Royal Mencap Society

Royal Mencap Society - Domiciliary Care Services - South London

Inspection report

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Date of inspection visit:
23 February 2017

Date of publication:
20 April 2017

Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

This inspection took place on 23 February 2017 and was announced. This service was rated 'good' at our last inspection in January 2015.

This service provides personal care and support to people living in supported living schemes across the London boroughs of Croydon, Lambeth, Lewisham, Merton and Sutton. Supported living is a model of social care where people rent their homes from a housing provider and receive an agreed amount of care and support hours from a separate care provider according to their individual needs. At the time of our inspection there was a total of 44 people using the service. There was a registered manager in post. 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 had built very good relationships with staff, who were friendly and respectful and who knew people well. The service used creative and innovative methods of supporting people to express their views and make choices about their care, including the use of accessible technology where needed. This included additional support for people who were able to communicate verbally but found it difficult to express their wishes for other reasons.

The service had a strong commitment to promoting people's independence. Staff worked closely with people to build their confidence and learn to do more for themselves. People had access to adapted equipment according to their individual assessed needs to enable them to carry out daily living tasks independently.

The provider used a person-centred approach to care planning based on evidence-based measures of quality of life. Support plans were personalised and centred around people's preferences, views and experiences as well as their care and support needs. They took into account people's history, family relationships and religious and cultural needs. People's care and support was planned in such a way as to facilitate working towards their goals and ambitions. The provider recognised people's achievements and encouraged them to always improve by setting new targets whenever their care was reviewed.

People received support to engage in a variety of activities to suit their tastes and abilities, both at home and in the wider community. This included taking more responsibility for their own household tasks but also pursuing their interests and hobbies, making new friends and finding new interests. Staff supported people to pursue education and employment opportunities and to join social groups.

People were satisfied with how the service responded to their complaints and concerns. There was an accessible complaints procedure and records showed the registered manager dealt with complaints according to the procedure.

The provider had a visible person-centred culture with a clear vision and strong values, which staff were familiar with and knew how to apply to their work. Leadership was accessible and people, staff and others involved with the service had opportunities to express their views about the service. Managers used people's feedback to improve services in a variety of ways.

The registered manager used several tools to assess, monitor and improve the quality of the service including internal audits carried out by people who used similar services operated by the same provider. They assessed the quality of the service against standards that were based on people's feedback about the care and support they wanted from services. People were also involved in the recruitment and selection of new staff. The provider worked to challenge discrimination and stigma in recruitment, for example by guaranteeing an interview to all applicants who identified as being disabled.

Staff knew how to keep people safe, because there were detailed risk management plans to reduce risks. Staff supported people to make sure their homes were safe. They received suitable training in safeguarding people from abuse and there were procedures in place to protect people from financial and other abuse. Medicines were managed safely.

There were enough staff to keep people safe and appropriate arrangements for emergency staff cover. Recruitment processes were designed to ensure only suitable staff were selected to work with people.

People benefited from being cared for by staff who received suitable, good quality training that was relevant to their work. Staff received regular support from managers and had opportunities to learn and discuss good practice with their colleagues.

Staff were aware of their duties under the Mental Capacity Act 2005. They obtained people's consent before carrying out care tasks and followed legal requirements where people did not have the capacity to consent.

Staff supported people to choose food they liked and to eat healthily. People received enough food and fluids to remain healthy and staff monitored this when required. People had adapted equipment to help them eat independently, if they needed it. People had detailed plans to help staff and health professionals provide the care and support they needed to remain healthy and manage any existing health conditions.

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. Staff knew how to keep people safe from abuse and avoidable harm. People had personalised risk assessments and management plans and received support to keep their home environment safe.

There were enough staff to keep people safe and suitable staff cover arrangements for emergencies. The provider followed safe recruitment procedures.

Medicines were managed safely.

Is the service effective?

Good

The service was effective. Staff received the support, training and information they needed to care for people effectively.

Staff were aware of the principles of the Mental Capacity Act 2005 and made sure they obtained people's consent, or a decision was made in their best interests using the appropriate procedures, before providing care.

People received the support they needed to remain healthy, access healthcare services and to have a varied and nutritious diet.

Is the service caring?

Outstanding ☆

The service was very caring. Staff used creative and innovative methods of supporting people to understand the information they needed to make choices about their care and support.

Staff treated people with respect and dignity and took time to build positive caring relationships with people. They knew people well and were well liked by people.

People received the support they needed to develop and retain their independence, including through use of specialised tools and adaptations.

Is the service responsive?

Outstanding ☆

The service was very responsive. People's care and support was personalised and was designed to promote quality of life and to meet their needs and preferences. People received support and recognition around setting and achieving goals for themselves.

People were able to take part in a wide variety of activities, which helped ensure they were actively involved in their own households and in the wider community. People's cultural and religious needs were met.

Is the service well-led?

Outstanding ☆

The service was very well-led. There was a visible person-centred culture, including a clear vision and values based on providing care that was inclusive and personalised.

The registered manager and provider used a variety of tools to assess, monitor and improve the quality of the service including better support for staff and involving people who used services in setting standards and carrying out audits. They listened to and learned from people's feedback, which was used to improve the service.

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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 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.

This inspection took place on 23 February 2017 and was announced. We gave the provider 48 hours' notice because we needed to be sure somebody would be at the office during the inspection.

The inspection was carried out by an inspector 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. This expert-by-experience had experience of caring for family members with learning disabilities and mental health needs.

Before the inspection, we reviewed the information we held about the service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We also reviewed the provider information return (PIR). The PIR is a document we ask providers to submit before our inspection about how they are meeting the requirements of the five key questions and what improvements they intend to make.

During the inspection, we spoke with thirteen people who used the service, four members of staff and the registered manager. We looked at six people's care plans, four staff files and other records relevant to the management of the service such as audits and incidents data. We also visited a supported living scheme to speak with people and staff and to observe staff caring for people. After the inspection we obtained

feedback from an advocate who worked with people using the service and one of the commissioners who worked with the service to find suitable places for people to live.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "All the staff help me to feel safe." Another person told us, "Yes, I feel quite safe." Each person had person-centred risk assessments so staff had the information they needed to provide care and support in a safe way to the person. Staff gave examples of how these were designed to be as least restrictive as possible. There were risk management plans with details of how staff should work to keep people safe while respecting their individual preferences about how to do this. Staff carried out risk assessments for any new activities or situations people took part in, as well as updating existing assessments regularly or when significant changes occurred such as changes in the person's health or mobility. We saw risk assessments for one person's holiday that was being planned and for another person to attend social activities with their boyfriend who used a different service. Staff were familiar with people's risks and how to keep them safe while maintaining their independence and choice as much as possible.

People had support plans, risk assessments and management plans designed to protect them from financial abuse. Staff checked the balance of any personal money they held on people's behalf daily and managers audited people's financial records monthly. People's families were involved in decisions about larger spends, such as for holidays. This helped to ensure that decisions about people's expenses were appropriately accounted for.

Staff were able to describe the different types of abuse and how to recognise them. They were familiar with reporting procedures and what they should do if they did not feel their concerns were appropriately followed up. Staff also demonstrated their knowledge of the importance of full and accurate documentation and recording of any incidents particularly those related to safeguarding people from abuse. We discussed recent safeguarding incidents with the registered manager, who was able to describe the actions they had taken to keep people safe and prevent the incidents from happening again. One person told us about an incident they were involved in and said although they were worried at the time, "it's alright now."

Staff ensured people's living environments were safe. For example, some refurbishment was due to take place at one of the supported living schemes and staff had carried out a risk assessment. We saw a form they completed to inform contractors of people's needs and any risks arising from these that were relevant to the refurbishment. We also saw evidence that staff supported people to carry out safety checks of their homes to raise their awareness about their safety and to increase their independence.

We saw evidence that managers fully investigated accidents and incidents and submitted reports to the provider, who analysed the data for trends and used this to improve safety. There was an escalation procedure for more serious incidents to be submitted directly to senior managers. On an individual level, managers reviewed people's risk management plans after accidents and incidents to ensure staff were following them as agreed and to add any extra information that became known as a result of the incident. This helped prevent people from coming to avoidable harm through repeat occurrences of accidents and incidents across the organisation. We looked at data from incidents across the London region and saw that while no categories of incidents had increased over the last five years, there was a significant decrease in

reports of incidents related to people's behaviour that challenged services. The registered manager told us they felt these had reduced markedly in their services because of an improvement in people's quality of life.

The registered manager used a tracker to monitor recruitment and review staffing levels on a monthly basis. We saw evidence that they discussed people's needs and staffing levels with scheme managers in supervision. Rotas were flexible and arranged to meet people's needs, for example if people required extra staff so they could go on outings or if they needed more support than usual because of illness. We saw an example of where staff hours had been changed to allow some people to attend an evening class. Staff confirmed that if staffing levels fell short they were able to arrange cover either by calling other supported living schemes or booking relief bank or agency staff. A professional working alongside the service told us the scheme they visited was always well staffed. We looked at staff files and found that the provider carried out the checks required by law when recruiting new staff. This included criminal record checks, proof of identity, evidence of fitness to work, references and work history. This helped to ensure the provider employed staff who were suitable to work with people.

One person told us, "[Staff] look after me. They give me my medication." Medicines were managed safely. Each person who took medicines had their own secure storage place for them. Supported living schemes each had a member of staff who was responsible for ensuring medicines were managed safely and were reordered when needed so people did not run out of medicines. We looked at four people's medicines administration records, which showed people received their medicines as prescribed. Staff checked medicines on every shift to make sure no administration errors were made. Where people were prescribed medicines to take only when required, they had detailed guidelines informing staff when they should support the person to take the medicines and these were signed off by the prescribing GP.

Good

Is the service effective?

Our findings

Staff told us they were "very happy" with the support and training they received. The provider had a programme called 'Shape Your Future' that was designed to give staff the training and development opportunities they needed to perform their roles well and provide effective care and support to people. Staff told us how this had helped them set targets and one member of staff showed us evidence of their development plan with targets they had met, which were reviewed at regular one to one supervision meetings. Staff also told us they benefited from a mentoring system and that people who used the service were involved in the induction process for new staff. We saw evidence of the induction process.

Staff told us the training they received was of high quality and that they were able to access courses they requested to meet their development targets as well as mandatory training and more specialised training relevant to the needs of people who used the service. The registered manager showed us the data they had about staff training, which made it easy to monitor when staff were due to attend courses and to check their training was up to date. We saw all staff had received a variety of training relevant to their roles.

We saw evidence that staff attended regular team meetings to discuss good practice and complex areas of their work such as mental capacity and consent. Staff also used a work related social networking tool to share good practice, current research and ideas that worked well in their service with other staff across the organisation. Managers also received regular updates from the provider about current research and best practice.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). The 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.

We observed staff asking for and obtaining people's consent before carrying out care tasks with them. Staff were aware of the principles of the MCA and were able to describe how they applied them to their work. Staff also knew that they could not provide any care that people had not consented to unless appropriate action had been taken in line with the MCA Code of Practice to confirm that this was in their best interests. There were written procedures for staff to follow if people refused to take their medicines, for example.

We saw that, where they were able to do so, people had signed their care and support documentation to indicate they agreed with them. If staff had reason to suspect that people lacked the capacity to consent to decisions about their care, they carried out capacity assessments to confirm this. If people did not have capacity, they were still involved in the process as much as possible. For example, one person's assessment showed they did not have the capacity to manage their own money or medicines but were still able to consent to the care they received to do this and their consent was recorded.

People told us they were able to choose what they ate and that staff supported them to make their own meals if they were able to do so. One person told us, "I choose what to eat. I cook what I like and I'm going out for a meal tonight." Another person said, "I do choose what I like to eat. I decide what to eat. I go shopping with the staff and choose. There's enough supply for a week." A third person told us, "They make a list saying "What would you like?". I do my own toast and make a pot of tea." People had support plans about nutrition, the support they needed to eat healthily and their likes and dislikes. We saw examples of support plans for people who used adapted plates and cutlery to enable them to eat independently. Staff told us some people they supported chose to eat communally and each person contributed their choices to the weekly menu plan, using pictures of different foods to help them choose. They also told us how they made adjustments to the menu to suit people's preferences, dietary needs and other factors, for example avoiding heavy meals just before activities such as swimming or horse riding.

Staff monitored people's weight where necessary and gave people the support they needed to remain at a healthy weight. Care records showed people supported people to participate in exercise that was suitable for them, such as dancing, cycling or walking. Staff recognised when people did not want to choose what they deemed to be healthy options and we saw examples where they had given people information about these and encouraged them to maintain their health but respected their choices if they did not want to exercise or if they wanted to eat less healthy foods. They worked with people to find the best compromises between what they preferred to do and what was best for their health. For example, staff encouraged one person to walk short distances at first but found they began to enjoy longer walks as time went on.

People had health action plans. A health action plan is a document designed to help people with learning disabilities access the healthcare they need and to make choices about their healthcare. We saw examples of health action plans with information about people's health conditions, how they expressed that they were in pain and how staff should respond, their medicines and any anxieties or fears they had and how staff should support them with these. As part of health action planning, staff asked people what aspects of their healthcare they would like to maintain or improve, such as losing weight or maintaining a healthy exercise programme, and how they would like to do this.

People also had hospital passports, which contained information about their healthcare and support needs and preferences so staff in healthcare settings could quickly familiarise themselves with people's needs.

Records showed that people attended regular appointments with healthcare professionals and the outcomes of these were recorded. One person told us they saw a psychologist to support their mental health. Each person had a health appointments chart. The charts showed all the services each person used, which for some people might include speech and language therapists, physiotherapists or podiatrists. The chart showed when people had last used each service, in a format that made it easy for staff to identify when people were due to book check-ups or had not used a service for a long time. This helped staff to ensure people had regular access to all the services they needed to maintain their health and wellbeing.

Outstanding ☆

Is the service caring?

Our findings

People told us they had good relationships with staff. One person said, "I like it here best. They are very kind." Another person said, "Staff listen to me and I listen to them." A third person told us, "I like the staff. They make me smile and make me happy." We observed that the atmosphere in the supported living scheme we visited was friendly and relaxed, with people and staff laughing and joking together as people completed tasks or took part in activities. We saw a board showing photographs and names of the staff who were due to work that day. One person who lived there told us, "I like it because I can see who's coming in."

It was evident from the way staff spoke about people that they held respect and affection for them and that they knew the people they supported well. For example, staff were very familiar with people's preferences, hobbies and life histories. They were able to tell us people's stories and told us proudly how those people had progressed with their support over time to develop their independence, make the most of their lives and spend more time doing things that were important or interesting to them. This was reflected in people's support plans, which contained detailed information people and their families had given about themselves to enable staff to get to know them. This knowledge of people's histories helped staff understand the context around people's strengths, needs and why they may need more support in some areas than others.

Where people had fears of medical procedures such as injections or situations such as crowded places, staff worked with them towards overcoming their fears if they wanted to do this. We saw examples where this had been successful and also one example of a situation where a person had received support to try several approaches but was unable to overcome their fear of a medical procedure so had agreed with their doctor that it was not in their best interests to carry it out. This showed how staff were concerned with people's wellbeing and provided the emotional support they needed while helping them maintain their health and engage in activities they enjoyed.

People told us they were able to make choices about their support and how they spent their time. One person said, "I choose my own clothes." Another person said, "Yes, I choose everything." Staff told us they offered people choices in everything they did because it was up to them how they lived their lives. The service used creative and diverse methods to communicate with people and support them to make choices about their care. Staff told us about one person who used a 'talking mat' to show staff what they wanted by putting pictures of people, places and objects under different symbols such as 'thumbs up' and 'thumbs down' columns. We heard how, even though the person was unable to communicate verbally, staff were able to establish that the person was not happy with their current daytime activities when they became more withdrawn than usual. Staff worked alongside a speech and language therapist to support the person to express the reasons why they did not like the activities and what they would like to do instead. Staff told us the person was now much happier and participated enthusiastically because they had a specially designed timetable that allowed them to choose one of three activities they liked each morning and afternoon. We saw the timetable, which was in accessible format and showed a diverse range of different activities to choose from.

We also saw in a person's support plan that staff had supported them to buy a tablet computer to help them

communicate. The registered manager told us they had done this after the person successfully used one to talk to others at a story telling workshop designed to help people with learning disabilities develop their communication skills, despite normally finding it difficult to talk to strangers. The person was not confident using the tablet at first, so staff also supported them to complete a 'Computers and Tablets' course at a local college. Staff told us the person was now "really enjoying" using the tablet and it helped them communicate more complex information than before.

Another person's support plan showed they were able to communicate verbally but tended to choose options they believed staff wanted them to choose. We saw evidence that staff had worked with this person to produce a new support plan to help them make choices based on what they wanted. This included information about how to avoid leading questions and how to tell if the person's choice reflected what they really wanted. There was evidence of the person's progress. For example, they had recently chosen their own college courses and had enrolled in a class about self-awareness. Staff had also noticed the person had stopped ordering the same dishes as everyone else when they went to restaurants. We looked at another support plan for a person who did not communicate verbally. There were details about what the person was likely to be communicating when they used certain signs, gestures and sounds, how to understand the person's body language and how to convey information in the best ways to help them understand it. There was also information about how to tell if the person was upset, uncomfortable or in pain and how staff should support them.

We saw evidence that some people, particularly those who did not communicate verbally, received support from independent advocates. Staff were aware of this and gave examples of times when they had contacted people's advocates to help them make decisions about their care. We saw several examples of how staff had planned people's care and support to help people make decisions for themselves where they found it difficult to do this.

We also saw examples of staff using flash cards, objects of reference and Makaton, a signing system developed to make spoken language more accessible to people with learning disabilities. We observed that staff used different styles of verbal communication depending on people's level of understanding. Staff also used social stories. A social story is a tool used to facilitate social interactions by giving people accessible information about what they can expect in certain social situations and how to respond appropriately. We saw an example of a social story designed with a person who was making excessive telephone calls to a family member. This explained what the person liked about making the telephone calls and when it was "OK" and "not OK" to make calls. There were explanations of why the family member might not always answer, for example because they were at work, and the positive outcomes the person could expect by following the guidelines within the social story. Staff told us this was important to the person as it helped reassure them, and they also told us the person had significantly reduced the number of calls they were making and as a result had a better relationship with their family and more time to engage in other activities.

People told us staff respected their privacy. One person said, "They knock at the door." Staff gave examples of how they made sure they maintained people's privacy when supporting them with personal care. People told us they had access to private space when they needed it. Staff told us they never spoke about people's health, finances or other private affairs in front of other people who used the service or anybody who did not need to know the information.

A professional working alongside the service told us staff were friendly and treated people with respect and dignity. Staff we spoke with clearly understood the importance of respecting people's dignity and rights. We observed that they used person-centred language that put people at the centre of their own care. For

example, one member of staff mentioned that "we support people to live their own lives, rather than doing things to them" and gave the example, "I would support [person] with personal care, not 'give them a bath.'" We observed other staff using the same communication style, which helped create an empowering and person-centred environment that promoted dignity and respect for people.

People's care plans had detailed information about which tasks they could perform independently and what level of prompting or support they needed with other tasks. This was to help staff support people to be as independent as possible and to retain and develop the independent living skills they had. We saw a comment one person had made during their care plan review that they were proud of being independent and happy with the support they received around this. Staff gave several examples of how they had supported people to develop skills and become more independent. We saw evidence that they had obtained adapted kitchen equipment such as safety knives, an adapted kettle and adapted chopping boards so that people could prepare food and drinks independently in their homes. One person's care review showed that the adaptations had helped them to achieve this and staff had helped them set new targets of independently recognising when tasks needed to be completed instead of being prompted. Supporting people to gradually develop their independence in this way helped them to learn new skills without becoming overwhelmed by too many new things at once and also may contribute to people feeling valued as their achievements are recognised over time.

Outstanding ☆

Is the service responsive?

Our findings

Each person had an individual, person-centred support plan based on the provider's 'What Matters Most' approach. The approach was based on evidence-based methodology such as use of the Personal Wellbeing Index, which is based on a tool originally developed by the Australian Centre on Quality of Life for measuring quality of life, satisfaction and happiness with life. This was meant to ensure that people received care and support based on their choices and what was important to them. Evidence that this approach had a positive impact on people's lives was shown by the provider's data on incidents, which showed that the annual number of incidents relating to behaviour that challenged services had declined from 853 to 378 across London and from 86 to 30 in this service since the provider introduced the 'What Matters Most' approach in 2014.

A service commissioner told us the provider was committed to providing person-centred care and another professional told us scheme managers "went the extra mile" to provide care that was responsive to people's needs. Each person's support plan was in a slightly different format and staff told us this was because people decided individually which parts of their support plan were most important to them and how the information should be organised. For example, there were different sections with headings such as "happy" and "healthy" and people made choices about which aspects of their care and support were relevant to each category from their point of view.

Each support plan contained details about who and what was important to the person, what they wanted support to do, what they found difficult and what they wanted to achieve in the future. There was detailed information about what support people needed and how staff should provide it to meet the person's preferences and avoid things they disliked. For example, one person's support plan contained information about the adapted cutlery they used and which hand they preferred to eat with. One person, who had a history of mental illness, had details about how staff should support them in order to prevent relapse, how to recognise early warning signs of this and what might trigger an episode of poor mental health. Information in the person's support plan stated this had not happened for several years, which showed the person's current support met their needs in this area. There was also information about why staff should respond to people in particular ways, to help staff understand people's needs and the reasons behind their behaviour.

People's support plans were reviewed regularly and there was evidence that they were involved in this process. To help ensure support plans remained up to date with people's needs, staff recorded in daily logs how much support people required for each personal care task (for example, whether they supported the person physically or prompted them) and these were taken into account during reviews. Support plans also took into account what support people were likely to need in the future and how staff should help prepare them for this, particularly if they were diagnosed with a progressive illness such as dementia. For people whose mobility was declining or likely to in the future, staff supported them to choose physical activities such as dancing classes to help them remain mobile for as long as possible. Care records and shift plans from the month before our visit showed that people took part in these activities as planned. Staff also involved professionals such as occupational therapists and physiotherapists when needed to ensure people

were using the right equipment and doing the right exercises to help them retain their abilities in this area. One person was experiencing a reduction in mobility due to dizzy spells and the provider had sought input from doctors, physiotherapists, psychologists, neurologists and other health professionals to put together a support plan that met the person's needs.

People's care and support was planned with their goals and ambitions in mind. Staff supported people to set their own targets and achieve them within the time they wanted to. The registered manager told us the process used to plan these outcomes was based on the San Martín Scale, another evidence-based tool for measuring quality of life in people with learning disabilities. This helped to ensure that people received the support they needed to live well and achieve their desired outcomes. An example we saw was of a person who received support to develop their communication skills. The person had become more involved in their community and was building social relationships, engaging in more activities, learning more life skills and developing their independence as part of their measured outcomes.

Each person had a keyworker, a member of staff who took the lead on ensuring they received the care and support they needed. Keyworkers helped people to review their progress against their goals at agreed intervals and we saw examples of records from these reviews indicating that people were moving towards achieving goals. The provider had an annual 'reflection day' where people had the opportunity to celebrate what had gone well for them and the goals they had achieved alongside those who were important to them such as family and friends. People told us it was important to them that others recognised their achievements and staff told us the mayor of their London borough had attended the last celebration, which had helped people feel valued and proud of their achievements. We saw photographs of people celebrating with the mayor. Examples of people's achievements included greater independence around the home, getting a job and being involved in recruiting new staff.

We heard several other accounts of people making progress towards their goals, developing new skills and trying new activities all of which contributed to improving their quality of life. Staff gave several examples of indicators that this was the case. They told us about one person who became anxious and upset in crowded places. They had worked with the person to overcome this by discussing their feelings and what activities they wanted to work towards doing and by engaging a speech and language therapist to help the person express what made them anxious or upset. Staff reported, and support plan reviews confirmed, that the person was now much more confident in crowded places and regularly attended social events, including a music festival designed specifically for people with learning disabilities. They told us this person regularly enjoyed activities they would have been unable to do before.

Staff supported people to complete household tasks and to be responsible for the cleanliness and maintenance of their own homes. One person said, "I like everything about living here. I like to cook, do my washing, hoover the floor and empty the dishwasher. I like the other people who live here." Another person was less independent with household chores and we saw that staff had supported them to set targets to develop skills in this area. One person showed us their bedroom, which they had decorated according to their tastes, and we saw evidence that staff supported them to pursue their hobbies and interests such as reading and writing.

People and staff told us about activities people had been doing recently, including a disco, dance classes, cycling, horse riding and other activities to suit their individual interests and abilities. People told us, "I go to college for dancing and sport. I got to football matches. I go swimming. I go to the theatre," "I like finger knitting and needle knitting. I am making a blanket for a friend, I will make a hat and I will make a scarf from the instructions" and, "I work in Sainsbury's doing the trolleys two times a week. I go to the library on Friday. I go to the cocktail café on Saturday and to church on Sunday." We also saw photographs of people clearly

enjoying activities staff were supporting them to participate in.

Staff made every effort to make sure people felt part of their local community. People were involved in organising events with local groups and clubs for people with learning disabilities. One person was involved in a community gardening project and some were members of local gyms and libraries. Some people had their own adapted cars that staff were able to drive to support them to access the community. We saw how staff supported people to develop their confidence in accessing the community by introducing activities gradually, supporting people to try out activities they thought they might like and either continuing or stopping them depending on whether people enjoyed them. We also saw how staff supported people to plan day trips and holidays of their choice, according to their interests, and where necessary developed temporary support plans for these trips to make sure people received the support they needed. Staff told us about one person's adventure holiday where they participated in extreme sports including paragliding and that person confirmed this was the case.

People received the support they needed to develop and maintain relationships with people in their lives. Each person had a 'relationship map' showing the people who were most important to them and others who they wished to remain in contact with. We looked at the support plan of one person who had a boyfriend and saw that staff had supported them to plan and do activities together such as going out for meals.

The service had a focus on diversity and supported people to meet their cultural and religious needs. One person wanted to learn about and experience different cultures as one of their care planning goals. Staff had supported them to learn about the different cultural backgrounds of the people they lived with and to attend a Chinese New Year celebration, visit a Buddhist temple and go to world food markets. Staff continued to support the person to meet their own religious needs, including regular church attendance and Christmas carol concerts.

People knew how to make complaints and told us staff were responsive to their concerns. One person said. "[Staff] help me, they talk to me when I'm nervous and panicky." Another person told us, "I talk to the manager. He gets it sorted." A third person said, "If I'm upset, I'd go to the staff." We saw an example of a complaint a person's relative made about the way staff supported the person. The registered manager had acknowledged the complaint verbally at the time it was made and wrote to the relative within a week summarising what action they would take. We saw evidence that the complaint was discussed at the next staff meeting, the person's support plan was reviewed and the relative had since contributed to the person's daily notes, writing whether they were happy with the care the person had received on that day. These showed that the relative was satisfied with how the complaint was handled.

Outstanding ☆

Is the service well-led?

Our findings

Each supported living scheme had a manager and the scheme managers received support from the registered manager. People and staff spoke highly of managers. One person said, "I see the manager but not every day. He's doing a very good job." Another person told us, "The manager comes round to chat sometimes." A commissioner said the provider was a "valued partner" who worked well with them and other services and also told us the registered manager and scheme managers were professional and knowledgeable.

Staff said the service had visible leadership and the commissioner also told us they were able to engage with senior management, which was valuable. One member of staff said the scheme manager was very supportive and "always listens to us." Staff told us they had opportunities to express their views, including a staff forum, and said they were always comfortable doing so because the culture of the service was open and person-centred. The registered manager told us about support staff received after difficult shifts, including opportunities to speak with managers and a diary tool to write down what had happened to help them process it. They had introduced this after their 2016 staff survey had identified a need for better emotional support for staff. This support helped ensure that people received better support from staff because the provider had taken steps to help ensures staff were emotionally and psychologically equipped to do their jobs well. We also saw evidence that the registered manager supported scheme managers by offering workshops on subjects such as time management and communication in response to their feedback that they required additional support in these areas.

People told us they were able to express their opinions and their suggestions were acted on. We saw evidence of meetings where people were invited to feed back about the service and make suggestions for improvements and other plans. This included suggestions about décor, staffing and plans for parties or other activities and staff had made most of the suggested changes. One person told us, "I have one problem: my bedside lamp is too small and doesn't work. They already know and will do something about it. We already have new curtains, a new dishwasher, new cabinet, new toaster, new chairs, new kettle, new washing machine and tumble dryer. The freezer cabinet and fridge are fairly new." Managers told us people always had a say in how services were run and that they continually asked people for feedback and suggestions. We saw completed questionnaires from an annual survey the provider had carried out in 2016, where people had made suggestions and expressed their views about what they wanted to do differently or what changes they would like made to the service. There was evidence that the provider followed up on these. For example, where people said they would like to try new activities or to work towards something specific, staff had added these things to people's goals and supported them to achieve them.

The provider had developed an innovative new approach to management called 'Our Leadership Way' in 2016. This included a set of values specifically for managers and provision of clear information about the provider's plans to develop services and how managers were expected to work towards these. This included specific goals about making a positive impact on people's lives, such as better healthcare support, supporting people's relationships and improving quality of life in general. Managers were encouraged to work productively, be supportive, keep the provider's plans for the future in mind and to treat people, staff

and others with respect at all times. The registered manager told us they had found this helpful and it had provided a good structure within which to introduce several of the new initiatives we saw.

There was a number of audits, checks and other systems in place to monitor the quality of the service and we saw several examples of how these had been used to make improvements. For example, systems to monitor staffing and recruitment showed that there was a relatively high staff turnover with more staff than expected leaving their posts within the first year of employment. In response to this the provider had developed better processes to support new staff such as introducing learning mentors who were people with learning disabilities, holding welcome days for new staff to learn about what support was available to them and closer monitoring of the training and supervision new staff received during the first year of employment. The provider had also introduced a scheme called 'You Rock' to recognise good work and outstanding contributions from staff. Staff told us they liked the scheme and felt valued by their employer. The registered manager said it appeared that the staff retention rates were beginning to improve but it was too early to tell whether the scheme had made a significant difference as it had been in place for less than a year.

We saw evidence that the registered manager carried out a quality visit to a different supported living scheme each month. As part of these visits, they looked at the quality of staff interactions with people including whether they treated people with respect, how much they involved people in activities such as health and safety checks and household tasks and how well they communicated with people. The registered manager also took time to speak with staff, discuss good practice and ask them for their feedback. They encouraged scheme managers to share good news stories about people's progress towards their goals and what was working well for people. We also saw evidence that they encouraged staff teams to reflect on their own practices, what they did well and what they could do better, and to review this later to see if they had been able to make positive changes.

The provider had a set of standards as part of their 'What Matters Most' approach, which were used to measure the quality of services based on what people using the services said was important to them. We saw an audit of this service that the provider's quality team had carried out in 2016. This included a person with a learning disability as part of the audit team. The audit looked at the management of the service, individual support plans and management of people's finances. The member of the team who had a learning disability spoke with people and carried out observations of staff providing care and support to people as a way of checking the quality of caring interactions and finding out what people liked or disliked about the service. The audit had not identified any major concerns but a minor issue with the organisation of some paperwork had been rectified by the time of our inspection. The registered manager reviewed progress against action plans from audits to make sure they were completed within the given timescales.

The registered manager used a computerised tool to check various other aspects of the quality of the service such as staff performance, quality of people's support plans and other documentation, staff files and health and safety checks. The registered manager also told us they personally checked and signed off each person's financial records once a year.

The provider had a clear vision and values, which staff were able to describe consistently and gave examples of how they applied the organisational values to their work. For example, one of the values was inclusion and we heard about and saw evidence for how the provider involved people who used services in the recruitment process. This was intended to ensure that the provider maintained a visible person-centred culture that contributed to people feeling valued. People were able to take part in interview panels and had a say in who was or was not recruited. We saw lists of interview questions presented in an accessible format to help people ask them during interviews. The provider's accessible selection process highlighted that

people should have a choice about how to decide whether they thought each applicant should be recruited, for example by doing an activity together or having a conversation about their interests. People were then offered the opportunity to have a discussion with recruiting managers to agree on who should be selected.

The provider actively worked to challenge discrimination and stigma, particularly about disability, and had a strong reputation for doing this. For example, the provider was part of the Disability Confident scheme, which works with employers to recruit and support employees who are disabled. This was reflected in the provider's recruitment policy, which stated that disabled applicants would be guaranteed an interview. We also saw evidence that the registered manager had used their regular meetings with scheme managers to talk about cultural differences within staff teams and how to respond positively when these affected aspects of work such as communication.