Affinity Trust

Affinity Trust - Domiciliary Care Agency - South

Inspection report

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Date of inspection visit:
09 October 2017
10 October 2017
11 October 2017

Date of publication:
08 November 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place on 9, 10 and 11 October 2017 and was announced to ensure people and staff we needed to speak with would be available. The service is registered to provide personal care to people living with a learning disability, physical disability or sensory impairment. They do this through teams of staff that are managed from a central office location. For some people, living at one of 22 supported living locations; this means they receive dedicated staff support for up to 24 hours a day, seven days a week. Whilst other people receive staff support for a few hours a day, through one of the provider's two outreach services. At the time of our inspection, 120 people were provided with the regulated activity of personal care. People who received care were living across the local authorities of: Berkshire, Oxfordshire, Surrey and the unitary authority of Portsmouth.

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

People felt safe from the risk of abuse and relevant processes, procedures and staff training were in place to protect people. The provider was transparent in their safeguarding reporting and ensured all potential safeguarding incidents were reported to ensure people's safety.

People's support plans and risk assessments identified potential risks to them and how these would be managed to reduce the likelihood of harm to them. Incidents were documented and relevant action taken to reduce the likelihood of repetition for people.

Some relatives reported there had been too high a use of agency staff at some locations. Although agency usage was high at some locations, people still received the care they needed safely. The provider was taking a proactive approach to recruit staff and in the interim had taken measures to ensure there were sufficient staff to deliver people's care safely and that staffing was as consistent as possible for people. Safe recruitment processes were in place for all staff recruited since 2014. Further pre-employment information is required for some TUPE staff that transferred to the provider pre 2014 and the provider has requested this to ensure it is available.

People received their medicines from trained staff. Some aspects of people's medicines management required improvement and the provider took action during the inspection to ensure people's safety.

Overall, feedback about the effectiveness of the service was good. People were supported by staff who underwent a thorough induction and who had received on-going training. The provider was aware through their own monitoring that not all staff were receiving one to one supervisions at the frequency the provider required and actions were already in place to address this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had clear records of their dietary needs, preferences and any associated risks, which staff had read and understood. Where staff were responsible for preparing people's meals, records indicated they had been provided with a suitable, varied and balanced diet.

Staff supported people where required to see a range of health and social care professionals in order to ensure they maintained good health.

Overall people and relatives reported staff were caring and kind. We saw people were relaxed in the company of staff and familiar with them. People's records documented their needs in relation to communication and staff understood how people communicated. The provider had ensured information for people was provided in an accessible format. Staff supported people to make choices about their care and to be independent where possible. Staff provided people's care in a manner that promoted their privacy and dignity.

People were involved in planning their care where possible and had comprehensive care plans, which staff including agency staff had read and used to familiarise themselves with people's care needs and preferences.

People received individualised care that reflected their needs and interests. Staff supported people to have a presence in their local community and to participate in a range of activities. It was not always possible to roster a driver at all locations at all times; however, we found no evidence at the locations sampled of people not being able to go out regularly due to a lack of driver provision.

There was an effective process in place to enable people or others to raise issues if required. The provider had responded to any complaints received appropriately.

Staff upheld the provider's values when they provided people's care. People were involved in decisions about the service where possible. The provider listened to staff's views and actions had been taken in response when they had raised concerns.

There was a clearly defined operational structure, management had a good understanding of the issues facing the service and were proactively taking action to make improvements to the service where required. At all levels of management there were regular visits to locations to meet with people and staff.

Processes were in place to monitor, audit and analyse the quality of the service people received. This information was used to improve the service for people.

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.

People were kept safe from the risk of abuse.

Risks to people were identified and measures put in place for people's safety.

There was a high use of agency staff at some locations. The provider used regular agency staff to ensure continuity of care for people who still received the care they needed safely. The provider is pro-actively addressing this for people.

Safe recruitment processes were in place for staff recruited since 2014. Some pre-employment information is required for some staff who transferred to the provider pre 2014 under TUPE and this has been requested.

Some aspects of people's medicines management required improvement; the provider took action during the inspection to ensure people's safety.

Is the service effective?

Good

The service was effective.

Staff received a thorough induction to their role and a good level of training, which was tailored to the needs of the people receiving care.

The provider was taking action to ensure staff at all locations received supervisions as regularly as the provider required.

Staff supported people to have maximum choice and control of their lives. Where people lacked the capacity to consent to their care legal requirements were met.

Staff supported people to eat and drink sufficient for their needs.

Staff supported people to maintain good health and to access healthcare services as required.

Is the service caring?

Good

The service was caring.

People experienced positive and caring relationships with the staff that provided their care.

Staff supported people to make choices about their care and to be independent where possible.

Staff provided people's care in a manner that promoted their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People had comprehensive care plans in place, which staff had read and used to familiarise themselves with people's care needs.

People received individualised care that reflected their needs and interests.

Staff supported people to participate in range of activities at home and in the community.

There was an effective process in place to enable people or others to raise issues if required and any complaints were responded to appropriately.

Is the service well-led?

Good

The service was well led.

The service promoted a positive and open culture.

There was a clearly defined management structure and regular management presence at the supported living locations.

Processes were in place to monitor the quality of the service provided and to drive service improvement.

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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.

The inspection took place on 9,10 and 11 October 2017 and was announced because the service provides domiciliary care, and we wanted to be sure staff we needed to speak with would be available. The inspection team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for people with a learning disability.

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 the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we spoke with or received written feedback on the service from three social workers, three service commissioners and one social services contracts officer. We sent out questionnaires to 22 people of which 10 were returned, 22 relatives of which 3 were returned, 144 staff of which 15 were returned and six professionals of which two were returned. Prior to the inspection, we also sought telephone feedback from seven relatives and one person who used the service.

During the inspection, we visited both the service office and six supported living locations where people received personal care. Not everyone was able to share with us their experiences of the care provided so we observed the care people received in the communal areas. We spoke with nine staff, four support managers,

an interim support manager, the temporary recruitment lead, one of the two registered managers and the divisional director.

We reviewed 11 people's care plans, six staff recruitment and supervision records, staffing rosters covering the period 21 August to 22 October 2017 for the six locations visited, records of agency staff usage across the service for the months of June-August 2017 and other records relating to the management of the service.

The service has not previously been inspected at this location.

Requires Improvement

Is the service safe?

Our findings

All of the people who responded to our questionnaire agreed with the question 'I feel safe from abuse and or harm from my care and support workers.'

Staff completed the provider's safeguarding training during their corporate induction and then updated this training annually. Staff spoken with understood their role and responsibilities in relation to keeping people safe from abuse. All staff who responded to our questionnaire agreed with the question 'I know what to do if I suspect one of the people I support was being abused or was at risk of harm.' Processes and external checks were in place to ensure the safe management of people's monies and to protect them from the risk of financial abuse.

The level of safeguarding notifications made to the Care Quality Commission during the ten-month period up to August 2017 was high, compared to services of a similar size. A number of these were not actually assessed to be safeguarding alerts by the local authorities and other alerts were not substantiated. A commissioner told us "They report a high level of incidents under safeguarding but they are encouraged to report anything." The divisional director told us a number of the notifications made related to one person and of the actions taken to safeguard them and others, in collaboration with other professionals. Commissioners and social workers confirmed that when safeguarding issues had arisen, appropriate measures had been taken to reduce the risk of repetition for people and to keep them safe. The provider was transparent in their safeguarding reporting and ensured all potential safeguarding incidents were reported to ensure peoples' safety.

People's support plans and risk assessments identified potential risks to them and how these would be managed to reduce the likelihood of harm occurring. For example, whether the person required staff support to access the community safely. Risks to people in relation to their mobility had been assessed and identified if the person required any equipment to mobilise safely. In addition to the number of staff required to support them safely. Staff demonstrated a sound knowledge of the risks to people and the measures to manage these safely. For example, an agency care staff described to us how a person needed to have their wheelchair secured if they used the car in accordance with their support plan.

A person's relative did raise a concern about their loved one and we confirmed the correct risk assessments were in place and appropriate actions had been taken to ensure the person's welfare.

Staff were instructed on what an incident was and how to report them during their induction. Staff logged any incidents electronically. These were then rated as red, amber or green depending on the level of risk and any required actions were taken for people before they were signed off.

People each had a personal evacuation plan in the case of fire and an agreed emergency re-location plan in the event their own property was not habitable, to ensure their safety. There was an on-call system to ensure staff could access a manager at any time if required.

Some but not all relatives reported there had been too high a use of agency staff at some locations. Their comments included, "My only issue is that there are so many different staff," "Consistency of staff would be my only issue," and "All her favourite staff have left."

Where permanent staff could not meet people's commissioned support hours, bank and regular agency staff were booked and their usage was monitored. For the month of August 2017, agency usage at 19 locations ranged between 0 and 25% of staffing, at two locations it was between 25-50% and at another two, it was in excess of 50%. One of these was a new service and agency usage had since reduced as new staff were recruited and the other had been experiencing recruitment issues. A commissioner told us "There are recruitment issues but they use the same agency staff from reputable agencies," which records confirmed. Agency staff demonstrated a sound knowledge of people's care needs, which ensured a level of consistency was provided for people. One told us "There is always an Affinity Trust person (staff) in charge."

The provider had appointed a temporary recruitment lead, who had utilised a range of recruitment strategies, some of which were tailored to specific locations to attract staff. The provider had also reviewed and increased staff salaries. The provider was taking a proactive approach to address staffing for people. In the interim they had taken measures to ensure there were sufficient staff to deliver people's care safely and that staffing was as consistent as possible for people at this time.

Staff told us they had undergone recruitment checks, which included the provision of suitable references, which were verified, proof of identity, a health declaration and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Since 2014, the provider had stored all staff recruitment records electronically and had a process to ensure all required evidence such as the date the applicant completed full-time education and their full employment history had been provided. However, some staff had transferred to the provider before this date under TUPE when new locations were taken on and their previous employer had completed their pre-employment checks. The TUPE Regulations preserve employees' terms and conditions when a business or undertaking, or part of one, is transferred to a new employer. We found one of these staff records checked did not contain the applicant's date of completing education and a second did not contain their full employment history. The associated risks were low, as these staff had been working for the provider for three years and formerly, for a previous provider. The required information was obtained immediately for one staff. The provider also requested the information from the second staff member and from all other relevant staff, to ensure they have all of the necessary evidence on record as required.

Only permanent staff administered people's medicines and the staff in charge of medicines for the shift at each location was indicated on the staff roster. Staff told us they completed medicines training and had their competency assessed. The provider's electronic recording system showed 14 staff needed to update their annual medicine competency assessment and there was a plan in place to achieve this. People received their medicines from staff who had undergone relevant training and had undergone or were updating their medicines competency assessment.

We visited one location and found two people were prescribed an emergency medicine for seizures that trained permanent staff had to administer. There were some nights when agency staff were rostered who were not permitted to administer this medicine. The risks were low as one of the people was not actually resident and the other had not had a seizure at night, staff had never had to administer the medicine to either person. Guidelines were in place for staff to ring 999 if the medicine was required. We asked that this guidance was ratified by the person's GP to ensure it was safe, which has been done. The provider identified that in total 18 people were prescribed this medication across nine locations. At six locations, there were

always sufficient permanent trained staff to administer the medicine if required. The provider took swift action at two other locations to ensure they sought assurance from each person's GP that the guidance was clinically safe. The provider also told us they will be reviewing whether to allow agency staff who have completed the relevant training to administer the medicine if required. The provider took immediate action to check the arrangements in place were safe for people.

We observed staff safely administer a person's medicines, before they signed the medicine administration record (MAR) sheet. We noted at one location that although one person's medicines were listed on their MAR, their list of medicines in their file was not up to date as required to ensure there was an accurate record, we brought this to the support manager's attention. People's medication was stored in locked cupboards in their bedrooms, as per their risk assessments.

People had protocols for medicines they took 'as required' to provide relevant guidance about their safe use. The use of homely remedies, which can be bought over the counter, had been agreed by people's GPs to ensure their use was safe. Where people were given covert medicines, which are medicines people are given without their knowledge, legal requirements had been met in relation to how these decisions were reached for people.

Good

Is the service effective?

Our findings

Overall, feedback about the effectiveness of the service was good. All of the people who responded to our questionnaire agreed with the question 'My care and support workers have the skills and knowledge to give me the care and support I need.' Relatives comments included, "Whenever there has been new staff, they shadow for a couple of weeks," "Shadowing for new staff is written in the care plan," "The food seems reasonable" and "They cook for her every day."

Eighty per cent of the staff who responded to our questionnaire agreed with the statement 'I completed an induction which prepared me fully for my role before I worked unsupervised.' Agency staff told us they also received an induction to their role, which records confirmed. The recruitment lead informed us staff received a two-week induction, during which: they met people, read people's care plans, underwent training and completed shadow shifts with more experienced staff. Those new to care completed the Care Certificate, which is the industry standard induction. Staff who were not new to care completed a self-assessment to identify any areas of the Care Certificate they needed to complete or revise. New staff were subject to the satisfactory completion of a six-month probationary period in their role. Staff had a good induction to prepare them for their role in supporting people.

Staff told us they received good training. Staff were provided with a range of training specific to the needs of the people they supported, in addition to the provider's required training. This included areas such as autism, challenging behaviour, epilepsy, mental health awareness, diabetes awareness, dementia and percutaneous endoscopic gastrostomy, (PEG) feeding. This is when a person is fed through a tube in their abdominal wall. A relative commented, "The staff are all trained in using the feeding tube." Staff received both on-line and face-to-face training to enable them to provide people's care effectively.

Seventy-three per cent of staff who responded to our questionnaire agreed with the question 'I receive regular supervision and appraisal which enhances my skills and learning.' The provider required staff to receive a one to one supervision every six weeks. A support manager told us they were unable to complete these as frequently as required. A staff member confirmed they had not received regular supervision, although they felt supported in their role; records showed their last supervision had been in June 2017. The provider was aware of this issue through their electronic monitoring of the service, which showed that on 10 October 2017, 50% of staff had received supervisions within the required six weekly frequency. The provider had already responded to this and put action plans in place for specific locations to ensure all staff received the required frequency of supervisions.

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. In the case of people, being deprived of their liberty in the community applications must be made to the Court of Protection (CoP). The service was working within the

principles of the MCA.

People were asked to sign their consent to their care where they were physically able to do so and where they had the capacity to understand what they were signing.

Ninety-three per cent of staff agreed with the question 'I have had training in and understand my responsibilities under the Mental Capacity Act (2005).' Staff spoken with understood the application of the MCA as it related to their work with people.

The provider used a screening tool to identify if restrictions were in place upon people. Where staff identified that people were potentially deprived of their liberty, they had approached the local authority as the applicant to the CoP to request an application be made. A number of applications had been authorised by the CoP and others were in process for people.

Where people lacked the capacity to consent to decisions about their care, legal requirements had been met. MCA assessments had been completed and the best interest's checklist applied to ensure any decisions made involved relevant others and were in people's best interests.

Each person's support file had a separate section on nutrition, with information on the person's food preferences, allergies, needs and risks. For example, whether they required a pureed diet, experienced difficulty swallowing or required staff assistance required to eat their meals. Staff spoken with including agency staff understood people's dietary requirements, which they were observed to follow. There was guidance on assisting those with specific dietary needs, for example those who required their meal to be a soft consistency. Where people had a PEG feed there was detailed guidance on how to manage this to ensure people received this aspect of their care effectively. People had their weight monitored by their GP. People had been referred to the dietician where required if there were concerns about the person's diet, to ensure this was addressed for them.

At the locations visited staff prepared people's meals for them. At one location, we saw staff used pictures to enable people to choose what meals they wanted. Where people could not choose their own meals, staff devised meal plans for them based on what was known about the foods they preferred to eat. A staff member told us "You have to see what people's reaction is. Then you would realise they don't like that meal." Staff documented what people ate in their daily diary at each meal and these records indicated they were provided with a suitable, varied and balanced diet. We saw that staff offered people drinks regularly throughout the day to ensure they remained sufficiently hydrated.

People had health action plans in place, which documented people's health, medicines, health appointments and any actions required to keep them healthy. People's records documented how staff would know if the person was unwell, to enable them to respond appropriately. For example, the facial expressions the person might exhibit and their body language if they could not verbalise to staff that they were in pain. There was also guidance for staff about when they should seek medical assistance for the person. People's records demonstrated the level of assistance they required to either book or attend appointments to ensure they were appropriately supported by staff. There was evidence in people's records that they were supported to see a range of health and social care professionals as required for their welfare.

Good

Is the service caring?

Our findings

Overall people and relatives reported staff were caring and kind. Ninety per cent of people who responded to our questionnaire agreed with the question 'My care and support workers are caring and kind,' whilst one person disagreed. Relative's telephone feedback was positive and included: "They are very caring and understanding," "The actual staff are wonderful" and "The caring on the ground is fantastic."

We observed staff including agency staff chatted with people as they provided their care. People were relaxed in the company of staff and familiar with them. Staff used humour appropriately when interacting with people and involved them in conversations. People who did not communicate verbally were seen to respond well to staff, smiling and making positive sounds.

People's records documented their needs in relation to communication. For example, if a person needed to wear their glasses this was noted and why. People's communication methods had been documented, for example, whether they communicated verbally or non-verbally. If people communicated non-verbally they had communication dictionary's which provided guidance for staff about what the person might be communicating through their facial expressions, mannerisms , gestures, behaviours or the use of objects of reference. These are objects, which have meanings assigned to them, for example, a cup might mean the person wants a drink.

All of the people who responded to our questionnaire agreed that 'The information I receive from the service is clear and easy to understand.' The complaints procedure, safeguarding information and service feedback forms were presented in a clear and accessible format, to make the information easy to understand. The service is complying with the Accessible Information Standard, which is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

We observed people got up when they were ready to do so. One person was feeling unwell and did not want to get up; staff were seen to respect their choice. Staff explained to us that where people could not easily make their own choices, then they would show them a couple of options from which to choose. People's records documented their preferences about what type of staff they would like to provide their care. For example, whether they liked bubbly or quiet staff, male or female staff and whether they required a driver. Staff enabled people to participate in decisions, which affected them.

Ninety per cent of people who responded to our questionnaire agreed with the question 'The support and care I receive helps me to be as independent as I can be.' People's care plans documented what activities they were independent with. For example, a person's care plan noted what aspects of shopping they could do, such as pushing the trolley and loading the conveyor belt. Staff told us how they encouraged people to be independent, for example, by putting their washing on. Staff supported people to be independent.

As part of their induction programme staff completed training scenarios to enable them to understand how to promote people's dignity. Staff told us they knocked on people's bedroom doors before entering, which

we observed. Staff checked with a person if they were happy for us to enter their bedroom. Staff described to us how they would uphold a person's privacy and dignity during the provision of their personal care. Staff provided people's care in a manner that promoted their privacy and dignity.

Staff were required to undertake equality, diversity and inclusion training to ensure they understood their responsibilities for promoting equality and tackling all forms of discrimination people might experience.

People's care records were stored within their bedrooms to ensure their privacy. We noted that in the locations visited people's records were stored in colourful files that did not mark them out as 'care files.' This was normalising and respectful of the fact that people did not necessarily want their care records to be very visible or readily identifiable in their own home.

Good

Is the service responsive?

Our findings

There was mixed feedback from relatives we spoke with by telephone about the responsiveness of the service. All of the people who responded to our questionnaire agreed with the question 'I am involved in decision-making about my care and support needs.' Professionals also provided positive feedback. A social worker told us there were "Plenty of activities, regular reviews, and family have regular contact." Another social worker told us how staff had supported a person during their hospital stay. Relatives also confirmed staff had visited their loved ones in hospital. People and professionals provided positive feedback in this area.

People's records documented how they had been involved in their care plans. For example, whether they prepared the plan with staff or whether staff had read through the plan with them. Where people's relatives had been involved this was also noted. Eighty per cent of people surveyed agreed with the statement 'If I want them to, the care agency will involve the people I choose in important decisions.' People were involved in planning their care wherever possible.

Each person had four care files, which were well maintained, with current person centred information, which was easy to navigate and of a good standard. Person centred care is when the person's care reflects their needs as an individual. There was a good level of detail about each person's health, lifestyle and support needs with guidance on their specific care needs where necessary. The provider was currently running a programme of workshops for staff in order for them to further develop their skills in writing person centred support plans. A relative commented to us that, "His support plan is massive." Work was being done at one location to simplify people's care plans, in order to make them more accessible for staff.

People each had a pen picture to document their personal history and life experiences. There was also a record of the most important things to the person. The most important areas with which they required support, their likes and dislikes and what made a good or bad day for them and their daily routine. This provided staff with sufficient information about the person to enable them to provide individualised care based on the person's priorities. For example, a person liked aromatherapy and staff ensured they received this regularly. Another person's records noted they liked to bathe regularly and we heard staff running their bath in accordance with their care plan. Eighty-seven per cent of the staff who responded to our questionnaire agreed with the statement 'I am told about the needs, choices and preferences of the people I provide care and support to.' Staff including agency staff demonstrated a good knowledge of people's care needs and preferences. They told us what support people required, what they liked and disliked, how they liked to spend their time and what information might indicate the person was not settled. Staff had access to sufficient information about people's backgrounds, care needs and personal preferences about their care.

If people were assessed as experiencing behaviours which could challenge staff, then they had positive behaviour plans in place, these detailed the physical and verbal behaviours with which the person might present. They also detailed the behaviours, potential triggers and strategies for staff to use to calm the person. Staff underwent a recognised programme of crisis intervention and prevention training to enable

them to support people safely. One of the provider's accredited trainers delivered this training in-house and this was supplemented where required by support from external professionals. This ensured staff had the knowledge and skills required to respond to people's individual behaviours.

Where people lived with health conditions such as epilepsy, they had care plans in place to provide staff with guidance about their specific care needs in relation to their condition, and how these should be met.

People's records documented how they liked to spend their time, at home and in the community. For example, one person really enjoyed the garden. We saw there was a summerhouse, which the person often spent time in, relaxing. People each had their own weekly activity schedule based on their interests and were supported to attend a range of activities, such as music groups, pottery groups, the cinema and spas. People also spent regular time in their local communities visiting the shops. For example, a person was looking forward to going to the local pub for a meal and chatted to staff about it. Staff had supported people to attend events that interested them such as performances at the theatre. Relatives also commented to us, "They take her out and about, such as to pottery classes," "Carers take her to day centre every week" and "They take her to concerts and other places." Staff supported people to be present in their local community and to participate in a range of activities.

At a number of locations, people had cars that they required staff to drive for them. Two relatives expressed concerns to us that there were insufficient drivers for the supported living locations. One of the registered managers told us 93 of the 148 staff were drivers. Staff told us there were sufficient drivers rostered to enable people to go out. At one location staff told us the two staff who drove were rostered on different days to ensure there was a driver most days, which records confirmed. A support manager at another location told us, authorisation had been given for agency staff to drive people in addition to permanent staff, to ensure there were sufficient drivers for people. In addition, staff used public transport with people where possible and appropriate, which promoted their independence. It was not possible to always roster a staff member who drove. However, nearly two thirds of staff were drivers and we found no evidence at the locations sampled of people not being able to go out regularly due to a lack of driver provision.

All of the people who responded to our questionnaire agreed with the question 'I know how to make a complaint about the care agency.' They also all agreed with the question 'The staff at the care agency respond well to any complaints or concerns I raise,' A relative told us "I would talk to the manager if I had a concern." A social worker fed back to us 'The day centre has recently commented that they (the service) are always very responsive to any issues they may have and generally sort out any issues quickly.'

The provider's complaints policy was provided in an accessible format for people. Staff learnt about their role in responding to complaints during their induction, and those we spoke with told us they would report any complaints to their manager. This year six complaints had been received. Records showed these had all been investigated, any relevant actions were taken and the provider met with or wrote to the complainants to discuss the outcome. There was an effective process in place to enable people or others to raise issues if required and any complaints were responded to appropriately.

Good

Is the service well-led?

Our findings

Ninety per cent of people who responded to our questionnaire agreed that 'The care agency has asked what I think about the service they provide.' Relatives provided mixed feedback about the management of the service. Their comments included "The manager there seems nice enough," "They are trying to improve," "Management doesn't seem to be in touch" and "Management are lovely but ineffective." Professionals however provided positive feedback about the management of the service. A commissioner told us, "They are very responsive on any issues. We inform X (divisional director) and she delegates and acts." Another commissioner informed us that management were responsive to issues at all levels.

The divisional director told us people's families were not due to receive a quality assurance survey until 2018 and that families had not raised the issues they fed back to us with the provider. However, based on the feedback received, they immediately decided to bring the survey forward. This demonstrated a pro-active approach once issues were brought to their attention.

The provider's aims were to 'Enable people with learning disabilities to achieve active and fulfilling lives, gain increased independence and achieve equal rights as citizens.' They aimed to ensure they were committed, reliable, honest and open, respectful, inclusive, creative and flexible.

The recruitment lead informed us staff's values were explored during the recruitment process to ensure they recruited the right staff. New staff then learnt about the provider's values during their corporate induction day. They also learnt about the whistleblowing policy to ensure they were aware of how to report any concerns about people. Staff we spoke with knew how to do this.

People had been involved in some staff recruitment, either as part of a panel or with applicants being asked to complete a planned activity with a person. This enabled the provider to assess the quality of their interactions with the person. People were involved in decisions about the service.

Staff's views were sought via supervisions, staff meetings, the staff forum and the staff engagement survey. The results from this year's survey had just been collated and showed overall a good level of satisfaction. An action plan was due to be prepared in response to the feedback received. Staff were happy working for the provider. A staff member told us "Everyone works as a team." Another told us "They're really good here – we have lots of training."

There was a clearly defined operational structure. There was a divisional director, three operations managers, two of whom were also registered managers, one covering the Maidenhead area, one the Oxford area and one the Hampshire and Surrey areas. There were then 11 supernumerary support managers reporting to the operations managers. These were allocated a number of the supported living locations to manage or the outreach services. There were 13 team leaders linked to the support manager's. They spent part of their time rostered on duty within the supported living locations, working alongside staff in the delivery of people's care. Managers from the team leader role and above were offered a range of management training including a leadership development programme to develop their leadership skills and

support them in their role.

The divisional director was very aware of the challenges facing the service, in terms of: its size, the time required to embed the provider's values and culture within the new locations they had acquired and staffing at specific locations. They told us the provider would be taking the time to embed the new services.

The provider had identified there were issues at one location and had been proactive in their response. They had brought in an interim support manager to support staff in addition to the regular support manager for the location. The interim support manager had been able to focus on the issues within the location and was working for example, on simplifying the care plans for staff. They had also met with people's relatives to ensure their voices were heard. Improvements were being made for people living at this location. The provider had identified that staff at another location were not working together effectively, so a staff meeting had been held recently. Staff were involved in drawing up their own action plan to address the issues to improve the service.

Staff we spoke with all provided positive feedback about the management of the service. One told us "Management are visible," another commented, "Management are approachable." Sixty-seven per cent of staff who responded to our questionnaire agreed that 'My managers are accessible and approachable and deal effectively with any concerns I raise,' whilst 33 per cent disagreed. Records demonstrated there were regular management visits to locations to ensure oversight of the services and to review the quality of the care provided. We sampled seven of the locations and found the support manager's had completed an average of 31 checks at each of these locations within the past year. The operations managers, divisional director or director of quality had made an average of nine service visits to each of the locations, which is a visit every six weeks. In addition, the finance team completed regular visits to audit people's finances. Senior management also had a good level of oversight of people's care. The chief executive had personally visited eight of the 22 supported living services in 2017 and other members of the board had visited 11 locations in the past year. At all levels of management there were regular visits to locations to monitor the service and to meet with people and staff.

The management team were able to access a 'service dashboard' from the provider's electronic monitoring system, covering areas such as people's care plans, staff training and supervisions. This enabled support managers' to monitor the performance of their locations and the operations managers to have oversight of the performance of all locations. Actions were taken where issues were identified. There was continuous monitoring of the quality of the service for people.

Support managers audited each person's medicines quarterly, the operations managers' then 'spot checked' one completed audit for each person per year. Each audit identified any areas for action with expected completion dates and these were checked for completion at the next audit. Processes were in place to audit people's medicines.

Each person had an annual comprehensive quality audit completed, by a support manager from another service, which audited all aspects of the delivery of the person's care. Where any required actions were identified, then an action plan was devised and there was a re-audit within three months to check the actions had been completed. As part of the audit, the person was provided with an easy read template to provide their feedback on the care they receive. If the person could not complete this then the manager met with the person and observed their interactions with staff. Processes were in place to monitor the delivery of each person's care.

A health and safety report for the service was produced quarterly. This enabled any emerging trends to be

identified and relevant action taken. For example, the provider had identified that there were a high number of medicine incidents across the period October 2016 to July 2017. Further analysis of these was completed and an action plan drawn up which included: staff training and identifying a medicines staff lead for each shift. Information about the service was analysed and used to improve the service for people.