Bettertogether Limited

Newham Shared Lives Scheme

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 5 and 6 July 2017 and was announced. The provider was given 48 hours notice as the service is a shared lives scheme and staff are often out completing visits to people. We needed to be sure someone would be in.

Newham Shared Lives Scheme is a shared lives organisation based in the London borough of Newham. At the time of inspection 49 people were living in shared lives arrangements with 37 shared lives carers.

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

People told us they felt safe living in their shared lives arrangements. Shared lives staff and carers were knowledgeable about safeguarding adults from harm and abuse. Records showed the provider took appropriate action in response to allegations of abuse.

The level of detail in care plans and risk assessments varied. Although some contained a good level of detail to ensure people were supported in a safe, personalised way, other plans and risk assessments lacked detail and did not contain sufficient information to ensure safe care. Care plans did not contain enough information about medicines for them to be managed in a safe way.

Shared lives carers were recruited to the service in a way that ensured they were suitable to provide accommodation to people and their home environments were safe. After they had joined the scheme staff and shared lives carers were given the training and support they needed to perform their roles.

People had indicated their consent to their shared lives agreements. Where people lacked capacity to consent to their shared lives agreements appropriate processes had been followed. Some people had care plans that were restrictive in order to ensure the safety of people. The service had taken steps to ensure appropriate authorisations were in place and the principles of the Mental Capacity Act 2005 were followed.

People told us they were involved in preparing their meals in their shared lives arrangements. Records showed people were encouraged to eat healthy, balanced diets. The support people needed to maintain their health and attend health appointments was included in care plans.

People had developed strong, positive relationships with their shared lives carers. Shared lives carers and staff spoke about the people they supported with kindness and compassion. People were supported with their religious, cultural and relationships needs. Care plans contained details of how to support people to maintain their dignity. People told us their privacy was respected.

The service completed regular reviews and monitoring of shared lives agreements. However, the records kept did not consistently reflect the amount or level of support provided. Reviews did not show that people were fully involved and did not lead to care plans being updated.

The provider had a robust complaints policy and records showed complaints had been responded to in line with the policy. Shared lives carers told us it was easy to get in touch with shared lives staff who responded to their concerns in a prompt way. The provider was in the process of collecting feedback questionnaires from people and shared lives carers.

People and shared lives carers spoke highly of the registered manager and felt the service was well organised. The provider was in the process of developing the values of the organisation in a way that ensured they were embedded across the service and shared between staff and shared lives carers. The registered manager was linked with shared lives support networks and organisations who provided them with support and a network for sharing ideas and learning about best practice in the area.

During the inspection a number of issues with the quality and standard of documentation were identified. However, the registered manager was aware of all of the issues and had plans in place to address them.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the full version of this report. We have made one recommendation about ensuring reviews are robust and people are involved in the process.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Risks people faced were not always mitigated against and there was not enough information about people's medicines to ensure they were supported to take them safely.

Staff and shared lives carers had a good understanding of safeguarding adults, and took action to ensure people were protected from abuse.

The service followed robust recruitment practices when recruiting shared lives carers that ensured they were able to provide a suitable home to people.

There were enough shared lives staff to provide support to shared lives carers.

Is the service effective?

Good

The service was effective. Staff and shared lives carers received the support and training they needed to perform their roles.

People consented to their care and where people lacked capacity to consent appropriate processes had been followed in line with legislation and guidance.

People were supported to eat and drink enough and care plans contained details of people's dietary preferences.

Care files contained details of people's health needs and the support they needed to maintain their health.

Is the service caring?

Good

The service was caring. People had built up strong relationships with their shared lives carers.

Shared lives carers and staff spoke about people with kindness, compassion and respect.

People's cultural, religious and relationships needs were identified and supported by shared lives carers.

Supported people to maintain their dignity was embedded in care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive. Needs were assessed but the records of these assessments had not been retained in the service.

There was variation in the level of detail about people's preferences and personalisation of care plans.

Reviews focussed on shared lives carers and did not lead to people's care plans being updated.

The provider had a robust complaints process and complaints were responded to in line with this.

Is the service well-led?

Good

The service was well led. People and shared lives carers spoke highly of the registered manager and told us they thought the service was well run.

The registered manager was part of wider shared lives networks that provided support and guidance on best practice.

The service was developing its core values with shared lives carers and staff being involved with the process so the values were embedded.

The registered manager was aware of, and working to address, issues with record keeping within the service.

Newham Shared Lives Scheme

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 5 and 6 July 2017 and was announced. The provider was given 48 hours notice as they provide a home based service and we needed to be sure they would be available to meet with us.

The inspection was completed by one inspector.

Before the inspection we asked for feedback from the local authority where the shared lives scheme is based and from the local Healthwatch. We reviewed the information we already held about the service in the form of notifications they had submitted to us.

During the inspection we spoke with four people who lived in shared lives arrangements, seven shared lives carers and four staff including the registered manager and three shared lives project workers. We reviewed six shared lives carers files including recruitment, selection and reviews. We reviewed the assessments and care plans for seven people. We also reviewed training and supervision records for shared lives carers and staff, various policies, procedures, meeting minutes and audit records relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Staff were knowledgeable about the risks people faced in their day to day lives and described the measures in place to mitigate risks to people. For example, where people were at risk due to lack of road safety awareness, or had memory problems that put them at risk of getting lost in the community, staff described measures in place to mitigate these risks. These included supervision by shared lives carers when accessing the community and travel training.

However, care plans and risk assessments did not fully capture the risks people faced or measures in place to mitigate them. For example, one person's care plan identified that they had dysphagia. Dysphagia is a condition where people have difficulties swallowing and puts them at risk of choking. Although the care plan did state the person should only eat soft foods in small pieces and that shared lives carers should encourage them to eat slowly there was no specific risk assessment about dysphagia and no descriptions of the indications of choking or how to respond to incidents of choking. This meant the risks had not been fully assessed or mitigated.

Another person was at risk of harm due to behaviours which put them and those around them at risk of harm. Although their care plan contained some risk assessments with measures in place to mitigate risks, these were not comprehensive or robust. The shared lives service and carers relied on a risk assessment produced jointly with the local authority which only addressed four areas and did not cover relationships which had also been identified as an area of risk for the person and their shared lives carers. The measures in place provided insufficient guidance for the person and shared lives carers. For example, to address one of the risk areas the plan was "To look at ways that structure is in place." This did not detail what structures might be helpful to the person to mitigate risks. After the inspection the provider sent us an updated risk assessment for this person. This contained a greater level of detail regarding the steps that should be taken to mitigate risks.

Needs assessments and care plans included information regarding whether people needed support to take medicines as prescribed. People's medicines were listed in the documentation. However there were insufficient details regarding the nature of medicines or prescription information to ensure shared lives carers had the information they needed to administer medicines in a safe way before people commenced their placements.

The registered manager told us they required shared lives carers to record medicines administration on medicines administration records and that these were checked by shared lives officers during support and monitoring visits. However, this was not captured in the records of the monitoring visits and the records remained in people's homes so we were not able to review them.

Records showed where errors were identified in the medicines records appropriate action was taken. This included training for shared lives carers and liaison with medical professionals. Shared lives carers told us they received training in medicines. One shared lives carer told us, "We had training on medicines before we started having people live with us." Training records showed shared lives carers had their competence to

administer medicines assessed and reviewed by shared lives staff.

The above issues with risk assessments and medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I do like living here with [shared lives carers] because I feel contented, happy and also safe." Staff and shared lives carers had received training in safeguarding adults both as part of their induction to the service and as stand-alone training sessions. Records of incidents and investigations showed staff appropriately identified and escalated concerns that people may have been abused. During the inspection an incident took place which constituted an allegation of abuse. Staff responded in an appropriate way, putting measures in place to ensure the person and their shared lives carers were supported and protected from further harm while making appropriate referrals to the police and safeguarding authorities.

Shared lives carers were confident in what they would do if they were concerned that a person was being abused. A shared lives carer told us, "I'd call the office and tell them what I knew. They would tell me what to do and if there was anything I needed to do." The shared lives staff operated an out of hours on call telephone support service for people and shared lives carers to call if there was an emergency outside of office hours. A shared lives carer told us this worked well. They said, "The on-call works. They get back to you straight away if you contact them." Another shared lives carer told us they had used the on-call system when a person had just moved into their home and was behaving in a way that caused them concern. The shared lives carer told us the on-call response was helpful and reassuring. The systems in place meant people were protected from avoidable harm and abuse.

The service employed four shared lives project workers as well as the registered manager. These staff had transferred to the service from the previous organisation that had managed the scheme. Shared lives carers told us they felt there were sufficient staff available to them to ensure their needs as shared lives carers were supported. They told us there was always someone available from the scheme to support them. One shared lives carer told us, "The office are really good. They always get back to us and check we are OK if we phone them up."

The service had recruited new shared lives carers since it had set up as an independent business a year ago. Records showed staff from the service completed a comprehensive assessment of potential shared lives carers which included an evaluation of their experience and values as well as the physical environment of their home. Assessment and recommendation reports completed by the service showed staff considered shared lives carers previous experience and skills in deciding whether or not to recommend them as shared lives carers. The provider collected employment and character references to ensure shared lives carers were suitable to provide a service. In addition, they carried out checks on people's criminal records histories to ensure they were suitable to provide a safe home environment to people.

The service followed best practice guidance to ensure that shared lives placements resembled family life and did not place more than two people in the same household in the long term. Records showed the service did not accept referrals where they did not have capacity to provide a suitable placement for people. The provider explored different methods of recruiting shared lives carers, including attendance at events, local advertising and word of mouth. The provide found most shared lives carers found the service through word of mouth and social connections with existing shared lives carers. This meant the service ensured they had sufficient shared lives carers to meet people's needs.

Good

Is the service effective?

Our findings

Shared lives carers told us they received the training they needed to be able to support people in their homes. One shared lives carer said, "We get our training, we have a meeting every month." Another shared lives carer said, "There's been plenty of training, and they do workshops to update us." Records showed both shared lives staff and carers received training in areas relevant to their roles. The service was in the process of rolling out the Care Certificate for shared lives carers. The Care Certificate is a recognised qualification in care that ensures staff have the fundamental knowledge required to work in a care setting. The shared lives project workers had received training in supervision as this had been identified as a training need through their supervisions.

Shared lives project workers received supervision in line with the provider's policy. Records showed these meetings were used to discuss staff welfare, people's placements, any issues with shared lives carers and to monitor progress with appraisal goals. Each member of staff had a personal development plan with specific goals which related to the organisational objectives. Shared lives carers received support through regular monitoring visits which were used to identify training and support needs. Shared lives carers told us they felt supported by the project staff. One shared lives carer told us, "[Staff member] is my officer. She calls in on me and is prompt to offer help if I need it." This meant staff and shared lives carers were given the support and training they needed to perform their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Staff demonstrated they understood the fluctuating nature of some people's capacity to make decisions about their care. This was clearly demonstrated in one person's care plan where their capacity to make decisions was recognised as being fluctuating and the service had made appropriate referrals for a comprehensive capacity assessment to be completed by a qualified professional. Where people had capacity to consent to their shared lives arrangements this was clearly recorded in their records as they had signed copies of their shared lives agreements.

Where people did not have capacity to consent to their shared lives arrangements there were appropriate records that showed best interests decisions making processes had been followed. It was noted that a relative had signed a form regarding consent to share information without demonstrating they had legal authority to provide this consent. This was discussed with the registered manager and staff from the service who explained the person had had capacity when they joined the service, but due to their health conditions they no longer had capacity. The person's relative was in the process of applying for legal authority to make decisions on their relative's behalf.

Some people's support needs were such that their care plans were restrictive. For example, people were not

able to access the community without a shared lives carer being with them due to risks to their health and safety. In community settings, restrictive care must be authorised as being appropriate by the Court of Protection. The service was liaising with the appropriate local authority representatives to ensure the appropriate court authorisations were in place where people's care plans were restrictive. This meant the service was working within the principles of the MCA.

People told us they were supported to eat what they liked by their shared lives carers. One person told us, "I help with the cooking." Another person showed us photographs of them helping their shared lives carer in the kitchen. Care plans contained details of people's dietary needs and preferences and the support they needed to eat. For example, one person's care plan listed different foods they were known to like, but also stated, "I will say 'juice' or 'chips' when I am hungry or thirsty but I would not choose or say other items." The care plan explained how to support the person to have a balanced diet. This meant the service ensured that people were supported to eat and drink enough and maintain a balanced diet.

People and shared lives carers told us they were supported by the service to ensure people's health needs were met. One person told us, "[Shared lives carer] comes with me to the doctor and hospital appointments." A shared lives carer told us, "The service was very helpful with their health issues. They help us find services to support him." Care plans contained details of people's health conditions and the support they needed to access healthcare services. Where appropriate, the service ensured that people had health action plans in place. Health action plans are documents containing information about people's health conditions and the support they need to stay healthy. They are considered good practice in supporting people with learning disabilities as they ensure that all health information is contained in one place and is easily available to all the health professionals involved in their care. Monitoring visit records showed shared lives staff checked that people had been supported with healthcare appointments and routine checks. They also showed the shared lives staff supported people and shared lives carers with professional referrals to specialist health services where this was required. This meant people were support to maintain their health and access healthcare services as appropriate.

Good

Is the service caring?

Our findings

People and shared lives carers told us they had developed strong relationships with each other. One person said, "I think [shared lives carer] is like a mother to me, she is very caring, understanding and she makes me laugh. She is a good listener." Observations showed shared lives carers smoothly facilitated communication with kindness and patience. This demonstrated the shared lives carers knew the person very well and they supported them to be involved in the conversation.

Care plans contained information about people's cultural background and religious beliefs including the support people required to practice their faith. People and shared lives carers told us they attended their places of worship, with support if required. One shared lives carer explained, "Both the people who live with me cherish their faith. They go to their own churches, and I go to a my church. We invite each other when there are special events at our churches. It's [our faith] something that we have in common but do separately."

Care plans included information about people's significant relationships and the support people needed to maintain them. People and shared lives carers told us they were supported to maintain these relationships and people were involved with the family lives of their shared lives carers. One shared lives carer explained how, with the person's agreement, they were visiting relatives in a different part of the country for a large party next week. The person indicated they were looking forward to the party.

Assessments and care plans considered people's needs in relation to sexual relationships. This included whether people identified as lesbian, gay, bisexual or transgender (LGBT) and ensured care plans and shared lives carers were clear on how to support people with all types of relationships. A shared lives carer told us, "[Person] is young, but they've not really spoken about having a girlfriend or a boyfriend. We talked about it once and he just looked at me like I was mad. He wasn't ready yet, but he'll talk when he's in the mood. He'll give you snippets and if you time it right he'll talk more." This meant people were supported with all aspects of their relationships needs in a sensitive way.

People and shared lives carers told us they respected each other's privacy and had time on their own when they wanted. One person said, "I've got my own bedroom. It's got all my things in it. It's my space. They [shared lives carers] don't come in without my permission." A shared lives carer explained, "Of course we give people privacy. I'll check that they're OK, but then their time is their own." Where people needed support with intimate care, care plans contained details about how to uphold their dignity during these tasks. This meant people were treated with dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

People and shared lives carers gave us mixed feedback about the amount of information they received about each other before shared lives arrangements started. One shared lives carer said, "We didn't know much about him before he visited. We used our knowledge to work it out." However, another shared lives carer told us, "Of course we get enough information before we start, otherwise we wouldn't know how to support them."

The registered manager recognised that the amount of information available to shared lives carers about people varied depending on the urgency of referrals. When there was an urgent need for a swift placement they were not always able to gather lots of information about people's needs and preferences before placements started. The registered manager explained the risks of placing people with limited information were mitigated through initial placements being made with experienced shared lives carers who had the knowledge and skills to identify and adapt to people's needs during the first few days of a placement.

The provider completed a needs assessment when people were referred to the service. This considered people's personal care needs, personal safety inside and outside the home, eating and drinking, daily living skills including finances, health issues, communication, mobility, activities and other areas that people may need support with. The provider told us this was used to form the basis of the initial care plan. The initial assessments had not been retained in the service's files after they had been used to create the care plans. The provider recognised these should be retained in future to demonstrate people's needs had been assessed before they were accepted into the service.

The level of detail in care plans varied according to the level of detail received by the service by the referring agency. The registered manager recognised that care plans reflected the knowledge the service had at the start of placement, and had not always been updated to reflect new information learned about people. For example, one person's care plan regarding activities stated, "No preferences known at the moment." The plan suggested the shared lives carer try new things with the person to establish their preferences. Discussion with staff revealed they had good knowledge of the preferences this person had developed, but the care plan had not been updated to reflect this. Other care plans viewed contained a greater level of detail regarding people's needs and preferences. For example, one file contained a detailed transition plan and clear information about their communication and ability to be involved in household tasks. For example, their plan stated, "I will take my plate to the sink. I do not wash up."

The provider recognised that matching of people to shared lives carers was primarily based on the capacity of shared lives carers to receive people into their homes. However, they recognised once the highest level need of placement had been met, that more detailed matching based on shared interests, values and culture was made. This had led to some shared lives carers not having anyone living with them for some time, as their homes would not be a suitable match for people who did not share their cultural background. The matching process was not recorded. However, a team meeting was observed during the inspection and staff had detailed discussions regarding possible matches based on their extensive knowledge of people and shared lives carers. The registered manager recognised the need to record the decision making process

for matching people with shared lives carers.

People and shared lives carers told us they completed introductory visits and meetings before placements were agreed. One person told us, "They [shared lives staff] had told [shared lives carer] about my past, and then they came to meet me. We got on OK and I agreed to move in." A shared lives carer told us, "We were introduced to a couple of people before [person] came to live with us. We needed to make sure it was someone who would get along with the whole household. He came for a visit first to meet us first." Another shared lives carer told us, "When people first move in, it's a three month trial to see if it's working. If it's not working, if it just isn't the right fit for the family they [shared lives staff] help us to help the person move on."

Shared lives carers told us staff visited them regularly to monitor the placements. Records showed there had been a period of time when the provider had taken over the service when these monitoring visits and reviews had lapsed. This had been identified by the registered manager and records showed monitoring visits and reviews were now being completed regularly by shared lives staff. Reviews considered feedback from people living in the placements, observations of interactions between people and their shared lives carers, and identified any training needs for the shared lives carers or any issues that they needed support in addressing.

The reviews focussed on the skills and abilities of the shared lives carers. Although feedback was sought from people, there was no record they had been asked in detail for their views on the placements independently of their shared lives carers. Although placements were reviewed at least annually, care plans were not updated to reflect changes in people's needs and skills.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring reviews of shared lives arrangements are robust and include both people and shared lives carers.

The provider had a robust complaints policy with clear timeframes for investigation and response. This was provided to people and shared lives carers as part of the introduction pack to the service. The service had received one formal complaint which had been thoroughly investigated and responded to. The provider also held quarterly meetings with shared lives carers. Minutes of these meetings showed they were used to celebrate successes and achievements as well as providing an opportunity for shared lives carers to raise any issues or concerns. The minutes showed actions were taken in response to concerns raised. This meant the service listened to and responded to feedback received.

Good

Is the service well-led?

Our findings

People and shared lives carers spoke highly of the registered manager. A shared lives carer told us, "It [organisation] feels organised. I'm very happy with the service and how it is organised." Another shared lives carer told us, "[Registered manager] is a good leader. She keeps on top of it all. Whenever I need anything from the service it gets sorted out." Observations during the inspection showed the registered manager and shared lives staff spoke about the people they worked with and shared lives carers with compassion and demonstrated they really cared about the quality of life people lived in the service. This was shown by how distressed the staff team was when a serious incident was disclosed during the inspection.

The service had a registered manager in post. The registered manager was also chair of the London Shared Lives Network. This is a support network for shared lives schemes and involves regular meetings of shared lives providers in London where information about best practice in shared lives schemes in shared. This role meant the registered manager also attended national shared lives network conferences and was able to gain information and knowledge from shared lives schemes across the country. The registered manager was utilising this network to research for an appropriate information management system for the service. The registered manager had identified that the current case recording systems in place were not robust and did not capture the work of the shared lives scheme in a way that reflected the work completed.

The shared lives service had previously been provided within the local authority. In June 2016 they had become an independent not for profit company limited by guarantee. During the handover and set up of the new legal entities they had continued to deliver the shared lives arrangements that had been in place prior to the transfer, and had set up new placements. The registered manager recognised and acknowledged that this had been a huge undertaking and some of the quality assurance mechanisms had lapsed during the transition. This had been identified by the registered manager and work was underway to ensure quality assurance was completed.

The provider had facilitated an away day and a specific team meeting with staff to consider the core values of the organisation. There had been a further meeting with shared lives carers to ensure that the values of the organisation were clear and embedded across the organisation. The meeting had been used to prioritise different values proposed and ensure there was agreement and commitment to the values of the scheme. This work was still in progress, but there was broad agreement that values focussed on compassion, respect, commitment, tolerance and communication were priorities for staff and shared lives carers.

The provider had developed a plan for the organisation based on PATH, a creative planning tool. This had been broken down into various stages with clear goals to help the organisation develop. The goals within this plan had been used as the basis for individual staff appraisal goals which demonstrate the organisation was working towards a common purpose.

The provider was in the process of supporting people and their shared lives carers to complete feedback questionnaires about their views on the service. This was a questionnaire provided by Shared Lives Plus, a support organisation for shared lives schemes. Those returned so far showed people were mostly happy

with the support they were receiving and felt shared lives arrangements supported them to feel part of a family and have greater access to the community than their previous living arrangements.

The registered manager submitted monthly reports to the local authorities who funded packages. These considered progress against the target number of referrals as agreed in the business plan when the provider became independent of the local authority. These also contained information about any particular issues or concerns, such as incidents and safeguarding alerts that had taken place during the month. There was no evaluation of quality of the service within the contract monitoring with the local authority.

During the inspection a number of issues with the quality and completeness of information and records were identified. For example, needs assessments had not been retained, some care plans lacked details, monitoring and support provided to people and shared lives carers had not been captured in a consistent way. Throughout the inspection the registered manager was open and transparent about the issues that were identified, and had been aware of them prior to the inspection. The registered manager was working with support organisations and their networks to find better ways of recording information and capturing the work they completed.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not always been identified and addressed through risk assessments. There was insufficient information on medicines in people's care files to ensure they were managed in a safe way. Regulation 12 (1)(2)(a)(b)(g)