Leeds and York Partnership NHS Foundation Trust

St Mary's Hospital

Inspection report

St Mary's Hospital
1 Woodland Square
LS12 3QE
Tel: 0113 855 0520
Website: www.leedspft.nhs.uk

Date of inspection visit: 30 September 2014
Date of publication: 16/01/2015

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?	**Requires Improvement**

Overall summary

We carried out an inspection on 30 September, 1 and 2 October 2014. This was a short notice announced inspection to ensure people were available. The last inspection took place on the 25 and 26 November 2011 and there were no breaches of regulation.

The Supported Living Service provides support to 94 adults who have a learning disability and or a profound physical disability. People live in a variety of properties across the city of Leeds and received 24 hour support provided by Leeds and York Partnership NHS Foundation Trust

There is 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.The level of responsibility for the registered manager had been expanded within the Trust and they were not managing the service on a day to day basis.

We observed people who used the service smiling and interacting with the staff, using both verbal and non

Summary of findings

verbal communication. People told us the staff were "Okay" and they "Felt safe with their carers." They told us about their experiences within the service and that they were involved in developing their own care plans. One person told us "I have joined a local gym to keep fit"; and "I am learning new things and meeting people." We saw from records and when speaking with staff that they understood peoples support needs, were enabling and encouraging and treated people with kindness and respect.

We saw that staff were able to communicate with the people they were supporting. One member of staff told us "I have worked in the service for six years and I have been working with the same people over that time. This means I have had the opportunity to get to know them and understand how they communicate. People who used the service have an individual weekly plan. This meant each person was able to do activities suited to them. Two people we met went to college to study daily living skills. Other people enjoyed baking, going on holiday, going out for a trip to the seaside and spending quality time in their house doing personal activities. We saw the staffing levels were adequate to meet people's needs. The service was carrying a high number of vacancies but staff were working extra hours and bank staff were being used to limit the impact of these vacancies.

We were able to visit four houses. The properties had been adapted by the landlord to allow people who used wheelchairs and requiring the use of hoists to help them move around to continue to live there. We saw that where people's needs changed and the property they were living in had become unsuitable they had negotiated with their landlord a moved to new accommodation. People who used the service told us they had been able to help design the décor of their new accommodation and had been able to visit the bungalow before they moved. We saw evidence in people's care records that this process had been managed in an inclusive and sensitive way.

We saw evidence that staff received training that enabled them to provide appropriate support to people. We saw that staff had an annual appraisal and this allowed them to identify and plan for their future training needs. We observed positive interactions with people who used the service and staff. One member of staff said "This has been the best year of my life I have helped support a person in their own home and whilst doing this I have developed my own skills." A person who used the service said "The more independent you get the greater the challenge for your staff. Staff are getting to know me a step at a time."

We saw evidence that CQC had not been notified of incidents that had happened in the service. However they had notified the local authority as required. This was a breach of Regulation18 of the Health and Social Care Act 2009 (Registration) Regulations 2009. The action we have asked the provider to take can be found at the back of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were appropriate risk assessments in place that enable people to do activities in a safe and measured way.

Whilst the service had a number of vacancies there were enough staff to ensure people's needs were being met.

Staff knew how to raise a safeguarding concern and followed the services' own policies and procedures in order to maintain people's safety.

Accidents and incidents had been reported and recorded in line with the services policy and procedure. These had been analysed and actions taken to prevent a reoccurrence where possible. We saw that risk assessments had been reviewed and care plans developed in response to the notifications.

Is the service effective?

Good

This service was effective. All staff received induction and further training appropriate to their position.

The care plans were detailed and effective and there was evidence that staff sought specialist health advice such as dietitian, physiotherapist, and specialist dental care. Specialist equipment was provided where necessary to ensure people could be supported in a safe manner.

Staff had not received training in the Mental Capacity Act (MCA) 2005, although they had received other training for their role as support. Staff spoken wih understood that it was important for people who received the service to make their own decisions and what support they needed to do this. This meant they understood the importance of putting the person who used the service at the centre of everything they did.

Is the service caring?

Good

The service was caring. People who used the service told us that they were treated as individuals. We saw that all interactions between staff and people who used the service were positive and respectful. People told us that their privacy and dignity was respected and they were involved in all decisions made about their care and support. They told us that staff cared about them.

Staff knew the people they were supporting including their preferences.

People told us that staff never entered their rooms without knocking and always asked permission before carrying out any care task. People were encouraged to be as independent as possible.

People were able to speak with staff and therapists at any time to express their views about the care and support they received. People who used the service attended monthly tenant meetings to look at issues concerning the house.

Summary of findings

Is the service responsive?

Good

This service was responsive. People were encouraged to be as independent as possible and to be involved in all aspects of their lives. People were able to identify and plan new activities for themselves such as cooking, going to the gym, and being involved in partnership board meetings for the service. People had also been involved in recruitment of some staff and this was an area for further development.

People told us they were involved in their care plans and the development of their weekly diaries and activities. Staff used a variety of methods to engage people such as one to one meetings, pictorial prompts and trial and error.

Staff encouraged all the people who used the services to be involved in planning their life. To try and engage with people staff had introduced a 'drumming session.' These sessions required no verbal explanations and people of all abilities were encouraged to join in by staff placing drum sticks in their hands and encouraging them to join in. These interactions helped staff and people who used the service to interact without their usual limitations.

Staff noted where people wanted to worship and what was important to them if their cultural background was different. For one person this might mean wearing traditional dress and for another it might mean attending a local festival. These issues were noted in their care plan and staff were aware of these differences.

Is the service well-led?

Requires Improvement

The service requires improvement.

There has been a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009 as there had been 10 safeguarding notifications which had not been made to the Commission. This has resulted because the management arrangements of the service have changed and it is unclear who has responsibility within the organisation to ensure these are referred appropriately.

The service was led by an operations manager who was an effective role model. There was a registered manager but their role within the Trust had changed and they now had more managerial responsibility within the organisation. This meant that the day-today running of the service was managed by the operations manager. The operations manager maintained a positive culture in the service and we observed staff who respected people and showed care and compassion in a practical way.

The service produced an annual report. This process was about the people who used the services and the staff who supported them. People who used services were very involved in developing the service.

St Mary's Hospital

Detailed findings

Background to this inspection

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

This inspection took place on 30 September, 1 October and the 2 October 2014.

This was an announced inspection as it was part of the inspection of Leeds and York Partnership NHS Foundation Trust

Our inspection team was led by:

Chair: Michael Hutt, Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection (Hospitals –Mental Health) Care Quality Commission

The team included CQC inspectors 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.

Before visiting, we reviewed information provided by the Trust about the Supported Living Service. They provided data about incidents and the environments that people were living in. They also told us how many people received support.

During the visit we met with six people who use the service in a meeting organised by the operations manager. We met a further 14 people who use the service in their own homes. We met with three staff who assisted people to the meeting and ten staff at a meeting organised by the management of the service. We met another 17 staff when we visited people in their own homes. We spoke with three house managers, an involvement coordinator and the operations manager. We observed how people were being cared for, spoke with 30 staff and reviewed care or treatment records of people who use services. We spoke to Leeds Social Services contracting team and their safeguarding team.

Good

Is the service safe?

Our findings

People who use the service told us they felt safe in their houses. They showed us pictorial information in their files that explained what they should do if they felt unsafe. One person told us "The staff explained this leaflet to me and if I needed to I would talk to them." Where people were not able to verbalise their needs we observed staff interactions with them. For example, we saw staff ensured they had eye contact with the person they were communicating with and asked a question with a simple yes or no answer. We observed staff gave people time to respond.

Care plans reflected the behaviours people might exhibit if they were unhappy or uncomfortable. One member of staff said "We know what behaviours the person exhibits when they are unhappy but sometimes it takes us several tries before we find out what they want." We observed staff taking their time with people, talking to them and offering them choices. In one house the person who used the service was asked if they wanted to be on their own, then staff took them in to the lounge area to listen to some music.

The manager of the service told us there were instances where safeguarding referrals had been made. They informed us there had been 10 referrals to the local safeguarding authority in the last 12 months. The safeguarding referrals made involved aggressive behaviour between people. These referrals had not been reported to the Care Quality Commission; however the referrals had been made to the local authority. Care plans had also been reviewed to ensure they reflected the needs of the person accurately. The Trust has a safeguarding policy and whilst the manager of the service made referrals to the Trust's risk management group the referrals only then went to the Local Authority. According to their procedure the referrals should also have been made to the National Patient Safety Agency (NPSA), this had not happened. The systems of the Trust are flawed as these notifications had not been referred to the NPSA.

Staff were able to describe what they would recognise as abuse and what action they would take to ensure the safety of the person receiving a service. All staff spoken with told us they would ensure the person was safe and then they would report the incident to their manager. They were all clear that if their manager was involved they would keep reporting the alleged abuse to more senior managers until someone took some action.

Staff were able to tell us how people without verbal communication would make themselves understood. Staff explained that they observed facial and body movements and over time had learnt when someone was expressing when they were happy, unhappy, if they wanted to be moved and if they wanted to go out. Several people at the meeting understood what was being said to them but could not verbalise their response and used actions. Where family or external professional staff were not involved staff advocated for people on a daily basis based on their knowledge of them. Staff had recorded examples of how people responded when they were expressing themselves this meant the staff team as a whole were able to understand what each response meant. The person then received a more consistent service.

We saw 10 care files for people who used the service. The information in the files was presented in a clear way and used a mixture of pictures and words. The files contained detailed risk assessments pertinent to the person they were about. Staff explained they used risk assessments so that people could engage in their chosen activities safely and as independently as they were able; such as going out independently or baking a cake. We saw information given to staff in an operating manual which outlined what was expected of staff such as person centred approaches to risk. This meant that rather than generic risk assessments the risk assessments carried out within the service were person centred.

One person showed us their care plan which contained a 'route assessment'. This document identified the usual routes used by this person and the risks around crossing the road and other distractions. Staff had worked with this person to ensure they could access the community without support. The risk assessments had been signed by the person involved and staff. Another person who used the service told us "Today is the first time I am going home alone from this place." They told us they went out regularly by themselves. We also saw risk assessments for people who could not move about independently, where someone had epilepsy, when they went cycling, or horse riding and these were pertinent to the support that person required when in the community.

Good

Is the service safe?

Staff were subject to appropriate vetting procedures to ensure they were suitable people to support vulnerable adults. Staff recruitment information was provided to us by the manager during our visit. We saw completed application forms that detailed each staff member's employment history and gave reasons for leaving previous roles in health and social care, and two written references. Each staff member also had an Enhanced Disclosure and Barring Service check documenting that they weren't barred from working with vulnerable people.

People received support at their homes; each property had a contracted number of hours to receive support. Where care plans had identified the level of support for the person such as one to one or two to one this was provided. The manager told us they used the admission process to ensure that level of support each person needed could be provided within the confines of the contract hours.

The service had 50 vacancies across the 16 houses and was in the process of recruiting to these posts. We spoke to staff about the vacancies and they told us they were helping by covering some of the vacant shifts. They had also started working in a cluster of two houses so that staff were interchangeable between the different houses. They said that this was a challenge because of the comprehensive support needed by each individual. They however, recognised the benefits of working in different environments as it allowed them to refresh their skills and identify where they needed further training. Where staff could not cover the vacancies agency staff were used and we saw evidence that the same staff were requested from the agency to ensure a consistent service.

At the time of this visit the service was waiting for checks to be completed on 10 new starters. The manager discussed with us the importance of recruiting the right calibre of staff. They felt that if they managed this then their retention of staff would be good. They told us they would continue the recruitment process until their vacancies had been filled. People who received services still received the support they required but the staffing did not always allow them the flexibility to go out at short notice.

We saw from information provided before the inspection that the service had reported 47 incidents where a person had been restrained in the last year. We looked at the persons care records. This person has 24 hour supervision and displays behaviour that challenges. Staff were aware that the inspection would have a negative effect on their behaviour so they had taken them out for the day. We saw that there was a mental capacity assessment in place relating to their behaviour and that they had needed on occasion to be restrained. The incidents had all been reported and we saw that some had been where the staff had to hold the persons arm to stop them hitting out at another person or object. On other occasions staff needed to restrain the person by a member of staff each holding their arms and sitting with them to prevent them from going out until their behaviour had calmed down, because they were at risk of harming themselves or someone else. We saw that other relevant health and social care professionals had been involved in reviewing the care plan, risk assessment and capacity assessments.

We discussed these situations with the manager and they confirmed that each incident was recorded and reviewed. Staff confirmed they had reviewed the situations where restraint had been used and were able to explain why restraint had been used. Staff told us "They (person who used the service) have very challenging behaviour and we try and use distraction techniques and we use restraint only when absolutely necessary and in line with their care plan." Another member of staff told us "We can usually distract people when their behaviour becomes more challenging, sometimes it is as simple as moving the person to another space within the home." All staff receive training in the Preventing and Managing Violence and Aggression on an annual basis to ensure their practice follows best advice.

People's medicines were obtained, stored and administered appropriately and safely. People were supported to administer their own medicines when they could do so safely, otherwise staff provided full support. One person told us "When I go out to college I take my tablets for the day and staff at the college remind me to take them. I don't always bother." Staff discussed with them why it was important to take the medication and always contacted the college to find out what had happened. Medicine administration records (MAR) we looked at were checked on a daily basis to ensure they were being completed correctly. Where people had been prescribed medicines to be taken 'when required', rather than according to a schedule, we saw there were guidelines from the person's GP about the circumstances in which they were to be taken, and each instance was appropriately recorded. Where these were medicines to help people to

Good

Is the service safe?

calm down when they were agitated or upset, records showed these were used in line with the instructions from the GP. These instructions were regularly reviewed to ensure medication was not being used incorrectly.

Good

Is the service effective?

Our findings

People who used the service told us the staff supported them with the daily living and personal care tasks that helped them to live as good a life as possible.

We saw training records to show that all staff had or were in the process of completing their mandatory training. This training included but was not exclusive to infection control, information governance, health and safety, resuscitation and fire safety. Staff told us they had completed training around equality and diversity and this was reflected in peoples care notes where differences had been identified. Other courses include Intensive Interaction training and Preventing and Managing Violence and Aggression (PMVA). We noted one training area included a course run by the Royal National Institute of the Blind (RNIB) that explains how people manage their restricted vision. Information was available in people's files about their condition. This meant staff were able to access information that enabled them to provide appropriate support.

We saw supervision records for the managers that confirmed that issues including training and experience in different houses were discussed. The operations manager told us they also discussed incidents and accidents during supervision. We saw evidence that extra training and support for staff had been provided to try and ensure incidents and complaints were not repeated. Staff told us they received supervision every 6 to 8 weeks and attended a monthly team meeting. We saw minutes from these meetings.

Staff told us they received training in the safeguarding of vulnerable adults and children. They told us this training was provided annually via eLearning and it was mandatory. We saw training records that confirmed all the staff employed in the supported living services had received this training. We spoke with two staff on an apprenticeship. They told us they had a comprehensive induction and did not provide support to people they had not been introduced to or spent time with this meant they could provide the right support in a safe way.

Staff told us that if the person being supported indicated they did not want a visitor in the house then they were not immediately allowed in. Where these were officials staff explained to the person they were supporting why they were visiting and then they were allowed entry to their home.

The care plans contained information pertinent to people's dietary needs. We saw it had been identified where people required specialist equipment to aid them in managing their meal independently and the equipment had been provided. We observed several meal times. We observed staff offering choices to each person and where people needed assistance this was provided appropriately and staff didn't rush people to finish their meals. Where necessary the Speech and Language Therapist (SALT) had been involved in the dietary assessment process. They had recommended whether people needed specialist diets such as soft food or food thickened to aid with swallowing. This meant people could receive their nutrition and hydration safely. We observed staff getting people drinks on request and where people could get their own drinks they were encouraged to do so. We observed one person helping themselves to a cake out of the fridge and other people enjoying a light lunch.

People lived in a shared house with up to eight people sharing the accommodation. They were able to choose what they wanted to eat from a range of pictorial prompts and staff assisted them appropriately. Staff told us that over time they had developed a basic knowledge of what people liked to eat and they continued to try different food items to see if they could expand their choice. In one instance staff discovered one person really enjoyed paella and since then they had included a high proportion of sea food in their diet. The person concerned required a softened diet and eating fish meant food did not have to be blended too much. Several people required a percutaneous endoscopic gastrostomy (PEG) tube for their food. The decision to have the PEG had been made at a best interest meeting as people affected were not getting their nutritional needs met. This tube allowed staff to feed the person through a tube surgically inserted into their stomachs with a prescribed liquid diet. Staff spoken with told us they had received training in the safe use of the PEG tube. They received regular updates in how to safely manage the PEG, records seen confirmed this. Where support was provided to smaller houses people chose what they wanted for their meals on a daily basis.

Good

Is the service effective?

The manager told us they had employed a physiotherapist for an eleven month period so that all the staff could be trained in better posture techniques. This meant staff were more aware of what a good posture was like for each person and understood the benefits of maintaining a good posture. We also observed staff supporting someone to transfer from their wheelchair to a specially designed chair meant to help their posture, and they spoke about what they were doing and made sure the person agreed at each point of the transfer. Staff training records showed that staff had been trained in the principles of dignity when providing personal care.

We saw evidence that people were supported by staff to attend the opticians, dentist, the GP when necessary and specialist appointments with the learning disability team when their behaviours changed.

Staff told us they had not received any training in the Mental Capacity Act 2005 (MCA). However, we saw from care plans that people had been involved in best interest meetings. These meetings usually revolved around medical decisions, but included any major life changes. Best interest decisions are a collective decision about a specific aspect of a person's care and support made on behalf of the person if they lack capacity following consultation with professionals, relatives and if appropriate Independent Mental Capacity Advocates (IMCA). An IMCA is a statutory role created by the Mental Capacity Act 2005 to support people who lack capacity to make certain decisions. Following this process demonstrated openness and transparency in providing services for people who lack capacity as defined within the Mental Capacity Act 2005 (MCA). This helped to ensure that people's legal rights were safeguarded. The operations manager and staff told us they made decisions on a daily basis for some people who used the service. They explained these decisions were in relation to the suitability of clothing when going outside and spending personal monies on the persons behalf. It was clear from discussions held that people did consider what was in the best interest of the person they were supporting. However, there was no evidence in the care plans that best interest decisions had been taken in relation to daily living plans or financial plans.

Good

Is the service caring?

Our findings

People told us that staff were caring. One person told us, "I like living here, the staff are nice." Another person said, "I know the staff very well by now. I've been living here a long time." One person told us "Moving in to supported living has turned my life the right way around" and "Staff listen to what we have to say and don't rush when we have something to say."

A regular team of staff work in each house. These teams are stable and this means they are able to get to know the people they are supporting. We spoke with 30 members of staff. One staff member said, "The most important thing is knowing who you are supporting, that means you get to know how they communicate and what they like doing and more importantly what they find difficult."

During our inspection we were able to visit four houses where support was provided. Each house supported people with differing needs. Staff demonstrated a good understanding of people's needs, in particular their communication needs, and worked according to people's preferences when providing support. Staff told us that people were seen as individuals and were able to describe each person they helped support. We observed that where people who were extremely dependent on help from staff, they were always included in tasks carried out for them. For example, people collecting their own post, being supported by staff when their room was being cleaned and encouraged to open the front door when visitors arrived.

A member of staff spoken with told us "When I am supporting someone I don't see their disability but I treat them as I would want to be treated, as an individual. I enjoy going out for a drink or to the cinema so why wouldn't the people I support. They can do anything they want." Staff were sensitive to people with different cultural needs and helped support them access services based in their local communities.

We observed staff responding positively to requests to go out at short notice and dealing sensitively with someone who had received bad news. We spoke with people who used the service and they told us they could plan their own day. One person said "I have lots to do and I can make my own mind up about what I do. I have a job at a local charity shop." We saw staff supporting people with a variety of physical and learning disabilities. People were always offered a choice and were treated with respect and dignity throughout the interactions.

Staff were able to describe how people without verbal communication skills would be able to make themselves understood. This information was also contained in the persons care plans. We observed throughout our visit positive interactions between staff and people who used the service and staff were able to provide positive support that people wanted. Where people had little or no vocal communication staff looked for facial movements, body responses such as unexpected movement. They were skilled at knowing what people wanted or were expressing. Over three days we observed a variety of situations where staff provided appropriate support by following non-verbal communications.

Staff supported people to use communication aids when they needed to, such as pictorial communication aids, including communication passports. Staff also used objects to assist people to make choices and express their decisions, and some people used Makaton, a type of sign language. For example, one person who had a visual impairment and very limited language was supported to plan a holiday, and staff described brochures of different destinations so they could choose which they wanted. Staff also described the different activities they could participate in while on their holiday so they could decide.

In all our observations interactions between staff and people who used the service was positive and respectful. It was clear the people who used the service were, as much as possible in charge of their own lives. Staff told us "I enjoy working in this job, there is always something to learn. I have recently done a Royal National institute for the Blind course because one person I support has very limited vision. I now know why they move their head so much and I have a better understanding of how they see the big picture."

Staff noted where people wanted to worship and what was important to them if their cultural background was different. For people this might mean wearing traditional dress and for another it might mean attending a local festival. These issues were noted in their care plan and staff were aware of these differences. Several people who used the service told us that whilst they shared their tenancy with others they still had their own space, usually in their

Good

Is the service caring?

own rooms. One person described it as a "Man cave," another said "I can take a time out in my own personal space which can be either my bedroom or the kitchen when no-one else is using it."

Staff were in people's house on a 24 hour basis due to the level of support they required. People who used the service told us the staff always knocked before entering their room. Where people could manage a key they were able to lock the door to their own rooms. This helped ensure that people's privacy and dignity were respected by staff.

Good

Is the service responsive?

Our findings

People who used the service told us they were involved in developing and reviewing their care plans. One person told us "I decided who should come to my review and I posted the invites to them." Another person said "The staff listen to me and help me with my care plan" and "I do everything for myself and if I need help I ask for it."

Staff told us that if the person who used the service was unable to organise their own review they then invited people who had been involved in their care over the last year. They told us they were sensitive to the nature of the review and people invited to the review only stayed for as long as they needed to contribute. This meant that where possible the people who the review was about were able to make their own decisions.

Staff told us the care plans were person centred and when they were reviewed, the review was led by a support staff and key worker - the involvement coordinator may help manage these reviews. Staff told us this person was not involved in supporting the person over a 24 hour period so they brought some independence to the process. One service user told us "I decided who should come to my meeting and it felt okay to be in a meeting where people were talking about me. Staff were there to support me." Another told us "They (staff) helped me organise my own review and we used pictures to help me decide what I wanted to do." We saw from care plans that people had been enabled to develop personal skills such as accessing the community independently, getting a job and baking.

Several people had recently moved house and one person told us "We moved house because the stairs in our old house were difficult and we now interact more." Another person told us "Our house changed but the people we lived with stayed the same." This meant that people were able to manage the change in a positive way.

People were supported to maintain relationships with their families and friends. One person told us, "The staff help me to phone my family on special occasions, and I have them and my friends come to visit." Another person told us "The staff help me to go to my parents for the weekend but I am always glad to get back home." Staff told us that with recent social events between the houses they had discovered that most people who used this service had been transferred from the same hospital and were enjoying reconnecting with people they had known in hospital.

Care plans started with a brief page with statements covering 'What People like about me.' This information contained elements such as 'I have a good sense of humour', or 'I smile when I am happy'. 'What is important to me' covered elements such as 'I like having privacy in my own room' or 'I want to go out a lot' and 'How best to support me'. This told staff to speak to the person directly; give them time to respond. They then went on to personal information and individual support plans, with associated risk assessments. There was also information on how the person communicates. Decision-making was documented in their care records. People's records showed that they, and those close to them, were involved in reviews of their care and support.

Many people had used the service for about 18 years so these were established services. Staff had worked with people over a long time and were able to discuss how they enabled people to be involved in their own care plan. The manager told us that people recently provided with support were younger and more independent because they had come from their family home. Their expectations and aspirations were different to those people established within the service. Staff had found this challenging because their roles altered slightly from providing comprehensive personal support in all areas to providing less support but rather enabling people to be more independent. Staff told us they were enjoying enabling people to be independent, one staff member said "It was nerve wracking when they (person who used the service) went out for the first few times by themselves but it's done their confidence wonders and we haven't had any problems. They know to take their phone and they ring us if there is a problem or if their plans change."

People who used the service had been involved in the recruitment of staff including a Lead Psychiatrist and a support worker. Staff told us they needed to look at this as an area for development for people so that it was a meaningful exercise. One person who used the service told us they had done some training in how to interview someone before they had been involved.

People were admitted to the service after a lengthy assessment period. One person recently admitted to the

Good

Is the service responsive?

service had spent nine months getting to know the staff and other tenants in the house. This ensured they would get on and staff would have the skills to enable them to be as independent as possible. The other tenants in the house told us they were consulted before the admission was finalised. Staff confirmed that if someone didn't get on they wouldn't make the placement.

People told us "I can talk to the staff if I am unhappy", "The best thing about supported living is that I have good company and can go to art classes, shopping, and for a coffee on my own." Opportunities were available for people to attend Partnership Board meetings. These meetings looked at issues that affected the service and how the service might develop.One person who had attended wanted the opportunity to express their opinions, they did however, feel they were hampered in that the person who accompanied them did not always immediately understand what they were saying in a timely manner because whilst they knew what they wanted to say but had difficulty expressing themselves.

The manager told us that they held two open days a year for people to come to the office and express their views on the service. They found this to be a valuable event as it was attended by board members, staff and people who used the service. A staff member told us "Doing it this way means we can include everyone; including those people who have profound communication issues. No one is left out. We are looking at other ways to gather feedback from people." A relative told us "They (relative of a person who used the service) have not been here long but they love their independence. Staff tell us what is going on but usually our relative tells us."

We also saw a pictorial complaints procedure in people's files. At a group meeting of six people who used the service, people told us they would tell someone, either a member of staff or a family member if they were unhappy.

People were helped to be independent. Where possible people who had diabetes were encouraged to manage their own blood sugar levels and tell staff what their sugar level was rather than have staff do it. Other people were encouraged to go out on their own for a walk around town, for a coffee, to a job and to college. One person told us their carers had helped them go to the gym and they now had the confidence to set up their own equipment. The carer told us "They tell us when they want to go to the gym and we make sure that staff are available to facilitate this."

Another person who used the service acted as a steward at triathlons and was part of a governance group that looked at developing the work done by staff. The high level of vacancies had resulted in some activities; such as going out in to the community more frequently being restricted. People who used the service told us they were unable to go out on request and had to plan outings because of staffing issues.

People told us "The staff are great; they help me to be independent." Another person told us "The staff have helped me plan my routes for walking and I go out by myself. I like going in to town to watch people."

People were supported to maintain contact with their families and friends. Within the supported living group, different houses held different events such as, 'Come pie with me' where someone had expressed an interest in baking and so once a month people got together to make and eat pies, a similar event was also held for baking cakes. Staff told us they tried to involve people as much as possible as they don't want it to become 'tokenistic' with staff doing all the baking. Several people who used the service told us they attended cooking classes and enjoyed baking. One person told us "I am going out to a cooking course and my staff are helping me cook more at home."

We spoke with 30 staff, some of whom we met in a meeting others whilst they were supporting people in the community. They were all motivated to support people to be as independent as possible. For one person this meant organising holidays, life skills sessions and helping people access the community independently. In another instance it involved setting up a drumming group, specifically for people with profound disabilities.The group does not require verbal interaction and they try to be responsive to the needs of the group. Staff had found that people have benefitted from the drumming sessions as they have been able to develop interactions and relationships. One person told us "The more independent you get the greater the challenge for your staff. Staff are getting to know me a step at a time".

People who used the service had access to a pictorial complaints policy and those people spoken with told us that staff had explained what they should do if they were unhappy with anything. The service kept a log of complaints made formally, the scope of the investigation and the outcome of the complaint. The complaints procedure was available to everyone and it gave clear

Good

Is the service responsive?

timescales that complaints must be responded to. Each house had monthly meetings to discuss what was happening and what they wanted to happen. People who used the service told us “I just tell the staff if I am unhappy and if they don’t help I go to the manager they are really good” and “They (a member of staff) are good, they listen to me and make changes when I suggest it”. In a group meeting with people who used services, they all said they made their concerns known. Staff confirmed that people without speech were able to make themselves known when asked to do something they didn’t like or want to do. During a house visit we saw how one person made it known they were not happy with the choices available and staff responded appropriately.

Requires Improvement

Is the service well-led?

Our findings

Leeds & York Partnership NHS Foundation Trust had recently undergone a reorganisation of their management arrangements. This meant the registered manager for the Supported Living Service was responsible for all the Learning Disability Services held by the Trust. The responsibility for managing the service on a day to day basis sat with an operational manager (OM).

The OM held monthly management meetings with the support managers and following a recent safeguarding referral they identified governance as an area that required improvement. The OM told us there were audit systems in place for the whole service, where issues had been identified but there was no system for ensuring the actions noted had been followed through. An example of this was the safeguarding alerts. The OM told us they had made 10 safeguarding referrals to the local authority between the 1 October 2013 and 1 October 2014 but none of these had been referred to the Commission. When questioned about this a senior manager from the Trust told us they had been reported through the National Patient Safety Agency (NPSA). On further examination of these incidents it transpired they had neither been reported to the NPSA or to the Commission. The OM told us they were not sure of what they needed to report to the Commission or just to the risk management board within the Trust. The systems of the Trust are flawed as these notifications had not been referred. This meant there was a breach of Regulation 18 of the Health and Social Care Act 2008. The outcome for people who used the service appeared to be minimal however there was no mechanism for recognising patterns or themes that might suggest a greater problem within the service. The action we have asked the provider to take can be found at the back of the report.

Staff told us that there was an open and transparent, culture that encouraged good practice. Staff told us they attended regular team meetings. Staff told us the meetings were useful, and they included discussion about values, diversity, health and safety, training, incidents and activities, and allowed sharing of good practice.

We spoke with three managers, each of whom was responsible for the management of two supported living sites. They told us they provided both management support and they worked shifts in each site to enable them to maintain an understanding of each service. They told us they received positive support from their management group and from the OM. One person told us "I can always ask the manager if I am unsure or need some clarity around an issue" and "The manager is great and their door is always open and you can ask them anything." The support managers told us they held monthly meetings with their staff and we saw records to confirm this. They also told us that they carried out regular audits of the care plans, accident records and staffing levels to ensure the service was running in a safe and effective way. We saw records to confirm this happened.

We spoke with people who use the service and staff and they all told us that the management structure was supportive. Staff told us "We are well supported by the manager now, we haven't always been but it is much better now." Other staff told us "I can go to either the support manager or the OM and I find them very supportive."

The service produced an annual report. This process was about the people who used the services and the staff who supported them. People who use services were very involved in developing the service. The 2014 Report has been produced on DVD and covered Management and Leadership Strategy, Dignity, Training, Supporting Staff who worked with people who challenged services, Recruitment and Retention and Driving up Quality. Staff told us they supported these visions and values and supported people to be involved in the ongoing development of the plan. This will be done though further open day events and working with people on an individual basis so that their ideas are incorporated into the work already done.

We spoke to a group of staff in a meeting and they told us they received good support from the managers attached to each house and from the general manager. They told us they operated an open door policy and were approachable at any time.

The service had a whistleblowing policy for staff to follow, and staff told us they were free to report any concerns to managers and knew they would be addressed. A recent whistle blowing event had raised concerns in one house and the manager had taken steps to address the concerns. This included removing the manager and introducing a new management system in to the house and providing extra training for the staff. Staff told us they would have no hesitation in whistleblowing because their experience this time had demonstrated where practice was not good the organisation was prepared to put it right.

Requires Improvement

Is the service well-led?

The manager told us they monitored the incidents and accidents on a monthly basis and these were discussed with the managers of each supported living service.

People who used the service were invited to attend parts of or all of a two day event aimed at gathering their opinions of the service. Staff recognised they couldn't use the traditional surveys and looked for other ways that enabled everyone to express their view. They had sessions of theming information. One person we spoke to said, "We told staff what we enjoyed and wanted to do." One member of staff told us "It will always be hard to directly involve many of the people we support but we plan on extending the sessions so that we can work more closely with people and hopefully make their involvement more meaningful."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Important events that effect their welfare, health and safety were not reported to the Care Quality Commission including allegations of abuse. Regulation 18 (1) (2)