London Borough of Brent

Brent Shared Lives

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Brent Shared Lives Scheme provides personal care for people as part of a shared lives scheme. A shared lives scheme supports a variety of different arrangements where families and individuals in local communities can offer accommodation and/or support for people. At this inspection, they were providing a regulated activity for 19 people.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

People's experience of using this service and what we found

People were safe and protected from avoidable harm. Carers had received up-to-date safeguarding training and they knew how to identify and report concerns. There were effective systems and processes in place to minimise risks to people. Carers had been recruited using appropriate checks and thorough assessments. There were systems in place to ensure proper and safe use of medicines. Effective processes were in place to reduce the risk of infection and cross contamination. The service reviewed accidents and incidents to minimise reoccurrences of risk.

People's outcomes were consistently good, and people's feedback confirmed this. People confirmed their care was tailored to their needs. There were arrangements to ensure people's nutritional needs were met. People's care was co-ordinated with a range of health and social care professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. When people were unable to make decisions about their care and support, the principles of the Mental Capacity Act (2005) were followed.

People were supported and treated with dignity and respect and involved as partners in their care. The service invested time to know people well and involved them in decisions about their care. People told us they were treated with dignity and respect. Individual care plans considered people's values, beliefs, and wishes. This meant there were established ways of working which were person centred and not discriminatory.

People's needs were met through good organisation and delivery. We observed a range of practices that

reflected person centred care. The service considered people's choices and expressed needs. Families were involved as appropriate and people's values were respected. People had access to appropriate care and information, which was presented in an accessible way. Support plans were regularly reviewed to monitor whether care was up to date and reflected people's current needs. We discussed with the supplier relationship manager the need to develop more creative ways to explore people's choices and preferences regarding their end of life care.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care. The registered manager had a sense of responsibility. There was a quality assurance process, which allowed the service to monitor its performance against standards to be achieved. Information to measure quality was collected in several ways, including audits, complaints, accidents and incidents and surveys. This information was used to drive improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was 'Good' (published 06 June 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Brent Shared Lives

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was undertaken by one adult social care inspector.

Service and service type
This service is a shared lives scheme, they recruit, train and support self-employed shared lives carers (SLC) who offer accommodation and support arrangements for vulnerable adults within their own family homes in the community.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke

with 12 members of staff including the nominated individual, supplier relationship manager, five placement relationship officers (PRO), and three carers.

We reviewed a range of records. This included nine people's care records and multiple medicines records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with the registered manager on his return from leave.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm and abuse. One person told us, "Staff are doing their best to support me. I feel safe."
- A safeguarding policy was in place. Carers had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. They were aware they could notify the local authority, the Care Quality Commission and the police if management staff had taken no action.
- The service had worked in partnership with safeguarding teams to ensure that safeguarding concerns were addressed.

Assessing risk, safety monitoring and management

- There were effective systems and processes in place to minimise risks to people. Risks had been identified, assessed and reviewed.
- There was information to guide carers to protect people without unnecessarily restricting their freedom. There were examples of how the service promoted positive risk-taking. Demonstrable impact included people gaining confidence and exercising choice and control. One person told us, "I have been shown how to travel on my own. There are arrangements to keep me safe when I use the underground train." This demonstrated the service identified risks associated with a particular activity and put measures in place to ensure that activity was completed in a safe way.

Staffing and recruitment

- Safe recruitment procedures were in place. Carers had been recruited using appropriate checks and thorough assessments. This included, at least two references, proof of identity and Disclosure and Barring Service checks (DBS) to establish whether the potential carer was barred from caring for people.

Using medicines safely

- There were systems in place to ensure proper and safe use of medicines. There were policies and procedures in place. Medicine administration records (MAR) were completed appropriately and regularly audited.
- Carers had received medicines training. They confirmed they had been trained and assessed as competent to support people to take their medicines.

Preventing and controlling infection

- People were protected from the risks associated with poor infection control because the service had processes in place to reduce the risk of infection and cross contamination. Carers were supplied with appropriate personal protective equipment including gloves and aprons, where this was required.

● Care workers had also completed training in infection control and prevention and knew how to minimise the risks of infections.

Learning lessons when things go wrong

● The service reviewed accidents and incidents to see if any further action was needed and to minimise reoccurrences of risk. Information about accidents and incidents were recorded and escalated to the registered manager for their review. They analysed these incidents to identify recurring themes and patterns and to ascertain if things could be carried out differently in the future to minimise the risks of harm to people.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been holistically assessed in line with recognised best practice. Their care plans offered step by step description of their needs and interventions to meet those needs. People confirmed their care was tailored to their needs. One person told us, "I am happy with the care and support I am receiving."
- The service delivered person-centred care. Key to this was the matching process. Based on the assumption carers and the referred person will know little about each other, the service followed a matching and introductory processes to ensure the placement was right for both parties. Notable impact included lasting mutually beneficial relationships between people and their carers.

Staff support: induction, training, skills and experience

- Carers received training, supervision and professional development as was necessary to enable them to carry out their duties. Training completed included, safeguarding, medicines handling and health safety.
- New staff completed an induction programme based on the Care Certificate framework. This is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
- One carer told us, "I feel very supported. My 'shared lives officer' is approachable. She visits every three months. I have done mandatory training and I also do over and above."

Supporting people to eat and drink enough to maintain a balanced diet

- There were arrangements to ensure people's nutritional needs were met. Their care plans considered their individual requirements in relation to nutrition and these were known to staff. One person told us, "The food is great. I choose what I want to eat."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's care was co-ordinated with a range of health and social care professionals including GPs, speech and language therapists, occupational therapists and physiotherapists.
- People received their annual health checks. An annual health check can improve people's health by spotting problems earlier, so people get the right care.
- People with learning disabilities had a Health Action Plan (HAP) in place. A HAP contains actions needed to maintain and improve the health of an individual and any help needed to accomplish these. This enhanced access by serving as a prompt throughout the year for the person with learning disabilities.
- Carers spoke knowledgeably about people's healthcare needs and knew how to support them in the best

way to ensure people's health outcomes were met.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA

● People who were unable to make decisions about their care had been assessed in line with the MCA 2005. They were supported to participate in their care and to make decisions about their day to day lives.
● People told us care workers consulted with them during visits. We examined people's records, which confirmed decisions had been made in their best interests and by whom. Where appropriate the service had involved families and professional representatives to ensure decisions were in people's best interests.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People's values, religious beliefs, gender, race, age and lifestyles were treated with respect. Individual care plans considered these characteristics. This meant there were established ways of working which were person centred and not discriminatory.
- The management promoted equality and diversity. An equality and diversity policy was in place and had been read and understood by staff.
- Carers were knowledgeable about diversity and human rights. They had received training in dignity, equality and diversity. They knew how to respond to a wide range of religious and cultural beliefs and traditions.
- Examples existed where some people had been matched with carers on grounds of a mutual language and religion, thus highlighting the service's commitment to meeting people's cultural needs. For example, one person of a Muslim background was matched with a carer who lived near a mosque.
- One person told us, "I am from a different culture and I can choose food from my own country."

Supporting people to express their views and be involved in making decisions about their care

- The service invested time to know people well and involve them in decisions about their care. People told us they felt involved in discussions about their support needs.
- People were provided with information in the most accessible format. For example, one person was partially blind and was supported to use assistive technology, which converted text to speech. This allowed the person to be involved and could understand and take an active part in their care.
- Where necessary, families or advocates were consulted. This ensured people with limited capacity understood options available to them.

Respecting and promoting people's privacy, dignity and independence

- People told us they were treated with dignity and respect. They told us their privacy was supported by carers.
- The service recognised people's rights to privacy and confidentiality. Care records were stored securely in locked cabinets in the office and, electronically. The service had updated its confidentiality policies to comply with the General Data Protection Regulation (GDPR) law, which came into effect in May 2018.
- People were supported to develop their independence and skills. By adopting a positive risk approach, it meant people were supported to be able to do as much as they could for themselves. For example, one person's risks in the kitchen had been highlighted with corresponding action to minimise the risk. Thus, rather than discouraging the person from taking risks because of fear they might be harmed, the service's

focus was on enhancing the person's abilities and therefore promoting their independence.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received person centred care. One person told us, "I am very satisfied with the care. I have a medical condition and my carer knows how to support me." Another person said, "I am happy with support. I go to school and I am so happy with this."
- We observed a range of practices that reflected person centred care. For example, the service considered people's choices and expressed needs, families were involved as appropriate and people's values were respected. In a nutshell, the service ensured people were central to their care.
- The supplier relationship manager told us the process of matching a person to a family varied depending on their needs. We saw the transitioning process was consistent with values of person-centred care. People's wishes, aspirations, lifestyles and needs were some of the key factors used to match with a carer who could best support and care for them. In essence, the service did everything possible to ensure people were happy with the arrangements before moving in with a carer.
- Each carer was linked to a PRO, who visited the carer on a quarterly basis to undertake reviews of the care provided and people's person-centred plans. People confirmed were involved in reviews. This helped to monitor whether support plans were up to date and reflected their current needs. As a result, necessary changes were identified and acted on at an early stage.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The supplier relationship manager was aware of the AIS and a policy was in place. The service identified and recorded people's information and communication needs. Information was presented in different formats to enable people to communicate to the best of their abilities. For example, support plans contained people's communication requirements, including whether they preferred information "written (large print), braille, audio, pictorial or sign language."
- We spoke with a person who confirmed they were being supported with their communication needs. Another person spoke Guajarati and was matched with a carer who spoke the same language.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to maintain personal relationships with family and friends. Their care plans

detailed their preferences relating to social activities. The service encouraged people to access and be part of their local community. There were activities organised by the service in collaboration with people.

Improving care quality in response to complaints or concerns

● The service had a range of approaches to gather people's views and experiences. One of these was a complaints procedure, which people and their relatives were aware of. The procedure explained the process for reporting a complaint.

● People told us they were confident they would be listened to if they needed to complain or raise concerns.

● Two complaints had been raised in the last 12 months, which had been investigated and concluded promptly.

End of life care and support

● There was no one receiving end of life care at the time of this inspection. End of life care We discussed with the manager of the need to explore people's choices and preferences regarding their end of life care. This is important because a sudden death may occur. The manager told us the service will look it into this.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was evidence people's opinions mattered. For example, the transition process, involved a trial stay, before people moved in with their carers. This ensured people were supported to make informed choice and familiarise themselves with a change of environment. Furthermore, where people had communication needs, the service identified and recorded how they wished to communicate. This encouraged people to be actively involved in their support and care.
- People were involved in the review of their own care. The PROs regularly visited people to make sure carers were working in a person-centred way. This enabled the service to keep up to date with people's changing needs, so carers could continue meeting these needs.
- Carers were knowledgeable of people's needs. They could share detailed information about people, indicating they knew people well.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The leadership complied with the duty of candour. We had been notified of any notifiable events.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

- There were clear management structures in place. The hierarchy comprised the registered manager, supplier relationship manager and relationship officers. The structure defined the formal relationships and lines of accountability and staff demonstrated awareness of this. It was clear to us how tasks were grouped and executed. For example, when we announced the inspection, the registered manager was not going to be available due to planned leave. However, the supplier relationship manager was able to effectively deputise in their absence. Following our inspection, the registered manager communicated with us, clearly demonstrating there was clear communication within the hierarchy of the organisation.
- All staff spoken with described the managers in complimentary terms including "reliable, approachable, knowledgeable, and supportive."
- The registered manager had a sense of responsibility. There was a quality assurance process, which allowed the service to monitor its performance against standards to be achieved. Information to measure quality was collected in several ways, including audits, complaints, accidents and incidents and surveys. This information was used to drive improvements.

Working in partnerships; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service worked with other health and social care professionals which ensured advice and support could be accessed as required. We could see evidence of this in records, including appointments with relevant professionals.
- People using the service and their relatives were regularly asked for their views on the quality of the service. Results from a survey carried out in October 2019 were positive.