Royal Mencap Society

Royal Mencap Society – Domiciliary Care Services and Shared Lives – West London

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

About the service
Royal Mencap Society – Domiciliary Care Services and Shared Lives – West London is a supported living service providing personal care to people living in shared flats. At the time of the inspection there were 29 people using the service who received personal care across seven supported living schemes across South and West London. Personal care is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

Royal Mencap Society – Domiciliary Care Services and Shared Lives – West London also provides a shared lives scheme which provides people with long-term placements, short breaks and respite care, within shared lives carers (SLC) own homes.

People's experience of using this service and what we found
People and their relatives told us the service provided meant they were kept safe from harm and abuse. Staff levels were flexible and met the needs of people using the service. The provider had appropriate risk management procedures in place which helped to ensure people continued to lead independent lives whilst at the same time keeping them as safe as possible. People were supported to take their medicines in a safe manner from staff who were trained to do so. Staff followed good infection control guidance.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The outcomes for people using the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion.

Staff were recruited based on the values they demonstrated during the recruitment process and if these aligned with the provider's values. Staff completed a through induction and received ongoing observation of their practice. People were supported to access healthcare services and had care and support plans which helped staff to manage their health needs. People received appropriate support in relation to their eating and drinking.

The service was caring. People felt listened to and their views were considered. Long lasting, meaningful relationships had been established between people using the service and care workers. Staff respected people's privacy and dignity and accommodated people's diverse needs.

Care records reflected people's current support needs and key workers worked with people to identify goals which they supported them to achieve. People led active lives, pursing their interests and accessing community services. People's communication needs were met. The provider listened when complaints were made and resolved them.

The provider placed great emphasis on the values of the organisation and worked hard to ensure this was apparent across all areas of the organisation, including people and staff. Staff were recruited based on their values and they were expected to demonstrate how they lived these values during their supervision and appraisal. Staff who exceeded these values were recognised for their excellence. People's views were considered when recruiting staff and there were a number of internal working groups they were encouraged to take part in.

Rating at last inspection
The last rating for this service was Outstanding (published 26 April 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	Good
Is the service effective? The service was effective. Details are in our effective findings below.	Good
Is the service caring? The service was caring. Details are in our caring findings below.	Good
Is the service responsive? The service was responsive. Details are in our responsive findings below.	Good
Is the service well-led? The service was well-led. Details are in our well-Led findings below.	Good

Royal Mencap Society – Domiciliary Care Services and Shared Lives – West London

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was conducted by two inspectors.

Service and service type
Royal Mencap Society – Domiciliary Care Services and Shared Lives – West London provides care and support to people living in seven 'supported living' setting[s], so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This service also manages a shared lives scheme, they recruit, train and support self-employed shared lives carers (SLC) who offer accommodation and support arrangements for vulnerable adults within their own family homes in the community.

The service had two managers registered with the Care Quality Commission, one managing the supported

living scheme and the other, the shared lives service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection. Inspection activity started on 25 February 2020 and ended on 3 March 2020. We visited the office location on 25 February 2020 and 3 March 2020. We visited two supported living schemes in between these dates.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with seven people who used the service and three relatives about their experience of the care provided. We spoke with 11 members of staff including two registered managers, two service managers, three shared lives carers and four support workers. We received feedback from two health and social care professionals.

We reviewed a range of records. This included five people's care records and medicines records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including complaints, incident forms, policies and procedures were reviewed.

After the inspection
We requested additional evidence to be sent to us after our inspection. This included a number of policies, training records and records related to the management and governance of the service. This information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

- There were enough staff employed to meet people's needs. Staff rotas at each service were flexible to meet the needs of people. For example, some people required 1:1 support or needed additional support to access the community and the provider was able to meet their needs.
- People and their relatives told us there was always someone available to help them.
- Care workers were recruited locally by service managers. One manager told us, "We invite them (candidates) in for a service visit and see how they interact. It's a two way thing and we then arrange a start date pending DBS and references."
- Staff files included an application form, evidence of ID and a Disclosure and Barring service (DBS) checks for staff. A DBS is a criminal record check that employers undertake to make safer recruitment decisions. We identified the provider did not carry out regular monitoring of staff's DBS checks in line with good practice. This meant there was a risk people were supported by staff that had received a criminal record. We shared our concerns with the registered manager who told us they were aware of this and would ask care workers to complete an annual declaration during their yearly appraisals. We will follow this up at the next planned inspection.
- There was a values based recruitment process in place. This meant that prospective employees were recruited based on the values they demonstrated during the recruitment process and how closely these were aligned to the organisational values.

Systems and processes to safeguard people from the risk of abuse

- People and their relatives told us they felt safe and staff looked after their wellbeing. Comments included, "Yes, I feel safe. This is my home", "I'm happy" and "She's well looked after."
- Care workers and SLCs were aware of safeguarding procedures and what steps they would take if they suspected people were at risk of abuse. They told us, "We would call the safeguarding numbers if we need to", "People can be at risk of physical abuse. If we notice any marks or scratches, we would report it. We are familiar with the residents so if we notice anything unusual, we would pick it up straight away."
- Mencap's confidential helpline details, 'Speak out safely' were on display for staff to refer to if needed.
- Records showed the provider worked with the relevant authorities when safeguarding concerns were raised to ensure people were kept safe from harm. A safeguarding review panel consisting of various managers were responsible for overseeing all safeguarding concerns.
- Where people had behaviour that could be seen as challenging, guidelines were in place for staff to refer to. This included strategies that worked, those that didn't work and possible triggers for behaviours. This meant that staff were given clear guidance on how to support people should they encounter such behaviours whilst at home or within the community.

Assessing risk, safety monitoring and management

● There were individual records in place to monitor and manage risks to people and the environment. Each assessed area was reviewed annually or as and when needed and included a description of the risks and what could be done to make the activity safe. They were signed by staff to indicate they had read and understood them and staff were familiar with these risk reducing steps when we spoke with them.

● People were supported to take acceptable risks whilst at the same time remaining independent. For example, one person was at risk when accessing public transport. In order to support her, the provider had arranged safe travel training sessions and worked with her until she was confident travelling independently.

● The provider acted on recommendations included in risk assessments. For example, actions for a person at risk of choking was for staff to attend training with the salt team around dysphagia and for staff observations to take place to ensure the person was being supported in an appropriate manner. We saw training had been delivered and staff observations had taken place.

● Appropriate environmental checks took place, some of these were carried out by the housing provider. These included certificates for the fire detection and alarm system, firefighting equipment and gas safety. Other checks were carried out by the provider including emergency lighting and fire extinguisher checks, fire drills, hot water checks and health and safety checks.

Using medicines safely

● People using the service were supported to take their medicines in a safe manner. People told us care workers supported them with medicines. One person said, "Staff help me with my medicines. Everything seems to be okay."

● Staff received medicines management training and regular observations to ensure they were competent in the administration and recording of people's medicines.

● Care records included medicines profiles with details of the medicines prescribed, their use and side effects.

● Appropriate records in relation to medicines were in place. These included guidelines for medicines that had been prescribed as needed and which were signed by a GP and Medicines administration record (MAR) charts which were completed by care workers. Of the MARs reviewed, all were signed with no gaps or omissions.

Learning lessons when things go wrong

● Records showed that were incidents took place, the provider used these as an opportunity to learn lessons. For example, following an incident between two people using the service, behaviour management guidelines were put in place to try and prevent them from occurring in future.

Preventing and controlling infection

● Premises were observed to be clean. Domestic staff were employed in some services and we saw them on inspection, keeping areas clean.

● Appropriate protective equipment was available in services, including gloves and alcohol hand gel to try and prevent the risk of infection.

● Staff were observed adhering to good infection control and food hygiene practice during annual observations.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

- Care workers told us they were happy with the training and support opportunities available to them. Comments included, "We do get regular training opportunities when it is due", "I just had my first aid refresher training" and "We also have 'shape our future', it's like an appraisal."
- Newly employed staff underwent a comprehensive induction programme to familiarise themselves with their role and responsibilities. They completed a six months' probation during which they were supported to complete their induction training. This was based on the Care Certificate, an identified set of 15 standards that health and social support workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new support workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.
- The provider had put into place a 'learning hub' to manage and oversee all the required refresher training for care workers. Service and area manager used this system to monitor staff training which provided an alert when refresher training was due.
- Service managers completed yearly observations and competency assessments of medicines administration, finances and safe eating and drinking support.
- There was an effective supervision and appraisal system called 'Shape Your Future'. Records showed that care workers received regular supervision and an annual appraisal. They were able to discuss aspects of their job that had gone well, not well and what they had learnt and any future plans. Where actions had been identified for staff, these were followed up at subsequent meetings.
- Following annual appraisal, if care workers were rated as 'excellent', they were given the opportunity to put themselves forward to the providers talent identification programme called 'You've Got Talent'.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Prior to receiving care and support, the service carried out comprehensive preadmission assessments to determine if they were able to effectively meet people's needs. Pre-admission assessments covered all aspects of people's lives, for example, personal care, medical needs, communication, health needs and social needs.
- People's needs and choices were assessed through annual reviews of support plans and risk assessments.
- A 'shared lives panel' was responsible for assessing and recommending SLC's and carrying out assessments about their capability. The shared lives manager sat on this panel along with other managers and someone form the quality assurance team.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us staff supported them to prepare food that was to their liking. Comments included, "I like

eating steamed fish, salmon and lettuce" and "I eat everything, I have Weetabix for breakfast."
● There were support plans in place in relation eating and drinking and maintaining a healthy lifestyle. For example, some people had 'healthy eating goals' whilst others who were at risk of choking had prescribed food and fluid plans that had been developed by the dysphagia team.
● Staff were familiar with people's preferences and any goals they had in relation to their diet.

Supporting people to live healthier lives, access healthcare services and support;
● People told us that staff helped them to go see a doctor or other health professionals if needed. One person said, "If I don't feel well, I tell the staff. They will make an appointment to see the GP." Another said, "If I'm not feeling, I go down to the doctor."
● Each person had a Health Action Plan (HAP). These are records that state what is needed for a person to remain healthy, including the support which a person may require. These included hospital passports and records in relation to ongoing appointments, and treatments. A hospital passport is used to provide hospital staff with important information about people with learning disabilities and their health when they are admitted to hospital.
● Care plans detailed people's health and medical needs and the support people required to remain in good health.

Ensuring consent to care and treatment in line with law and guidance
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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People lived independent lives, they were able to access the community either independently or with staff support. They said their consent to care and treatment was sought prior to being delivered. One person told us, "I normally choose myself what I want to do. Sometimes the staff help me choose. If I don't want to go out, I don't have to." Another said, "I go out quite a bit, I usually go out by myself."
● Care workers were aware of the importance of seeking consent from people before supported them and they gave us a number of examples of how they did so. They were also familiar with the MCA. One care worker said, "MCA is about making decisions in their best interests and looking at least restrictive practice. They are allowed to make unwise decisions, and we don't assume they are incapable of making decision."
● The provider carried out capacity and best interests assessments for specific decisions. These considered whether people had the capacity to make decisions in relation to their care and support. Where it was assessed they were able to make decisions, their wishes were recorded and records signed by people. Where it was assessed that people were not able to consent, best interest meetings took place in consultation with appropriate people such as relatives and professionals which helped to ensure that any decisions made were in line with the MCA.
● Although tenancy agreements were in place, where people did not have the capacity to consent to their placement, this was not always documented. We spoke with the provider about this who told us they would look into recording these decisions more explicitly. Annual placement reviews did take place in a multi-

disciplinary team format during which it was evident that all the relevant people were happy that the placements were appropriate and in people's best interests.

Staff working with other agencies to provide consistent, effective, timely care

- There was evidence that the provider worked with external organisations when supporting people. This included working with day centres and local authorities' learning disability teams to ensure people's needs were met.
- One professional said, "They have liaised well with the local clinical and social work teams in their support of individuals in their service. They have supported a person with some significant challenging behaviours very successfully in his own service for a number of years."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has changed to Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People spoke positively about staff and how they supported them. For example, one person told us, "They [staff members] have done a grand job, they are very good, and I like the way they help me. They are my friends, any of the staff will help me." Other comments included, "The staff are nice, they are alright", "The staff are very nice", "My favourite is [name of care worker]. They support everybody here" and "I like living with [SLC], she looks after me."
- During the inspection we observed staff speaking respectfully to people and sharing jokes. There was a relaxed and welcoming atmosphere within the supported living services that we visited. We observed a care worker helping a person during breakfast, they did so in a calm way, gently encouraging her. It was clear that the person was at ease in the care workers company.
- People's cultural and faith needs were documented, and people confirmed their diverse needs were catered for. For example, one person told us, "I go to church on a Sunday, but it depends on the weather. I used to go to church on my own but now I go with someone." In one scheme, there was a person from Uganda. Common Luganda phrases to help staff communicate with them were on display. Luganda is one of the major languages spoken in Uganda.
- Shared lives carers demonstrated values that were empathetic and caring towards the people that lived with them. Many of them had lived with their shared lives carers since they were children and had continued this relationship when they had become adults. They were treated the same as relatives, with no distinction or discrimination. A shared lives carer told us, "It's a way of life, it's what we've always done. The long term relationships we build are invaluable. They are part of my family." Another said, "They are treated as part of the family, absolutely. No distinction."
- One of the values of Mencap was Inclusion. In order to meet this, 'Include Me' a group was set up to make sure the views and insights people with a learning disability were heard within the organisation. This gave people using the service to hear and get involved about any campaigns that were ongoing, to provide their input and to share these with other people.
- The provider had launched a campaign around sexuality and relationships in 2019. A member of staff from each service attended some workshops on how to support people in this area. They had supported two people in a relationship, educating them about safe sex and boundaries.

Supporting people to express their views and be involved in making decisions about their care

- People made everyday decisions which staff respected. They said, "I get to choose what I have to eat, my favourite is macaroni cheese. I can choose what's in the cupboard to eat. I have helped cooked the meals quite a bit, then I help to clean the table, other people might help tidy up after."

● A care worker said, "Menu plans are flexible, we do have menus but they can always choose if they prefer something different." One person showed us their room which was enhanced with their own personal belongings. They told us they chose the colour of their curtains and how her room was set up.
● People were able to make decisions related to their care and support. For example, residents meetings took place and people were encouraged to speak about any topics they considered important.

Respecting and promoting people's privacy, dignity and independence
● Care workers supported and encouraged people with personal care and activities of daily living which meant they led independent lives. One person said, "I prepare my own breakfast but someone comes with me and helps me with shopping." Another said, "I do my own laundry."
● Support plans included people's level of independence and how much support they needed. For example, in the use of equipment such as appliances, cooking/making refreshments, personal hygiene and looking after their bedrooms. Care workers spoke about how they engaged people and encouraged them to take part in household activities in a way that promoted their independence. One care worker said, "[People] are very engaging, they always help in meal preparation such as cutting potatoes."
● People were given privacy when needed and care workers were aware of the importance of giving people privacy. One care worker said, "We ensure windows/curtain are shut. We ask them if they are happy to have their personal care, we help them get dressed in the privacy of their bedrooms."
● People were able to maintain relationships that were important to them. Comments included, "My brother comes and visit me often." Shared lives carers told us, "[Person] does have a mother and sister and I try and encourage her to spend time with her" and "She has lots of relatives and does go and stay with her Aunty."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has changed to Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were regularly reviewed and where possible, people were encouraged and supported to contribute to their development. Care plans covered all aspects of people's lives, for example, medical and health needs, communication, mental health, behaviours and social needs.
- Care records included person centred information such as 'One page profiles' and 'This is my home' which included details about things that were important to people. Care workers used this information to provide appropriate care and support relevant to the person's individual needs.
- Care and support plans had specific goals set in conjunction with people's preferences, these were followed up at monthly key worker meetings. We saw evidence that where a goal had been identified, this was followed up. For example, one person had expressed an interest in dancing and their key worker had found a local community Irish dancing group for them to join. One person told us, "One of my goals is to get an Easter egg. We talk about my future and I am going to be the first Mencap radio DJ." Another said, "[care worker] is key worker, she takes me to lots of places." One care worker told us, "I key work [person], we basically discuss what they want to do throughout the week and we focus on their individual interest and we introduce new things to them. We have key work sessions every month."
- At the time of the inspection, the provider was due to roll out the POS (Positive outcomes scale) to further enhance and achieve long term positive outcomes for people. The aim of this was to try and give a meaningful score to the progress that people had made against identified outcomes and goals and to further encourage care workers to try and help them to reach their goals.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to take part in activities and pursue interests that they wanted to as members of their communities.
- People told us, "I'm going to Hampton Court Palace with [care worker] today. We are going by Taxi. I wanted to go there", "I go out quite a bit, I usually go out by myself", "I work in a café in Ashtead. I also go to Leatherhead link (day centre)" and "I've got a job in Clapham, I go on Tuesdays. I get the bus, it goes all the way there. I sort the clothes out, put them on hangers and put the prices on them."
- The provider worked with people to become more independent and do things for themselves, taking appropriate and well managed risks. For example, one person who volunteered in a shop and was previuslut supported by care workers to travel by bus had shown a willingness to try and travel independently. The provider arranged 'travel training' for her so she could travel to the day centre and the local community by herself. This was managed in a phase way, at a pace that was comfortable for the person so they wouldn't get anxious. This had been implemented successfully and the person told us she was very happy that she

was now able to travel by herself.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans detailed people's communication needs. During the inspection we observed staff in the supported living service, speaking with people in their preferred communication method.
● The service had a pictorial AIS policy in place that stated information would be shared with people in a way they understood.

Improving care quality in response to complaints or concerns
● People confirmed they knew how to raise any complaints they may have. Comments included, "I would tell the staff when I'm unhappy. The staff would help me and I think that's nice", "I would tell someone" and "If I was unhappy with would speak to [service manager]."
● At the time of this inspection there had been two complaints in the last 12 months. Complaints were acknowledged in a timely manner and a positive resolution sought where possible.
● An easy read complaints and feedback information guide in place in the supported living schemes we visited. The provider had a complaints policy in place which gave people clear guidance on how to raise any concerns or complaints.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Outstanding. At this inspection this key question has changed to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider ensured people's voices were heard throughout the organisation through regular engagement and asking them to give their views across a whole range of issues. The provider's vision statement was based around inclusion and listening to people with a learning disability in all aspects of life. A number of groups and initiatives were set up to drive this. For example, people using the service were involved in the recruitment of care workers. 'Include Me' was the name of an inclusion group which was made up of people using the service with support from Mencap staff. We met one person who was part of this group during the inspection and they told us they found this a good platform for them.
- Residents and staff meetings were held every month. These gave an opportunity for them to give their views and discuss issues that were relevant to them.
- Residents meetings were recorded in a person centred format, recorded what people had said and giving them an opportunity to speak freely. One care worker said, "[Person] would always stay in her room but she has started to attend residents meetings which she never used to do and sometimes joins in conversation. She has done really well."
- The provider had an effective appraisal system in place which was used to identify outstanding care workers who demonstrated the values of the organisation. Care workers that were rated as excellent during their appraisal were put forward to a 'You've Got Talent' pool where they met other staff and were invited to get involved in further development opportunities. They were assigned a mentor from the learning and development team to provide them with further support. As a result of this, one staff had become involved in the work the provider was doing around the positive outcome scale and another member of staff was working with the communications team on some team briefs.
- The provider had a well-established reward and recognition scheme called 'You Rock'. Staff were able to nominate peers who they felt demonstrated the values of the organisation. This was built into the providers Key Performance Indicators (KPI). KPIs evaluate the success of an organization or of a particular activity in which it engages. This meant line managers to continued to encourage, support and engage with their staff. One service manager had nominated their staff team for the work they had done supporting a person using the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was an open culture within the service. People spoke positively about the overall management of the service. One person told us, "I think I like [the home manager], he is so nice to me. He likes to help me

and when I say thank you, he says, "No problem."
● Staff also spoke in positive terms about their managers, telling us, "[Registered manager] tries her very hardest, I really like her", [Registered manager] is on my level and is brilliant. I'm really happy with the support we get" and "[Service manager] is here almost every day, she is supportive and has blended in really well. She is a really good manager."
● The registered managers were aware of their responsibilities under the Duty of Candour. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines providers must follow if things go wrong with care and treatment.
● The provider had clear vision and values that were understood and acted upon by staff. Staff were recruited based on the values of the organisation and these were explored during their interviews. This was further explained during the induction and monitored on an ongoing basis through regular supervision. Staff appraisals were based around these values and staff were expected to demonstrate how they lived these values in their roles. One care worker said, "Trustworthy, positive and inclusion are some of our values, we try our best to follow them."

Working in partnership with others
● The provider worked in partnership with commissioners, housing associations, and other community health care teams to meet people needs. One professional said, "We have no concerns about the quality of support provided. They act as good partners to the Council and are always prompt in providing contract monitoring information which is of good quality."
● The provider was involved in a number of national initiatives to change the perception of people with a learning disability. The 'Treat Me Well' was a national campaign to transform how the NHS treats people with a learning disability in hospital. Other initiatives included 'Hear My Voice', a campaign to put learning disability issues higher on the political agenda.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● The registered manager understood their legal their responsibilities and submitted statutory notifications of significant events or incidents that occurred with.
● The registered manager carried out regular audits to monitor the service provision and drive improvements.
● There was a system in place where service managers completed regular checks and reporting which were overseen by the registered managers and other managers within the quality team.
● Service managers reported on metrics such as their individual service improvement plans, the number of incidents, complaints and notifications amongst other areas.
● Registered managers completed quarterly site visits or more frequent desktop reviews of each service they were responsible for. These were comprehensive in scope and looked at all aspects of care records, access to activities and community and staff records.
● The registered manager overseeing the SLC's carried out quality assurance checks which consisted of monitoring visits every eight weeks. They looked at record keeping, financial records, goal setting and speaking to both the SLC and people using the service.
● There was a digital improvement programme in place. One of the aims for this was for each person to have their own iPad containing all their support plans and associated records enabling real time alerts to be sent to managers. The registered manager said, "The feedback has been really positive from the services that have piloted it so far, so I'm really looking forward to it coming to my services."