Southside Partnership

Southside Partnership Domiciliary Care Agency

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Good ●
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

Southside Partnership Domiciliary Care Agency provides care and support to people living in 16 supported living settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. People using the service lived in flats and houses in multiple occupation (HMO). HMO are properties where at least three people in more than one household share toilet, bathroom or kitchen facilities. Five supported living settings are in Lambeth, one in Westminster and ten in Bromley. At the time of the inspection 104 people were using the service in 22 schemes, however only 59 were receiving personal care in 16 schemes. Southside Partnership is part of a larger organisation providing social care services called Certitude.

At the last inspection, the service was rated Good.

At this inspection, the service was rated Outstanding.

There was a registered manager at the service. 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 provider was involved in a number of initiatives that demonstrated a strong person centred culture within the organisation. People using the service were involved across the services as quality checkers visiting services and speaking to their peers about their experiences and how services could be improved. The provider took part in initiatives to support people using the service to connect with their local communities.

The provider ensured there was a focus on building and maintaining open and honest relationships with people and their families. Formal listening events were held as a platform for family and friends of people to share their views and discuss issues with a range of operational staff.

Certitude had a clear vision which was supported by a five year strategy, yearly organisation business plans and individual service continuous improvement plans which enabled the vision to be promoted throughout the organisation and down to each individual service.

The provider worked in partnership with organisations to build seamless experiences for people using the service and explored new ways of connecting people with their communities based on good practice.

Governance was well-embedded into the running of the service. There was a robust framework of accountability to monitor performance and risk across all the schemes. All services were subject to rigorous systems of quality assurance. This included a member of the quality team completing an audit alongside a

service manager from a different service. A system was in place which allowed the management team to have a greater insight to how services were performing. At the end of each month, each service would complete a self-assessment tool including a care records tracker, medication, and food hygiene. The senior leadership and board members also completed visits looking at people support, staff, home and environment.

Relatives of people using the service were satisfied with the service and complimented the service and staff about how well their family members were looked after. We observed interactions between staff and people using the service in the individual services we visited to be friendly. Relatives said they felt their family members were cared for and they had no concerns about their safety. Care workers were familiar with safeguarding procedures and training records showed that safeguarding training was delivered to staff.

Care plans involved people, their families and external professionals, where required. People had person centred plans in place and communication profiles providing information about how people communicated. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Risks to people were assessed and reviewed on a regular basis. People's care files included risk management plans that provided information about actions needed to keep people safe and how risks could be mitigated. Checks and records which demonstrated that each scheme was safe were in place. There were systems in place to help promote infection control.

People were supported to take their medicines by trained care workers. Medicine Administration Record (MAR) charts were signed and up to date and medicines were stored safely and securely. Medicines audits took place on a regular basis.

People received support in accessing healthcare services at the time that they needed them. People's care files included hospital passports and health action plans detailing people's conditions and details of their healthcare professionals. People had health action plans and health passports in place. Records of correspondence and appointments with health professionals were seen.

People were supported to maintain a balanced diet. Care workers were aware of people's needs and provided the appropriate level of support. They were also familiar with people's preferences and likes and dislikes in relation to their food.

There were enough staff employed to meet the individual needs of people. New staff completed an induction which included an introduction into the organisation's vision and values. They also completed training within the first three months of employment based on The Care Certificate. Staff training compliance was monitored by local and senior management on a monthly basis and checked by service managers during supervision meetings.

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 remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Outstanding ☆

The service has improved to Outstanding.

The provider was involved in a number of initiatives that demonstrated a strong person centred culture within the organisation.

The service was exceptional at helping people to express their views so that staff and managers at all levels understood their views.

The provider ensured staff were highly motivated and offered care and support that was exceptionally compassionate and kind.

The provider ensured there was a focus on building and maintaining open and honest relationships with people and their families.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Outstanding ☆

The service remains Outstanding.

Southside Partnership Domiciliary Care Agency

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 23, 24 and 25 January 2018 and was announced. The provider was given 48 hours' notice because it is a supported living scheme and we needed to be sure that someone would be in. At our previous inspection on 14 and 22 October 2015 we found the provider was meeting regulations in relation to the outcomes we inspected.

The inspection team consisted of two adult social care inspectors. One inspector visited a supported living scheme on 23 January 2018. Two inspectors visited two supported living schemes on 24 January 2018 to speak to people in their homes, and two inspectors visited the provider's head office on 25 January 2018. Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. The provider also submitted a provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

We spoke with three people using the service and six relatives. People using the service have significant communication needs so more were not able to tell us of their experiences. We spoke with 11 staff including the registered manager, a quality improvement partner, family support manager, service managers and care workers. We also observed interaction between staff and people using the service. We looked at five care records, four staff files and other records related to the management of the service including training records, audits and quality assurance records.

Good

Is the service safe?

Our findings

Staff knew how to keep people safe. Staff were competent in their knowledge of how to address any safeguarding concerns and records we looked at showed that they had completed relevant training. One staff member told us "I would tell my manager and my area manager if I needed to". Care workers told us, "Safeguarding is to prevent people from harm and danger", "Once you get to know people, you can tell by changes in their behaviour", "If I notice anything odd I would first check the communication or handover and then report it to [the manager]." Where people were not able to communicate verbally, records were in place providing information about how they could report abuse, how they would communicate this to staff and what steps staff needed to take in response to this.

Risks to people were effectively assessed and regularly monitored and reviewed. People's care files included person centred risk management plans that detailed ways in which to keep people safe and actions to take to mitigate risk. A 'keeping me well and safe' assessment was in place assessing various areas such as safety at home, safety when out, medicines and personal care amongst others. Moving and handling assessments were in place, providing details of the manoeuvres that care workers were to employ when helping to transfer people from various situations such as bed to chair and others. Appropriate guidance was in place to mitigate the risk of any falls. Risk management plans were reviewed regularly and records we looked at were up to date. Fire risk assessments and individual fire evacuation plans for people were in place.

Checks and records which demonstrated that each scheme was safe were in place. Staff completed daily checks on lights, laundry, heating and hot water. Safety certificates were seen for equipment such as beds and hoists and also for gas and electrical safety. The quality team were responsible for carrying out audits of all services, including health and safety compliance, and monitored the completion of remedial action.

There were systems in place to help promote infection control. A regular cleaning schedule was in place at the supported living schemes we visited and any cleaning equipment was securely stored. Personal protective equipment (PPE) was available to use when staff helped people with personal care. Food stored in the fridge was labelled with the date they had been opened and when they were to be used by.

Staff said that there were enough staff to meet people's needs. Records we looked at confirmed this. Safe recruitment practices were in place to help protect people from the employment of unsuitable staff. There were safer recruitment practices in place and appropriate recruitment checks were conducted before staff started work at the service. Recruitment records included details of each staff member's full employment history, employment references, confirmation of identification and Disclosure and Barring Service (DBS) checks. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

Although there were vacancies in some of the services we visited, we found that staffing levels were sufficient to meet the needs of people. In one service for four people, there were two support workers during the day and one waking night support worker. None of the people using this service needed two support workers to assist them with personal care. In other services we checked staffing levels with the service

managers and saw there were enough staff to meet people's needs.

We reviewed the medicines records at the supported living schemes that we visited. Medicine Administration Record (MAR) charts were signed and up to date and medicines were stored safely and securely. Temperature checks were regularly conducted and records showed that regular medication audits took place. MAR charts were completed by care workers appropriately. GP consent for administration of homely remedies were in place where required alongside guidance of when to administer these and staff completed MAR charts when these were administered.

Procedures were in place to deal with any accidents or incidents that had occurred. Records we looked at across the schemes we visited and the head office showed that appropriate monitoring systems were in place. Each service submitted details of any incidents and accidents onto a central reporting tool to allow managers and the quality team to have an oversight into them and to try and identify common causes. Incident reporting, safeguarding concerns and CQC notifications were monitored centrally, reported to operational managers monthly and quarterly analysis was presented to the Health and Safety Committee and Quality, Performance and Compliance Committee.

Good

Is the service effective?

Our findings

People were supported by staff who received appropriate training and support. Staff said they felt supported by the management team. One staff member commented, "I have a very good relationship with my managers. They are approachable to discuss any concerns." One of the annual review records that we looked at praised the support that the staff member had received from their team leader during the year.

Staff files showed that staff received individual supervision and support on a regular basis. Staff were also subject to annual reviews and the staff records we looked at showed that these were up to date.

Care workers told us, "The induction was very good. I started the Care Certificate, the first week was getting to know the service and doing some training and the second week was shadowing", and "We have regular 1:1 meetings every month."

All new starters completed The Care Certificate within their first three months of employment with Certitude. They also completed a corporate induction, service-specific induction and mandatory training. The Care Certificate is an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. The Care Certificate was completed over three months and evidenced through workbooks which were signed off by management and submitted to HR. The 15 standards of the Care Certificate were covered in three workbooks called 'me and Certitude', 'me and the people I support' and 'me and working safely'.

Training was a mixture of e-learning and classroom based training. The training matrix was held centrally but the training needs of care workers was managed by the individual service. The training matrix gave a visual snapshot of the training that was current, about to expire and expired. Training compliance was monitored on a live dashboard by local and senior management on a monthly basis and checked by service managers during supervision meetings. We looked at the training matrix and saw that all mandatory training had been delivered.

One of the areas that the provider was looking to develop further in future was a support worker development pathway to provide greater depth of support to new staff during their first six months.

People were supported to maintain a balanced diet. People had different support needs in relation to their diet. Some people were independent whereas other people needed staff support. Care workers were aware of people's needs and provided the appropriate level of support. They were also familiar with people's preferences and likes and dislikes in relation to their food.

Care files that we looked at included health action plans which detailed people's needs and preferences in relation to eating and drinking. We saw that where a staff member had concerns around a person's weight that these issues were raised with management and that appropriate actions were taken to support the person with healthier eating.

Menus were in place for food planning. These were individual for the needs of the service, for example some services used pictures to offer menu choices to people. One person had a separate menu due to their specific dietary requirements. The menus we saw demonstrated that people were given a choice and varied options. Good quality produce food was purchased.

There was evidence that the provider worked within and across organisations to deliver effective support. People's needs and choices were assessed when they moved into the service and care, treatment and support was captured in care and support plans. These were reviewed on a regular basis which helped to ensure they contained up to date information. The provider worked with the local authority and other professionals to make sure they identified and met people's care and support needs.

Relatives told us, "I am always promptly informed of any health care related issues or appointments that need to be organised or attended" and "They were wonderful when they had to take him/her to hospital."

People received support in accessing healthcare services at the time that they needed them. People's care files included hospital passports and health action plans detailing people's conditions and details of their healthcare professionals. Records we looked at showed that people were supported to access services such as dentists, doctors and opticians. We saw that one person had been referred to a speech and language therapist, whilst one had been referred to their GP for a particular issue. People with a secondary diagnosis of mental health were referred to and reviewed by appropriate professionals for example Behavioural and Developmental Psychiatry.

People had a separate health folder in place which included a health action plan, reviews and correspondence from health professionals, health passports, and a record of heath appointments that people were supported to attend. One person with diabetes had a diabetes guideline in place. These had all been reviewed recently.

Specialist support plans in relation to health were in place, these included oral support plans, support plans in relation to eating and drinking from Speech and Language Therapists and dysphagia support plans.

Although some of the services we visited were dated in their décor, there was a homely feel to the services with communal lounges and open plan kitchen/dining areas for people to meet. People's bedrooms were furnished according to their taste and their ensuite bathroom had been adapted according to their individual support needs. The service manager of one of the services told us, "We worked with the families to choose the room colours and décor."

Premises were appropriately set out to meet the needs of the people using them. Where one person struggled with using the stairs they had access to a downstairs bathroom near their room.
One person showed us their room which was personalised and decorated to their liking with family pictures and personal ornaments.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA.

A relative told us, "[My family member's] best interests are always considered and choices put forward to her

with guidance."

Staff were clear on the requirements of the MCA and DoLs. Care workers told us, "The family is heavily involved, we also ask for their input when making decisions", "We don't assume they cannot make decisions. Any decisions we have to make we would involve all agencies in her best interest."

Applications had been submitted to the local authorities where it was felt that people were being deprived of their liberty. The registered manager told us there had been a delay in getting these authorised by the Court of Protection. However, he said that any restrictions on people were done in their best interests.

We found that deprivation of liberty checklists were in place confirming people who were under continuous supervision and not free to leave but no formal capacity assessments were in place. For example, at one service the door was locked overnight for the safety of one of the residents. An application had been submitted to the Court of Protection to deprive the person of their liberty for their own safety, however we could not see that a capacity assessment had been recorded. Appropriate records and support mechanisms were in place to show that best interests meetings had taken place and we were assured that there was appropriate support in place to support people that did not have capacity.

Some people had decision making records providing information about their capacity to make decisions, either through body language and how they were able to refuse or give consent and also how staff were able to present information to people to aid their understanding. Decision making records were in place in relation to finances. These gave details of whether people were able to make decisions in relation to spending their money up to a certain amount and if not then people that were to be consulted when making those decisions.

Outstanding ☆

Is the service caring?

Our findings

The provider was involved in a number of initiatives that demonstrated a strong person centred culture within the organisation.

The service was exceptional at helping people to express their views so that staff and managers at all levels understood their views. People using the service were involved across the services as quality checkers visiting services and speaking to their peers about their experiences and how services could be improved.

Quality checker visits were documented and the provider took action based on the feedback received to improve people's experiences of using the service. In one example, following feedback from a quality checker, a person's profile and decision making agreements had been updated resulting in better communication techniques and enabling staff to support them more effectively. In another example, following feedback from a quality checker staff purchased a table on wheels as a worktop replacement so a person could maintain their independence and be involved in meal preparation. In another service, a quality checker noticed the use of a drier in a laundry room was making the upstairs of a service very warm in summer. Staff took this feedback on board and reduced the use of tumble drier and started drying laundry in the garden.

The provider ensured staff were highly motivated and offered care and support that was exceptionally compassionate and kind. They cared for individuals and each other in a way that exceeded expectations. Services had 'staff matching' profiles in place which gave details about the characteristics of staff that would bond with people using a particular service. This was used when recruiting new staff but also when transferring staff between services. Staff were matched with people's interests and personalities which helped people to feel empowered and valued by the service. Two care workers were specifically recruited to work with a person in their native language, Yoruba. Staff who were confident swimmers were recruited or moved within services to work with two people who particularly enjoyed swimming as a regular activity. Carers with driving license were recruited to support a person who enjoyed going out for drives.

The provider worked alongside the National Development Team for Inclusion (NDTi) in the 'Time to Connect' project. This is an initiative that trains and inspires staff to support people using the service who were at risk of exclusion to connect with local communities, be active citizens and participate. Care workers felt this training gave them more confidence in helping people to become active citizens, build better circles of relationship and connecting with the community. A care worker gave feedback that this training had boosted their confidence, and they felt empowered to try more things with people.

The registered manager gave us some examples of how the Time to Connect project had bought real benefit to the person and their community which proved to be a mutually beneficial arrangement. One person with high support needs and had previously been in institutions before moving to his supported flat was labelled as a person who could not socialise. In order to facilitate a positive relationship with the neighbours, care workers supported the person to initially accept the neighbour's parcels, this developed further into both parties doing some gardening for each other and invitations to tea. This meant the person was empowered

to become an active member of their community after previously being marginalised. Another person enjoyed art and after their care support worker had been trained in Time to Connect, was encouraged to put in paintings on sale at local summer parties, resulting in some sales which made the person very proud and enabled them able to fund their own art materials.

The provider ensured there was a focus on building and maintaining open and honest relationships with people and their families. Formal listening events were held as a platform for family and friends of people to share their views and discuss issues with a range of operational staff. The provider identified improvements following these events and a project board consisting of people using the service, family members and staff was kept informed about the progress. A follow up event was held to list what feedback had been received and what action had been taken in response.

People were supported to maintain relationships that were important to them. Details of important people in their lives and important relationships were recorded in person centred plans. A relative told us, "I visit [family member] once a month and we watch television together or we play with a bat and a ball." A family support manager helped services across the organisation to develop better relationships with the families of people. They made sure that people and their relatives get the support they need and want, and were skilled in trying to resolve any conflicts and tensions involved which resulted in better relationships and seeing improved outcomes for people supported through developing support plans and effective communication plans with families.

We spoke with the family support manager about the work they did with families, they told us "Where things have not gone well or relationships have become strained between the service and relatives, it's my role to mediate and find a way forward. Often families want to be involved especially with younger people and we want to develop an equal partnership with families." They gave an example where they had mediated between a person, their relative and the service and set up a development plan and an agreement for all parties making them feel as equal partners. They also told us they organised conferences for carers and families and provided advice and signposted people to get additional support from advocates.

Care plans involved people, their families and external professionals, where required. For example, one care plan described what kind of meals were culturally appropriate, and records we looked at showed that the person was supported to buy these foods. A relative said, "We had a big care plan review and they sent me a copy." Another said, "We have an annual meeting about [my family member] to discuss how they are getting on and what to try next. We always start the meetings with "What do we like about [my family member]?" which is such a positive opening."

People had person centred plans in place with a one page profile and information about their preferences and things that made them happy and sad. They had communication profiles in place providing information about how people communicated and how staff could tell how they were feeling. This information gave support workers information about how they could communicate with people effectively. Support workers were given guidelines in relation to helping them understand people better for example, through the use of real objects, objects of reference, speech and tone of voice. Care workers told us, "[Person] has limited verbal communication but [they are] still able to make choices. We use objects of reference or by showing them." We observed staff using these methods to communicate with people with limited verbal communication. A relative told us, "I have learned so much from the example of the staff about how to respond to him."

Relatives said, "The carers are great", "Being so far away it gives us peace of mind that [my relative] is so well looked after", "[My relative] is definitely happy", "I saw [family member] recently and they look well", "Staff

are courteous and show great concern", "We are quite happy with how things are going", "[My family member] is very happy." Staff spoke respectfully of the people they cared for and knew their needs well.

People were treated with dignity and their privacy was respected. One staff member told us of the ways in which they would ensure curtains were closed and that doors were shut when supporting people with their personal care. One care worker said, "Everyone has an ensuite bathroom so we can do their personal care in private. I tell them what I am there for and then support them once they agree." Where people were more independent one staff member told us how they would prompt people to complete their daily care routine instead of providing full personal care.

Good

Is the service responsive?

Our findings

People's care files included an assessment of their needs, covering topics such as communication and networks, lists of preferred activities, keeping healthy and what successful support should look like. These files were regularly reviewed and clear actions for supporting people were recorded and acted on.

People had person centred plans in place with details of their support needs including support plans and working guidelines. Working guidelines were written in plain English that was easy to follow and contained detailed information about people's support needs in relation to a number of areas including medicines, mealtimes, activities and their day and evening routines.

Staff were clear on the individual needs of the people that they were supporting. One staff member spoke in length about one person's social interactions with their peers and their positive family relationships. Interactions that we saw between staff and people demonstrated their knowledge of people's individual preferences, likes and dislikes.

Personal care support plans were in place giving details about people's level of independence in relation to personal care so that appropriate support could be provided. Support workers were aware of the level of support that people needed, from those that needed full support to those that needed prompting. Some people had independence support plans indicating how staff could support them to be more independent in a range of activities in or outside of the home. Each task was broken down into small steps which support workers could use to promote the person's independence.

Staff completed individual daily logs for people that covered people's health and wellbeing, social interaction and activities in the community. People were supported to undertake activities such as bowling, swimming, shopping and meals out.

People were supported to communicate in their preferred manner. Records showed that where people used gestures to communicate appropriate guidance was in place for all staff to understand. Cultural needs assessment forms were completed covering areas such as clothing, personal care needs and food.

Technology was used to support people with their care and support, such as the use of tablet computers for looking at pictures and communicating. The provider was in the process of improving information recording through the use of mobile technology and tablets with a view to this being implemented towards the end of the year.

People had records in place with details of the activities they enjoyed along with a list of alternate activities that staff could offer. Where one person had expressed a wish to go on a holiday we saw that staff had arranged this. A care worker told us, "As a link worker I make sure all their needs are met, keep the family up to date and ensuring they have a good life." A relative said, "Carers take them for supper to the local pub at weekends and they belongs to Mencap's Gateway Club which they greatly enjoy."

Care workers demonstrated a good understanding of the people they supported. Care workers completed daily log books for tasks they completed during the day, evening and night. Tasks included monitoring charts, activities and night time monitoring.

There was an Intensive Support Team that was available to all services, providing advice and input to help staff support people with particular behaviour or communication that may present a challenge.

A relative said, "We feel our relationship with his carers works well and we deal with any problems that arise." Another said, "Communication between care staff and family is always easy. I have always been informed of any changes occurring within the service."

People and their relatives were able to raise concerns through an open culture at the service. They told us they knew who to speak with if they had concerns. All concerns received were recorded centrally to enable service managers and other members of the senior management team to see them. We reviewed the complaints received and saw there was a robust procedure for logging, investigating and responding to complaints within target timescales.

Outstanding ☆

Is the service well-led?

Our findings

This key question was rated 'Outstanding' at the last inspection in October 2015. At this inspection, we found the provider had maintained that rating, by continuing with some of the practices we found last time and improving in other areas.

There were high levels of constructive engagement with people, relatives and staff.

A series of listening events were held to develop a regular forum for open conversations to take place, these were hosted by a Board Member and a Director. The listening events were embedded to the provider as part of the business plan and strategy.

People using the service were empowered and given the opportunity to become quality checkers, visiting services, talking to people about their experiences and giving feedback so that services could improve. Quality checkers received formal training to enable them to carry out their roles effectively. We spoke with a person who told us, "I go and visit services, ask people how they are, what they do" and "It's important for me to do this work, it's very good, it gives me confidence."

The provider held monthly user involvement meetings called 'The Voice', where people were given the opportunity to speak up, learn and be consulted in the decisions the organisation makes. External guests from local communities were invited to talk about topics of interest such as how to complain or give feedback, how to get an advocate. One person who attended this meeting said, "We invited a policeman, he told us about safety."

A relative said, "I am also very impressed with the senior management and specialist staff of the Southside Partnership who show similar empathy and are keen to engage with relatives."

Certitude had a clear vision 'Everyone has a right to a good life' which staff were made aware of during their induction. This was supported by a five year strategy (2016-21), yearly organisation business plans and individual service continuous improvement plans which enabled the vision to be promoted throughout the organisation and down to each individual service.

The business plan stated, 'People we support and families will be the guardians of quality, in line with the Certitude quality framework and provided with the resources, support and opportunity to influence [at strategic and operational levels] both individually and collectively.' During the inspection we saw that the business plan was being implemented throughout the organisation, being led by operational senior management in collaboration with the quality team.

The continuous service improvement plans were specific for each service and underpinned the overall vision. These were rolled out across services and containing team goals, objectives and an action plan for the year that each service had developed. Examples of some of the objectives seen at one of the services included to develop and use specialist support, access to a wider range of activities and more family

involvement.

Managers were encouraged and supported to develop their leadership skills and those of others.

There was a registered manager at the service. 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.

All senior and team managers attended bespoke management development programmes called 'Leading at Certitude' and 'Succeeding at Certitude'. Registered manager forums took place which allowed the registered manager to meet other registered managers and the registered manager met with the service managers every month to share learning and best practice.

Staff were positive about the support they received from management. The provider held annual staff awards to reinforce person centred values and to recognise and reward staff achievements. Staff were given the opportunity to enhance their skills through specialist training designed in order to provide exceptional support to people such as the 'Time to Connect' project. An intensive support team, consisting of a range of professionals such as intensive interaction and total communication practitioners, Makaton trainers and positive behaviour support practitioners were also available to provide support without having to wait for referrals to external professionals.

The provider worked in partnership with organisations to build seamless experiences for people using the service and explored new ways of connecting people with their communities based on good practice. The provider was involved in the 'Treat me right' initiative which involved providing better support for people with learning disabilities following a hospital admission. This included providing training for hospital staff about how they could provide appropriate support to people using the service. The National Development Team for Inclusion (NDTi) is a not-for-profit organisation which works to promote inclusive lives for people who are most at risk of exclusion and who may need support to lead a full life. Through the NDTi Time to Connect initiative, the provider had trained staff members in a range of tools and interventions to promote greater community inclusion for people. The registered manager gave some examples where this had been used to connect people with their communities ad transform their lives.

Governance was well-embedded into the running of the service. There was a robust framework of accountability to monitor performance and risk across all the schemes. The quality team had grown since the last inspection, in line with the work they were carrying out across the organisation. They were responsible for a number of tasks including monitoring incidents and complaints across all services, satisfaction surveys, service audits and other reports related to performance and quality.

We spoke with the quality improvement partner who was part of the quality team regarding some of the quality assurance monitoring that took place. They explained that all the work they did fed into a quality framework.

All services were subject to rigorous systems of quality assurance. This included a member of the quality team completing an audit alongside a service manager from a different service. The audits looked at support records, staff records, environment, health and safety, medication and finance. Identified actions for improvement were then tracked and signed off when they were completed.

A system called 'certitrack' was in place which allowed the provider to have a greater insight to how services

were performing. At the end of each month, each service would complete a self-assessment tool including a care records tracker, medication, and food hygiene. This allowed the management team to monitor the supported living schemes and ensure they were meeting expected standards.

The senior leadership and board members also completed visits looking at people support, staff, home and environment. If any quality audits were not scoring well, they were provided with more intensive support.

We looked at records from the most recent staff survey and saw that it was highly positive. Where areas of improvement had been identified an action plan was in place to make improvements.

Incident and accidents were completed electronically on a shared document which allowed the managers and quality team to have oversight on the type of issues that were occurring cross all the services. There was evidence that the provider used incidents as a tool to learn lessons and drive improvement. Learning days were held where real life scenarios were brought forward and discussed, these were often held as a result of trends or underlying issues found during the provider's robust quality assurance checks and incident monitoring.

The Quality Team produced a regular Quality Briefing newsletter called 'Quality Matters'. This was shared electronically and in printed format with all staff teams at team meetings and on the staff boards to make sure that everyone was updated with hot topics regarding health and safety, customer satisfaction survey outcomes, audits, manager summaries, feedback and updates on improvements across the organisation's compliance and quality.

The provider was involved in a number of schemes to try to achieve and promote better outcomes and quality of life for people using their services.

The provider had piloted and rolled out a new initiative aimed at improving outcomes for people. This was called the Quality of Life outcomes and looked at eight areas - my choices, my development, my relationships, my communities, my money, my feelings, my rights and my health. Each area was explored and actions identified as to how people's quality of life could be improved. Actions were identified in consultation with people where appropriate but also their families, health professionals and link workers. We spoke with the project manager for this initiative who said the purpose was to develop a tool to monitor the outcomes for people. We saw this in place in one of the schemes we visited and we saw outcomes that had been identified for people, the six month planned follow up to see how staff had supported this person was still to come.

The registered manager told us one of their main areas identified for improvement was the access to prompt and up to date information across services and plans were in place to utilise technology in achieving this. The registered manager was part of the project team which was due to begin piloting a new electronic support plan system from September 2018 to enable this to happen.

The provider engaged all people and staff about the quality checkers programme through a number of ways. These included referencing them in the Quality Briefings that were sent to staff, putting out adverts to recruit quality checkers within services, existing quality checkers manning stalls at events where they showcased what quality checking was.