FitzRoy Support

Hampshire Supported Living

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

This service provides care and support to people living in 'supported living' setting, so that they can live in their own home 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.

There was a registered manager in place who was taking planned extended leave at the time of inspection. The two service managers were responsible for the running of the service in their absence. 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 provider's management team were practically involved in the day to day running of the service. They were on hand to provide guidance to staff and regularly worked alongside them to offer support and monitor their working behaviours and performance.

Risks to individuals associated with their health and wellbeing were assessed and monitored. People had plans in place to support staff to help people manage their anxieties and escalating behaviour. When incidents took place, the provider took appropriate action to investigate, report and follow up concerns, putting plans in place to minimise the risk of reoccurrence.

There were sufficient staff to meet people's needs. The provider had systems in place when recruiting candidates to ensure that only suitable staff were employed to work with people. There were currently some vacancies for permanent staff and the provider used agency staff to ensure there were enough staff to meet people's needs. People, relatives and social workers told us that permanent staff were skilled, but not all agency staff were as familiar with people's needs.

Staff had received training which was sufficient to meet people's needs. Where the provider had identified that staff required additional training in specialist areas such as communication, they had taken action to ensure staff received access to these skills. The provider monitored staff's ongoing work performance through supervision and observation of their work practice.

People's care needs were assessed by the service in partnership with funding authorities, people and families. The provider was proactive in reviewing people's care by making appropriate referrals to healthcare professionals when people's needs changed. When people transitioned to and from different services, the provider had a clear insight into the benefits of putting robust plans to help reduce people's anxieties about upcoming change.

People received personalised care. People's care plans detailed information about people's health, life history, wellbeing and preferred routines. The provider was committed to ensuring that people were

supported to be as independent as possible. Staff were caring in their role and treated people with dignity and respect.

People were encouraged to access healthcare services when required. The level of support people required around eating and drinking was identified in people's care plans. People had been supported to make referrals to healthcare professionals in order to meet their dietary requirements and staff encouraged people to follow recommendations given. There were systems in place to support people to manage their medicines. The provider had made improvements to its medicines management system, which had resulted in a significant reduction in medicines errors that had occurred.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People were involved in making decisions about their care and were supported to be part of their local communities. There was mixed feedback about how the provider communicated with people's relatives. The provider had identified the challenges to improve and had plans in place to improve its communication strategies with everyone involved in people's care. There were appropriate systems to manage complaints and concerns. The provider helped to ensure people were satisfied with the outcome of investigations of concerns by writing to them about their findings.

The provider had systems in place to monitor the safety and quality of care. They had implemented improvement plans which were regularly reviewed to track the progress of the service and identify where additional improvements were needed.

The provider worked in partnership with other stakeholders to help assess, monitor and improve the quality and safety of the service.

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 systems in place to help people manage their medicines safely.

There were enough staff in place to meet people's needs.

There were systems in place to protect people from the risk of infections spreading.

The provider had systems in place to protect people from abuse.

The provider used reflection from incidents in order to promote improved practice.

Risks to people's health and wellbeing were assessed and monitored.

Is the service effective?

Good

The service was effective.

Staff received ongoing training and support to be effective in their role.

People's rights and freedoms were respected.

People were supported to access healthcare when required.

People were supported to follow a diet in line with their preference and requirements.

People's needs were assessed to ensure that the care provided was sufficient to meet their needs.

Is the service caring?

Good

People were involved in making decisions about their care.

People were treated with dignity and respect.

People were supported to be as independent as possible.

Is the service responsive?

Good

There were systems in place to deal appropriately with complaints and concerns.

People's wishes and preferences were considered when planning their end of their life.

People received personalised care that met their needs.

Is the service well-led?

Good

There was a clear management structure in place

The provider had systems in place to monitor the safety and quality of the service.

People were supported to be part of their community.

The service worked with other stakeholders to improve the quality of the service.

The provider had implemented plans to improve the quality of the service.

Hampshire Supported Living

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.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection took place between 15 March and 10 April 2018. The inspection included visiting people in their own homes, speaking to people and their relatives, and speaking to social workers and health professionals who knew the service. We visited the office location on 15 and 22 March to see the two service managers and office staff; and to review care records and policies and procedures.

One inspector and two experts by experience carried out the inspection. The experts by experience spoke to 19 people and relatives over the telephone to gain their views about the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts in this inspection had experience in supported living services working with adults with learning disabilities.

Before the inspection we reviewed information we had about the service, including notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return. 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 visited six people in their home to gain their views about the care provided. We also spoke with the

providers' two service managers, three deputy managers and four staff members. We spoke to three social workers and one healthcare professional about their experiences working with the provider. We looked at the care plans and associated records of five people. We reviewed other records, including the provider's policies and procedures, incident reports, staff training records, staff rotas and quality assurance questionnaires.

This was the first inspection of the service.

Good

Is the service safe?

Our findings

People told us they felt safe receiving support from staff at Hampshire Supported Living. One person said, "This is my flat and I feel safe." Another person said, "Staff look after me well. I like it here." One relative told us, "Staff have been very good at dealing with issues and are very aware of safety." A second relative commented, "[My relative] is safe and happy. Staff are looking after them very well."

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Staff were knowledgeable about people's individual needs and the steps required to keep people safe. One person had a risk assessment in place around their anxiety and associated escalating behaviour. The assessment detailed communication and behavioural support strategies designed to support the person to manage their anxieties, helping staff de-escalate situations. Another person was at risk of choking. They had the capacity to choose not to follow all the dietary guidance recommended to them by a speech and language therapist. Staff put measures in place to encourage the person to follow this guidance. They also monitored the person whilst they were eating in order to pre-empt any incidents where they would be at risk of choking. This reduced the risk that the person would come to harm as a result of their dietary choices.

People were supported to manage risks in relation to emergencies in their home. People had a personal emergency evacuation plan, which provided an assessment of the safest way to support that person to leave the building in the event of a fire. Staff supported people to carry out regular fire drills to help give them the knowledge of how to respond in the event of a fire. The provider had also offered training courses for people around fire safety. This helped to increase their knowledge and confidence in managing this risk.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or safeguarding concerns. All staff had received training in safeguarding, which helped them identify the actions they needed to take if they had concerns about people or concerns had been raised to them. There had been a number of incidents relating to people's behaviours, which resulted in the provider reporting concerns to local safeguarding authorities. Records of investigations show that the provider had taken all the actions required in order to help people stay safe.

The provider reflected on incidents and implemented changes from this where necessary. One relative told us, "[My relative] is very complex. There have been a lot of issues for staff to deal with, but they have responded to incidents very well." All incidents, associated investigations and follow up actions were recorded and outcomes were shared with staff to promote future learning. The provider had recently changed their management support system for staff out of office hours. This was in response the provider's reflection on incidents and how effectively staff could access help and advice out of hours. This had resulted in increased support for staff if they needed help or advice outside of office hours.

There were sufficient staff in place to meet people's needs. One person's relative told us, "[The provider] really understands the need to recruit a certain type of staff with very particular skills. I can see they are trying to hold to this." Staffing levels were determined by assessments of people's needs by social workers and health professionals who commissioned their care.

The service manager told us that at the time of inspection, the provider was in the process of recruiting new staff, but in the meantime, agency staff filled these vacancies. People, relatives and social workers told us not all agency staff understood people's needs as well as permanent staff. One person said, "Agency staff are not all good." A relative commented, "There have been some issues with agency staff, who didn't understand my relative's needs." A social worker remarked, "Part of the key issues have been associated with the variation of training given to their permanent staff and agency staff that are called to cover some of their shifts."
The service manager showed us how there had been a gradual reduction in the number of agency staff who were used as the provider recruited more permanent staff. The provider received details about agency staff's pre-employment checks and training. The service manager had worked with people and the agency to identify effective agency staff that were sufficiently trained and skilled in their role. Where some agency staff had received negative feedback from people, families or after incidents took place, they were no longer used by the provider. A relative told us, "Staffing has got a lot better, the agency staff that are used now are much better than before." The provider had worked with people and relatives to help ensure only suitable staff worked with people.
There were systems in place to safely manage people's medicines. The level of support that people required to manage their medicines was identified in their care plan. Where people required staff's support, detailed plans about reasons medicines were prescribed, possible side effects and people's preferred routines around administration were identified.

There had been 14 medicines errors since the service registered with CQC in December 2016. These errors ranged from omissions in medicines records to occasions were staff forgot to administer people's medicines. In all cases, other staff picked up these errors quickly and took the appropriate advice from medical professionals. This helped to minimise the impact on people's health and wellbeing. The service manager followed up these incidents with staff and put additional measures in place to help ensure that these errors did not re-occur. There had been a significant reduction in these errors as a result of the service manager following up on these issues.

There were systems in place to protect people against the spread of infections. Staff had received training in infection control, which taught them practical ways in which they could prevent the spread of infections. They told us how they wore personal protective equipment such as gloves when supporting people with their personal care. This helped to minimise the risk infection spreading.

Good

Is the service effective?

Our findings

People and their relatives told us they felt staff were effective in their role. One person said, "The staff are good." A relative commented, "One staff member is really natural [with my relative]. They are a strong, positive character and that is exactly what is needed."

People's care needs were determined using assessments made in collaboration by people, their relatives, social workers, health professionals who commissioned people's care and the provider. These assessments were ongoing and regularly reviewed. Where people's needs changed and they required increases or decreases in staff support, the provider had contacted the relevant bodies in order for people's needs to be reviewed. Where external professionals had made recommendations to make changes to care plans, these were implemented accordingly. This demonstrated there were effective systems in place to ensure people's needs were appropriately assessed.

Each person had their needs assessed individually and had been allocated an amount of care and support hours, which reflected their needs. In some cases, people lived with other people who used the service and their support was shared. In these cases, a specific number of staff were commissioned to provide shared support to people who were living in one particular house (or supported living project).

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. The provider had identified where people were not able to make specific decisions around their finances, medicines, and care or accommodation arrangements. In these cases best interests meetings were held where decisions made and people present were clearly documented in people's care records.

Staff sought consent from people using a range of communication strategies before providing support by checking they were ready and willing to receive it. Staff told us they referred back to guidance in people's care plans around how people make and communicate choices. The guidance detailed the choices people were able to make and the support they needed from staff in order to make an informed decision.

The provider worked effectively with other organisations when people moved to and from different providers. One person was due to be moving into a house where the provider was commissioned to provide care. The provider had planned a three month transition period, which included a set of actions designed to prepare the person for the move. These included visiting the new property, socialising with people who already lived there and introducing staff, so the person was comfortable with them when they moved. Social workers, family members and existing providers were involved within this transition planning. This helped to ensure that the person's needs were effectively considered throughout this process.

Staff were given a programme of training appropriate to meet people's needs. This included training in; safeguarding, medicines, mental health, learning disabilities, fluid and nutrition, equality and diversity,

challenging behaviour, first aid, health and safety, infection control, moving and handling and epilepsy. In addition to practical training, staff had their competency assessed by senior members of staff in key areas such as medicines administration and moving and handling. This helped to ensure they were competent in their role.

New staff were given a structured induction into their role. This involved working alongside experienced staff, reviewing care plans, learning about health and safety arrangements in the work place and having supervision with a senior member of staff to review their progress. Staff received ongoing support in their role through supervision with a senior member of staff. Supervisions were used to review and reflect on staff's working performance and identify any development or training needs.

People's care plans identified their specific dietary requirements. The level of support people required from staff to meet these requirements was clearly documented. Some people were able to manage aspects of their diet independently when they went out on their own. Another person needed full assistance of staff to prepare their meals.

People had access to healthcare services when required. A social worker told us, "The Fitzroy (Hampshire Supported Living) team is consistent in promoting good health for people through monitoring of their food and fluid intakes, encouraging intake of food and fluid; keeping records, liaising with the GP and other involved professionals." Records confirmed people had access to a GP, dentist, podiatrists and an optician and that they attended appointments when required. Where people had more complex needs, the provider had made the appropriate healthcare referrals, such as to speech and language therapists to ensure that they received timely healthcare interventions.

People had a healthcare file which described the support they needed to stay healthy. This involved documenting the outcome of recent health appointments and evidencing how these outcomes had been implemented into people's care plans. The service manager told us this document, "Ensures that the professionals can access important information straight away." People also had a 'hospital passport' in their care files. A hospital passport is a document providing information about a person's health, medication, care and communication needs. People took it to hospital if admitted to help medical and nursing staff understand more about the person.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were caring and attentive to their needs. One person said, "The staff are lovely." Another person said, "Staff are all nice." One relative commented, "The staff are very good. They have tried hard to make my relative's house homely." A second relative said, "One or two staff in particular have a great relationship [with my relative]." A third relative reflected, "[My relative] loves it where they live. They get on very well with the staff."

People were given choice and were involved in making decisions about their care. One person said, "I can do what I want to." A relative commented, "[My relative] is given a lot of choice about things like what they want to eat and what they want to do." A social worker told us, "The service is good at promoting choices for residents and working towards achieving their goals. Staff involve residents in shopping and preparation of their meals, choosing healthy options." Each person had a 'keyworker'. The keyworkers role was to work closely with a person to help ensure their decisions were respected and their needs were met. As part of this role, 'keyworkers' regularly met with people to review how they were finding their staff, activities and general care and to look for areas of improvement. Some people were unable to feedback verbally, so used a range of symbols and communications aids to give their feedback.

In some cases people who shared a house would have 'house meetings' facilitated by staff to discuss important issues. The service manager said, "In some of the homes 'service user meetings' or 'tenants meetings' are held and this brings together the views of all of the people who might share a home. The people we support can then decide on important issues within their home." In one such home, people decided that they wanted an all-female staff team. One person said, "I choose the staff I like." Staff worked with people to identify particular characteristics in new staff which they desired. This was achieved by identifying which areas people required support in and what skills staff required to best support them to achieve this. In this case people had chosen to only have female staff as they felt more comfortable receiving support with their personal care from females. Staffing rota's confirmed this preference was honoured.

There was mixed feedback from relatives about how well the provider communicated with them about their relatives care. Most relatives felt the provider had effective communication systems in place. Comments included: "When an incident crops up, the communication is really good", "They [staff] always give me updates and phone me up if something happens", "We have been able to get prompt contact and responses from managers when we have asked", "I am promptly kept updated by Managers and Care Staff concerning occurring incidents" and, "The communication is really good." A social worker commented, "Fitzroy is openly communicating with families and relevant professionals."

However, some relatives felt that the provider did not always inform them in a timely manner about changes and decisions about their family members care. One relative said, "Fitzroy have communicated well, but often it is after things have happened. I would prefer to know about things happening in advance." Another relative told us, "I feel like I get most of the information from [my relative] rather than through updates or conversations with Fitzroy." A third relative commented, "I feel like the communication is a bit lax. Sometimes management are slow to get back to us."

We brought this mixed feedback to the attention of the service manager. They told us they had identified communication as an area where improvements could be made. They had introduced a variety of strategies to improve communication with relatives. Some people and their relatives now had monthly review meetings with the service manager to discuss how the care arrangements were going. Other people's relatives had worked with the provider to develop a weekly report that was emailed to them with key information about their relatives, activities, appointments and wellbeing. The deputy manager told that these reports had helped to establish more effective communication with relatives and they were always open to feedback about how communication could be further improved.
People were supported to be as independent as possible. The service manager told us "Encouraging people to take part as much as they can or wish to, in all aspects of their life is important." People were encouraged if possible to access the community independently to carry out daily activities such as shopping or attending day activities. Where possible, people were encouraged to manage small budgets which they could buy everyday items with. People told us how they were encouraged to develop their independent skills around their home. In some cases this related to managing aspects of their personal care needs. People's goals in relation to their independence were identified in their care plans. These goals were broken down into achievable steps, which meant people could review their progress against the goals set. One person had set a goal to access the gym independently and was working towards this.

The service had implemented the use of technology to promote people's independence. In one example, one person was encouraged to use a voice activated electronic speaker device to support them to independently manage their continence needs. Staff had arranged for the device to provide prompts to the person throughout the day in order to remind them to use the toilet. This had resulted in the person needing less support from staff and becoming more independent.

People were treated with dignity and respect. Staff were conscious to respect people's homes and be as unobtrusive as possible. Examples of this were staff knocking on doors and asking permission before entering people's homes and they talked to people patiently in a respectful manner, which people were comfortable with.

People's privacy and confidentiality was respected. Where people were in their own homes, staff were conscious to ensure that care documentation was stored securely out of sight. This helped to promote people's confidentiality and helped to ensure that people's homes felt like their own homes, as opposed to a formal care setting.

Good

Is the service responsive?

Our findings

People's relatives told us that staff were receptive to their family member's needs. One relative said, "Staff are very responsive and deal with challenges well."

People's care plans contained detailed information about people's backgrounds, relationships, hopes and wishes. Each person had sections in their care plan detailing their life history, which gave staff an understanding about people's backgrounds, motivations and aspirations.

People's care plans reflected their preferences regarding personal care needs. Each person had a document in their care plan which captured what 'a good day and a bad day' looked like for the person. This detailed the things that motivated people and provided staff with strategies to help and encourage people if they were reluctant to engage with their personal care routines.

People's care plans were reviewed as people's needs changed. When people received input from external professionals such as speech and language therapists, their care plans were updated to reflect these changes. The service manager told us they had recently reviewed all people's care plans and were in the process of transferring these documents into a new standardised format.

The service had complied with the Accessible Information Standard by identifying, recording and sharing the information about the individual communication needs of people with a disability or sensory impairment. People's individual communication needs were recorded in their care plans. Care plans included strategies staff needed to follow in order to provide effective support to meet their communication needs. Where people required additional support around their communication, the provider had arranged for communication training for staff to promote effective communication strategies to use with people. For example, one person communicated using Picture Exchange Communication System (PECS). Pecs is a communication system which allows people with little or no communication abilities to communicate using pictures. The service manager had recognised that staff needed additional support in order to use this system effectively and had arranged training for staff in this area. They told us, "We have arranged for communication training for me and [person's keyworker]. This will enable us to cascade knowledge and resources to all staff."

People were supported to follow their interests and take part in social activities. Each person followed an agreed set of activities as part of their care plan and used their commissioned hours of individual support to access this programme. Examples of activities that took place included: people attending day services, local social clubs, and leisure and sporting clubs. The provider had set up a series of day services, vocational opportunities and social networking initiatives which people accessed to build their skills and expand their social network.

People were encouraged to maintain relationships which were important to them. Details of important relationships were identified in people's care plans. The method and level of support people required to maintain these relationships was also identified in people's care plans. One relative told us, "The staff help

to facilitate video calls to us and we appreciate that."

There were appropriate systems in place to deal with complaints. People told us they felt comfortable in making a complaint. One person said, "I would talk to staff." The provider had a policy in place which detailed the way in which complaints would be investigated and responded to. The policy had been adapted to incorporate simplified language and symbols suitable for people it had been provided to. This allowed people to access and understand how to make a complaint. Records of complaints showed that the provider had investigated all concerns raised and had written to people or relatives with the outcome of their investigations.

People were supported to make decisions about how they would like to receive care at the end of their lives. Staff worked with people and their families to identify people's preferred care arrangements if they were to require end of life care. This included identifying people's spiritual beliefs, funeral arrangements and the people they would like with them when they were unwell. This information was captured within an 'end of life care plan'. This helped to ensure that people's wishes were considered in the event they required such care.

Good

Is the service well-led?

Our findings

There was a registered manager in place. 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 currently on planned leave from working at the service. In the meantime, two service managers were overseeing the running of the service. There were three deputy managers in place, whose role it was to oversee a designated number of supported living projects and people's care.

People's relatives told us they felt the service was well run. One relative said, "The service manager has their work cut out. It's a challenging role, but they have done well." Another relative, commented, "The service manager gets practically involved and pitches in where they can." A third relative reflected, "I feel like Fitzroy have a strong, person centred ethos and the managers there reflect this."
The service manager's and deputy managers were practically involved in the day to day running of the service and were available to provide support to people and staff. Each member of the management team were assigned to manage the day to day staffing and support needs of a designated number of people. Within their role, they would regularly meet with people and work alongside staff. If people needed support to get to appointments or required additional support at short notice, then the management team would offer this support. An example of this was on the 2nd day of inspection, where the service manager went to assist staff after a person had become anxious at a day service they were attending. The service manager helped staff to de-escalate the situation and supported the person to return home safely. This demonstrated that provider's management team was visible and understood the day to day culture within the service.

There were effective systems in place to monitor the quality and safety of the service. The provider had taken on a number of people's care packages from different providers. After taking over, deputy managers conducted quality audits of each individual care package, which focussed on assessing how, safe, effective, caring, responsive and well led each individual service provided within each supported living property was. The audit included areas relating to people's care needs, healthcare needs and support around their tenancy and home safety. Each supported living property had an 'action plan' in place which identified where improvements were needed. As this was a working document, the 'action plan' was regularly being amended and added to reflect the ongoing changes in people's needs.

The service manager regularly reviewed the action plan to help ensure that all actions identified were followed up. This helped to ensure that the provider understood the key challenges in providing and maintaining good quality care. The action plans had also been formulated in conjunction from feedback from social workers. One social worker told us, "Fitzroy is focused on delivering a high quality service but there have been some identified areas that needed improving .I think the provider has demonstrated an effort to work together and make improvements." In one example, the deputy manager supervised then monitored staff handover for a period of time. This was to help ensure staff understood what information

should be passed onto incoming staff. This helped to improve communication between staff about people's health and wellbeing.

The deputy managers also carried out regular audits in key areas to help ensure quality and safety. These included health and safety audits and infection control. The provider also had a system in place where support documentation such as Medication Administration Record charts, daily logs and financial transaction records were regularly returned to the office and audited. This helped to ensure that management picked up any issues, errors or irregularities. The service had recently made changes to its auditing processes around financial transactions to provide additional checks to safeguard people's money. This helped to ensure that there were robust systems in place to monitor key areas of the service.

There was an open and transparent culture within the service. Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory activities. We checked through records and found that the provider had met the requirements of this regulation. For example, the registered manager had notified CQC in good time about their planned absence from the service and the management arrangements in their absence.

Staff told us they felt confident raising concerns to the service manager and referred to the provider's whistleblowing policy as guidance to follow if they had further concerns. The provider's whistle-blowing policy provided details of external organisations where staff could raise concerns if they felt unable to raise them internally.

The provider had made a commitment to help people integrate into their local community. This included working with local shops by introducing people and staff to business owners, so they were familiar with people's needs. This helped people to safely access shops as proprietors were familiar with people and their needs around communication and anxiety. The provider also ran a series of day services, vocational day services, friendship finding services and social events which people could participate in if they wanted to.

People were involved and consulted about the service and their wider support needs. People participated in a 'local implementation group' run by the local authority. These meetings were attended by adults with learning disabilities, family and carers, providers of care, commissioners and other professionals, with the aim of providing feedback to the local authority about current services and support available to adults with learning disabilities. This helped to ensure that people had the opportunity to give feedback about their experience of receiving care services.

The provider worked in partnership with other stakeholders to monitor and improve the quality of the service. The provider had signed up to a number of external accreditation schemes which focussed on the safety and quality of care services. These included 'Driving up Quality Code'. The Driving Up Quality Code is a national initiative which outlines good fundamental practices and behaviour that organisations that support people with learning disabilities need to be committed to. The service had also signed up to 'The Social Care Commitment.' The Social Care Commitment is a voluntary agreement about workforce quality between all parts of the adult social care sector in England that has been developed by Skills for Care. These initiatives helped the provider to benchmark its own behaviour and practice against nationally recognised standards of conduct.