UK Supported Living Services Limited

UK Supported Living Services

Inspection report

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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

Overall summary

The inspection took place from 17 June 2015 with home visits being completed by 22 June. Further phone calls were completed by 7 July 2015. The inspection was announced as we wished to ensure there was someone at the office when we visited.

The service specialises in social support and care for people with complex needs related to learning disabilities or mental health diagnoses including people with Autistic Spectrum Disorders. The service is provided to people in their own home and currently supports around 40 people living in Dorset, Bournemouth and Hampshire. Currently eight people are supported with personal care, as defined in the Health and Social Care Act 2008 regulations. The inspection only looked at the service in relation to people receiving personal care as part of their overall support. This is because personal care is a regulated activity.

The service is required to have 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. The service had a registered manager in place.

Summary of findings

The people receiving personal care had need for support and care on a mostly continuous basis to ensure their safety and participation in everyday life. This was due to people's learning disability, including some people who had additional physical or mental health needs. Staffing was tailored to each person with small groups of staff providing the service on a rotational basis.
Staffing arranged in one geographical area was insufficient which meant one person did not get the care they needed on two occasions during the inspection. These issues were being addressed by the management, however due to the impact on the person we judged the service was not meeting the standard for having sufficient staff available when needed. This was raised with the local authority as a safeguarding issue by another agency who was involved with the person.

Most people could not tell us about their experience so we used observation, speaking with staff and people who knew the person. People were relaxed and happy when we visited. Two people told us they were happy in their home and felt supported to do what they wanted. The service supported people to have regular involvement with their families and friends, depending on individual circumstances. Feedback was recorded from three relatives as part of a recent survey which described their satisfaction with the standard of the service. We spoke with one relative who told us they were happy with the service provided.

People were relaxed and responsive in the presence of the staff providing the service and we observed that positive relationship had been developed. People were supported in a person centred way by staff who were enthusiastic and worked with people to enable them to positive outcomes. They understood their roles in relation to encouraging people's independence while protecting and safeguarding people from harm.

The service aimed to provide continuity and familiarity between people in the way the service was planned. The service was not responsible for people's accommodation however we found they had ensured people's homes were safe and comfortable, through effective liaison with the landlords and other relevant agencies.

The service demonstrated a culture which promoted people's rights. Risk assessments were used to promote a balance of autonomy and safety for each individual in relation to their day to day care and support. People were supported to visit friends, family and their chosen activities in the wider communities where they lived, however any risks associated with this had been considered and staffing arranged accordingly.

Staff received an induction into the service before starting work on their own, including opportunities for shadowing more experienced members of staff. There was a plan of ongoing training and supervision to ensure they had the necessary skills and knowledge to provide an effective and safe service. The needs of people were taken into account when making decisions about the qualifications, skills and experience required when appointing new staff and in the delivery of on-going training. Plans were in place to make recruitment safer by improving the quality of checking employment history.

Staff received supervision and told us they felt well supported by their supervisors however some staff told us they were worried about pressure on staff on occasions due to staffing shortages.

People's rights were protected because the management team understood where people did not have mental capacity to consent to their care that decisions had to be made within the framework of the Mental Capacity Act 2005 (MCA). Procedures had been followed appropriately in this area.

People received their medicines safely and staff understood the importance of safe practice in this area including their role in monitoring any symptoms or side effects.

People were supported to have a balanced diet through one to one support in their own home. Some people were supported to be involved in shopping for their food. Written care plans reflected individual preferences and any special dietary requirements.

Staff and managers ensured people had access to healthcare services when needed and worked with a range of health professionals to implement a health action plan for each person.

Systems were in place to make sure that managers and staff learnt from events such as accidents and incidents, complaints, concerns and investigations. This reduced risk to people who used the service and helped the service to continually improve. The service had addressed a number of issues raised through

Summary of findings

safeguarding procedures over the last six months. Action had also been taken by the service in response to recommendations made by two of the local authorities which commission the service, following a contract review in January 2015. From speaking with the management of the service and a number of external professionals, it was evident that each party wished to improve the relationship between the service and the commissioning authorities, particularly communication, and a plan was in place to address this.

New systems, policies and procedures had been developed to make sure that any unsafe practice was identified and people were protected. The workforce had been restructured and was in transition at the time of inspection. Recruitment for new roles was in progress and additional training had been delivered and arranged for the future. This was designed to develop the enabling ethos of the service and ensure people's needs were always met.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to how staff were deployed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

There were gaps in staffing which affected the ability of the service to deploy sufficient numbers of staff to make sure they could meet people's need for care.

Staff understood safeguarding and how to report concerns.

People's autonomy and safety was balanced using risk assessments and risk management which was understood by staff.

Medicines were administered safely.

Requires improvement

Is the service effective?

The service worked within the framework of the Mental Capacity Act 2005 to ensure people's rights were protected.

Staff were recruited, trained and supported to match the needs of people.

People had health action plans and received support to meet their healthcare needs.

People were supported to have a healthy balanced diet.

Good

Is the service caring?

People responded to staff who had got to know people and developed positive and caring relationships.

Care was expressed through an attitude of patience, tolerance and understanding by staff.

The service demonstrated an ethos of respect and consideration for people's individual histories and abilities.

Good

Is the service responsive?

People had detailed care plans which described their backgrounds including likes and dislikes. Staff showed they had read and understood these and tailored their response to each individual.

An electronic system allowed the capture of monitoring information about the service provided for each individual on a daily basis which helped the service to become more responsive.

Feedback from relatives was sought and acted upon.

Good

Is the service well-led?

The service had a clear set of values which were put into practice through training, monitoring of the service and response to concerns which were investigated and learnt from.

Good

Summary of findings

Staff had the confidence to challenge and question practice and staff were provided with constructive feedback.

The management team acknowledged the challenge of providing a remote service. They understood the need to enhance partnership working with external agencies and internal staff to improve consistency and performance.

UK Supported Living Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place from 17 June 2015 with home visits being completed by 22 June. Further phone calls completed by 7 July 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office and assist us to arrange home visits.

The inspection was carried out by a single inspector. We did not request a Provider Information Return (PIR) from the service before the inspection. A PIR 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. However before the inspection we looked at information we held about the service including notifications from the provider and recent information from the local authority. At the inspection we asked the provider to tell us about anything they thought they did well and any improvements they planned to make. We looked at a pharmacy report following a visit made by a CQC pharmacy inspection in February 2015.

We spoke with three people in their own homes and observed interactions between staff and three other people. We spoke with one relative and with two members of staff in a day centre regularly used by one person. We reviewed eight care plan records. We spoke with the managing director, registered manager, senior clinical nurse and nine members of care staff. We looked at management records including samples of the rota and the overall staff training and supervision record. We looked in detail at the content of some of the training. We looked at the templates used to carry out recruitment processes and performance management. We looked at the secure electronic system holding people's individual care plans, risk assessments and daily records of care and support given. We looked at the medicine plans for five people and the paper MAR for one person. We looked at a number of documents relating to the running of the service including communications with staff and people, such as the newsletter and website.

After our visits, we spoke with community professionals who had involvements with people who received personal care from the service, including a member of staff from the nutritional service, two members of staff from the social work team and two members of staff from a day centre. We also spoke with a member of staff from one of the local authority contract monitoring teams.

Requires improvement

Is the service safe?

Our findings

There were not enough staff to meet people's assessed needs. During our inspection we observed that one person did not have planned care on two occasions in one week. This resulted in them remaining in bed all morning and not receiving their meals or prescribed medicines until the second half of the day. The registered manager explained that the staffing shortage in that team had been created by a combination of annual leave, staff leaving and staff sickness. They told us that arrangements for cover by agency staff were made but that they had not turned up as arranged and neither had they alerted anyone in the service. On the second occasion four days later, although the service was alerted earlier in the day that the staff had not turned up, the person did not receive the care they needed all morning. Their relative told us they believed their relative was safe however expressed concerns about recent gaps in staffing which had affected their relative.

This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). The service was not deploying sufficient numbers of suitably skilled and experienced staff to meet people's needs.

Staff told us that they were usually able to ensure there were enough staff but this meant some staff working long hours and the use of agency staff. We saw information in one person's home which was designed for use by an agency staff which gave a quick reference summary of important information temporary staff would need to be aware of. This helped to reduce the risk of unsafe care by staff unfamiliar with people's routines and needs. The registered manager told us they also ensured they obtained a one page profile of the agency member of staff before they commenced any cover for the service, to ensure they were a suitable match for the service user.

The rota reflected some staff were working 'long days'. The registered manager told us that some staff selected these hours through choice however the hours of some staff reflected extra hours to help provide cover until staffing for vacancies were filled. Overall there was an element of consistency in staffing. For example, of the nine care staff, six had been in post for over one year. However the registered manager told us they wished to improve staff retention further as they recognised that stability of staffing was vital to a safe service. Arrangements were in progress to fill vacancies and a new member of staff started at the time of inspection.

Where people had any history of harm to themselves or others, this was documented in their care plans with likely or known factors which may have been associated with this behaviour. Care plans and risk assessments had been recently reviewed to bring together the latest knowledge of the person, current risks and practical approaches known to keep people safe with minimal restriction. For example, in one person's care plan we saw guidance to staff about how to reduce someone's risk of self-harm through specific actions in their environment. We observed this being effectively carried out by staff.

People receiving personal care from the service were either unable to verbalise their communication or their speech was limited. We observed that staff enabled people to express themselves in other ways which helped to minimise frustration and reduce the risk of people's behaviour escalating. For example, one person at risk of self-injury, was given time to express themselves with gestures and facial expression. We observed a member of staff using their detailed knowledge of the person to communicate effectively and the person responding positively. All six people we met appeared relaxed and calm in the presence of staff.

Staff we spoke with understood their role in protecting people from abuse. They knew what they should be aware of and who they could raise any concerns with. We spoke with staff about safeguarding and protecting people and staff gave explanations showing they understood signs of abuse and the actions to take. For example, they told us which agencies they would approach if they did not obtain an appropriate response from their management. They were able to explain what they would do if they thought anyone was at immediate risk. For example, one member of staff told us they would contact the on call duty senior for advice and that they had found they were available out of hours. Another staff told us they would not hesitate to contact emergency services should this be required.

We saw evidence the safeguarding policy was being updated and that all senior staff had either undertaken or were booked to undertake additional training on safeguarding. The registered manager told us staff would be sent a copy of the new policy and accompanying

Requires improvement

Is the service safe?

operational guidance. The registered manager explained that the additional training and updated policy was to ensure that the service worked effectively with other agencies in safeguarding people whilst supporting them to have opportunities to live a full life.

Accidents and incidents were recorded centrally. An electronic system was used for logging daily events, incidents and accidents so this information could be shared at individual service level and used to update risk management approaches. This 'live' system meant that risks could be effectively monitored and analysed for each individual. We looked at one example of where this risk information had been shared with other professionals about the number of times over each day where someone needed behavioural support. This could enable the service to work positively with external specialists to analyse possible triggers and devise preventive approaches. We were shown examples of information which had been shared to promote effective risk management for one individual.

There was a system for safe staff recruitment however this required some improvements to make it robust. We reviewed the files of four members of staff and saw appropriate recruitment procedures were followed. The registered manager showed us evidence that this system was being improved in recognition that more in depth checks helped to reduce the risk that any person who was unsuitable for this employment was not taken on as a member of staff. We noted that the supervision and disciplinary policy and procedures had also been recently updated. One senior member of staff gave us examples of how any actions and concerns identified in one to one supervisions were followed up more robustly, for example using a process of 'signing off' actions to ensure they were completed. This helped to ensure all staff were supported to understand their responsibility for safe practice.

Medicines were handled safely. We saw that detailed guidance was available for staff although information on variable doses and 'when needed' medicines for two people needed more detail to ensure avoidance of error. We looked at the systems for reporting any issues or incidents involving medicines. We found there were forms completed for incidents and 'near misses' in order that action could be taken, and recorded, in order to prevent these issues happening again. We checked electronic records and care plans for five people who were being supported with their medicines by the service. We found that there was information available for staff on computer records showing what current medicines people were prescribed, and any risk assessments for their medicines.

Arrangements had been made by the service for delivery of medicines using a pre-packaged system with times and dates, where this was agreed with the person, which helped to reduce error. We asked about staff training on safe medicines handling and administration. We were told that staff received training and were assessed before being allowed to give medicines and have annual refresher training. We checked the computerised training records which showed that many staff had received updated training in the last year, but for some staff there was no updated training showing on the records. One of the members of staff told us they had not received any training in medicines from the service however had been trained within the two years from their previous employer. We checked with the registered manager who confirmed that training was outstanding for some staff and they would be supported to ensure this was up to date. We also checked training on epilepsy rescue medication administration and training for medicines administration given through a tube, rather than by mouth. We found members of staff included on a rota for one person's care had their training updated for these aspects of care recorded on the computer system. We found staff knowledgeable about people's medicines and the effect on the person, for example understanding how to monitor someone on sedative medicine and noting any adverse or unusual side effects. This helped to ensure medicines were administered in a person centred way.

In relation to the delivery of personal care, their care plans included appropriate guidance about infection control including particular risk areas for each individual and what action staff were to take to reduce and minimise the spread of infection. For example, one gave staff guidance about regular hand washing; another gave guidance about the infection control risk associated with a specific behaviour and how to reduce and manage the risk from this.

Good

Is the service effective?

Our findings

People were offered choice and control and staff demonstrated an ethos of seeking consent and communicating about each aspect of people's support. We observed in each of the houses we visited that people were offered choices in their everyday life. Staff used ways to communicate including non-verbal communication, guidance about which was documented in each person's care plan. We observed these methods in practice and found staff shared with each other their experiences of what worked well. Where people could not weigh up information to take decisions due to mental incapacity, for example about their own safety when in the community, the service had held best interest decisions meeting to consider the least restrictive option to support the person.

The Mental Capacity Act (MCA) governs decision-making on behalf of adults who may not be able to make particular decisions because they do not have capacity to do so. This could be because of long term conditions such as a learning disability. We looked at whether the provider had considered the act in relation to how important decisions were taken on behalf of the people using the service. As people were subject to continuous care and supervision and did not have capacity to consent to such arrangements, this meant their liberty was being restricted. Decisions about people's liberty when living in their own homes are normally only made by the Court of Protection. We saw a record of correspondence showing the registered manager had appropriately contacted the local authority to request applications be made to the Court of Protection. This meant the service ensured that people's rights were protected in relation to any restrictions on their liberty.

Staff received an induction into the service before starting work. The training record indicated that all staff had received an induction. We spoke with one relatively new member of staff who told us they had a two day induction in the head office which included safeguarding, how to support people well, offering choice, and face to face training on moving and handling. Some induction training was online and these had not been completed. One member of staff told us this was because they had difficulty accessing the material but that this was being addressed by the office. Staff received training on the use of the bespoke database for the service. This was an important part of the delivery of the service as it required regular input from staff for 'logging on' when they started work and 'logging off' when they finished and acted as a time sheet. It contained all the updates and daily notes required to be recorded by staff. Staff had periodic opportunities to receive training on this. Feedback on the use of the system was mixed with some staff saying they found it very effective and useful and other staff still expressing uncertainty about not using paper records.

Staff received training to enable them to develop their knowledge and skills in carrying out their role. Some senior staff took part in a training programme with an external trainer, arranged by the registered manager. The content of the course was delivered over several days in a group setting and encouraged staff to discuss their values in relation to the people they served and consider what would be an effective service for people with learning disabilities. The training was designed to help senior staff develop an effective service with people and staff. For example, a tool about behavioural support asked staff to consider what someone might be communicating when they expressed particular types of behaviour. It gave a format for staff to record observations which could be later used to evaluate methods of support and improve understanding of and communication with the person. The management team told us that this type of training was designed to promote confidence in staff so they could support staff effectively and meet people's needs. Two senior staff we spoke with told us this training was, "excellent" and "brilliant". From looking at the registration record for this training we saw that over eight members of staff from the service had undertaken this training on two occasions over the last six months and we saw that another session was booked. Care staff told us they found the supervision and support they received from senior staff working alongside them to be effective and helpful

Staff received ongoing training in the essential elements of delivering care such as medicines, equality, risk, first aid, infection control and record keeping. Of 26 staff delivering the personal care service, eleven staff had level 3 or were working towards level 3 of the Qualifications and Credit Framework (QCF) which is the relevant nationally recognised occupational qualification. Four of these staff were working towards or had obtained additional leadership qualifications. Two staff were receiving support to enable them to complete a qualification in English and Maths. We noted that some staff were either leaving or going on maternity leave and had therefore not signed up

to a course. We noted that the new staffing contracts issued as part of a staffing restructure required all staff to complete the new Care Certificate, which has now replaced the QCF.

The training plan for the service took account of specific needs which related to particular individuals. We spoke with the local nutrition service for example, about whether the staff caring for one person who needed a special tube for all oral intake, were sufficiently knowledgeable about how to ensure this was managed appropriately. They told us that they had helped to train staff. We saw that the rota for the care of this person was arranged to ensure someone with this training was always part of the team on duty. Some staff had additional training in mental health, autism and epilepsy reflecting the specific needs of the individuals they were involved in supporting. There was a policy in the service and training in relation to how staff could protect themselves in the event of any harmful behaviour which be directed at them during care and support interventions. This is known as breakaway training and had been undertaken by some staff. However, the registered manager told us they were responsible for ensuring this was delivered appropriately i.e. only for those members of staff where their role in supporting particular individuals had indicated this was necessary. From looking at the training plan we saw elements of training were being considered related to sensory impairment and end of life care. The registered manager explained these related to the specific needs of people they were currently supporting. A senior member of staff told us they would like increased opportunities for formal training and supervision. Staff told us overall they felt supported and in particular four members of care staff told us they highly valued the support they received from their supervisors.

The dietary needs of people were described in their care plan with a good level of detail, including their likes and dislikes. We looked at eight care plans and all included sections on diet, any food intolerances and any special requirements, for example, restrictions on certain types of food for health reasons. People needed staff to prepare food and this was done on an individual basis, using a menu planner. Care detailed how people could be supported to manage their own eating and drinking, for example, by the use of adapted cutlery or utensils. We observed one person having lunch and saw they were independent with their eating and encouraged by staff to express their opinion of their food and what else they might like, offering choices and suggestions. The meal time was a pleasant and calm time. We noted one person whose cultural origins were referred to in their menu planner and this was addressed, in partnership with staff and family. There was detailed guidance on care plans relating to people who needed pureed food or thickened drinks due to swallowing difficulties. Staff showed awareness of people's individual specifications when we asked them about this. This helped to ensure people received a balanced and healthy diet.

People's health was considered as an integral part of their care plan and advice and expertise was regularly sought by the service. As well as regular liaison with the GP and community nurses including the Speech and Language Therapist (SALT) and Learning Disability nurse, people were supported to obtain foot care, vision tests and dental care. These needs were detailed in individual care plans and we found that staff knew about these and updated records where there were changes and sought further advice as instructed by the care plans. The care plans gave detail about dates and times and whether a best interest decision was in place in respect of these aspects of people's care.

Good

Is the service caring?

Our findings

People were treated with respect. People were given time to express themselves and were prompted in special memories or to express their feelings about an activity they had done in the past. We observed one person who knew all the staff by name and took an interest in asking when they would see them again. All the people we met were well groomed in appearance, animated and smiling. Care plans recorded small details about people's appearances and how they liked to be cared for.

People's autonomy and independence was prompted. All the staff we spoke with told us how even if someone had a severe level of disability they were able to encourage small gestures of independence such as choosing a colour, a TV programme, noticing if someone responded positively to fresh air and being out in the garden. We observed a member of staff prompting someone in things which helped to make them comfortable such as their glasses or their slippers.

People's privacy and dignity was respected. We observed that staff were respectful about their presence in people's homes and told us this was central to how they treated people. For example, one staff member told us, "we must always remember we are guests in people's homes and respect people's privacy even though this is where we work." The management team told us they were promoting through a code of conduct a culture of 'customer care'. This increased awareness of staff about their conduct when in people's homes, for example, about sharing personal information and displaying a positive mood, in recognition of the impact of staff attitude and behaviour on people, particular when working in close contact with people in their own home for prolonged periods of time.

Information about people was stored confidentially in the electronic system with appropriate arrangements for security and access.

People benefitted from a person centred service. Staff noticed if people seemed distressed or uncomfortable and took action to relieve their discomfort. We found staff had been proactive and persistent in seeking advice for someone with special nutritional needs which had resulted in an improvement in their general health and wellbeing. We observed when one person started to appear restless, the member of staff promptly responded offering reassurance and arranging to accompany the person for a walk. We observed staff maintaining a tolerant and patient approach to one person's prolonged period of activity and which helped them to maintain a calm and relaxed mood throughout the day.

Staff showed understanding of what was important to each person both in the small everyday things and were also able to tell us about the relationship each person had with their family. Where people had particular friendships we observed that these were supported by staff. We observed one person supported to visit another person with whom they had a long standing friendship. Staff showed persistence in dealing with the hosing provider for one person where improvement in the garden area remained outstanding. Although this was still not completed at the time of inspection staff told us they would ensure this was pursued because it was very important to people's wellbeing.

Good

Is the service responsive?

Our findings

The staff knew people well or if they were new in role, were developing their knowledge. We observed two relatively new members of staff supporting two different people and observed them using the electronic care plan system where care plan information was stored. We saw another member of staff inputting notes about one person for monitoring purposes. Staff told us the system was helping them to keep up to date with people's care plans and informed about changes. This helped to promote a consistent and responsive service.

People's care and support needs were well understood by the service which was reflected in detailed care plans and risk assessments and in the attitude and care of staff towards people. Staff encouraged choice, autonomy and control for people in relation to their individual preferences about their lives, including friendships, activities and menus. Activities were planned with people's interests, for example we saw one person was supported to attend a concert of music they were particularly fond of. Other people were supported in routine attendance at day centres, where staff used a communication book to handover to staff at the day centre at the beginning of each day. This helped to ensure a person centred service was provided.

People's diversity was respected. For example, cultural and language needs were actively considered as part of one person's care plan. People's gender was taken into account when recruiting staff and planning the service to ensure a person centred service. Consideration of the matching of staff to people was documented in the care plans we looked at. One member of staff told us that they were aware that people did not all respond the same way to everyone, for example, one person tended to drink more when with them.

People's needs were reviewed by the service and care plans had recently been updated. We noted that where people's needs had appeared to change, this was noted in their record and staff made the appropriate referrals for assessments. For example, staff told about one person we visited who was thought to be showing signs and symptoms of dementia and a specialist healthcare assessment was arranged. In another care plan we looked at guidance was included about what changes to look out for in relation to the person's health and what to do if these occurred. A member of staff told us how they arranged for one person's continence assessment to be brought forward by two weeks to ensure the person received appropriate care.

Although most people could not comment directly about their care, we saw from care plans and speaking with staff that people's history and background were taken into account in how the service was planned around their needs. The service worked with the social worker for the person however at the time of inspection there was no independent advocate involved with anyone. People's family had been contacted in April 2015 through a written questionnaire and we saw three written responses, all of which were very positive about the care of their relative. The service was developing other communications with people, their families and staff including a newsletter and the use of social media. This helped to encourage feedback and discussion between relatives, staff and people involved in the service. Where there had been a concern raised by a relative this was investigated and an explanation was given to them.

Good

Is the service well-led?

Our findings

The management team expressed a vision of an enabling and empowering service for people with learning disabilities. They put this into practice through value based bespoke training and induction, monitoring and audit of the service, and response to concerns. The management team acknowledged the challenge providing an intensive service over a remote area and told us they had invested in the database and in staffing to improve the stability of the service. Practical steps to translate the vision into practice included the development of new roles, responsibilities and a career progression path to enhance staff retention. The restructure of the staffing by the service in March 2015 was designed to improve the quality and continuity of staffing and also respond to national legal requirements relating to pay and conditions. In addition we were informed that the purpose was also to deploy senior and experienced staff with people and staff to improve the quality and consistency of outcomes for people. The management team told us that they would not be taking new referrals if this meant the size of the service would increase over the next 6 months as they wished to consolidate the changes made within the service infrastructure. We found that outcomes for people were positive however that staff were aware of the need for consistent staffing for this to be sustained.

At the time of inspection some roles were still being recruited to and staff we spoke with were still getting used to the new roles. For example, one staff said, “I get brilliant support from my supervisor but I am not sure what the new structure is all about”. One member of staff expressed the view that more communication with staff was required to ensure the purpose of the changes was widely shared and understood. The management team demonstrated awareness of this and showed us how this was being addressed. For example, as well as regular team meetings, most staff received more frequent supervision, a newsletter had been issued and social media was used to share information about the service as well as wider issues in the sector.

This service learned from incidents and issues which had arisen in the service A senior clinical member of staff acknowledged that staff development was a work in progress and the safeguarding concerns which had arisen earlier in the year were a ‘wake up call’ for the service. A greater focus on performance management and accountability within the service was evident in a detailed template for staff supervision including prompts for staff to raise any concerns about poor practice. The frequency of supervision had been increased for most staff from every two to three months to monthly. A code of practice for staff had been introduced by the management team in March 2015 setting out standards for the conduct of staff. We saw evidence that the central database used by the service was an innovative development which had improved in function and accessibility over the last six months, to fulfil the aim of a shared platform underpinning a safe and effective service.

Feedback from some of the external professionals we spoke with raised the issue of communication, particularly when there might be issues of concern. For example, where there had been a missed visit for one person, the social worker expressed concern about delay in feedback from the service. Another external professional expressed a positive view of outcomes achieved for one person, for example in links with their family, their activities and general wellbeing, however was concerned about a lack of communication when changes occurred. Plans were being developed to bring together the management team and the local commissioners to discuss these issues and determine a positive way forward in a spirit of partnership and collaboration.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The service was not deploying sufficient numbers of suitably skilled and experienced staff to meet people's needs.