Northern Life Care Limited

# UBU - Harrogate

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

We inspected UBU-Harrogate on 9 and 11 August 2016. This was an announced inspection. We informed the provider the week before that we would be visiting to inspect. We did this because we wanted to make sure the registered manager would be available at the registered location office.

At the last inspection of UBU-Harrogate on 15 April and 22 May 2014 the provider was meeting all the regulations that were assessed.

UBU-Harrogate provides personal care to people who live independently on their own or in shared houses or individual flats in larger complexes. The registered location is in Harrogate in North Yorkshire. It provides a range of care and support services to 420 people in 102 properties over the North West, North Yorkshire, West Yorkshire, the East Midlands and in the North East of England. Most people who use the service are young adults with a mental health illness and / or learning disability.

The service has 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.

Comprehensive risk assessments were completed and these covered practical and emotional issues. Risk assessments were reviewed and updated on a regular basis.

Staff had a good understanding of safeguarding processes and followed these in practice. A document called 'Keeping safe' was held on people's records and this included useful information on how to keep safe on the internet.  People were given special cards called 'alert' cards, which they could use to contact a senior manager in the organisation if they had any worries or were upset.

Staffing was organised according to agreed care packages. Where new services had been developed we were told that staff had been recruited to these posts, meaning staff could be recruited with shared interests with the people they supported. People told us that they were involved in the interview process, and looked to appoint staff who were kind.

Some areas had staff vacancies. However, appropriate measures were in place to address these.

There were detailed care plans around the support people needed to take their medicines safely.

Training was well organised and staff were knowledgeable about the needs of the people they worked with to support them as individuals.

We have made a recommendation in relation to the interpretation and delivery of the Mental Capacity Act

2005 (MCA). Best interests meetings and documentation about the use of monitoring equipment was not as clearly documented as they should be to demonstrate that decisions were made in line with the principles of the MCA.
We received positive feedback from people who used the service. We saw that where they had raised issues people were listened to and action was taken in response.

Care planning and assessments were very detailed and these were updated to reflect people's current and changing needs. We have made a recommendation that the provider reviews best practice guidance on care planning for people who use mental health services, to enhance staff understanding and knowledge and support the smooth transition of people between services.

Good systems were in place for people to give feedback on the service they received through survey responses, audits and meetings.

Effective management systems were in place for the provider to monitor the quality of the service and drive improvement. This included independent monitoring through accredited awards such as the Investors in People gold award and Customer First award. Senior managers knew people very well and provided a person centred, inclusive culture for the benefit of people using the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People were protected by the provider's approach to safeguarding and whistle blowing.

While some services had staff vacancies, measures were in place for the on-going, safe recruitment of staff.

Risks were identified and action was taken to reduce risks while supporting people's rights and freedoms.

There were safe systems in place for managing medicines.

Systems were in place to manage accidents and incidents and minimise the likelihood of their reoccurrence.

### Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received on-going training and support to ensure they carried out their role effectively.

Staff had received training on the Mental Capacity Act 2005 (MCA). However, records were not always available to show that staff were acting within the principles outlined in the MCA. Easy read documents in people's care records did not focus on the law as it related to supported living settings.

People were involved in planning, cooking and shopping for their meals where they were able.

Arrangements were in place for people to access health professionals and services.

### Is the service caring?

Good

The service was caring.

The organisation's values and culture included principles of fairness, kindness, respect and responsibility. People told us they

were involved in interviewing and looked for kindness in the staff they employed.

People confirmed staff helped them to lead independent lives and that they were treated with respect and dignity.

People were comfortable and at ease with the staff who supported them. Staff took time to speak with people, to listen to what they had to say and responded in a kindly way.

Staff spoke positively about their work and they were respectful when talking about the people they supported.

People who used the service had access to advocacy services to represent them.

## Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and detailed care and support plans were in place.

Care plans were comprehensive and included detail on how to support people who may become anxious and distressed.

People were supported to follow their own interests and pursuits.

People were confident that they could raise any issues of concern. We observed people were reminded about the complaints process and supported to follow this when they had a complaint.

## Is the service well-led?

Good

The service was well led.

Effective management systems were in place to safeguard people and to monitor and improve the quality of the service provided.

Staff told us that the organisation's core values were explicit. They said managers were approachable and helpful.

People were asked about their views of the service on a regular basis.

# UBU - Harrogate

**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.

We inspected UBU-Harrogate on 9 and 11 August 2016. This was an announced inspection. We informed the provider the week before that we would be visiting to inspect. We did this because we wanted to make sure the registered manager and other key personnel were available to speak with us at the registered location.

The inspection team consisted of two adult social care inspectors, an inspector with the Hospitals Directorate (Mental Health) and two experts by experience. Another four inspectors assisted with telephone interviews with people who used the service and with staff.

Before the inspection the provider completed a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all of the information we held about the service such as safeguarding notifications sent to us by the registered manager. A notification is information about important events which the service is required to send us by law. We sent questionnaires to 49 people who used the service, 93 staff, 49 relatives and 66 community professionals involved in supporting the people who used the service. We planned the inspection using this information.

On 3 August 2016 the three inspectors met with a group of 54 people who used services provided by UBU-Harrogate and staff members. We met with people individually and in small groups and we observed how the staff interacted with people who used the service and with each other. We spoke with the staff who supported them. This included the registered manager; quality and clinical managers; two specialist managers; and a service manager. We viewed risk assessments and documents including 'My holiday plan', and 'Get me better plan'.

Two adult social care inspectors visited the agency office on 9 and 11 August 2016. We spoke with the organisation's chief executive officer and two chief operating officers; the quality manager; two regional

development managers (one of whom was also the registered manager); and an independent practitioner who also sat on the clinical board and carried out assessments and training for the organisation. We reviewed records relating to the management of the service such as staff recruitment and training; policies and procedures developed and implemented by the provider; quality assurance systems; survey responses and audits. We reviewed care records, including support planning documentation and medication records for eight people in detail. We looked at the support plans for another 10 people to check that information was available, they had been signed and dated, and had risk assessments and reviews.

Following our visit to the agency office two experts by experience and a group of inspectors spoke with people who used the service and staff by telephone to ask for their views about the service. We contacted 17 people who used the service and 31 members of staff.

Good

# Is the service safe?

## Our findings

Policies and procedures for safeguarding adults and whistleblowing were in place and these were accessible to members of staff. Records showed that staff received safeguarding training and staff confirmed they had refresher training on a regular basis. This helped to ensure staff had the necessary knowledge and information to protect people from harm. The staff we spoke with were aware of how to make referrals and knew that safeguarding teams could also be contacted for advice about specific incidents.

The registered manager told us that issues about abuse and safeguarding were discussed on a regular basis with staff at supervisions and staff meetings. Staff confirmed this to be the case. We found staff had a good understanding and knowledge of safeguarding processes. When asked, one member of staff explained safeguarding as, "Any area where a person is in a compromised or vulnerable position. Protecting [people] from any sort of abuse, financial harm or damage and put appropriate measures in place."

Staff told us that they would refer any issues of concern to their manager. One member of staff said, "We have a very good support network in place and I feel that both [people who use services] and staff feel safe and protected from any forms of abuse." Another staff said, "First of all, report to my line manager and use the on-call system if needed. But we all take responsibility to inform the safeguarding team if the manager is not available and make sure people are safe."

People's care records included information about keeping safe. People's files contained useful documents titled 'Stay safe' and 'Staying safe from people who pretend to be your friend', about safe internet use. When we spoke with people they confirmed that staff regularly discussed this aspect of care with them, particularly where this could be an area of risk. People using the service and their relatives had 'alert' cards, with the contact details for a manager. The quality manager gave us an example of when people had contacted them and the responsive action the provider had taken. This included putting a specialist support team into services to address shortfalls and effect improvements. People who used the service told us that if they were upset or had any worries they would speak to a member of their family, to a manager or one of the staff team. Comments we received included, "I speak to [the manager] if I am upset by anything," "I trust them [the staff], "They keep me safe when I am out," and, "They take good care of me. I feel safe."

The service regularly raised safeguarding notifications about incidents between people who used the service. The service had a clear approach to people's safety and responded in a timely way to address such incidents, to make sure protection plans were put in place when issues between individuals were identified. Where needed, medical and psychological advice was sought to minimise potential risks. People's records contained evidence of this happening.

We looked at the arrangements in place to manage risk, so that people were protected and their freedom was supported and respected. We saw risk assessments had been generated following an assessment of people's needs. People who used the service were involved in developing their risk assessments and included in agreed actions. Risk assessments were personalised and linked to people's support, together with guidance for staff on keeping people safe while also supporting their independence and positive risk

taking.

Staff had completed relevant training on how to respond when people were at risk of causing harm to themselves or others. There was detailed information about the different ways people expressed that they were unhappy or upset and how to provide positive support. For example, we saw care records included details of how a person's body language and behaviour would alert staff if there was a problem. They contained detailed intervention plans for when people were distressed or anxious, which gave staff clear information about the action to take to keep people safe. One person told us they had a 'panic button', which they could use if they were upset. They said staff always responded promptly and this helped to reassure and calm them.

We saw that risk assessments were reviewed every 3 months or sooner if required and staff told us managers alerted them to any change and checked they had read these. For people on holiday we saw that risk assessments were developed to provide staff and others with information about how they could ensure an individual's safety while away from home.

Generic risk assessments were also undertaken covering fire safety, first aid and people's home environment. People were involved in the routine health and safety checks undertaken in their homes and we were told checks included door and bed alarms where these were fitted.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of re-occurrence. The provider's chief operating officer explained the levels of scrutiny that all incidents, accidents and safeguarding concerns were subjected to within the organisation. This included computer generated management reports, audits and quarterly safeguarding reviews.

Robust recruitment processes were followed. The staff recruitment process included completion of an application form, a formal interview, previous employer references and a Disclosure and Barring Service check [DBS] which was carried out before staff started work at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions.

Prospective staff applied online and those suitable were invited to planned weekly or fortnightly interview dates, where their documentation was checked, and applicants were invited to give a presentation and undergo a formal interview. People who use the service also participated in these sessions, which they told us they enjoyed. Staffing levels were set according to individual assessed needs and the registered manager said these were kept under review to ensure they remained relevant and appropriate.

Some people told us that they had a settled staff team and that they did not use agency staff. In other cases people told us that they sometimes had agency staff, which they did not like. The registered manager explained that each area had its own business plan regarding staff recruitment and retention. They told us about the measures in place to address staff vacancies. This included attendance at staff fairs, recruitment road shows and venues such as at shopping centres and football games. One regional development manager told us staff recruitment in their area had been successful and they aimed to dispense with the use of agency staff within the next month. Where agency staff were used they requested the same agency staff so people could get to know them and they said this helped to provide more consistent care.

Appropriate arrangements were in place to support people to manage their medicines. Information regarding each person's support requirements was held on their file. This included the provision of locked facilities for those people responsible for administering their own medicines. In addition to a weekly

medicines audit staff told us they received training on the administration of medicines and had monthly administration observations. This meant that there was a system in place to ensure that people received their medicines as prescribed. Regional development managers carried out a medicines audit quarterly. These covered the use of self-administration and the use of covert medicine administration when this formed part of a person's care plan. Covert administration is the administration of any medical treatment in disguised form.

In their PIR the provider told us about plans to improve the audit system. We noted that the current system allowed the auditor to modify the checklist being used. In addition, we noted that areas highlighted for improvement did not always include a timescale, making it difficult to measure progress. The registered manager said that plans were in place to computerise the medicines audits in line with other audits already taking place and thus making it easier for the registered manager to check for accuracy and consistency.

Requires Improvement

# Is the service effective?

## Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.. The application procedure for this in care settings is called the Deprivation of Liberty Safeguards (DoLS) and can be legally authorised by the local authority. However, this is not relevant for people who receive domiciliary care in their own homes and the people who used the supported living service provided by UBU-Harrogate, are considered 'tenants' within supported living accommodation. This means any decision to deprive a person of their liberty must be legally authorised by the Court of Protection.We were told that applications had been made to the Court of Protection but the service was awaiting the outcome from these.

We checked whether the service was working within the principles of the MCA. We saw examples in people's files of best interests decisions being made, and the involvement of advocates when applications were made to the court of protection. For example, the change of the service to a tenancy from residential care and the involvement of the local authority and courts in approving the tenancies. We could see people had been consulted together with other professionals when decisions were made. For example, for one person we saw a best interests decision was made to restrict the person's access to snack food. Best interests documentation included consideration of fluctuating capacity and included the methods that were used to assist the person to understand the decision making process. One example was the use of picture cards.

Care files contained an easy read document about the MCA and how people's liberty might be restricted lawfully. This demonstrated inclusion and understanding of consent and restrictive practice. However, this document referred to the use of the Deprivation of Liberty Safeguards (DoLS) application procedures which are in place for care homes and hospitals. The staff we spoke with also referred to DoLS and one person told us that they had agreed for a DoLS to be put in place. When we met the person they said they had changed their mind and were unhappy with this decision. This person's records also demonstrated they did not like the restrictions placed upon them. We spoke with the community psychiatric nurse about the care of this person. They explained that the decision making process had been undertaken through the Care Programme Approach (CPA) under the Mental Health Act 1983 on their discharge from hospital. However, the person's file did not contain clear information about the decision making process. Another four people whose files we looked at had telecare monitoring, either door sensors or bed sensors to alert staff of their movements. It was clearly documented and risk assessed about why telecare was required but information about best interests meetings or authorisations made by the Court of Protection were not evidenced in these cases. This could place people at risk of restrictions that were not in line with the requirements of the MCA.

We recommend that the provider reviews the guidance for consent to care and treatment in the Mental Capacity Act 2005 and associated Code of Practice.

For some people we were told they had experienced more than one admission to hospital due to deterioration in their mental wellbeing that required hospital care. We saw that crisis plans were not in place to progress people's treatment urgently without them attending accident and emergency (A&E). This could cause delay and further distress and difficulty for people who require urgent treatment and for staff. We heard of two recent occasions when a person had left the A&E department before they could undergo an assessment from a mental health practitioner. This potentially placed both themselves and other people at risk from their distressed reactions. Guidance on the development of crisis plans is contained in The National Institute for Health and Care Excellence (NICE) publication 'Transition between in patient mental health settings and community or care home settings', which was issued in August 2016. We discussed the development of crisis plans as part of people's care planning with senior managers for them to discuss further with people's health practitioners who would have the responsibility for progressing these. This would help improve the way people's treatment is planned and carried out when they move between services.

We recommend that the service finds out more about crisis planning, based on current best practice, in relation to the specialist needs of people who use mental health services.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people who used the service. We saw that staff had undertaken training in a range of topics. Staff we spoke with told us they received training relevant to their role. One staff member told us, "We have a training calendar which shows all the training which needs refreshing. I have also done epilepsy and autism training."

Each person using the service had a comprehensive 'All about me' assessment which was completed before receiving care. These identified people's support needs and plans, risk management, together with people's ambitions and goals for the future. This meant that people's preferences with regard to their care and support needs were known and the quality manager told us this enabled managers to identify staff training requirements. For example, for some people there was a requirement for staff to undertake accredited training on management and intervention techniques to cope with escalating behaviour in a safe way. The independent training provider for this course was also an independent practitioner. They were a member of the clinical board and undertook pre admission assessments and reviews for the organisation. This meant that the training provided was highly relevant to the care needs of the people using the service.

Staff had access to e learning, together with classroom based training delivered by external providers. Staff told us they completed training that the provider considered mandatory for all staff and in addition they said they could check the training calendar and request a course that interested them. One member of staff told us, "We do yearly mandatory training and I have also done training on epilepsy, autism and mental health." Another staff member said, "The training is good. I recently completed safeguarding, and this included dignity and respect."

Each member of staff had a named manager who provided them with regular supervision. Some staff told us that staff vacancies impacted on the frequency of their supervision sessions. For example, one staff told us, "I am meant to have a meeting with the manager, every two weeks I think. This doesn't always happen. It gets cancelled due to short staff." However, other staff confirmed they received regular supervision sessions and we saw records to confirm that supervision, observations and annual appraisals had taken place. One staff told us, "Managers are approachable. We have a support session [supervision] usually every month. If I

need to speak with anyone outside of that they are very approachable." One of the service managers we spoke with said, "I have monthly individual support sessions with staff. We discuss how staff are, any concerns, and their development options."

Induction processes were in place to support newly recruited staff. This included reviewing the service's policies and procedures, undertaking the Care Certificate and shadowing more experienced staff. These were supernumerary hours on the rota, meaning that new staff had time to learn before providing care. The Care Certificate is a set of standards that social care and health workers are expected to follow. This covered the minimum standards that should be part of induction training of new care workers. Staff told us that guidance was provided by the registered manager and support managers in regard to work practices. One staff said, "The team get on well and it is a stable team. We understand how to support the people at [Name]. We share knowledge and good practice."

Staff told us that menus and food choices were discussed with people who used the service on a daily basis. One person told us that they would like more help to prepare food that reflected their cultural background. However, most people told us that they discussed their food choices and were helped to prepare the food of their choice.  One person had limited access to their snack food but this was agreed as part of their care plan. When we spoke with the person they fully understood the arrangements in place and explained how they kept their food in a store cupboard and staff helped them access this at agreed times.

People were supported to maintain good health and had access to healthcare professionals and services. Risk assessments were undertaken in relation to people's health needs and we saw referrals had been made to appropriate health professionals such as dietitians, occupational therapists and mental health services. Records showed us that people had an annual health check and any issues were reported to families (as appropriate) and care plans updated. People who used the service confirmed they were consulted about their health care needs and had access to healthcare professionals. Specialist support was sought when required including community mental health services.

Good

# Is the service caring?

## Our findings

Policies and procedures on dignity and respect were in place. The provider told us in their PIR that the interview process focused on the organisation's values and culture, which included fairness and kindness, respect and responsibility. They said that the interview process focused on the caring qualities and attributes. One person who used the service told us, "Sometimes I do some interviewing. I look for kindness, not someone who is miserable."

People told us they were treated with respect and dignity. They said they were involved in planning their care and support needs and these were reviewed and updated regularly. People told us that they were able to exercise choice and control and were encouraged to maximise their independence. One person said, "I like to be independent and I like to go out and this is reflected in my [care] plan."

When asked if staff were caring and kind one person told us, "They are absolutely brilliant and amazing with me." Another person said, "I like all the team. [Name] is lovely," and, "It is great, I can do whatever I like." Other comments we received about the staff included, ""They are very helpful and kind in every way," "They are kind and caring. They listen to me really well," "The staff here are very good," and, "They take good care of me; they are kind and caring and very supportive."

People said they were appreciative of the support that was available. People told us they were helped to access health services and independent advocacy to help them on their behalf. For example, one person told us that staff helped them with their healthcare by being present when they rang the GP, and that they went with them when they had a GP appointment. One person told us, "The staff are really nice. If you press the buzzer someone always comes. There is someone [staff] here 24 hours, which is good." Another person said, "The staff are very good and there is always someone around." People told us that staff respected their privacy. One person commented, "When someone buzzes your flat, the [staff] always ask first if you want them to let them in." Another person said, "If my family or friends are here, my carers make sure I have quality time with them. They tell me they will come back later and to buzz if I need them."

Feedback from staff included, "I love the job. It is very rewarding," "I enjoy working with other people. I love feeling I am helping", "It's very rewarding when people I support achieve things," and, "I love my job, best thing I ever did was to join UBU." Another staff member said, "I have progressed in my job and never looked back. I am happy and if I gave a score out of ten it would be a ten."

When we met people who used the service they appeared comfortable and at ease with the staff who supported them. Staff were patient and took time to listen to people and engaged positively with them. Staff spoke with warmth and were respectful when talking about the people they supported. It was evident from our discussions that staff knew people well, including their personal history, preferences, likes and dislikes. We saw all of these details were recorded in people's support plans. Several staff told us about the care needs of people who were non-verbal and how they got to know about their care preferences. One staff member said, "Staff know people well and know their ways of letting them know things. For example, [Name] smiles when happy and pouts if they do not want something." For another person staff said, "Staff

know and understand the different sounds that people make, so we know what they mean."

Dignity champions promoted people's life choices with regard to their religious beliefs, life-style choices and preferences and we saw these formed an integral part of the care planning and risk assessment processes. This commitment was reflected in accreditation schemes such as 'Think local, act personal', which demonstrated the provider's commitment to moving forward with personalisation and community based support, and 'Positive about disabled people', which outlined good fundamental practices for organisations that support people with learning disabilities.

The registered manager told us that in one house where a person had been on end of life care, the staff team had developed a care plan to ensure the person's wishes were respected at this important time.

Good

# Is the service responsive?

## Our findings

People we spoke with told us they were involved in developing their plan of care according to their needs and preferences.

A standard format was used to assess and record people's needs and aspirations. People's needs were fully assessed before a placement was agreed. This meant that people could be confident the service could meet their care needs before care was provided. When asked about assessments one member of staff told us, "People come here for a pre placement visit; they meet other service users and staff. It is a gradual process, we work at the pace of the person and make sure we get to know them well."

We saw detailed information about people's abilities and needs in relation to their personal, health and social care. Support plans were written from the perspective of people using the service and these detailed the support the individual needed with their daily living activities. Information about people's preferences and aspirations for the future were also recorded. Each plan was very detailed and the titles of each section demonstrated a person centred approach which showed that the person was central to the care and support they received. Examples of information in care plans included citizenship and tradition and managing my stress. This included the action staff should take to help people and reduce any distress. We could see that the provider responded to people's individual needs. For example, due to the level of anxiety one person experienced the staff had arranged for a local shop to open early so that this person could carry out their shopping independently.

People had completed 'All about me' documents which detailed their social histories, friends and families, and likes and dislikes. This information helped staff continue to support people to experience a positive quality of life and wellbeing.

People were included in reviewing the care and support they received and were encouraged to take an active and leading role in review meetings. They told us that their support was personalised and that the staff respected their choices and wishes. Staff told us that they encouraged people back into their community via employment and voluntary options. One staff said, "It is important because we want people to be supported to be as independent as they can be and it helps people's confidence and self-worth grow. We are a happy service and we care about the people we support." Another member of staff said, "People have lots of choices and make their own decisions about what they want to do and where to go." Examples we were given included clubs and football matches, and days out. One person had saved their money to go on a holiday with staff support. One of the people using the service told us, "I like to go to the art group. I get together with other people and one of my pictures was displayed in the art gallery." We saw people were supported to maintain their appearance and were supported to maintain contact with family and friends. The use of technology such as 'face time' had been used.

Care plans were stored on the electronic system and these were password protected and could be accessed by the staff team. This helped to make sure people's records were stored safely and their privacy was respected. The registered manager told us that a copy of these were printed out and kept in a 'welcome

pack' in the services for agency staff to review. They said that agency staff also received a full handover when they came into work. This was confirmed by the staff we spoke with.

People told us that they knew who to speak with if they had any worries or were upset for any reason. For some people they told us they would speak with a family member, while other people said they would speak to their social worker, to a manager or one of the staff team. It was evident from speaking with people and from our observations that the provider took action to respond to any concerns in a timely way. We observed that people were reminded about how to raise a complaint when speaking with us about their staff team so that these could be explored further with them. This included staff not completing work as they should; telling people 'What to do'; and checking their mobile phones. In one case a person told us they had been unhappy with their placement, but they said a meeting had been planned with their social worker and with the manager to discuss plans for the way forward. A relative subsequently contacted us to confirm this was the case. A staff told us, "[Name] made a complaint regarding staffing, the [regional development manager] visited and explained what they were doing about the staff situation here, which was reassuring."

Good

# Is the service well-led?

## Our findings

Everyone we spoke with understood the organisation's values and principles, which placed people using the service at the heart of the service. The organisation's stated values were clearly displayed on the provider website. These were:

- Openness and honesty
- Fairness and kindness
- Respect and responsibility, and
- Accountability and clarity

Our observations of interactions between staff, members of the senior management team including the registered manager and the chief executive showed us that inclusive, positive and respectful relationships were in place. We found evidence of a clear and effective management structure. The board and the senior management team were proactive and were actively involved in service improvement. Annually reviewed business goals and business plans summarised the organisation's aims, with defined goals and forward strategic planning implemented. The service had achieved the Customer First award. It was accredited to gold status with Investors in People, which demonstrated a strong commitment towards excellence.

From our observations and discussions with the senior management team it was very evident that they were knowledgeable and knew the people who used the service extremely well. One of the chief operating officers told us that all the senior managers frequently visited individual services and met with the people who lived there and staff. This was confirmed by the people who used services and the staff we spoke with. We were told that the chief executive officer also visited each service annually.

There were five regional development managers who managed a group of supported living services in a geographical area. One of the regional development managers was also the registered manager. Staff told us that they felt supported to carry out their role effectively by the management team. Comments included, "I really like working here, it is fast paced and different every day. I am supported by my line manager and managers further up as well," "I love the job. It is easy to contact someone for support if needed," "My manager is always available, we've got a good relationship," "The manager is good and responds to staff," and, "Supportive and approachable manager."

We saw there were arrangements in place to enable people who used the service and staff to affect the way their service was delivered. Feedback from people using the service, relatives and staff was regularly sought. Examples included surveys, regional forums and 'Significant Friends' meetings held every three months. These were meetings that people's family and friends were invited to and helped them keep informed about the organisation and share ideas. We viewed the results of the staff survey undertaken in November 2015. We saw that responses were broken down into categories of age, geographical area, gender and length of service. This meant that any themes, trends or causal issues could be identified.

Peer audits were undertaken where people using the service had the opportunity to monitor the quality of

the service people received. Staff spoke positively about this in terms of shared learning. The provider told us in their PIR that they also intended to involve relatives in future audits, by agreement with people who used the service, to further enhance communication and share learning.

Staff told us they had a team meeting monthly and the records of these were checked at supervisions sessions and in audits to confirm a minimum 80% attendance record. Meetings included a staff 'morale metre' to gauge how the staff team were. Staff told us that they were confident about challenging and reporting poor practice, and said any concerns would be acted upon. One staff member told us; "I am confident that anything I reported would be dealt with straightaway." Another staff said, "Expectations [on staff] are high but I like that and I wouldn't want it any other way." Some staff told us that staff vacancies were causing additional pressures on the established staff team. However, everyone in this situation said they knew about the action being taken and were confident this would improve.

We looked at the arrangements in place for quality assurance and governance to assess the safety and quality of the services being provided. One of the regional development managers told us about the checks they completed. These included a monthly visit to each supported living service to carry out a supervision session with the scheme manager. They said they would also meet with people living at the service on these visits. An audit based on the CQC key lines of enquiry was undertaken quarterly to ensure services were safe, effective, caring, responsive and well led. The regional development manager explained that any audits achieving a score of 70% or below was highlighted for consideration at clinical board and at strategic board level. The clinical board was chaired by the chief executive and included both staff representatives and independent practitioners, including a psychologist and accredited training provider.

Effective risk assessment, support planning and auditing systems were in place. We found that medicines audits were not always being carried out consistently, but we were told that measures were in place to review the medicines audit system and the way these contributed towards the oversight of the services. One of the regional development managers also told us that the regional management structure was under review, to ensure the registered manager was not carrying a disproportionate workload in relation to the other regional development managers.