was available with pictures. It also explained what would happen to make things better. The complaints procedure gave details of who people could speak with, including external organisations such as the Care Quality Commission (CQC), if they had any concerns and what to do if they were unhappy with the response. Complaints were responded to in line with the provider's policy. For example, we reviewed a complaint about timescales for a house move. The person was met with and explanations about the delay. We saw the move had since taken place. This had been completed within timescales. The operational manager reviewed complaints and outcomes during their audit process. We also saw a number of compliments had been received by the service.

Good

Is the service well-led?

Our findings

The leadership of the service was good. The registered manager had a good understanding of what was required to manage the service safely and effectively and there was a clear management structure. Each service manager had their own areas of responsibilities and there were plans for each service manager to become registered with the Care Quality Commission to ensure each area of the service was well managed. The registered manager was a positive role model. Staff made comments such as "[Registered manager] is brilliant" and "She is very good and very supportive".

The service had a positive culture that was person-centred, inclusive and empowering. It demonstrated a good understanding of equality, diversity and human rights and put these into practice. For example, people had been supported in their personal relationships and aspirations around these had been achieved. The provider had used a variety of methods for capturing information and monitoring data, including online systems such as a safeguarding log and 'Supported Individual Incident Recording' (SIIR). All of the databases were reviewed and monitored by senior managers, and enabled managers to produce reports for committees such as the Health & Safety group and various regulatory authorities.

Quality assurance systems were in place to effectively monitor the quality of service being delivered and the running of the service. Audits had been completed at each shared living location. These included monthly health and safety checks, support plans audits, medication and finance audits. Accidents and incidents were recorded on the computer system and an analysis was produced which was reviewed by registered manager and operations manager. The service had a recent compliance check with the local authority and no concerns were raised in this.

The service had developed a questionnaire that was sent to all family members to obtain feedback on the service their relative received. This feedback was looked at to see if there were any issues/concerns that were raised. One relative we spoke with said, "As communication is difficult with my [relative] I would like more meetings with the management. We used to have them but don't seem to anymore". Another relative told us they did not feel the service communicated with them enough about their relative. This feedback was passed on to the registered manager who said they would look into these comments to try and improve the situation.

When good practice was highlighted this was celebrated with the teams. The registered manager implemented a more 'formal' feedback with people supported. This was done in a written format or via meetings on one to one basis. The registered manager also met with families at their own local family meetings. This gave them the opportunity to speak to her in person and enabled her to give them information on the service in general. For example, workshops were arranged to help families understand local and national issues such as MCA and DoL's and also the future proposed redevelopment.

Staff told us the communication was good. Staff said information was provided to them via team meetings and newsletters. We looked at the team meeting minutes and found regular staff meetings had taken place. Staff said that they felt able to contribute to staff meetings and felt listened to. We saw that staff held

handovers between each changeover of staff.

All staff had clear job descriptions, which set out the line of responsibility and delegation. Staff members told us they felt the service was well managed and organised.

HF Trust run 'Gem' awards scheme for staff. The managers could nominate team members who they felt have gone 'above and beyond'. We saw that staff from the service had been nominated and received awards.

The service had policies and procedures in place which covered all aspects of the service. We saw these had been reviewed and kept up to date. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training programme.

The registered manager was actively involved in key local and national organisations. The registered manger also attended the service managers meetings where all managers attended and discussed relevant issues about their services. This ensured that managers were aware of the accountability of their staff teams. It also ensured that training was up to date and staff practice was monitored and any issues addressed and good practice celebrated.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.