

Manchester City Council

Manchester Shared Lives

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 ●

Summary of findings

Overall summary

We inspected Manchester Shared Lives on 17, 18 and 19 May 2016. As this was a 'shared lives' scheme, we contacted the registered manager the afternoon before the inspection. This was so that she could arrange visits for us to meet the people in their placement homes. At the last inspection in October 2013 we found the service met all the regulations we looked at.

At the time of our inspection, 79 people were being supported by the shared lives scheme as long term placements. A further 18 people used the service for respite care. 'Shared lives' describes the arrangement whereby people either live with or near self-employed care providers who support them according to their assessed needs.

The homes care providers shared with people were located across Manchester; up to three people were supported per household. The Manchester Shared Lives office team consisted of the registered manager and six placement workers. They supported the care providers, assessed prospective care providers and matched new people to care providers who had a vacancy in their home.

The service had 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.

We saw that one 'as required' medicine did not have a medicine protocol and was not recorded on the person's medicine administration chart. Other than this, medicines were managed properly by the care providers that supported people.

The support plans of one person who had problems swallowing food had not been updated with this information and they had no swallowing risk assessment. Two of the homes we visited did not contain copies of people's risk assessments. Risk assessments in other people's homes and at the office were appropriate and people were supported by care providers to take positive risks if the benefit of the activity outweighed any potential risk identified.

People we spoke with told us they felt safe in their placement homes. The relatives we spoke with agreed. The care providers and placement workers could describe the forms of abuse people using the service might be vulnerable to and said they would report any concerns appropriately.

The recruitment process for new care providers was robust; we saw all the required checks had been made and documentation was in place. There was a disciplinary policy which the registered manager had followed when addressing an issue with a care provider.

The homes where people were placed were assessed for safety and cleanliness at regular intervals.

The service complied with the Mental Capacity Act 2005; staff had a good working knowledge of the principals and how they applied to the people using the service. People were given choices and supported to make their own decisions.

Staff received the training they needed to support people safely. They also received regular supervision and an annual appraisal, all of which was documented properly. Care providers said they felt supported by their placement workers.

People told us they enjoyed the meals they had in their placement homes. People and their relatives said that people were supported to access a range of healthcare professionals and care providers showed us how they arranged and documented this for the people.

People and their relatives told us that the care providers were caring. Care providers described people as members of their families and the interactions we observed were warm and friendly.

Care providers gave us examples of how they promoted the independence of the people they supported. We saw that placement workers made referrals to advocacy services if people needed independent help or support to make decisions.

People's support plans were individualised and person-centred and produced in a format that made them accessible to the people they related to. We saw that people who could sign their plans had done so.

People had access to a range of activities, voluntary placements and employment opportunities. All of the people we spoke with said they had lots to do and their relatives agreed. People regularly went on holidays with the care providers and their families.

No one we spoke with had ever made a complaint but all of the people and relatives we spoke with said they knew who to complain to and would do so if they had a problem.

People, their relatives and other healthcare professionals involved with the people gave us positive feedback about the management of the service. We observed that there was an open culture at the service and staff seemed happy.

There was a comprehensive system of audit and quality assurance at the service. Incidents and accidents were recorded and there was a risk register in place which was reviewed on a monthly basis.

Staff worked according to the vision and values of the service to support the people and the service was an active participant of the UK Shared Lives Plus network.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

We found issues with how one person's medicines had been recorded. Other medicines were recorded properly.

One person with swallowing problems lacked a risk assessment and care plan. Other people's support had been thoroughly risk assessed and control measures were in place to mitigate any risks identified.

People using the service told us that they felt safe. Staff could describe how people might be at risk from abuse and said they would report any concerns appropriately.

Is the service effective?

Good 

The service was effective.

The service was compliant with the Mental Capacity Act (2005) and staff could explain how the legislation affected the people they supported.

Records showed and staff told us they were trained and supported to care for the people using the service. People and their relatives agreed.

People were encouraged to make healthy meal choices and to join in with meal preparation, although care providers respected people's right to eat the foods that they liked.

Is the service caring?

Good 

The service was caring.

People and their relatives said that the care providers were caring. We saw that care providers had formed deep and lasting bonds with the people that lived with them.

Care providers respected people's privacy and dignity and gave us examples of how they supported people to be independent.

People were involved in designing their care and were referred to advocacy services when they needed them.

Is the service responsive?

Good ●

The service was responsive.

People's support plans were individualised and person-centred. They were updated at regular intervals and people were involved in the process.

People told us that they had enough to do and their relatives agreed. They went on holidays with the families they lived with or were helped to book their own if they preferred.

Complaints made to the service had been dealt with appropriately by the registered manager. No one we spoke with had ever complained.

Is the service well-led?

Good ●

The service was well-led.

The system of audit and quality monitoring in place was comprehensive and robust.

People, their relatives, staff and other healthcare professionals had opportunities to feedback on the service.

Staff described how the service's vision and values underpinned the support they provided. We saw that there was an open and supportive culture at the service.

Manchester Shared Lives

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 17, 18 and 19 May 2016. The inspection team consisted of one adult social care 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. The expert by experience on this inspection had been a carer for an older relative. We telephoned the registered manager the afternoon before the inspection. This was to make sure there would be someone at the office the next day and to ask that they arrange visits for us to meet the people using the service.

We did not ask the registered provider to complete a Provider Information Return (PIR) before the inspection.

Before the inspection we reviewed the information we held about the service. This involved contacting Healthwatch Trafford. They had no information of concern to share with us. After the inspection we contacted five healthcare professionals involved with placing people with the service; those that responded gave very positive feedback.

During our inspection we spoke with six people who used the service and five care providers in their homes. The expert by experience spoke with five people who used the service, five care providers and six people's relatives over the telephone. We also spoke with the registered manager, the locality strategy manager for learning disabilities for the provider and two placement workers.

As part of the inspection we reviewed nine people's care files at the office and 11 in the homes where people were supported. We also viewed five care providers' recruitment records, placement worker and care providers' supervision and appraisal records, various policies and procedures, care provider and placement worker training records, two people's medicines administration records, audit and monitoring records and other documents relating to the management of the service.

Is the service safe?

Our findings

People we spoke with told us they felt safe in their placement homes; they also told us their possessions were safe. One person said, "I feel safe and I can lock my room", and a second person told us, "I am happy and I feel safe here." People's relatives also thought that the people using the service were safe. One relative told us, "100% safe. The house [name] lives in when [they] go on respite is specially adapted and it is very clean and tidy", and a second relative said, "I'm absolutely certain [name] is safe. I can speak to [the care provider] about anything."

The care providers supporting people in their homes could describe the various forms of abuse that people using the service might be vulnerable to. One care provider said, "It's to do with protecting vulnerable people from abuse, such as physical, mental, financial or sexual." Care providers told us they had received safeguarding training and said they would report any concerns to their placement worker or to the registered manager. The placement workers also knew about safeguarding and how to manage any concerns properly. One described how they would follow the local authority's safeguarding policy. This meant that care providers and placement workers understood how to safeguard the people supported by the service and knew how to report any concerns.

As part of the inspection we looked at how medicines were managed for people who needed assistance with this aspect of their care. Only nine people using the service were supported with their medicines so we looked at medicines management and medication administration records or MARs for two people. We saw that people's medicines were stored safely in a locked cupboard in the person's home. Their MAR charts were detailed, showing when medicines were received and sent back to pharmacy and what the stock of each medicine was. The administration of medicines on the MARs was also recorded correctly. This meant that regular daily medicines for these people were managed safely by the care providers.

We noted that one person was prescribed an inhaler for a chest problem on an 'as required' basis but this was not on their MAR and there was no 'as required' medicine protocol for it. 'As required' medicines are taken when a person feels they need them or have certain symptoms. Medicine protocols help staff supporting people with their medicines as they describe when 'as required' medicines should be taken, what the correct dose is and how frequently they can be administered. Not having a protocol for a medicine or recording it on a MAR could mean that care providers may not support people with their medicines safely. We spoke with the care providers whose home this person lived in. They had supported the person for many years and could explain how this medicine should be administered safely, and confirmed the person was receiving it properly. We raised this issue with the registered manager. She said she would ensure that 'as required' medicines were recorded on MARs when people received support with their medicines and that 'as required' medicine protocols were put in place, when required.

We looked at how risk to the people was managed by the service and what assessments had been done to mitigate any risks identified. We saw that each person had been assessed individually and either had risks explained in their support plans or had separate risk assessment documents for different risks identified. For example, two people we met needed support all the time, which meant that their care provider would be

there to manage any risks to them; this was noted in their support plans. Other people using the service were more independent and had risk assessments for being in the house unsupervised, using public transport alone and gambling. The risk to the person from each of these potential hazards had been assessed and control measures put in place. We looked at the documentation held by care providers in their homes and noted that care files for people in two homes we visited did not include their risk assessments. The care providers we spoke with about these people could describe the risks to each individual and the control measures in place to mitigate them; however, copies should be available for their reference.

One person we met had been discharged from hospital over a year earlier with an identified need for soft foods and thickened fluids. This was because the person had a bad cough and it was thought that making their diet easier to swallow would help. When we looked at their support plan we could see that soft foods were mentioned but there was no reason given as to why it was required. The person also had a health action plan, but this said the person did not have swallowing problems and did not cough, even though both the care provider and placement worker told us the person often coughed after food. The person's care provider had supported them for many years and could describe to us how foods and fluids were prepared for the person to take safely; however, not having an up to date support plan and risk assessment in place meant that a care provider not familiar with the person would not know how to support them safely. We spoke with the person's placement worker who confirmed that the person's swallowing issues were still under review and that a speech and language therapist was due to see them soon. They also said that the person's support plan and health action plan would be updated.

We saw that people were supported to take risks and to become more independent by their care providers and placement workers. One person liked to visit the hairdressers. Their care provider explained that they had gone with the person the first few times to show them the route and how to pay and then after time starting to observe from a distance. This went on until the person could go there and back on their own. We saw this was described in a risk assessment. Another person wanted to walk to a friend's house nearby so their care provider had accompanied them until the person felt confident to go alone. The care provider had then developed a phone texting system with the friend's parent so that the person's arrival and departure was known; they were also in the process of documenting the risk assessment with their designated placement worker. This meant that people were supported to take positive risks when the benefits of the activity outweighed any identified risks.

We wanted to know how care providers had been recruited to the shared lived scheme so we looked at their personnel files and spoke with the registered manager. The registered manager told us that care providers were classed as self-employed. She explained that the assessment process for new care providers was rigorous, involving an initial application form, home visits, four references, a Disclosure and Barring Service (DBS) check and an assessment of the existing family structure. Prospective care providers also had to provide a family history and describe a day in their life, so that the placement workers could assess whether the applicants would be suitable to support people in their homes. When all of the information was gathered the applications went to an independent panel for approval; this was made up by people who used the service, care providers and placement workers from different shared life schemes and other healthcare professionals. The five care provider recruitment files we saw evidenced the process as described by the registered manager and the service's recruitment policy. This meant that new care providers were recruited safely by the service.

The service also had a disciplinary process in place. We saw this had been used when an investigation had shown that a care provider had behaved in a manner deemed to be unacceptable. The care provider had received a formal written warning in line with the disciplinary policy; however the service then proceeded to support the care provider so that they could once again provide a safe shared lives placement in their home.

The assessment process for new care providers involved a health and safety check on their homes to make sure they were safe for people to be placed there. This included making sure they were clean and tidy. New care providers had to provide a certificate to show their home had passed a gas safety check and then repeat this on an annual basis. The health and safety check formed part of the care providers' annual appraisal and placement workers made observations around care providers' homes at each monitoring visit to make sure the environment where people lived was safe. We saw records of initial health and safety assessments, gas safety certificates and annual health and safety updates during the inspection. This meant that people's placement homes were assessed for health and safety prior to them moving in and on a regular basis to make sure they remained safe and clean.

Is the service effective?

Our findings

People told us they were supported to be independent and make their own decisions. One person said, "I can go and come in when I want. I decide when to go to bed." Care providers described how they encouraged people to make their own decisions about what to wear or eat, or how to spend their money. One care provider explained how they had supported a person to buy their own clothes; they said, "I always leave them to make their own decisions." Relatives agreed that staff supported people to make their own decisions. One relative told us, "[Name] has choices but [their care provider] does give [them] help."

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

The care files we looked at described people's ability to make decisions if there was any question around their mental capacity. We also saw that capacity assessments had been made to determine whether people could make big decisions, such as large purchases, managing their own money and changing medical treatment. When people were judged to lack capacity to make decisions, we saw best interest decisions had been made for them following the correct procedures.

Care providers and placement workers all told us they had attended a MCA course and could describe how the legislation affected the people supported by the service. One care provider said of the MCA, "You need to evaluate what a person can do and what they can't", a second said, "I don't tell them what to do", and one placement worker described how people and their care providers were involved in any assessments of capacity or best interest decisions. This meant that the service was compliant with the MCA.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in community settings are called the Deprivation of Liberty Safeguards in Domestic Settings (DiDS). In shared lives, the care provider must request that the local authority applies to the Court of Protection for DiDS authorisation if they think the person's liberty must be deprived to keep them safe.

In the case of the Manchester Shared Lives service, the registered service provider is Manchester City Council which is also the local authority in terms of making applications to the Court of Protection for DiDS. We asked the registered manager if the service supported any people who lacked the capacity to decide where to live or who would be prevented from leaving their homes unaccompanied if they tried. She said that it did, which meant that these people needed DiDS authorisations. The registered manager was aware of this and said that assessments for all of the people the service supported who lacked capacity to decide where to live had been supplied to the team within Manchester City Council who dealt with DiDS applications. This meant that the service was compliant with the legislation relating to the deprivation of people's liberty.

We asked people and their relatives if the care providers were well trained and they told us that they thought they were. One person said, "[My care provider] is good and well trained", and a relative told us, "[The care provider] is well trained and knows what to do."

Care providers described the training they had attended; this had included all of the usual mandatory topics, such as safeguarding, medicines management, health and safety, moving and handling, first aid and food hygiene. The care providers also told us they were offered additional training on more specialist courses when they were supporting people with specific needs. One care provider said, "I'm going on an epilepsy awareness course next week", and another told us they had seen an autism awareness course in the most recent service newsletter and had asked for a place. We checked the training matrix of all the care providers and saw they were up to date with their training courses. The placement workers who supported the care providers were also up to date with their mandatory training courses. This meant that the care providers supporting the people and the placement workers supporting them, had received the training they needed to do their jobs.

We asked the registered manager about the training and induction new care providers received when they were approved to join the shared lives scheme. She told us that new care providers received all of the mandatory units as part of their induction and approvals process. She also told us that the service was working with Shared Lives Plus (SLP), the UK support network for shared lives schemes, to integrate the Care Certificate into the induction for care providers new to health and social care. The registered manager explained how most of the Care Certificate had been incorporated, but that some aspects, such as the timing of competency assessments, were still under discussion between SLP and Skills for Care. Skills for Care is the body jointly responsible for developing the Care Certificate. She also told us that no care providers who were new to care had been recruited since the Care Certificate came into effect in April 2015. This meant that new care providers received mandatory training during their inductions and that work was ongoing to ensure the Care Certificate would be fully integrated into the induction process.

We asked the care providers if they felt they received enough support from the service and they told us that they did. One care provider told us, "They support us really well. Even if [my placement worker] is on holiday, they (other placement workers) will ask if they can help. They're 100% behind me", and a second said, "I am well supported by [my placement worker] and [they] are very approachable if there is a problem."

The care providers had regular supervision and an annual appraisal with their placement worker. Care providers told us that this happened in monitoring meetings they had every eight to 10 weeks. At these meetings the placement workers checked if the care provider was happy, if there had been any issues with the person or people they supported and if they needed any support themselves. One care provider said of their placement worker, "She says if I make your life better, you can make their lives (the people's) better." The annual appraisal was a more in-depth meeting, which the placement workers prepared for by seeking feedback from others involved with the person or people they supported, for example the local day centre. This feedback was then discussed with the care provider, along with their personal and professional development, the issues which had arisen through the year and any training that was required. We saw that these meetings were documented. The registered manager had oversight of, and contributed to, the care providers' appraisals by providing feedback of her own. Placement workers also had regular supervision and annual appraisals with the registered manager and we saw they were documented. This meant that care providers and placement workers received the support they needed to do their jobs.

People and care providers explained how meal choices were made and food was prepared in their homes. Some people liked to get involved in writing shopping lists, going shopping and cooking, whereas others chose not to take part in these tasks. All of the people we spoke with said they were happy with the food

they ate at their homes. One person told us, "I can eat what I like and the meals are good", and a second person said, "I like to cook and [my care provider] helps me and I get enough to eat." Relatives also commented on the meals their family members using the service had. One told us, "[Their care provider] helps [them] with [their] cooking and there is also a choice of food if [they] don't want to cook", and a second said, "[Name] goes out for meals with [their care provider] and [their spouse] and [their] food is well catered for." Care providers described how they supported people to make healthier food choices, but respected their wishes if they wanted to eat less healthy food. A care provider we visited was busy making a healthy stir fry from fresh vegetables when we arrived. One person told us, "Sometimes we go to the chippy." This meant that people enjoyed the meals provided and were encouraged to make healthier food choices but could eat the foods that they chose.

People told us that they saw their GP and other healthcare professionals when they needed to; one person said, "[My care provider] helps me with the doctors and all that." Care providers we spoke with described how they managed appointments with healthcare professionals on behalf of the people they supported. These included GPs, nurses, chiropodists and various outpatient departments. Care providers kept a diary for each person and they showed us the appointments they had made. They could also explain which healthcare professionals were involved with each person and why. Placement workers checked these diaries on each monitoring visit and made referrals to other healthcare professionals if people needed them. We saw referrals placement workers had made for people to psychiatrists, community nurses and physiotherapists. This showed us that people were supported to maintain their holistic health by the care providers and placement workers.

Is the service caring?

Our findings

People and their relatives told us they thought the care providers were caring. They said, "[My care provider] is very caring. I have been with [them] a long time", "[My care provider] is very nice looking after me and [they] listen if I have a problem", and, "[My provider] looks after me well and knows what I need and like." One relative told us, "[The care provider] is very caring and we can visit anytime and discuss [name's] care with [the care provider]", and a second said, "They are very caring and respect [their] dignity and privacy and we can visit anytime."

At the homes we visited we saw that care providers respected people's privacy by knocking on people's bedroom doors. Some of the houses had been modified so that people had their own bathrooms or only shared with other people who were supported there too. Two care providers said that the people had their own living rooms but that they could choose to sit there or with the rest of the family as they wished. Another care provider described how they promoted the dignity of the person who lived with them by supporting them with personal care; they told us, "It helps [them] to be confident in [their] appearance and well-being and allows [them] to go out feeling confident and independent." This meant that care providers respected people's privacy and dignity.

We saw that people and their care providers had formed deep and often lasting bonds to one another. In each of the houses we visited when the people were there, the people and their care providers interacted in a warm and familiar way. Care providers described people as part of their families and the people said they felt at home. One care provider told us how their family and the people they supported went out for a family meal once a week; they also said, "If I get an invite to a family wedding and we're not all invited I won't go." Three of the care providers we spoke with had people placed with them who had originally lived with older members of their family that had either retired or died. One said, "[My relative] was a carer and fostered [person] for years and [they] were part of the family so I had no problem with [them] continuing to live with me", and a second said, "It was just a natural thing to do in caring for them because they were part of the family." People's relatives also commented on the bonds people had formed with their care providers. One relative told us, "[The care provider] treats [them] as family and not as though [they] were in an institution", and a second said, "[The care provider] is like [their] mother. She is a natural nurturer, a people person."

We spoke with the registered manager about boundaries in terms of the relationships people had with their care providers. She said that boundaries were discussed during the approvals process for new care providers and agreed that the relationship between a person and their care provider was very different to what would be seen in a care home. She said that it did not suit everyone but when it did work, people could live happily in their care provider's home for many years and lead fulfilling lives as part of a family within the community. One care provider told us, "The people become part of your family." This meant that people were supported in a family environment where care providers knew them well as individuals.

Care providers were allocated a number of 'short breaks' per year which they could use as they pleased. The locality strategy manager for learning disabilities was most insistent that the service did not use the word 'respite', rather they preferred the term short breaks, as respite implied the people were a burden the care

providers needed a rest from. Aside from these short breaks, care providers were responsible for the care and support of the people who lived with them; for some more vulnerable people or those with complex needs, this meant being available 24 hours a day, seven days a week. One care provider described getting up in the night to help a person that lived with them take medicine and another care provider regularly provided reassurance and support to a person who experienced anxiety at night. We found that the level of commitment the care providers had towards the people that they shared their lives with was both humbling and inspirational.

We asked care providers how they promoted the independence of the people they supported. One care provider explained how they encouraged the person who lived with them to do domestic chores, such as cooking, cleaning and shopping. The care provider told us, "I could do everything for [them] but I try to involve [them] instead." A second care provider said that one of the people who lived with them liked to fold laundry, wash dishes and help in the garden. A third care provider described how in the past one person who lived with them would ask for their medicine at the same time every day and never forgot. The care provider had then worked with the person until they could self-medicate and collect their own medicines from the pharmacy. This meant that care providers supported people to become and remain independent.

We saw that the service regularly referred people to advocacy services if they felt they needed them. Most often these were Independent Mental Capacity Advocates for best interest decisions but some referrals were made for advocates to act on behalf of people without families with day-to-day issues, such as paperwork and at placement reviews. The service used a local advocacy hub and we saw referrals they had made on people's behalf. One care provider described how the person they supported had recently been referred to the advocacy service to help them complete the service review form they had received. They explained how, as the care provider, they could not complete this form as they were not independent. This meant that the service referred people to advocates when they needed independent assistance to make decisions.

People were also involved in planning and reviewing their care. We saw that support plans were in an easy to read format and people who could sign their support plans had done so. People also told us that they had one-to-one meetings with their placement workers as part of their care providers' regular review meetings, and could say how they felt or if they had problems. Relatives said they were involved in planning people's care. One relative told us, "We have meetings with [the placement worker] and [name's] care is reviewed every so often", and a second relative said, "We talk to [the care provider] and [name] [their] care manager (placement worker) about [my relative] and we are happy with the situation." This meant that people and their relatives were involved in planning the care and support people received.

None of the people using the service at the time of the inspection was receiving end of life care. One care provider of an older person we spoke with said that they would do everything they could to make sure the person could die at home when the time came, if their needs could be met. The registered manager also said that the service would support this if all involved were happy.

Is the service responsive?

Our findings

We looked at nine people's support plans in the office and 11 people's support plans during home visits made as part of the inspection. The support plans we saw were all in an easy to read format so that they were accessible to the people they related to; we found that they were individualised and person-centred. The areas covered in them included how people preferred to communicate, eating and drinking, help with money, health problems, personal care, the contact they wished with friends and family and getting upset or angry. Each aspect described what people could do and what support they would need from their care provider. A section on 'keeping safe' referred to any risk assessments which had been completed with or for the person and a section of 'important contacts' listed the person's GP and placement worker, amongst others.

Apart from the support plan discussed earlier in this report, those we saw had been reviewed recently with the person and were up to date. People who had long term health conditions also had health action plans which detailed any additional support they needed with chronic conditions. These were also in an easy to read format. One person's care documents included a separate epilepsy support plan. This had been written by the person's placement worker and signed off by the person's GP. This meant that people's support plans were personalised and addressed their assessed needs.

People's support plans were reviewed at an annual meeting which they attended where any changes or updates could be made. Placement workers told us changes could also be made after the regular monitoring meetings they had with the people and their care providers at their homes. One placement worker told us, "Support plans are what we call living documents." Care providers did not keep daily records as would happen in a care home environment; instead they recorded any significant events in the diary they kept for each person. We saw guidance had been issued to care providers by the registered manager on the use of these diaries and the information to be recorded. This included any incidents or accidents, changes in health or behaviour, healthcare appointments and any special events or celebrations. Records showed and the care providers told us that diaries were checked by placement workers as part of the regular monitoring visits, along with the financial records care providers kept for the people who needed help managing their money. This meant that there was a process in place for checking people's ongoing care and support and for reviewing and updating their support plans.

We saw that the process of 'matching' a person who wanted a shared lives placement with a care provider was rigorous. The locality strategy manager for learning disabilities for the provider explained that the service tried hard to place people in homes where they would fit in and be happy. She told us, "It's not a 'vacancy' to us. It's about matching people to providers." In addition to the information gathered during the initial assessment process, each care provider completed a form detailing the composition of their household, including pets, as well as any house adaptations available, for example, a modified bathroom, whether they smoked, what hobbies they enjoyed, whether they observed a religion or drove a car. They were also asked to specify the kind of person they would like to support, for example, their age range, gender and any needs they did not feel they could meet. This information was used to help match people to potential care providers. Care providers told us they received the support plans of potential new people to

be placed with them and that they could say no for any reason. A list of care providers a person had been matched with and that had agreed to be considered was then given to the person and they could visit as many times as they wished before they decided whether or not to move in.

We found that emergency placements worked the same way, but with shorter timescales. One person we met had been placed with a care provider six months earlier. After a few days the person had expressed an interest in staying there long term; however, the service had made sure that enough time had passed for the person to settle in properly and make sure it was what they and the care provider wanted before making the final decision. This meant that consideration was made as to how people would fit in when arranging placements and that ultimately it was the person who chose where they wanted to live.

People told us they had lots of activities to keep them busy and several people supported by the service had regular employment. One person said, "I go to outdoor pursuits and bike riding", a second person told us, "I go to [local park] and do things at [club name] and I like the gym and acting", and a third person said, "I've been to the pictures and on an aeroplane. I'm doing things I've never done." A care provider said of the person who lived with them, "[Name] has a brilliant social life and the emphasis is on what [they] want to do, within reason of course." Relatives also told us that the people had opportunities to socialise or to work. One relative said, "[The care provider] takes [them] to the Scouts, to [local football club] and they go bowling and have a pint together", and a second relative told us, "[Name] has plenty of activities to do. [They] like gardening and go to the local centre (day centre)." Other people we spoke with attended local day centres and accessed activities there which they told us they liked. In addition, some of the care providers organised trips and events which were open to other people in the shared lives scheme to join in.

The shared lives team had links via the provider to two charities specialising in finding work placements and paid employment for people with disabilities. We spoke with one person who had a regular job at a charity shop and had also done a placement at a café, which they had really enjoyed. We saw a letter the registered manager had written to the café to thank them for providing the opportunity and for the support they had given the person. The shared lives team had referred this person back to the work placement charities to see if they could find the person another similar opportunity. This meant that people were supported to access activities, voluntary placements and paid work if they wanted to.

People and their care providers told us that they went on holidays together. One person said, "I've been to Spain and Turkey with them (the care provider and their family)", a second person told us "I am going on a holiday to [Spanish location] for seven days", and a third person said, "I am going to [English location] for two weeks with [my care provider]." A care provider said that their family had decided not to holiday this year, so instead they had helped the people they supported to choose holidays for themselves. One of the people that lived with them was in Spain at the time we inspected and the other people living at the house both had holidays booked. This meant that people were included in family holidays with their care providers and also supported to choose their own holidays if they wished.

None of the people or their relatives we spoke with said that they had ever made a complaint but that they would say something if there was a problem. One person told us, "I would complain to [my care provider] or [my placement worker]", and a second said, "I can say things no problem." A relative told us, "If I had a complaint I would call [the placement worker] who visits us regularly but I have no complaints", and a second said, "I could raise concerns if I had to without any fear."

The registered manager explained that complaints made about the service could come directly to the shared lives team or via the Manchester City Council complaints department. Either way, she was responsible for investigating and resolving them according to the service's complaints policy. We read the

complaints policy and reviewed the complaints made in the year prior to our inspection and found that registered manager had investigated and responded to all complaints received in an appropriate manner.

Is the service well-led?

Our findings

We asked the people, their relatives, staff and other healthcare professionals involved with the people if they thought the service was well managed. All of the people we spoke with told us they thought it was. One relative said, "The management and the service is very good. I am exceptionally happy with the service," and a second told us, "I am very satisfied with the service."

Healthcare professionals who referred people to the service gave us positive feedback about working with the shared lives team. One told us, "We have found the team very accommodating and flexible", and a second said, "I find the team very helpful with a thorough process that I feed into", and, "The placements have been very successful and in both cases transformed their lives. I really value the service and the team's overview of the placement."

Placement workers told us they thought the service was well managed. One placement worker said of the registered manager, "She's very, very approachable. She keeps us updated and is very knowledgeable", and a second told us, "I think she's very approachable and open. Things are going in the right direction."

We spent the first day of the inspection in the shared lives open plan office. We observed that the registered manager and locality strategy manager for learning disabilities (the registered manager's line manager) sat with the placement workers and there was a friendly, yet professional atmosphere. This extended to the phone calls made to care providers and people using the service which we heard being made during the day. One placement worker told us, "The relationship we all have is good. I like the ethos of the service", and a second said, "We all try to help each other." Our observations showed there was an open and supportive culture across the service.

There was a tiered approach to the audit of quality and safety at the service. Placement workers would check the documentation care providers kept, including medicines administration records, financial records and people's support plans and risk assessments, at meetings they had regularly with the care providers. Placement workers would then take a sample of the documentation relating to the people on their portfolio to their regular supervision meetings with the registered manager. We saw that she recorded the checks she made during these meetings along with any actions that were required. These actions were then checked at the next meeting. This meant that the quality and safety of people's care and support was monitored by the registered manager.

Care providers recorded any incidents, accidents and near misses in the diaries they kept for each person and the registered manager kept a central register of each. We saw examples of when incidents had occurred that had required risks to be assessed and management plans put in place. The service also had a risk register where ongoing concerns were recorded. The risk register was discussed monthly at both team meetings and at a meeting between the registered manager and her line manager. Any alerts were then made by the locality strategy manager for learning disabilities to her line manager who would inform the council's corporate risk panel. This meant ownership of risk was shared by the team and the provider.

People, their relatives, staff and healthcare professionals involved with the people using the service were asked to give feedback about the service for quality assurance purposes. At the time of our inspection, the shared lives service was undergoing a service review by an internal review team within the council. This had been requested by the locality strategy manager for learning disabilities who had joined the team in 2016 in order to form the basis of an updated business plan. She explained that the review involved an audit of the team's processes and sought feedback from the service's stakeholders, including people and their relatives, in order to find out what the service did well and what the areas for improvement were. The registered manager had completed a 'SWOT' analysis for the service, which we saw. SWOT stands for strengths, weaknesses, opportunities and threats. This meant that the people, relatives and staff were asked to feedback about the service in order to drive improvement.

In the past the service had held regular meetings for the care providers to network with each other and provide peer support. However, these meetings had often been poorly attended. In December 2015 the service had started a quarterly newsletter to keep care providers informed about news, training, support and success stories. We saw in the Spring 2016 issue that one of the placement workers had asked for care providers to volunteer to take the lead on organising future care provider meetings with the hope that this would improve attendance. One of the placement workers was also in the process of setting up a focus group of people who used the service with the aim of developing accessible resources on subjects such as advocacy and safeguarding. This meant that the service tried to keep people and their care providers informed about the service and provided them with opportunities to give support to, and receive support from, their peers.

We asked care providers and placement workers what the vision and values of the service were and how they were communicated to them; we also asked care providers why they had joined shared lives. One care provider said, "So that they (the people) can be listened to and progress. It's important for people to live in the community", and a second told us, "I do it because the kids are gone and I feel I have a lot to give and I find it enjoyable and rewarding." Placement workers told us the purpose of the service was, "To get the best care they (the people) can get that's person-centred", and, "For customers (the people) to have a family life as they might not have that opportunity otherwise." Placement workers said that the service's vision and values were communicated to them at team meetings and in their supervisions with the registered manager. This showed us that staff understood the vision and values of the service; feedback and our observations demonstrated that this underpinned the support they provided to the people and to each other.

As noted earlier in this report, the service was part of the Shared Lives Plus network of UK shared lives schemes. The registered manager attended quarterly meetings with other representatives from shared lives schemes in the region, to share good practice and to give and receive support. The registered manager said that all care providers were encouraged to sign up to the network as individual members, as they could access advice and resources on aspects such as income tax and training. We saw that this was promoted in the most recent service newsletter. This meant that the service worked in partnership with other organisations to better support the care providers who formed the basis of the shared lives scheme.