The Brandon Trust

Brandon Trust Supported Living - Oxfordshire

Inspection report

Innovation House, Suite 5
Parkway Court, John Smith Drive
Oxford Business Park
Oxfordshire
OX4 2JY

Tel: 01452886307
Website: www.brandontrust.org

Date of inspection visit:
26 June 2017
27 June 2017

Date of publication:
10 August 2017

Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

We inspected Brandon Trust Supported Living - Oxfordshire on 26 and 27 June 2017. Brandon Trust Supported Living provides support to people who live in their own homes. At the time of our visit 59 people were being supported in 18 different houses.

There were four registered managers in post supporting the 59 people. 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.

During the inspection, we found the service provided outstanding care and support to people and was very responsive to their needs, wishes and preferences. All people, relatives and staff spoken with were extremely positive about the service. Staff were fully committed to the values of the service and carried these out in practice. These included 'Let's start with the individual'; 'Let's try something new' and 'What options do we have?' Throughout the inspection, we saw numerous ways of how this value was implemented and embedded into the ethos of the service.

People spoke highly about staff that had often supported them for a long time and knew them well. Staff used the knowledge to enhance people's lives supporting them to experience a full life with lots going on and individual to their preferences. People told us staff always treated them with dignity and respect. People benefitted from compassionate and caring staff that were enthusiastic about their roles and aimed to provide support in a kind and empathetic way. Where people reached their end of life stage the staff worked with various professionals, such as hospice teams to ensure people received a holistic approach that ensured a pain free and dignified death.

People were supported to live their life enjoying many experiences and activities to enrich their lives. We saw that every effort was made to engage people in meaningful activities and events and to continuously look at all opportunities.

People told us they were safe. Risks to people's well-being were assessed and recorded. Staff knew how to report any safeguarding concerns and they were confident the registered manager would take appropriate action when needed. Where people needed assistance with taking their medicine this was monitored and carried out safely.

The registered managers' ensured staff were continually developed so this approach could be sustained. Staff were well supported and had access to development opportunities to maintain and increase their skills. The provider ensured appropriate checks were carried out before staff started working with people to ensure they were suitable to work with vulnerable people.

People were supported by staff that had the right skills and knowledge to fulfil their roles effectively. Staff

told us they were well supported by the management. The team worked closely with various local social and health care professionals. People were supported to meet their nutritional needs and maintain an enjoyable and varied diet.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and report on what we find. 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 supported this practice.

People's needs were assessed prior to commencement of the service to ensure staff were able to meet people's needs. People's care plans gave details of support required and were updated when people's needs changed. People knew how to complain. People's input was valued and encouraged to feedback on the quality of the service and to make suggestions for improvements.

People, their relatives and external professionals told us they felt the service was well run. The acting area manager and registered managers promoted a positive, transparent and open culture. Staff told us they worked well as a team and felt valued. The registered manager had systems in place to ensure the service delivery was monitored and actions taken if needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service operated a robust procedure for the recruitment of staff. There were sufficient numbers of staff employed that ensured people experienced continuity of care.

Risks to people's well-being were assessed and recorded.

Staff received training on safeguarding adults from abuse and understood their responsibility to report any concerns.

People received their medicines as prescribed. All records seen were complete and up to date.

Is the service effective?

Good

The service was effective.

The manager and staff understood their responsibilities in respect of the Mental Capacity Act (MCA) 2005.

People were supported by staff that had the right competencies, knowledge and skills to meet their individual needs.

People were cared for by staff that received support from their managers.

People were supported to maintain their health and well-being and enjoy a varied diet. The registered managers and staff had good links with social and healthcare professionals.

Is the service caring?

Outstanding

The service was very caring.

People benefitted from caring and positive relationships with staff.

People's individual needs were understood by staff and used to

enhance people's lives. They had an in depth appreciation of people's needs and wishes and fully respected their rights to privacy, dignity and independence.

The service promoted a strong person centred culture which ensured people were listened to and their ideas were discussed and put into action.

The registered managers and staff were enthusiastic and motivated to deliver kind and compassionate care.

People told us their privacy and dignity was always respected.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People received individualised and personalised care which had been discussed and planned with them. Staff had a thorough understanding of how people wanted to be supported.

People were enabled by staff to be involved in identifying their choices and preferences and were supported to lead fulfilling lives.

People's views were encouraged, listened to and acted upon by staff.

Is the service well-led?

Good ●

The service was well-led.

The registered managers and management team worked together to provide good leadership.

Communication was effective and clear.

Staff were motivated to develop and provide quality care.

Staff were aware about the whistleblowing policy and knew how to raise concerns.

The registered manager had systems in place to ensure the quality of the service was being monitored and strived for continuous improvement.

Brandon Trust Supported Living - Oxfordshire

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 and 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 26 and 27 June 2017 and was announced. We gave the registered managers 48 hours' notice of our intention to inspect the service to ensure they were available at the time of the visit. This inspection was carried out by two inspectors and one 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). The provider had completed and submitted their PIR. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sent a satisfaction questionnaire to 16 people using the service, 16 relatives and friends, 131 staff and 11 community professionals. We received responses from five people, two relatives, 14 staff and three community professionals.

We also looked at notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. After the inspection we contacted the commissioners of the service and external professionals to obtain their views about the service.

During the inspection we spoke with six people using the service and five relatives. Many of the people who lived in the homes were unable to speak with us so we used the Short Observational Framework for Inspection (SOFI). The SOFI is a way of understanding the care of people who are not able to communicate with us. We also spoke with the acting area manager, four registered managers, two support co-ordinators

and five members of support staff.

We looked at a range of records relating to the management of the service including five people's care plans and other associated documentation, six staff recruitment files, a sample of policies and procedures and quality assurance records. We also viewed a range of other records that related to management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe when staff supported them. Comments included, "I feel nice and safe because people are around", "Staff during the day and at night are good" and "Safe? They make me feel safe."

All the relatives we spoke with felt people were safe. Comments included, "Very safe. Never had any worries whatsoever. I visit every Sunday always lovely. More staff at night now, much better", "When I leave I know that he is safe and well cared for", "Definitely safe, she is well cared for and putting on weight which was a real concern. Weight went right down because of a medical condition" and "I live a considerable distance away but I have chosen not to move [person] because they are in a good place. If it wasn't good I would have moved [person]".

People were protected by staff that had received training on how to recognise and report suspected abuse. Staff we spoke with demonstrated they would know who to report concerns to. The provider had a safeguarding policy and procedure in place. We saw that safeguarding was discussed in staff's one to one meetings and team meetings.

Staff recruitment was undertaken by Brandon Trust's human resources team. The provider followed safe recruitment procedures before staff started working for the service. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. For example, staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

There were sufficient staff to keep people safe. The registered managers and team leaders were responsible for managing the rota to ensure people were supported in line with their needs. During our visits to people's homes we observed enough staff to support people, both physically and emotionally. For example, staff sat and listened to people and spent time with them.

Where people needed support with taking their medicines, they received their medicines as prescribed. Records showed staff administered medicines to people in line with their prescriptions. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given. Records showed all staff who administered people's medicines had received training to do so and their competency was assessed. One person said, "They (staff) give me tablets and make sure I take them. In the morning and at night" and "(Staff) bring them (tablets) to me and I take them myself."

Risks to people's safety had been assessed and people had plans in place to manage the risks. Risk assessments included areas such as fire evacuation, travelling in car, bathing/showering and hoisting. Ways of reducing the risks to people had been documented as well as the action to take to keep people safe. For example, one person suffered from epilepsy and had a high risk of seizures. The person's risk assessment for

seizures sited possible triggers and risks in the bath. The risk management plan included use of rescue medicines, reduction of hazards and reassurance.

The provider had a health and safety manager who supported services to check and review health and safety in the home. The health and safety manager also circulated relevant information to services. For example, we saw information about the recent heatwave had been sent out. Each house had a working folder where they recorded health and safety checks they had undertaken, such as fire checks, water temperatures and food storage. Each person's premises had an emergency plan in the event of an occurrence such as adverse weather conditions or damage to premises. This provided information on emergency numbers. The service had emergency bags with all relevant information on people if needed to evacuate at short notice. This ensured people who used the service were protected against the risks of unsafe or unsuitable premises or equipment.

We looked at the arrangements that were in place for managing accidents and incidents and preventing the risk of their re-occurrence. All incident reports were sent to the head office and were analysed. We saw an audit of incidents and saw one incident had led to the support plan being updated to give staff information about what could have led to the incident and about monitoring to see if any further action may be necessary.

Good

Is the service effective?

Our findings

People's needs were met by staff who had the knowledge and skills to support them effectively. Newly appointed care staff went through an induction period which gave them the guidance and confidence to carry out their roles and responsibilities. This was linked to the Care Certificate. The Care Certificate is a set of standards that social care workers are required to work to. It ensures care workers have the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The induction included training for their role and shadowing an experienced member of staff.

Records showed staff received mandatory training when they started working at the service and were supported to refresh this training regularly. Mandatory training included safeguarding, medicines management, infection control, fire safety and manual handling. The provider ensured that staff had training to cover people's needs. Staff had attended specific training courses such as epilepsy awareness, positive behaviour support and supported living in practice. Staff told us they felt the training was comprehensive and they could request training if needed.

People told us staff knew what they were doing and were well trained. Comments included, "I had an episode (seizure) here. Girls look after me. They understand epilepsy. My records say epilepsy. I've had it since I was eight. My medicine is under control and helps me a lot." A relative told us, "There is no problem with the staff. They know [person] and have the skills to be able to take care of her.

Records showed staff received supervisions. These were a mixture of one to one meetings and group supervisions. One to one meetings are an opportunity for staff to discuss any ongoing issues or training requirements with their line manager. The meetings were comprehensive and focused on staff wellbeing, objectives as well as well as Brandon Trust values and behaviours. Feedback was sought from team members, managers and people who received support. Records showed staff received yearly appraisals where they discussed staff development plans.

People's nutritional needs and preferences were outlined in their records. The records contained all the information staff needed to support people. One person's care plan indicated the person was to be supported only by staff trained by the speech and language therapy team (SALT) to reduce risk of choking. Some people had special dietary needs and preferences such as soft or pureed food where choking was a risk. At one of the premises, staff had brought a new, powerful blender which meant that the range of meals could be extended to foods that could not be blended with standard blenders. For example, Indian meals, rice based meals and pasta dishes containing nuts and seeds were available to people. Staff had shown imagination and creativity to ensure that people could experience a range of tastes despite their needs. A staff member said, "People can have anything now, such as smoothies made from ingredients that we couldn't use before. This has given greater choice and very helpful to people who need a fortified diet."

We saw that people with an interest in cooking were enabled to access cookery classes. Whatever they prepared and cooked was brought back for the other people in the house to have for an evening meal. This enabled the person to enjoy their interest and also get the enjoyment of seeing other people share the food

they had prepared. People were encouraged to help with the cooking. We had comments about the food such as, "Food good! Love porridge, fruit. Brunch on Saturday. Roast dinner on Sunday. Tasty." And "Love the food. Favourite today – having a brunch" and "We have lovely food. Like it all but favourite is roast."

Records showed people or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Daily records showed staff knocked on people's doors and sought verbal consent whenever they offered care interventions. For example, where people were supported with personal care, we observed staff asking peoples' permission before they carried out any support task.

Where people lacked verbal capacity, staff spoke and used hand gestures to communicate. In one case a person was repositioned and gave consent through gestures and sound vocalisation.

People were supported to stay healthy and their care records described the support they needed. People's care records showed details of professional visits with information on changes to treatment if required. We saw people had an annual review of their health with their GP's. People received timely support where necessary. For example, a person had choked and had been taken the hospital and discharged. We saw the following day that the GP and the Speech and Language Therapist (SALT) had visited and the person's care plan reviewed. Other health professionals were involved including psychology, dentists and occupational therapists. Comments included, "[Carer name] takes me to the surgery for an injection in my shoulder" and "A lady [chiropodist] comes in to do my feet and nails."

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. For example, we saw a best interest decision around supporting a person with personal care and the health implications if this was not maintained. Records showed people were supported in line with the principles of the MCA. People were supported to make choices. Care plans guided staff on how to support each person to make simple choices like what food they wanted and what to wear. For example, one care plan stated 'Show two outfits and give a minute to decide. May look at one they want to wear. If they do not respond, we think it means they don't mind.' Daily records showed this person was offered choices in line with their care plan. Another person's care plan stated 'I can repeat an option that I like.'

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The deprivation of liberty safeguards do not apply to supported living services, therefore any deprivation of liberty requires authorisation by the Court of Protection. The service had asked the relevant local authority to seek authorisation from the Court of Protection, where necessary.

Outstanding ☆

Is the service caring?

Our findings

People benefited from staff who had an outstanding caring approach to their work and were totally committed to providing high quality care. All staff spoken with were highly motivated and inspired to offer care which was kind and compassionate. One member of staff told us, "Do the best we can to give people the life they want". Another member of staff said, "I love coming into work." Many of the staff had worked for the service for a number of years. This meant staff knew people really well and had an in-depth understanding of people's preferences, needs and aspirations. Staff used this knowledge to ensure people's needs were met. One person told us, "Same carers all the time. That's good, lovely." We saw that one carer had been caring for the same person for 10 years. This continuity contributed to people feeling cared for by staff that knew them well.

People and their relatives were complimentary about staff and their caring nature. Other comments included, "Happy here. They (staff) cheer me up", "Girls help me a lot. Push my wheelchair for me" and "Shower me all nice and are kind to me." We had comments from relatives including, "You can tell they love him there, know him and take care of him in the right way", "Can't fault any of the carers. They all empathise with clients. They do far more for [person] than I could ever do for", "Good relationships, always a calming atmosphere" and "Know I can walk in any time. Very grateful, very happy with the care that he gets."

Staff showed compassion and kindness when people experienced bereavement. We saw a person who had experienced a family bereavement had been supported to remember the person. Staff had helped the person create a small garden of remembrance in the house garden. The person took us straight to this when we arrived and it was clear how important this was to them. They told us that this was a place where they remembered. They also planned to buy some more plants and ornaments to put there. They were keen to show us an album of photographs and memories which staff had helped them to put together.

People were supported to have a choice to reflect when they had developed positive relationships with people. For example, in one house people were enabled to select who they would like to go out with. They were shown photographs of the other residents and could make a choice of who he or she would like to take out with them. This meant the service had considered the importance of giving people choice about who they would like to spend time with and respected this.

We saw that one person who acquired a lot of possessions on a frequent occasion was supported sensitively to regularly donate some to charity shops. On the day of the inspection, staff were helping a person to sort through items. We later heard that these had been put in the car ready to take to the charity shop. However, the person had decided they weren't ready to let them go so the staff had respected this and were working with the person to go through them again. This was important to the person that they were in control of ensuring the room did not become too cluttered.

Brandon Trust had recognised the need to ensure people were enabled to have relationships if they chose. This was in response to people supported in the Trust saying they wanted more support to explore relationships, sex, and sexuality. A policy had been produced alongside guidance and training for staff on

relationships, sex and sexuality. The policy described how staff should support people who want to learn about relationships, sex and sexuality, respecting choices and differences, the law, keeping safe and other organisations that can help. Information had also been produced so people could understand it and to make it meaningful. We heard that a person in the service had been supported by staff to use and access internet dating sites. The person would seek advice from staff when chatting to people on line. A member of staff had worked with the person to put some guidelines together about using the internet to ensure they remained safe. This included, when meeting someone for the first time, ensure it was a local and busy place. The guidelines also suggested that when the person was ready to meet up with someone, to consider using a video type call so that they knew if the person looked like their photographs on social media.

People were able to attend social activities where they could meet other people. This included the 'Stingray Club', a social event held in a nightclub every month and 'Mates and dates', which holds events each month to help people find friends, and a relationship if that is what the person wants. They also run a group for people with learning disabilities who are gay, lesbian, bisexual, transgender or cross dress.

The Trust had also set up a new monthly LGBT social group in Bristol for people with learning disabilities. Records showed staff had received training in dignity, equality and diversity. Staff one to one records showed staff had discussed how each person was an individual and should be treated with respect.

People's communication needs were optimised. The service had an 'Intensive Interaction lead'. Intensive Interaction is a practical approach to interacting with people with learning disabilities who do not find it easy communicating or being social. The lead was auditing what was in place in the Oxfordshire services and had provided a self-evaluation form for managers on five communication standards, with questions such as ensuring people had hearing tests. We heard about how ensuring people could communicate effectively meant that behaviours that harmed had often been prevented. For example, a positive behaviour plan had made a difference by changing the way staff interacted with a person as they understood them better. For example, it suggested diversions such as offering pain relief, hot chocolate, or leave them in peace.

People's individual communication needs were clearly documented. Care plans guided staff on how each person preferred to communicate and any special methods of communication such as by body language and hand signals used by those who could not communicate verbally. Understanding people's specific ways of communicating also meant staff ensured people were able to consent to and be involved in decisions about their care. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. For example, if one person opened their mouth, it meant they wanted a drink. If they pushed you away, it meant they didn't like what was happening. A relative told us, "Staff know her really well, what she likes, wants to do and she likes them. Can be vocal at times so she lets them know."

Staff promoted a strong and visible person centred culture. We observed staff reacting to peoples' needs, reading body language where people had impaired communication and listening to verbal requests from others. Attention was immediate and person centred in that staff knew how people liked to be approached, spoken to and where they liked to receive the support. For example, at coffee time, a resident, with limited communication skills, was keen to have a drink (conveyed through gestures.) Staff showed the person a coffee jar and a drinking chocolate container. They were encouraged to smell the contents and were able to make an informed decision, indicating that they wanted a coffee. Staff told us that a person who loved coffee had tried nearly every variety on the market, and they always bought any new ones for the person to try as this was a real love of theirs.

People's privacy and dignity was respected. We saw people choosing to spend time in their rooms. Staff were aware of when people wanted those moments by themselves. One person commented, "Staff do knock on my door before they come in." People were referred to by their chosen name, listening to people, and taking time to find out what they wanted. Care plans and daily records showed people's dignity and privacy were maintained. We saw references to ensuring people were treated with dignity, for example, "Cover person's body with towel and transfer to bedroom" and 'Protect [person's] dignity when moving from bedroom to bathroom with towels whilst using hoist'. The person's daily record showed staff followed this guidance.

The service supported the use of assistive technology to promote independence and maintain safety. Assistive technology promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing. For example, records showed some people could stay overnight without the need of constant staff presence in their rooms by utilising bed monitors for epilepsy.

People had end of life care plans. This allowed people to record their wishes such as what sort of funeral they would like. When people reached the end of life stage, the registered manager and the team ensured people's experience was comfortable and pain free. One person's wishes were to remain in their home. Their end of life plan stated 'It is important to me that I have people around me I know' and 'Someone to look after my [pet].' The staff team worked with other professionals such as the GP and district nurses to enable this to happen. A member of staff told us, "We are doing all we can to keep [person] at home."

Outstanding ☆

Is the service responsive?

Our findings

The service was highly person centred and therefore people's quality of life was maximised to ensure they lived the lives they wanted. We found many examples of people that had been enabled to take on new challenges, irrespective of learning and/or physical disabilities. Staff spoke with passion, excitement and enjoyment when describing what lives people led. Whatever was requested, staff did all they could to ensure this was acted upon.

People had access to a wide variety of experiences, both therapeutic and social. Comments from relatives included, "He goes to pop concerts, abseils, zip wires, Nothing ever you can't be doing" and "Go with what he wants to do, such as IT access as bit of a computer nerd. In the past very frustrated - not now". Staff told us that they tried to ensure everyone got to experience what other people do. For example, one young person went to a concert, stayed in a hotel and had a Chinese takeaway. This was important as the person was quite young and wanted to experience what other young people would do. Another person purchased a laptop and had written a story which Brandon Trust had published. Other people who were passionate about flowers and gardens were members of the Royal Horticultural Society. They told us about a local show they had been to the day before and how much they had enjoyed it. One person said, "Loved the colours, and loved all the flowers. We like flowers here." Another person had expressed a wish to go and see a popular television show that had a live audience. Staff subsequently organised this and took the person along to be part of the TV audience.

Community resources had been sourced and used. This included a local facility which had a trampoline that people could be hoisted on to and could be massaged from underneath. This facility also had a Jacuzzi and hydrotherapy that people were supported to go to weekly. People were visited by professionals to have a massage to relax their muscles. In response to a suggestion by families, the service had sourced a private physiotherapist to visit people in their homes to work with people individually. Music therapy was offered on an individual basis. We heard that the music therapist had learnt the songs of an international well known band, to play to a person who was a keen fan. People were supported to go swimming. One person, who could not go horse riding due to their disability, did this on an adapted carriage to allow them to experience this as closely as possible. People also had opportunities to have individual activities such as going to the cinema and bowling. People had been supported to get passes to national organisations to reduce costs and maximise the chances of going out without it being too expensive. A member of staff said, "People's social lives are very good. Better than mine!"

We saw where people had a particular interest that this was integrated into their décor and activities. For example, one person loved clocks and birds. Her room had been decorated in clock wallpaper on one wall and bird wallpaper on another. She had a tray of watches and other jewellery which they selected to wear each day. Staff said they took her to a local shop to see the clocks and in one shop the staff set off all the cuckoo clocks for her. Staff also knew that the person loved feeding the birds so they took her to the local market to buy bird seed and she can spend time in the garden feeding them. We saw in another person's room that a mirror had been angled above the bed so the person could see. The person had a physical disability which restricted the position and ability to look around. Therefore, this enabled the person to

experience as much vision as possible to avoid isolation and boredom.

We heard about another person who wanted to do a parachute jump, possibly for charity. Their relatives had done this and they were keen to do it as well. The staff were gathering information from the person and his family with a view to him doing one either this summer or next year. This would be a tandem jump. The person had also stated they would like to live more independently in the future. So in preparation for this, staff were encouraging them to take care of all of their personal care and housework. They were also working with them to think about shopping budgets and how to shop within this and cook their own meals. Finally they had expressed an interest in learning to read and write. Staff supported the person to find a personal tutor to help succeed with this to goal.

People were protected from social isolation and loneliness because of social contact and companionship. One person had been supported to go on their first holiday. We heard that the staff had got the computer out and the two people in the house had looked at holidays within their budget. They chose to go to on a seaside holiday. The option was given for them to have separate holidays but they decided to go together. The person said, "Going on the first holiday I've ever been on. Never been on holiday before." Another person had passed their driving theory and test first time. They used their own transport to visit their family providing a high level of independence.

People had a say in who moved into their house. Staff had encouraged people in one house to draw up a pen picture of their ideal housemate. This included having similar interests and what gender. We saw in another house that the staff had waited for the appropriate person to be identified who would be compatible with the existing people. A person who had recently moved in had been on a few visits to the house to meet people and see if they wanted to move in. This acknowledged that it was people's homes and that it was important they were in agreement with who moved in, and not seen as just a vacancy to be filled.

People had received consistent, personalised care and support. Records showed people's needs were assessed prior to accessing the service to ensure their needs could be met. Staff completed an assessment with people and their relatives which was then used to create a person centred plan of care which was thorough and reflected people's needs, choices and preferences. Care planning had included the person's whole life, including goals, skills, abilities and how they preferred to manage their health. People and their families where appropriate, were proactive in planning their own care and making decisions about how their needs were met.

We noted the format of the plans differed according to people's individual needs. For example, one person liked tigers and their care plan was completed on a tiger logo template. Changes in people's care needs were identified promptly and with the involvement of the individual were reviewed and put into practice by staff. The plans were reviewed every six months as a minimum; however we saw people's plans were constantly updated in response to their changing needs. The support plans contained photographs of the person so they could relate to the information and included a one page profile which set out what was important to the person. The service had good systems in place to ensure smooth transition between services. People had 'hospital passports' which had all the important information to allow continuity of care. These included important information on communication, likes and dislikes, health information and allergies.

Staff completed records of daily support given to each person. These were descriptive of daily events and provided key information on the support provided and the person's general mood. They had sections on 'How do I seem today, concerns and my choices'. Where complex support was provided the daily notes reflected this. For example, when one person had a seizure, this had been clearly documented and showed

the action taken by staff.

People were encouraged to maintain relationships that mattered to them such as family. One house we visited said families popped in and when they did would often make staff a cup of tea, empty the dishwasher or help with the garden. One person said, "My [relatives] come in to see me. They always get a good welcome from staff." People had also formed close friendships with each other in their homes.

People were part of the local community. For example, going to the local pub for lunch, cookery classes at local schools and colleges and going to the local shops and cafes. We heard one neighbour often took things round, such as some rhubarb from their garden. One house had decided to set up a friendship group where people could drop in for coffee. This was advertised through a local advocacy group and on Facebook.

Information was provided to people in a variety of ways which gave them the best opportunity to understand it. These included pictures of reference, photographs and symbols. For example, we saw an example of how to make a complaint entitled 'I want to complain'.

People told us they were supported to raise any concerns they may have. We spoke with people during the day and they said that staff chatted to them and spent time with them, so if they had any worries they could talk about things. However, people told us they did not have any big worries. One person said, "I'd talk to [carer's names] if I have any troubles or worries and I'd tell the staff". A relative said, 'They phone from time to time to ask if I am happy with things.'

A complaints policy was in place and we saw that a complaint had been responded to in line with this guidance. The complainant had been contacted and an acknowledgement that their views would be used to improve practice in the future.

Good

Is the service well-led?

Our findings

Brandon Trust became the new provider for the service in April 2016. Many of the staff had transferred from the previous provider to continue working in the services they had for many years. They said the transfer had been done well and there had been information given to them via roadshows and induction about working for the Trust.

The provider had a clear vision and set of values and behaviours which promoted true person centred care. There was a well-developed understanding of equality, diversity, and human rights. A relative commented, "Feel we are back where we were when this was a flagship for supported living." Another relative said, "Atmosphere more of a buzz, why don't we do this, why don't we do that, what would you like to do, approach. All comes from the house manager. A year or two ago one or two staff would want to go on trips, holidays, visits. Now they all want to go with the residents."

The feedback received from staff and people's relatives reflected the positive and open culture of the organisation. Staff were positive about working for Brandon Trust and understood their role and what was expected from them. A staff member said, "Brandon is a breath of fresh air. Very person centred, but also focused on staff and interested in staff skills." Staff were happy in their work and were highly motivated and had confidence in the way the service was managed. Staff comments included, "We've all been here longer than 10 years. We all get on well as a team. We all love it", "Very good. I feel fortunate to have come into Brandon. It's all about the people. We aim to develop their lives as much as we can" and "Great team of support workers who will always try to help out whenever they can."

Staff were complimentary about the management and told us they felt the service was run well by managers that were consistent and were available for support to staff. A staff member said, "Management is very accessible and central support always answer phone. Brandon Trust is very person centred. We meet for supervisions at the local office. We can all ring and ask for guidance at any time." Another staff member said, "[Manager] trusts me. I can see myself staying. They are organising management training for me." Staff felt supported and one said, "Definitely feel confident and valued. Encouragement is used not punishment."

There was a clear staffing structure, the registered managers were responsible for people in different areas and oversaw the day to day service delivery provided by the team of staff. There were regular staff meetings and staff told us they were able to approach the management whenever they needed. Staff meetings minutes reflected discussions on guidance for staff on files about key documentation, fire evacuation procedure and about safeguarding, what it means and how referrals were made.

The provider understood the importance of gaining the perspective of people using the service, their relatives and staff. This was acted upon. For example, people using the service were encouraged to become part of a regional Members' Board. The Board was made up of people who used the service throughout the Trust and helped to shape policy making. There are also 'Brandon Voices' events which brought thoughts and views together. These views were then shared with management, support workers, and trustees. The provider also had a Dream Fund which provides equipment and experiences for people supported across

Brandon Trust. Applications were submitted by people using the service in an easy read form. We saw one of the homes we visited had won funding for new patio.

Relatives told us that there was effective communication between them and managers through telephone calls, face to face meetings or written questionnaires. Comments included, "Always phone me to let me know if [person] is not well and tell me what's happening about it", "They e-mail me to let me know how things are. I know that in an emergency they would phone", "At the moment we are exactly where we would hope to be - open relations with the staff" and "Do keep us in the loop. Will phone to let us know if things need to change. Invited to care review meetings."

There were effective quality assurance systems to monitor the quality of service such as reviews of documentation, policies and procedures and the safety of the service. We saw checks had taken place such as medicines audits, weekly sling checks, checks on hoists every six months. We saw where concerns had been noted that referrals had been made. For example, we saw an incident where medicines were not delivered on time. The service changed pharmacies and now has a good relationship with the local pharmacist. Brandon Trust collates all information at an area and company level to oversee trends and issues to feedback best practices. For example, guidance was issued to services after certain incidents so learning was used to ensure safety.

A quality assurance programme had been designed to inspect services based upon the CQC key lines of enquiry. The aim was to help capture the standards and enable teams and managers to feel more confident in line with legislation. Each key question was to be completed within two months and information to inform them such as team meetings or supervisions. Each registered manager reviewed these for different services and awarded a rating and any actions necessary. This helped to provide an overview and to share good practice.

The provider had policies in place which guided staff. Some of the policies were in 'easy read format' which allowed people who used the service to understand information easily. These included a safeguarding and complaints policy. There was a whistle blowing policy in place and staff were aware how to escalate concerns. Staff were confident any concerns would be followed up by the management and also aware how to report externally.

Brandon Trust has signed up to the Driving Up Quality Code which is a national initiative where signing up shows a commitment to improving quality in services for people with learning disabilities. The provider also has the Investors in People accreditation which relates to employment standards for staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered managers were aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.