Royal Mencap Society

Mencap - Taunton Deane Support Services

Inspection report

2 Scott House, Bindon Business Park
Cook Way
Taunton
Somerset
TA2 6BJ

Tel: 01823288061
Website: www.mencap.org.uk

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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

This inspection took place on 26 May 2016 and was carried out by one inspector. The location provides a supported living service to people with a learning disability living in their own homes in the community. The provider was given 48 hours' short notice of inspection to ensure the manager (or a suitable deputy) would be available to meet us at the provider's office and also to make arrangements for us to visit some of the people in their own homes.

The service is registered with the Care Quality Commission (CQC) for the provision of personal care in people's own homes. This includes assistance or prompting with washing, toileting, dressing, eating and drinking. We call this type of service a 'supported living' service. At the time of the inspection the service supported 36 people living in single occupancy and shared occupancy houses, flats or bedsits in Taunton, Chard, Street and Frome. Personal care was provided to 11 of these people. The service also provided other forms of social care support that are not included within CQC's registration requirements for a supported living service. For example, in addition to personal care, the service also assisted people with their housekeeping, shopping, attending appointments and other independent living skills.

The service was responsible solely for the provision of people's support services and not for the provision of their premises. This meant people's personal care was provided under a separate contractual arrangement to their housing provision. Accommodation was provided by separate housing providers or landlords, usually on a rental or lease arrangement. People could choose an alternative service provider if they wished. Some of the people received support from more than one support service provider. People who used the service had varying degrees of difficulties and support needs, ranging from mild to severe learning disabilities and autistic spectrum conditions. Some people had complex needs and required 24 hour support, whereas others were relatively independent and just needed assistance for a few hours each day.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was on annual leave during the week of our inspection. We therefore agreed to meet with another of the provider's area operations managers who knew the service well. The area operations manager told us the service philosophy was "To have a stable team supporting individuals in the best possible way, to maintain their health and wellbeing and promote their independence".

People told us they were happy with the personal care and support they received from the service. One person said "They are very kind. I'm very happy". Another person said "Staff help me to shower but I get dressed myself. They are alright and always turn up on time". The relative of a person with complex support needs said "They are doing a great job, I'm very happy. [Person's name] is always happy, clean and well fed".

We found staff were motivated and committed to ensuring people received the agreed level of support. Each person had a core team of support staff specifically assigned to them. This ensured people were familiar with the staff who supported them and the staff understood their needs and preferences. Staff were available to support people with personal care when needed, but the service tried to encourage people to be as independent as possible. This boosted people's confidence and self-esteem and enabled them to become much more self-reliant and independent.

People and their relatives told us the management and staff were very accessible and approachable. They said they could raise issues or concerns informally with any member of staff or with the Area Managers and they always received helpful responses. Staff said everyone in the organisation, from the top down, focused on the well-being of the people they supported.

The service had good links with the local community. This included the local authority transition teams and the local specialist colleges for people with learning disabilities. They also had links with local voluntary shops, local businesses, and a local voluntary group that organised trips and parties for people with a learning disability.

Systems were in place to ensure people received their prescribed medicines safely, where they needed assistance or prompting to take their medicines. Where necessary, people were also supported to access other health and social care professionals to maintain good health and well-being.

The provider had an effective and comprehensive quality monitoring system to ensure standards of service were maintained and improved.

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.

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual support needs.

People were protected from the risk of abuse and avoidable harm.

Risks were identified and managed in ways that enabled people to maintain as much independence as possible and to remain safe.

Is the service effective?

Good

The service was effective.

People received personal care and support from staff who were trained to meet their individual needs.

People were encouraged to carry out day to day tasks with staff support to develop daily living skills and to maintain their independence.

People were supported to maintain good health and to access health and social care professionals when needed.

The service acted in line with current legislation and guidance where people lacked the mental capacity to make certain decisions about their support needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect and were supported to be as independent as they wanted to be.

The staff and management were caring, friendly and considerate.

Staff had a good understanding of each person's preferred

communication methods and how they expressed their individual needs and preferences.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Good

The service was responsive.

People were consulted and involved in decisions about their support needs to the extent they were able to express their preferences.

People's individual needs and preferences were understood and acted on.

People's views and suggestions were taken into account to improve the service.

Is the service well-led?

Good

The service was well led.

The service had a caring and supportive culture focused on meeting people's individual support needs and increasing their social inclusion.

People were supported by a motivated and dedicated staff team and accessible and approachable management.

The provider's quality assurance systems were effective in maintaining and promoting the standards of service provision.

Mencap - Taunton Deane Support Services

Detailed findings

Background to this inspection

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

This inspection took place on 26 May 2016 and was carried out by one inspector. The location provides a supported living service to people with a learning disability living in their own homes in the community. The provider was given 48 hours' short notice of inspection to ensure the service's manager (or a suitable deputy) would be available to meet us at the provider's office and to make arrangements for us to visit some of the people in their own homes.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

The service was last inspected on 4 and 14 August 2014 as part of the Wave 2 testing phase for our new comprehensive inspection approach. At that inspection all five questions were rated Good and the service was rated Good overall.

During the inspection we visited the service's administrative office in Taunton, spoke with a person who used the service and visited three other people in their own homes in the Taunton area. We spoke to one of the provider's area operations managers, the local service manager, a practice leader and five support workers. Following our inspection, we telephoned a person who used the service in the Chard area; and a relative of a person with communication difficulties from the Street area. We also reviewed the responses

from people, relatives and staff as part of our pre inspection questionnaire process and the feedback from the service's most recent relatives and stakeholders' satisfaction questionnaires.

We reviewed three people's care plans and other records relevant to the running of the service, including: staff training records, medication records, complaints and incident files.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe and secure with the staff supporting them. When we asked a person if they knew what to do if they had any worries, they said, "I would tell Mum and Dad or talk to staff". Another person said "I'm fine, I feel safe in my flat. But if the fire alarm goes off I have to go really quickly". The relative of a person with complex needs said, "No worries, he's definitely safe. I don't worry about him, I have peace of mind". All of the people we met looked relaxed and happy with the staff who supported them. We observed the interactions between people and staff were friendly and appropriate.

People who used the service were potentially vulnerable to abuse due to their learning disabilities. The service protected people from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff told us they had no concerns about any of their colleagues' practices but they would not hesitate to report something if they had any worries. Staff were confident the registered manager would deal with any concerns to ensure people were protected.

The risk of abuse to people was reduced because the provider had effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Care plans contained risk assessments with measures to ensure people received safe personal care and support. For example, there were risk assessments and control measures for managing anxiety and aggression, epileptic seizures, people's finances, medicines management and choking. Staff received positive intervention training to de-escalate situations and keep people and themselves safe.

All incidents were investigated and action plans put in place to minimise the risk of recurrence. The number of incidents was low and records showed the provider met their statutory requirements to inform the local authority safeguarding team and the Care Quality Commission of notifiable incidents.

Staff knew what to do in emergency situations. For example, some people's support plans contained protocols for responding when they experienced epileptic seizures. Staff received training in providing the required medicines and knew when and who to notify if the seizures were prolonged. Care plans included personal emergency evacuation plans in case of fire or other emergency situations. Although the service was not directly responsible for people's premises and equipment, the staff still carried out risk assessments and checks to ensure the physical environment was safe. If any concerns were identified, the service informed the relevant landlord or housing association for action. The provider had a range of health and safety policies and procedures to keep people and staff safe.

There were sufficient numbers of staff deployed to meet people's needs and to keep them safe. The staffing support required was agreed with the relevant funding authority to meet each person's individual needs.

This ranged from 24 hour one to one staff support for people with complex needs to just a few hours support each day for people who were relatively independent. We were told about examples of staffing hours being increased where people's needs had increased and other examples where support had been reduced as people became more independent.

Each person had a core team of support staff specifically assigned to them. This ensured people were familiar with the staff who supported them and the staff understood their needs and preferences. Wherever possible, staff absences were covered by other staff from the person's core team. Staff told us the staffing levels were appropriate to meet the needs and preferences of the people they supported. One staff member said "There are no staffing problems. We have a very consistent, close team of four and cover each other very well. We even do our own rotas".

The provider operated a 24 hour on-call system for staff to access if they needed management advice or additional staff support. A staff member said "We hardly ever use the on-call, but it's reassuring to have the security of knowing it's there".

Some people required assistance or prompting to take their prescribed medicines. Systems were in place to ensure people received their medicines safely. Staff received medicine administration training and shadowed more experienced staff until they were assessed as competent by their manager. The assessment involved observation of their practice and successful completion of a detailed medicines questionnaire. Staff were reassessed every 12 months to ensure their practice continued to be safe.

We observed medicines were kept in suitable storage facilities and medicine administration records were accurate and up to date. Staff said they checked to ensure people took the correct medicines at the right times. The service managers carried out monthly audits to check the accuracy of medicine records and supplies.

The provider maintained an online database of all incidents, including medicine errors. Most of the medicine 'errors' recorded over the last 12 months related to one individual who regularly refused their medicines. This was despite the fact that they had voluntarily requested the service to administer their medicines on their behalf. The service had sought professional advice and had agreed protocols with the local safeguarding team for staff to follow in these circumstances.

Good

Is the service effective?

Our findings

People told us the service was effective in meeting their personal care and support needs. One person said, "Staff help me. The ladies help with my personal care. I do my own shopping but staff help me go to the bank and to do my shopping list". Another person said, "Staff help me with cleaning my teeth and washing my face". The relative of a person with high dependency needs said, "They are doing a great job, I'm very happy. [Person's name] is always happy, clean and well fed".

Staff were knowledgeable about people's individual needs and preferences and provided support in line with people's agreed care plans. Staff received training and supervision to ensure they knew how to meet people's needs effectively. They told us some of the training was face to face with a local trainer, such as safeguarding and positive intervention, and other training was through e-learning modules.

The provider had a national learning and development team and a national training programme. New staff received a 12 week induction programme which included five days of face to face training and completion of an in-depth work book. This covered the core competencies required for the job and the provider's key policies and procedures. During the induction period a lot of time was spent shadowing experienced staff. The induction formed part of the new staff member's six month probationary period. As part of the new member of staff's assessment, managers observed their practices and sought the views of people who used the service and other staff. This enabled them to assess the member of staff's competency and their suitability to work with people who used the service.

All staff received mandatory annual training updates. Much of the refresher training was in the form of e-learning and/or completion of work books. The provider used an electronic system with traffic light indicators to monitor completion of staff training and to book update training when it was due. Staff training included; safeguarding vulnerable adults, the Mental Capacity Act (2005), epilepsy, medicines management, positive interventions, first aid, fire safety, food hygiene, moving and handling and other topics specific to people's individual needs. For example, where necessary staff received individualised communication training to enable them to understand and communicate with people who had limited verbal communication skills. This included sign language, picture boards, symbols, and other physical forms of communication.

Staff said the training provided was very good and the provider also supported them with continuing development, such as vocational qualifications in health and social care. Training and development needs were discussed at their quarterly 'Shaping Your Future' meetings and at annual performance and development appraisals.

Staff in each of the services visited said everyone worked really well together as a supportive and close knit team. This helped them provide effective care and support to people who used the service. People's care needs and staff practices were also discussed at each service's monthly team meetings and at area wide team meetings for particularly important issues or developments. These meetings helped to keep staff up to date with current best practices and new developments or initiatives. The service manager and the

registered manager also visited each service regularly to discuss any local issues and to obtain the views of people and staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available.

People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The Deprivation of Liberty Safeguards (DoLS) authorisation procedure does not apply to supported living services. For this type of service, where a person's freedom of movement is restricted in a way that may amount to deprivation of their liberty it has to be authorised by the Court of Protection.

We checked whether the service was working within the principles of the MCA. Staff had received training and had an understanding of the requirements of the MCA. When people lacked the mental capacity to make certain decisions the service followed a best interest decision making process. The service also reviewed any restrictive practices with a view to reducing the number and impact of any restrictions on people's freedom and choices. For example, a stair gate was needed to prevent a person from accidentally falling down their stairs during the night. The service took advice and installed a catch on the gate which could be opened by the person themselves. This meant the gate was no longer restricting their freedom of movement as they could release the catch when they wished.

When required, staff assisted or prompted people to have sufficient to eat and drink and to have a balanced diet. Most people were relatively independent and bought their own food shopping but some were assisted by staff to prepare their shopping lists and some of their meals. One person said staff helped them to eat a healthier diet. They said, "I watch what I eat. Salads are good for me. I've lost 2 stone". Another person who needed a soft diet due to swallowing difficulties and a risk of choking said, "I like potatoes but I have to have it mixed. [Support worker's name] puts cheese on the potatoes for me". They had previously been assessed by a speech and language therapist who had prescribed the soft diet.

Staff monitored people's health and wellbeing to help ensure they maintained good health. Care plans contained details of people's hospital and other health care appointments. Staff prompted and supported people to attend their appointments. People told us they were supported to see various health and social care professionals including: GPs, social workers, the epilepsy nurse, speech and language therapist, dentists and a podiatrist.

Good

Is the service caring?

Our findings

We visited people in their homes and observed the interactions between them and staff. All of the people we met appeared relaxed and happy with the staff. People told us they liked the staff who supported them and would talk to staff if they needed anything. One person said, "They are very kind. I'm very happy". We observed people had a close, trusting and friendly relationship with staff. For example, one person engaged in a lot of friendly banter with their support worker and made jokes about giving them a haircut. A woman who received 24 hour support from the service, sat on a female support worker's lap and hugged them for comfort and reassurance while talking with us.

We had difficulty understanding some of the things people said to us due to their speech difficulties, and some people did not understand everything we said. In these circumstances we observed people had no hesitation looking to their support workers for assistance and reassurance. This showed people were comfortable with their support workers and trusted them when they needed help. The area operations manager told us they tried hard to ensure people and staff were compatible. If a person was not happy being supported by a particular member of staff, they would move the staff member to another team.

A relative of a person with complex support needs said, "[Person's name] is happy and that's the main thing. They support him with all his personal care and take him out to day centres. They assist with cooking. It's as if they are a family really".

When staff spoke with us they were respectful in the way they referred to people. Staff appeared compassionate and wanted to promote people's welfare and well-being. For example, staff supported some people to approach their landlord for approval to keep their own pets.

Staff understood people's needs and preferences and engaged with each person in a way that was most appropriate to them. Each person had their own core team of support staff who knew the individual's needs and behaviours well. People were encouraged to express their views and to be actively involved in making decisions about their care and support. People told us they had a say in the amount and type of support they received. We observed care plans had been developed with people's involvement and with input from family members, where appropriate. In addition to face to face conversations, a range of individual communication tools were available to assist people's understanding. This included easy read information, pictures, signs and symbols.

Staff were available to support people with personal care when needed, but the service tried to encourage people to be as independent as possible. For example, people were encouraged to carry out as much of their own personal care and cooking as possible, with just a little assistance or prompting from staff when needed. We were told of one person, who initially needed 24 hours a day support, who had progressed over a 12 month period to only needing three hours a week to support them with their meal shopping. Staff had supported the person and encouraged them to become more independent with their daily living activities. This had boosted the person's confidence and self-esteem and enabled them to become much more self-reliant and independent.

Staff respected people's privacy and dignity. For example, staff told us they ensured doors were closed and curtains or blinds drawn when personal care was in progress. People told us staff assisted them in a discrete and respectful manner. One person with a medical condition that sometimes resulted in "little accidents" said, "Staff help me get changed in the lavatory with the door shut. If I'm out I normally use the public toilets".

People were supported to maintain ongoing relationships with their families. Some people needed staff support to visit their families and the service encouraged relatives and friends to visit people where appropriate. For example, one person visited their parent regularly and liked to attend church services with them. Staff were aware of people's beliefs and preferences and respected their views and choices. Care plans included any known information about people's end of life preferences and any cultural or religious beliefs.

Good

Is the service responsive?

Our findings

The service provided personal care based on people's assessed needs and preferences. This included assistance or prompting with washing, toileting, dressing, eating and drinking. Some people needed 24 hour support with all of their personal care needs. Others were relatively independent and only needed limited support or prompting with some of their personal care. One person said, "Staff help me to shower but I get dressed myself. They are alright and always turn up on time". A relative said, "[Person's name] struggles to vocalise but he knows how to get his own way. He chooses his clothes and his meals". The relative said the service was very responsive, they told us "They contact me if there are any issues. We talk all of the time. There is good two way communications with all of the care staff. I have all of their mobile phone numbers".

The service also provided other forms of social care support that are not included within CQC's registration requirements for a supported living service. In addition to personal care, the service also assisted people with their housekeeping, shopping, attending appointments and other independent living skills. For example, one person told us in addition to their personal care, staff also helped them to go to the gym, cook their meals, go for walks, do their shopping and visit their parents.

Each person had a comprehensive care and support plan based on their assessed needs. The care plans provided clear guidance for staff on how to support people's individual needs. They included an assessment of people's needs, their support plan, risk assessments, health appointment records, medicines, health action plan, personal money records, significant events and, where appropriate, details of their tenancy agreements.

Care support plans were kept in people's individual homes and a copy was also kept in the provider's administrative office. Support plans were reviewed by members of people's core staff team and the service managers on an ongoing basis to ensure they remained appropriate and up-to-date. Care plans were formally reviewed on a quarterly basis or sooner if there was a significant change to the person's support needs.

Each person had a core team of support staff. This helped ensure staff were familiar with and understood people's individual support needs and preferences. It also meant staff understood people's individual communication methods and were better able to assist them to express themselves and to contribute to the assessment and planning of their care.

Each person had a say in the membership of their core team of support staff. Where people expressed a preference, they were usually able to choose the member of staff on duty who they wanted to support them. Staff members of the same gender were available to assist people with personal care, if this was their preference. The Mencap policy was for female staff only to support women with their personal care.

The service sought people's views through a variety of methods. This ranged from regular informal contacts with people and their relatives, to more structured support plan review meetings and an annual satisfaction

questionnaire. Where people were supported in shared occupancy houses or flats, the service sometimes organised 'tenants meetings' to discuss matters of mutual interest. Similarly, ad hoc relatives meetings were sometimes arranged to discuss particular matters affecting a group of people living in shared accommodation. For example, we were shown details of an extensive garden make-over project involving the tenants, their families, and staff from the service and the housing association. The improvements included raised vegetable beds, low maintenance landscaping, and easier access for people with mobility difficulties.

People and their relatives told us the management and staff were very accessible and approachable. They said they could raise issues or concerns informally with any member of staff or with the Area Managers and they always received helpful responses. Most of the people we spoke with said they did not have any complaints. However, one person told us one of their support workers was "bossy" and "I will talk to [registered manager's name] about it". Other members of the person's core staff team, and the area operations manager, said the person went through phases of criticising particular members' of staff. They had complained about different members of staff at different times. They told us the support worker in question was always professional and nice to the person. However, the area operations manager said, "If someone really doesn't want a particular member of staff to support them, then we would move the member of staff to another team".

The provider had an appropriate policy and procedure for managing complaints. This was available in an easy to read format with pictures and symbols. The policy included agreed timescales for responding to people's concerns.

In the last 12 months the service had managed three complaints under their formal complaints procedure. One related to unclear communication with a person's family members and two related to billing errors. The registered manager had resolved the complaints personally, to the satisfaction of the complainants.

Good

Is the service well-led?

Our findings

People told us they were very happy with the personal care and support they received from the service. They said they got on well with the staff and with the local management team and could talk to them about any issues or concerns. The relative of a person with complex support needs said, "Mencap and the managers are excellent. I've got no qualms, nothing but respect for Mencap, they're marvellous".

One of the provider's area operations managers was registered with the Care Quality Commission as the registered manager for the service. They were on annual leave during the week of our inspection so we agreed to meet with another of the provider's area operations managers who knew the service well. The area operations manager told us the service philosophy was, "to have a stable team supporting individuals in the best possible way to maintain their health and wellbeing and promote their independence".

The provider had a person centred service ethos. This was promoted through staff training programmes to give staff the confidence and skills to meet the specific needs of the people who used the service. This approach was also reinforced through staff meetings, shift handovers and one to one staff supervision sessions. The provider's policies, procedures and operational practices were designed to support this person centred approach.

We found staff were motivated and committed to ensuring people received the agreed level of support and people were enabled to be as independent as they wished to be. Staff said everyone in the organisation, from the top down, focused on the well-being of the people they supported.

Staff were well supported by the management team and by their colleagues. One member of staff said, "Management are good at listening and are very supportive." Another staff member said, "I get on well with management, they are very approachable". Several members of staff commented on the turnover of Mencap managers and said they found this unsettling. However, they didn't think this had impacted adversely on people's care. They said the current managers were all very approachable, visited the services regularly and were always "at the end of the phone" if they needed help or advice.

Decisions about people's support needs were made by the appropriate staff at the appropriate level. Specialist support and advice was also sought from external health and social care professionals when needed. There was a clear staffing structure in place with clear lines of reporting and accountability. The support workers were supervised by service managers who reported to the area operations managers. The line of accountability then went up through the regional operations managers, operational director, board of trustees and chief executive officer.

The provider had a comprehensive quality assurance system to ensure people's needs continued to be met effectively. They employed a national quality team that could visit and audit services identified as in need of improvement, or at the request of senior or local management. The local service also employed a dedicated practice leader who could go into any of their teams to provide extra support to staff, carry out complex risk assessments or undertake medicine audits.

The provider's service managers carried out a programme of monthly audits to assess the quality and safety of their service. The outcomes were recorded on an internal online system called the Quality Compliance Tool. This was linked to a continuous improvement plan for each service which identified any improvement actions required. For example, a strategy meeting was held to discuss incidents of challenging behaviours at a service. Subsequently, a referral was made to a psychologist who developed an improved behavioural support plan which helped to significantly reduce the number of incidents. Staff also received positive intervention training to provide them with the skills and confidence to intervene more successfully.

The Quality Compliance Tool recorded every aspect of each person's care and support, including: their support plan, risk assessments, health action plan, medicines, and core staff team. The area operations managers carried out quarterly peer review audits of each other's services. The provider's National Quality Team sampled some of these audits to ensure consistency and progress with implementation of agreed action plans. These checks enabled any trends or themes to be spotted and helped ensure the service continued to meet the needs of the people they supported. For example, a new process for speech and language therapy assessments and recording was introduced following learning from a choking incident in another area covered by Mencap.

The provider met their statutory requirements to inform the relevant authorities of notifiable incidents. They maintained an electronic record of all incidents, incidents were investigated and action plans put in place to minimise the risk of recurrence. The provider promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

People and their relatives were encouraged to give their views on the service directly to management and to staff through daily conversations and more structured care plan review meetings. Where people were supported in shared occupancy houses or flats, the service sometimes invited people to 'tenants meetings' to discuss matters of mutual interest. Similarly, ad hoc relatives meetings were sometimes arranged to discuss particular matters affecting a group of people living in shared accommodation.

Annual relatives and stakeholder questionnaires were also circulated to gain people's views. The latest questionnaires were circulated in January 2016 and the responses were generally very positive. Comments included, "I think you're doing an excellent job", "Your support workers have helped widen his life experience. This has made him happier" and "She has some excellent carers to always help her and offer support". However, one relative commented "There is quite a change in staffing, it needs more stability with regular staff".

The provider participated in various forums for exchanging information and ideas and fostering best practice. These included care provider forums organised by the local authority, housing provider forums, and specialist college meetings and open days. Managers attended service related national and local conferences and seminars. They also accessed a range of online resources and training materials from relevant organisations, including the British Institute for Learning Disabilities and the National Autistic Society's websites. The area operations managers had monthly meetings with their service managers to disseminate any new ideas or learning to their teams. Regional days were also organised to share good news stories, celebrate exceptional staff performance and share good practices. These events were attended by a support worker and a service manager from each service across the whole of the South Region.

The area operations manager said they had very good relationships with the local authority transition teams and the local specialist colleges for people with learning disabilities. They also had links with the local

community, including: local voluntary shops, local businesses, and a local voluntary group that organised trips and parties for people with a learning disability. The service was hoping to recruit local people as volunteers to provide more variety and interest for the people they supported. For example, one person had a fascination for tractors and the service was looking to find a local farmer who may like to help.