East Sussex County Council

Wealden Community Support Service

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 and 16 January 2018 and was announced to ensure that the management team and people using the service would be available during the inspection.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and supported living homes. It provides a service to people with learning disabilities or autistic spectrum disorder. The care agency has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Wealden Community Support Service provided support to 47 people with a learning disability in the community. However, only three people received support with personal care which is a regulatory activity registered by CQC. In addition to the domiciliary care service there was also a supported living service for six people who received support under the regulated activity. This inspection focused on the care and support provided to the nine people where they received a service registered by CQC.

At the time of our inspection there was not a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the operations manager had submitted an application to the CQC to register as manager.

People were kept safe from abuse and harm and staff knew how to report suspicions around abuse. Risks were minimised through the use of effective control measures. There were sufficient numbers of staff deployed to meet people's needs and ensure their safety.

People received their medicines when they needed them from staff who had been trained and competency checked. Staff understood the best practice procedures for reducing the risk of infection; and audits were carried out to ensure the environment was clean and safe. The service used incidents, accidents and near misses to learn from mistakes and drive improvements.

People had effective assessments prior to a service being offered. This meant that care outcomes were planned for and staff understood what support each person required. Staff were trained in key areas and had the skills and knowledge to carry out their roles. Staff could request additional training and had been supervised effectively by their managers. People were supported to receive enough to eat and drink and staff used nationally recognised guidance to ensure people had a balanced diet and enough sustenance.

The service worked in collaboration with other professionals such as speech and language therapy and people's GPs to ensure care was effectively delivered. People maintained good health and had access to

health and social care professionals. Environments were risk assessed to ensure people were safe in their homes and staff could work without the risk of danger.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful and the least restrictive option.

Staff treated people with kindness and compassion. Staff knew people's needs well and people told us they liked and valued their staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to be as independent as safely possible.

People received a person centred service that was supportive of their needs. People's needs were fully assessed and care plans ensured that personal details were carried through to care delivery. There was a complaints policy and form, including an accessible format available to people. Complaints were used to improve the service delivered to people Staff were open to any complaints and understood that responding to people's concerns was a part of good care.

There was an open and inclusive culture that was implemented by effective leadership from the management team. People and staff spoke of a person centred culture that was empowering. The management team had ensured that audits of quality were effective in highlighting and remedying shortfalls and the management team understood their regulatory responsibilities.

People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice and of working collaboratively with other professionals and health providers to ensure partnership working resulted in good outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Wealden Community Support Services was safe.

People felt safe and were protected from the risk of potential harm and abuse.

Risks to people, staff and others had been assessed and recorded and control measures were effective in reducing potential harm.

There was a sufficient number of staff to ensure that people's needs were consistently met.

People who received support with their medicines did so safely.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Lessons were learned when things went wrong and accidents and incidents were investigated with learning fed back to staff.

Is the service effective?

Good

Wealden Community Support Services was effective.

People received extensive assessments that ensured effective support outcomes were set and worked towards.

Staff received effective training to meet people's needs.

People were supported to eat and drink enough to maintain good health.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

People were supported to remain as healthy as possible and had access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice.

Is the service caring?

Good

Wealden Community Support Services was caring.

People were supported by staff who were caring and respected their privacy and dignity.

People were involved in the development of their care plans and their personal preferences were recorded.

Staff had access to people's likes and personal histories and used the information to support people in a way that upheld their dignity and protected their privacy.

Is the service responsive?

Good

Wealden Community Support Services was responsive.

People's needs were assessed, recorded and reviewed.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to people.

Is the service well-led?

Good

Wealden Community Support Services was well-led.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people.

Staff understood their responsibilities and knew who the management team were, and felt able to approach them.

The views of people and others were actively sought and acted on.

The service continuously learned and improved and staff were given opportunity to progress.

The service worked effectively in partnership with other agencies

Wealden Community Support Service

Detailed findings

Background to this inspection

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

The inspection took place on 12 and 16 January 2018. We gave the service 48 hours' notice of the inspection visit because it is office based and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 12 January 2018 and ended on 16 January 2018. It included direct observation of care and support, interviews with people, their relatives and staff employed by the service, and review of care records and policies and procedures. We visited the office location on 12 and 16 January 2018 to see the manager and office staff; and to review care records and policies and procedures. We also visited a supported living service registered as part of Wealden Community Support Services on 16 January 2018 to speak to people and observe the care they received.

The inspection team consisted of one inspector. We spoke with the operations manager, the service manager, two senior carers, four care staff, five people and two people's relatives. We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

This is the first time the service had been inspected under their new registration.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe being supported by Wealden Community Support Services. One person told us, "I feel safe here because it is safe here." Another person commented, "I feel safe here because the house is safe. I've lived here a long time and it is safe." One relative told us, "Yes it is a safe place he lives in and the staff are on point; he's been there with four or five people his adult life and it's a well-run place."

There were effective systems and processes in place to help keep people safe from abuse. The service kept a safeguarding folder with a log of all recent alerts made to the local authority safeguarding adults team. Actions taken to keep people safe had been recorded, as well as notifications made to CQC. The safeguarding folder contained information about the Social Care Institute for Excellence's six key principles for safeguarding and also referenced the different types of abuse including more recent definitions, such as modern slavery. There was a flowchart for staff to follow for how to report concerns. There had been four referrals to adult safeguarding in the last 12 months and in each case the correct procedure had been followed to keep people safe. Safeguarding information was given to people in accessible formats to encourage people to stay safe and understand what keeping safe means. Staff members we spoke with demonstrated a sound knowledge of safeguarding and how to keep people safe. One staff member told us, "Our duty is to ensure people are safe. If I saw something I was unsure of I would ask my colleagues for advice; if it was a safeguarding I would go to my team leader and we have the safeguarding team we report to."

Risks to people were assessed and managed safely without unnecessarily impeding people's freedom. People had individual risk assessments to mitigate any potential hazards they may face. There were 'Initial assessment of risk' documents that provided an overview of the risks people faced such as, falls, medicines, and personal safety. Where a risk was identified there was a separate risk assessment completed with effective control measures to minimise the potential harm. People's records were legible, up to date and stored safely; they were available to staff to keep people safe from potential harm. There were clear whistleblowing procedures in place and staff understood how to use these. Where accommodation was provided, such as in the supported living service, there were up to date safety certificates for gas appliances, electrical installations, and portable appliances. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. The fire risk assessment was effective and up to date. Fire drills were happening and records showed that this included night time drills when staffing levels were lower. Staff were aware that each person had a personal emergency evacuation plan (PEEP) for the risk level associated with evacuating people safely in the event of a fire.

There were sufficient staff deployed to meet people's needs and to keep them safe. The staffing levels had been determined through a process where an initial assessment from the local authorities' assessment team recommended a number of hours. The service then conducted its' own assessment and applied to funding panel to confirm the number of hours that people required. This level of support included staff travel time for community support clients. When peoples' needs changed the management team asked the

person's social worker to re-assess their need and then conducted a review to return to the funding panel to agree a change in support hours. Staff across the whole service had the same training programme, so could work in different services. Rotas were based on which staff the clients knew and any preferences people had, such as the gender of the staff member.

Safe recruitment processes had been followed and recruitment systems were robust. We checked the recruitment files for four members of staff. In all cases thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. References had been taken up before staff members were appointed and were obtained from the most recent employer where possible.

There were safe medicines administration systems in place and people received their medicines when required. The service used a monitored dosage system where tablets arrived from the pharmacy pre-packed and in separate compartments for each dosage time of the day. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted correctly, meaning that audits of medicines were being conducted accurately. MAR charts had been signed correctly to indicate that people had received their medicines. Medicines were stored in people's bedrooms in lockable cabinets. Staff were observed following best practice when supporting people to take their medicines. Where appropriate, people had been assessed to manage their own, or part of their own medicines, and people had been supported safely to do this. People had been supported to have regular reviews of their medicines and were supported to attend GP appointments to ensure that any changes in medicines were understood and transferred to their care plans.

People were being kept safe against the risk of infection by the prevention and control of infection hazards. Infection control training had been evidenced for all staff and this training had been competency checked. There was an appropriate supply of personal protective equipment throughout the service and we saw that staff used this as needed. Staff were provided with kit bags containing hand gel and sanitiser, first aid kits, gloves, aprons and face masks. All staff had food hygiene training in place and staff had access to an occupational health department.

Staff understood their responsibilities to raise concerns and report incidents. Accidents and incidents had been recorded and investigated appropriately. The acting manager had completed a regular 'manager's audit' document which reviewed incidents and accidents and established trends and learning points. Incidents had been logged monthly and we reviewed the two months preceding our inspection and saw that five incidents had been reviewed and investigated. One incident we reviewed detailed how a person missed a dose of their medicines as a result of the pharmacy delivering the medicines to the person and staff failing to sign them in to the service. As a result an email had been sent to all staff reminding them of the importance of singing medicines in to the service upon delivery and of auditing medicines correctly. Managers had been kept informed of national safety alerts via the quality assurance team who attended the organisation's Health and Safety steering group and experiences were shared across all services.

Good

Is the service effective?

Our findings

People told us that they felt the service was effective in meeting their needs. They told us staff had the necessary skills to provide the care they needed and that they supported them to access health services as needed. One person said, "The staff know what they're doing and they know how to look after me." Another person told us, "The staff are nice and they look after us." One relative commented, "Some of the carers have been there quite a while so they know how to care for him and the newer ones get to know him quickly too."

People's needs were assessed and their care was planned to ensure their needs were met. There were assessments of people's needs prior to a service being provided. The service received a care plan and assessment, conducted by a care manager, as part of the referral process. We reviewed these documents and they were detailed and covered multiple areas of people's needs. These documents were reviewed by the management team to determine if a potential person met the service criteria. If the criterion were met a 'client information' plan was completed which looked at areas such as consent and asked questions about people's culture, faith and ethnicity to ensure that there was no discrimination when making decisions about people's care. The assessment process takes place over several visits and looks at which staff will support the person by matching the person's assessed needs and preferences. The service was using technology and equipment to promote peoples independence and deliver effective support outcomes. Staff members had electronic devices they used to update care plans and people could sign the plans in real time via the devices. They can also be used by staff to produce easy read versions of care plans. One person living in the community had a 'talking' microwave due to being partially sighted. The microwave will read out the settings and time remaining on the dial. Another person had a talking pen that was pre-programmed to say what was in each cupboard when scanned over a tag on each cupboard.

Staff members had appropriate skills, knowledge and experience to deliver effective support to people. Staff members had formal supervision as well as observed supervision with their line manager or a more senior manager. Supervision in care settings is a process whereby through regular, structured meetings with a supervisor, care staff can develop their understanding and improve their practice. Where appropriate, people receiving support gave feedback at the end of the supervision on how they thought the support had been and on the supervision process. Staff had an annual appraisal of their performance where they were asked to rate their areas of success and identify any areas for improvement. This had been facilitated by a line manager who gave positive critical input to staff member's performance and set targets for the following year. There was an extensive training programme for staff members to access. The Care Certificate was in place for all new staff to complete to ensure their induction was effective and they had a good grounding in care and support. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care services are expected to uphold. Before staff start work with the service there is an assessment of their training level to determine which courses they are required to complete. There was a new induction programme in place that was comprehensive and robust. It detailed each staff member's development over an 18 month period.

People received enough food and drink to meet their needs and maintain good health. One member of staff working in the supported living service told us, "We have training in malnutrition and dehydration and there

is always food and drink available. We support people where possible, so if someone wasn't drinking enough we would prompt them to take a flask or drink out with them." There were resources for staff to use to engage people in making decisions about their diet. There was a toolkit containing the Department of Health 'eatwell plate' which served as a guide for obtaining the correct balance between different food groups; a hydration awareness quiz for staff to do with people, and the Food Standards Agency 'Eat well guide'.

Staff worked together to ensure that people received a consistent and person-centred support when they moved from or were referred to the service. Wealden Community Support Services worked with people who were often being supported by other services and they liaised effectively with other services about people's needs. Reviews had been held with professionals working with people where possible, to ensure consistent support and awareness of other services. Information had been made available to other services with people's permission, to promote person centred and consistent support.

People had been supported to live healthy lives and had access to health and social care professionals. Records confirmed that people had access to a GP, dentist and an optician and could attend appointments when required. Care plans demonstrated that a wide range of professionals were involved in people's care. For example, one person had a medical condition that impacted on their dietary requirements. The person had been seen by their GP several times for this illness. They had been given a specialist diet to follow with information about which foods to avoid which had been presented in an accessible format. This information was included in their care plan and staff were knowledgeable about how to support the person with their diet and there was an action plan for staff to follow. The service had ensured that that people could understand the information and explanations about their healthcare and treatment options, as well as any likely outcomes. For example we saw one care plan that contained an easy read version of a breast cancer screening procedure that staff members had drawn up in order to assist the person in making a decision about their care.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. People's right to make decisions was promoted and the principles of the MCA were adhered to. For complex decisions, such as whether to have surgery, people accessed a formal mental capacity assessment and best interests meeting, with an advocate if required, to arrive at a decision. For less complex decisions there was a supported decision process where the principles of the MCA were followed. This meant that people were able to make their own decisions where appropriate and that they had maximum control over their lives.

Good

Is the service caring?

Our findings

People, and their relatives, told us they felt the staff were caring and treated them kindly. One person told us, "The staff are nice here and are caring: sometimes we play dominoes together." Another person commented, "The staff are nice and they help me." One relative told us, "I think the staff are caring and they certainly come across as very caring. The interaction I can see between them and X and his friends that live there: they're a very good bunch."

People were treated with kindness and compassion by staff and were given emotional support when needed. People walked freely into the office and sat and chatted about their social plans for the evening with the staff and team leader. Staff were mindful that they were working in people's home and always sought their permission before doing anything or supporting people. During the second day of our inspection an electrician was doing emergency work to the building and this was explained to people: what was happening, why it was necessary and reassurance was given to people who struggled with unplanned change. There was a keyworker system in place and people had been matched with a worker with the same interests where possible: people's preferences had been taken into account when the service rota was written.

We observed that the staff knew and respected the people they were caring for including their preferences, personal histories, and backgrounds. Most people had a small group of workers that they were familiar with and a person centred plan with personal goals and outcomes. One staff member described how they had supported a person when a family member moved and they were unsure whether this meant they also had to move. The staff member told us, "I was able to use the close relationship I had built up to explain that their relative was moving but they could stay here and still visit them at their new place." The staff team supported people to achieve their goals and improve their lifestyle as people had been well matched with their staff, creating an enthusiasm for their shared interests. People's interests, such as old films, were known by the staff team and staff were able to converse about them.

People were supported to express their views and be actively involved in making decisions about their care and support. We observed staff interacting with people and chatting with them at various times during the inspection about their day including asking what they would like to do later. People were supported to prepare meals with staff and to choose which order to do things in and which foods to prepare. We observed part of a support session where a staff member supported a person to sort through their pictorial planner. This planner showed the person which staff member was on each shift and also which staff was working with the person and supporting certain activities. The staff made sure the person had the correct and up to date pictures of staff, for example, the new manager, and the correct activities planned. This helped the person to feel in control of their life and enabled them to make decisions about which tasks and activities they wanted to do and who they wanted to support them. One relative told us, "We are active and involved. X's mum is getting old now and we had to adjust the time and dates X does home visits. We are involved in decisions about that and they're always there for discussion." A staff member commented, "In one residents meeting X just announced that he actually preferred brown bread so now we ensure there's always the choice. It's listening to the individual and enabling their preferences to be fulfilled."

People's right to privacy and dignity was respected. People felt that they were treated kindly and with respect. One relative commented, "The staff respect his privacy and he would certainly tell me or moan about it if they didn't." Staff members respected people's right to privacy and ensured that all personal information was stored securely in a locked room in line with the Data Protection Act 1998. Some people preferred to spend time in their bedroom and staff knew when and how to offer support to these people. People's daily support notes recorded where staff had respected people's privacy and their decision to have a lie in; however, they had also ensured that their dignity was upheld by prompting the person to have personal care and wear clean clothes that day before going out.

People's friends and relatives were free to visit without unreasonable restriction. Through the use of supported decision forms, people were able to make 'unwise' decisions and these were highlighted by the service. However, the decisions had been respected with advice sought from other agencies if a concern persisted. People's independence was promoted by the service and skills training and supporting independent living had been the driving ethos of the service. Staff had often undertaken short pieces of work, with management supervision, with people to achieve independence. For example, travel training to enable them to access activities safely. Care plans reflected the steps people required to achieve independence. One staff member told us, "People have their own room so other tenants are supported to remember other people's space is private so knock and wait. We always make sure everything for giving meds is ready before we go in to people's rooms and one lady prefers female support so that is provided to protect her dignity."

Good

Is the service responsive?

Our findings

People and their relatives told us that the staff were responsive to their needs and requests. One person said, "I like going for walks and going on the bus and staff help me to do that." Another person commented, "I like doing woodwork and the staff help me get to college to do it." One relative said, told us, "The residents all have slightly different needs so they are all treated slightly differently. They [staff] tailor their approach to suit them on the whole."

People received an individualised service that was tailored to their needs. One relative told us, "He's had really good carers over the years taking him out on their days off and that sort of thing." Wealden Community Support Service's stated goal was to support people to explore different opportunities within their own community. Staff had a sound knowledge of the areas and services that were available to people and were proactive in investigating new opportunities for people. Social opportunities were offered to people and they were supported appropriately to attend them. People were actively supported to make referrals, such as to local employment services, and a range of college courses to achieve their life goals. Staff had researched cultural, ethnic communities, and disabilities to ensure they were providing the best support to people in light of their needs. The Service liaised with families and friends to help them understand the person's needs better and people had been supported to maintain contact with friends and families who were important to them.

People were involved in writing their care plans. Peoples support plans were individualised to their needs. Care plans contained a 'client questionnaire' which asked people important questions about how their care plan should be presented. For example, one person had stated they did not want their care plan in a format different to the standard written one, but had requested to have their risk assessments in pictorial format. This had been provided and the person told us that they understood the risks much better now they could see the pictures and remember what to do to keep safe.

People had 'about me' documents that they had completed to capture their interests, histories, and preferences so staff could support them in a personalised way. One 'about me' document we reviewed had been written by the person and told staff which games consoles the person loved playing, which football team they supported and which they followed, other sports they liked to play, and social events and activities they attended regularly. The service had identified people's communication needs where they had a learning disability that affected their communication. These needs were met with detailed communication plans that set out how the person communicated, key words and phrases used and guidance for staff on how to support the person if they became frustrated. Staff were directed in one plan to remember that the person could understand what was being said to them, as this was the cause of the person's frustration.

People were able to make decisions about their lives and staff supported them in the way they chose. One person who was being supported in the community had chosen to smoke in their own flat. The person had signed a plan to state that staff had advised them it is safer to smoke outside but that they choose to smoke indoors. The service had taken extra safety measures around fire safety to enable the person to carry out this decision safely and live their live in the way they chose.

The service listened to people, supported them to make their voice heard and responded to their comments. There was a 'responsiveness log' where people could formally raise low level concerns and request the service respond to them. For example, we saw one entry where a person was concerned as they had two health appointments on the same day and would have missed one if their support times were not altered. As a result the times of the support session was moved and the person was supported to attend both of their health appointments. People's care reflected their physical, mental, emotional and social needs and staff were mindful of people's diverse backgrounds and ensured people were treated equally. All staff had been trained in equality and diversity and had access to an equality and diversity toolkit to develop their understanding of related issues. The service had identified a diversity champion and they would be trained to assist staff members in this area.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The service kept a complaints file with a copy of the complaints policy, which set out the steps on how to respond to and resolve the complaint. The policy made reference to the local government ombudsman if people were not happy with the complaints' resolution. There was also a guide for people on how to complain, who to complain to, what will happen when you complain and what to do if you are not happy with the outcome. The complaints log had recorded no complaints in 2017 but there had been eight compliments recorded in the same year. We checked with the acting manager that no complaints had been received and were told that only low level issues, as recorded in the 'responsiveness log', had been received. The acting manager told us that if complaints were logged then a development plan would be drawn up to include any actions as a result of the complaint and that the management team would share any lessons learned with other services in the county. Of the compliments all were positive feedback from people who had received support or from family members happy with the support provided to their loved ones.

Good

Is the service well-led?

Our findings

People and their relatives told us they felt the service was well led. One person told us, "I know the manager: she's alright her." Another person said, "[name] is nice and she is a good manager as she does all the staffing things." A third person told us, "I know the new manager; she came and talked to me." One relative commented, "The senior management I don't really know but the key workers and staff are all really good and we don't have any issues. We tend to deal with key workers and I presume they are well managed as they always know what they're doing."

There was not a registered manager employed at the service at the time of our inspection. The previous registered manager had left their post in November 2017 to take up another position within the same provider. However, the registered provider had taken steps to appoint a responsible person to oversee the service and to apply to CQC to become registered manager of the service. At the time of writing the report the acting manager, who was the operations manager for the registered provider, had submitted an application to CQC to register as the manager of the service.

There was an open and inclusive culture in the service. The service was person centred and each person was supported according to their own needs. The service had a stated motto of 'Achieving Independence Together' and the management team were looking at values with people and the staff team to find out what people expect from a good service. The management team challenged staff practice through observed supervisions and used these to pick up on any issues they wished to address with staff. Team meetings were forums where positive language was used and managers reviewed the wording of care plans. There was a transparent and open culture where the whistleblowing policy was promoted to staff through safeguarding training competencies and 'next in line supervision': this is a system whereby a staff member was occasionally supervised by their managers' manager. Equality and inclusion had been promoted within the staff team by ensuring that equal opportunities underpinned recruitment. There was an 'Equality and Diversity toolkit' available for staff to utilise; to challenge inappropriate views and promote learning and awareness about protected characteristics. The acting manager told us, "We have staff and clients with disabilities and have reasonable adjustments in place and use the occupational health service to review and assist people."

There was an effective governance framework in place to ensure that quality monitoring was reviewed and regulatory requirements were managed correctly. The registered provider had in place a quality assessment framework to monitor the standard of service delivered. There was an overall service development plan; however, the acting manager had also put in place an interim development plan for a more targeted approach to improving quality. Measures such as the acting manager supervising all frontline staff as part of the staff team's introduction to the new manager, and increasing the 'champion' roles to include other key areas such as quality and lone working had been planned to ensure the service was more effective. In addition there was an internal compliance team that conducted four audits per year around compliance with regulations. We reviewed one audit to the supported living scheme that had highlighted actions such as, one care plan and risk assessment had not been signed by the person. There were monthly manager's checks that covered areas including recruitment, training, client file audits and risk assessments. In addition

there were also audits of medicines, infection control, and spot audits conducted by a member of the management team of files such as the incident file or of people's risk assessments.

The acting manager and the management team were aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The acting manager confirmed that no incidents had met the threshold for Duty of Candour. The acting manager was given good support from the head of service who supervised and appraised their performance and oversaw quality monitoring with the acting manager.

People, their families and staff members were involved in the service and regular feedback was sought through questionnaires. There were regular residents, relatives and staff meetings and there were action plans produced from these meetings to ensure that people's views resulted in changes where possible. There had been a customer satisfaction framework developed that focused on key areas aligned to CQC's key lines of enquiry whereby each month one key question was focused upon. For example, we saw in previous months the focus had been on safe care and people were sent questions around this area, such as, 'Do you feel safe when you go out with staff?' People had been supported to have strong links with the local community and had built up relationships outside of their support provider. Some people were supported to attend a social group in Crowborough on a bi-weekly basis and there were various social clubs and nightclubs that people had been supported to attend. One person had been going to a local weight loss club and the service was part of a 'safe place' scheme. This is a scheme where people can go to specific designated places in their community if they need assistance and the 'safe place' will call the service to come and assist the person.

The service was continuously learning and improving and learning was shared with staff members. There was a service development plan with goals that were being worked towards and achieved. The acting manager was working on improving the turnaround time from receiving a referral to setting up a service for a person with the aim of reducing the time to a week. A new training course entitled 'positive approaches to providing support' had been identified and this had been agreed as a mandatory two day course for all staff, to help improve the support for people with behaviours that may challenge. The course focus was on least restrictive practices and recognising behaviours before they elevated to more serious incidents. Technology had been used to monitor and improve the services delivered to people. There was a lone worker monitoring system that had been implemented with an emergency function to contact a call centre that will check the person and notify the service or emergency services if required. This made one to one support sessions safer and more accessible to people.

The acting manager had a good working relationship with the local health and social work teams. The acting manager has planned to introduce the local community police liaison officer to people so they knew who to contact and so that the community policing services were aware of people with a support need. The service worked closely with the local community learning disability team, local health team, physiotherapy department, speech and language therapy department and occupational health service. The acting manager told us, "We work very closely with the assessment teams and local safeguarding adult's team. We also have close links with the patient liaison service and advocacy team based at the local hospitals so people can get help if they are admitted to hospital." The service had a multi-agency information sharing protocol and shared information appropriately with emergency services. If people moved to different accommodation information and care plans were shared with the new provider to ensure the persons safety.