The Brandon Trust

Brandon Trust Supported Living - Wiltshire

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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Brandon Trust Supported Living – Wiltshire on 17 and 18 May 2018. The inspection was announced. At the time of our inspection Brandon Trust were supporting 12 people who were living in their own homes.

This service provides care and support to people living in eight supported living settings, 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.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy.

There were three registered managers in post. 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.

At our last inspection we rated the service as good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People told us they were safe. Staff were knowledgeable and knew how to recognise and report any concerns. Risks to people's safety were assessed and recorded with guidance for staff on how to manage those risks. Medicines were stored, administered and managed safely.

People were supported by staff who had the training, skills and knowledge to undertake their role effectively. Staff had access to one to one support from their line manager.

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

People told us the service was caring. People's achievements were celebrated in 'good news stories'. People and staff had developed positive, compassionate and trusting relationships. Care and support plans were person centred. People were treated with dignity, respect and kindness.

People received care which was responsive to their needs and accommodated changes when needed.

There were a variety of activities available according to individual likes and dislikes.

The service was well-led. People and their relatives told us they thought the service was well managed and organised. The registered managers had systems in place to audit and monitor the quality of the service. The values of the service were demonstrated throughout the staff group.

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 remained safe.

Is the service effective?

Good

The service remained effective.

Is the service caring?

Outstanding ☆

The service has improved to Outstanding.

People and staff had developed positive and trusting relationships.

We observed kind, compassionate and attentive interactions.

People were treated with kindness, dignity and respect.

The service promoted a person centred culture.

Staff understood people's individual needs, which enhanced their life experiences.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service remained well-led.

Brandon Trust Supported Living - Wiltshire

Detailed findings

Background to this inspection

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

The last inspection published on 14 March 2016 found that the service was rated good.

This comprehensive inspection took place on 17 and 18 May 2018 and was announced. We gave the registered managers 48 hours' notice of the inspection to ensure they were available at the time of our visit, and to make appointments to visit people at home. This inspection was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider 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 improvements they plan to make. We reviewed the PIR and other information we held about the service prior to the inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We visited the office location and looked at a variety of records relating to the management of the service. These included six people's care plans, six staff personnel files, policies, procedures, audits and quality assurance documents.

We visited 12 people living in the Devizes and Trowbridge areas, where we spoke with people about their care and saw their care records. We spoke with 16 members of staff, four relatives and two visiting professionals.

Good

Is the service safe?

Our findings

People told us they felt safe with the staff who supported them. Comments included, "Yeah, I'm safe, I'm okay", "The staff are kind, help me" and "They [staff] are here at night." All the relatives we spoke with said that their family members were safe. One relative told us, "Yes I think he is very safe" and another said "I have no concerns at all."

Staff were knowledgeable about safeguarding and their responsibilities to report any concerns. Staff we spoke with confirmed they had received safeguarding training and were able to say what they would do if they witnessed abuse. This included contacting outside agencies such as local authority safeguarding teams and the Care Quality Commission. The service had a safeguarding policy in an easy read format. These covered types of abuse and neglect, what to do if you were abused or neglected and what will happen next. Procedures were displayed in the office and in the service locations.

The service had introduced a 'Safeguarding Panel' consisting of a trustee, locality managers, team leaders and a person from outside the organisation, known as a 'critical friend'. They looked for any developing trends and to learn from the experience of others with regard to the management of safeguarding issues. Minutes recorded from a recent meeting of the panel showed that outcomes had included a review of current best practice with regard to communication with families and staff, and a review of the level of compliance with staff safeguarding training. Also, following an increase in reported slips, trips and falls over the previous year, the service had identified the need for further staff training, which had been acted upon. Statistics for the first quarter of the current year indicated a decline in frequency.

Staff were also knowledgeable about their responsibility to whistleblow. Whistleblowing is the term used when a worker passes on information concerning wrongdoing. Whistleblowing procedures ensure that the whistle blower is protected from reprisals when they raise concerns of misconduct witnessed at work.

One person's care plan had a 'financial passport' which had safe arrangements in place for assisting them to manage their money. Guidance was in place showing how to support the person in a practical way whilst also enabling them to be involved in the process. For example, '[Person] needs help to hand over items so they can be paid for'.

People were protected from risks. People's 'plans for life' folders, contained individualised risk assessments. For example, travelling in a car or mini bus, preparing meals, epileptic seizures, fire evacuation, medicines, challenging behaviour and being out in public. All risks were evaluated for likelihood and severity or consequence, using the service's risk assessment matrix. Detailed guidance for staff had been documented as well as the actions to be taken. For example, one person had a risk for accessing the community in the mini bus. The assessment highlighted which safety measures would be used to eliminate or minimise the risk. For this person, two members of staff would be trained in manual handling techniques and would ensure the person was strapped in correctly. Risk assessments had been regularly reviewed by staff, team leaders and locality managers.

People were supported in positive risk taking to maintain their independence. Positive risk taking is weighing up the potential benefits and harms of making one choice over another. One person's risk assessment gave detailed guidance on how to support the person to maintain and understand relationships, whilst ensuring the situation and people involved were kept safe from potential abuse or harm.

Each home had a 'working safely folder' where risk assessments and health and safety checks were recorded. These included, electrical safety, food hygiene and storage, fire checks, water temperatures as well as the employer's liability insurance. Checks on people's homes were carried out weekly and full health and safety assessments annually. The health and safety assessment was comprehensive and covered areas relating to staff knowledge and practice, to safety of the premises and any actions to be taken.

A system was in place to report accidents, incidents and near misses. Staff completed a daily report sheet that contained a section relating to whether the person they were supporting had any accidents or incidents. Team leaders and locality managers received written reports and recorded any follow up action required. The reports included a body map to locate and describe the site of the injury (if applicable). Locality managers logged and reviewed forms to look for recurring themes and trends to prevent re-occurrences. The provider had an on-call system in place for staff to be able to contact a registered manager or team leader at any time.

The provider had followed safe recruitment procedures. The staff recruitment records seen showed all the required safety checks relating to past employment, references, identity checks and DBS were in place. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

There were sufficient numbers of skilled staff available to meet people's needs. People confirmed that there were enough staff to support them and they regularly saw the same staff. One relative commented about staff retention that there had been "some improvement over the last six months." A staff member told us "There were enough staff now to support [people]" and added "There's more continuity of staff." Another staff member confirmed this stating "We've had a brilliant team over the last six months. Continuity is much better and we are able to cover illness with bank staff who know them [people] now." During our visits to people's homes we observed sufficient numbers of staff who spent time interacting as well as carrying out practical aspects of support.

People's medicines were managed and administered safely. Medicine Administration Records (MAR's) we saw in people's homes had been completed accurately. Medicines were administered according to people's prescriptions. There were two signatures for handwritten entries and amendments. Protocols for 'as required' (PRN) medicines such as paracetamol were in place. Further checks that medicines had been administered were recorded on daily handover checklists and daily report sheets. Staff confirmed that they had received training in medicines management and that they had undergone competency checks each year. These included a theory and a practical test.

People's homes were clean and cleaning records were up to date. Staff had access to disposable gloves and aprons and staff confirmed that they had received training in infection control practices. Related risk assessments were in place. Cleaning products were stored safely in compliance with CoSHH. Under the 'Control of Substances Hazardous to Health' Regulations 2002, employers need to either prevent or reduce their workers' exposure to substances that are hazardous to their health. The service had developed an infection control auditing tool to identify infection control requirements within their specific services and to implement change once this had been identified. It also allowed the manager to see where good practice

was achieved.

Good

Is the service effective?

Our findings

People's needs and choices were assessed to ensure those needs could be met. People's 'plans for life' detailed their preferences and the ways staff could assist them to make choices. One person's plan for life detailed how the person could be assisted to make decisions with limited communication abilities: '[Person] is reliant upon others to interpret [their] non-verbal communication and anticipate [their] needs and wishes based upon their knowledge of [person], [their] reactions and through trialling new things and gauging [their] reactions.'

A staff member gave an example of how the support given to one person had helped achieve an effective outcome. A person they supported used to give limited verbal responses, saying either yes or no. Through trying new methods of communication, the staff member described how the person was now able to speak on the phone and often sang. They said "I sing along as well. It's really great to see the progress they've made."

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. The provider's mandatory training was comprehensive and was delivered alongside the care certificate. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life consisting of the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This included duty of care, work in a person-centred way and equality and diversity. Staff were supported to complete their level 2 and 3 CACHE diplomas (Council for Awards in Care, Health and Education.) Staff who were new to care took additional modules in the care certificate.

Staff told us they had received the training they needed to meet the individual needs of the people they supported. For example, Makaton (Makaton is a language programme using signs and symbols to help people to communicate); epilepsy and behavioural support. One staff member who had training on relationships and sexuality was able to devise strategies to support a person by using a Wiltshire Council on line safety programme. They had supported the person to understand the meaning of the things they saw and heard relating to developing relationships, sexuality and sexual relationships. A mental capacity assessment and best interest decision was completed. This was a good example of enabling positive risk taking and using the least restrictive option, whilst keeping the person safe. The service had an easy read version of their new 'relationships, sex and sexuality' policy for people using the service to read.

A staff member described the training and support they had received as "Very good. It covered all I needed. I was given a mentor as well to support me." Another said of the support they received when they first joined Brandon Trust, "They were superb. I don't think you could beat it, the support I received from the team leaders and managers." They said that they had undertaken seventy five hours of shadowing shifts in order for them to get to know the people they were supporting.

A registered manager had completed 'train the trainer' training in medicines administration for epilepsy. Another registered manager was supported by the provider to train to become an in-house BILD (British

Institute of Learning Disabilities) accredited PRT (positive response training) trainer and advanced practitioner for behavioural support. PRT is used in respect of those people whose behaviour might challenge others. Staff had behavioural support introduction training when starting employment and they were able to access a more comprehensive course if they were involved in supporting people who required it. The locality manager said, "It has increased my skills and knowledge for Brandon Trust, which is then delivered free to staff. It is practical and theory based."

People were supported by staff who had supervision (one to one meetings) with their line manager. They confirmed that they had attended supervision sessions every two months and they felt they were able to have their say and raise issues if needed. Staff had an annual appraisal. A 'supervision tracker' was in place to closely monitor when supervision was due, what objectives were set and when they had been completed.

People were supported to have enough to eat and drink according to their needs and choices. People said or indicated that they felt they had enough to eat and drink, and confirmed that where necessary, staff supported them with preparing meals and food shopping. One person was supported to make their meal choices by being shown pictures of various meals that they had previously shown a preference for. Those pictures were then displayed on a menu board.

Another person was supported to eat and drink via a gastrostomy feeding tube. Staff supporting this person had specific training from a specialist nurse advisor. A dietician had developed guidance for staff to administer the person's measured dietary and fluid intake. This was monitored by the dietician on a three monthly basis. The person also received oral health care to keep their mouth moist and to offer them flavours.

The provider had developed an in-house newsletter, 'Good News Stories'. Comments added from two members of the community team for people with learning disabilities (CTPLD) included, "You really did go over and above in your support for [person], thank you" and "Can I take this opportunity to thank you and your team for all your support over the last year. Having someone who is so approachable and willing to work alongside makes all the difference." Another professional told us "Support staff are able to problem solve and will go above and beyond to ensure that things happen. Example being that [person's] wheelchair broke and they took it for repair as an engineer could not come to them. This wasn't something that they had to do but were willing to do this to support the customer and their family."

Staff said that monthly team meetings were held in order to discuss the needs of the people they supported. One staff member added "Brandon Trust are happy for us to put anything in place that we need to."

People were supported to have access to health care. A registered manager reported that support workers had noticed an escalation in one person's behaviours possibly due to a medical condition they had, or from being in pain. They arranged for the person to be reviewed by their GP, dentist and a behavioural nurse specialist. The person was subsequently admitted to hospital for assessment and received appropriate treatment. A support worker reported that there had been a gradual improvement in the person's behaviour following the treatment they received.

Peoples plans for life folders contained individualised health action plans. They had annual healthcare assessments along with letters from hospital consultants, GP's and members of the CTPLD. A 'hospital passport' had been developed which detailed people's support needs should they be admitted to hospital. Where able to respond, people confirmed that they were supported to attend appointments with healthcare professionals.

People's homes and rooms were decorated to their tastes. The homes were adapted to the needs of each individual including equipment and access. Some homes had undergone structural changes or improvements to accommodate wheelchairs. They also had homes adapted for people with specific needs related to their autism, for example, wide open spaces with a minimalistic design to easily de-clutter.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. For people receiving care in their own home, this is an Order from The Court of Protection.

The provider used detailed capacity assessment forms for specific decisions, in line with the Act. The forms recorded people's communication skills, such as how they indicated 'yes' and 'no', and the person's preferred method of communication. The decision making process consisted of the person being asked a series of questions about the decision such as 'Can you tell me about [the proposed issue/activity], 'What are the benefits/good things' and 'What are the risks/bad things'. The person's capacity was determined by their responses to the questions. Where the person had been assessed as lacking capacity for the particular decision, a best interest decision form was completed, which listed the people consulted during the process along with the outcome of the decision.

Easy read policies had been produced about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The policies informed people that they could request an Independent Mental Capacity Advocate (IMCA) for support if they wished. We saw copies of these policies in the main office locations and in people's homes.

Staff were knowledgeable about the MCA and confirmed that they had received training about mental capacity and deprivation of liberty safeguards. When asked what they would do if a person declined their support one staff member said "We have to report that. You can try a different approach but it's their choice in the end." Another said, "I'd try again but it's their choice if they want to do something or not." Consent forms using pictorial images to aid communication were in place.

Outstanding ☆

Is the service caring?

Our findings

People told us the staff were caring. They benefitted from staff who were committed to providing a kind and compassionate service. Comments included "Yeah very caring and kind." and staff were "kind and happy, nice." Another person made a happy gesture when asked the question.," We observed many caring interactions between people and staff. Friendly, gentle and kind with lots of joking and laughing together. People and staff were relaxed and enjoyed being in each other's company which showed they had developed close and trusting relationships. One person told us that the staff who supported them were "my friends."

For one person who was non-verbal and had limited interaction ability, we observed staff talking with them about everyday things happening around them, such as who was walking by or what the weather was like. The staff spoke gently, asking permission to do actions such as movements or wiping their mouth. They chatted to them about what was happening next, involving them entirely in the daily routines of the day. This meant the person was actively involved in everyday life and had positive human contact and dialogue, even though they were unable to verbally or physically respond.

Staff were highly motivated and enthusiastic to deliver a high quality service to the people they support. Comments included, "The whole ethic is to treat [person] as everyone else" and "The [people] are the bosses. They run the show and it's their home." For another person who was non-verbal in communication their support worker told us, "When there is eye contact, there is a connection, it is a meaningful contact." Staff said that they would be happy for a relative of theirs to be supported by The Brandon Trust. One staff member said "Absolutely. Going that extra step, giving people independence. Seeing the joy people get out of a fulfilled life; that culture comes from everybody I work with."

Relatives spoke highly of the caring nature of staff and the positive relationships staff had formed with their relative and their family. Comments included, "[Person] didn't think they would have the quality of life or life expectancy anywhere else" and "Staff are great and really know [my relative] well, they go over and above to give [person] a good life."

Two staff members told us that when the person they were supporting was ill and needed to go into hospital, they took turns to stay with them in hospital. They told us "It's not fair on the [person] if they are on their own." This meant that the person felt secure with a familiar face at an anxious time.

The Brandon Trust operates a 'Dream Fund' which is fully funded by their sponsors, from donations and from a staff lottery where 50% of all proceeds goes to the people they support and 50% to make up the prize fund. Staff commented that this made them feel part of the whole 'Brandon family'. Staff could apply on behalf of the people they supported for things like specialist equipment, furniture or specific activities. A registered manager told us how they had also applied for funding for regular outings for a person who was becoming more visually impaired. This meant that they could see things that they had always wanted to, before their sight deteriorated further.

The Brandon Trust 'Good News Stories' reflected on people's achievements locally. For example, one person had been advised by their GP that they should lose weight to improve their general health. With the support and encouragement of staff they learnt how to recognise the healthy eating information on food packaging and commenced a healthier diet. They lost a significant amount of weight and were continuing their healthy diet. Their achievement was celebrated in the Good News Stories newsletter.

The provider was caring towards its staff. New staff members were supported by a mentor. The induction process involved equipping staff for their role as well as making them feel part of a larger network of support. A new development has been 'coaching' for staff to step-up their skills and improve well-being. The registered manager told us that they were addressing the needs of their staff to ensure they were supported with their own mental and/or physical health with a 'well-being' passport.

Staff provided a person-centred service to the people they supported. Plans began with a one-page profile, which detailed important facts about the person such as, 'what is important to me' and ', 'this is what people like and admire about me'. This information ensured that care and support was firmly focussed around the person being at the centre. Plans also contained personalised information relating to decision making, how the person was involved in developing their plan and how their plan was reviewed. There were details on how the person wished to be supported such as; 'Positive interaction with me looks like this', 'This is how I feel and respond to physical contact', 'What I can do for myself' and 'This is how you can make me feel safe.' All support plans provided evidence that people had been involved in deciding the support they required.

One person had been supported to travel independently. This was one of the objectives they had identified as something they wanted to achieve. In various stages over time, the person was supported to find out which bus they needed, where they got on the bus, how to pay for the trip, where to get off, what happened if they missed their stop etc. This achievement had strengthened the person's confidence and enabled them to have autonomy in their life. The registered manager told us "[Person] was so proud, we were so proud, [their] face was beaming."

One person had requested to manage their medicines independently and this work had just started. It involved risk assessments and many stages of support, working towards the person's goal. It was hoped that this would empower the person to be more independent and actively involved in their own care and treatment. The person was very keen and excited to be starting this and told us, "I'm going to start doing my own [medicines], aren't I [name of staff]? Yeah I wanna do them myself."

People were involved in 'The Hundred Voices' project. People from all over the Trust met up and had talks on animals, music, driving up quality events both nationally and locally. There was also a presentation awards ceremony given to people around 'doing things that were hard'. This recognised people's strengths and acknowledged the hard work they had put in to achieve their aims.

One person told us they could call for help when their support worker became ill. The person had previously been guided to know what to do in an emergency. They called the on-call member of staff. This made the person feel proud and capable, they told us "I knew what to do, I rang the on-call number."

Another person who had a visual impairment, told us they were fully involved in the interviewing of their potential support worker. Brandon Trust and a peer did the first part of the interview process (the selection process) and the second part was undertaken by the person.The staff member was asked by the person, "Have you ever guided? Can you cook? Which team do you support?" This meant the person could direct their care and choose staff who would share interests and be able to support them in the way they wanted.

The Brandon Trust had recently developed a relationships, sex and sexuality policy which was available in an easy read format for people.. It had been produced in response to the service recognising that people had questions and had shown an interest in developing more intimate relationships. This enabled people to have safe relationships if they chose and gave guidance for staff on how to support them. People spoke of their relationships openly with staff and were actively engaged in discussing how to manage certain situations. For example, one person had been receiving texts from another person and was not sure how to respond. This showed that the person had a trusting and open relationship with the staff member supporting them and sought guidance when needed.

The Brandon Trust had also developed a new LGBT (lesbian, gay, bisexual and transgender) social group in Bristol, which people using the service in other areas were able to access if they wished.

People's dignity and privacy were respected. We observed staff always asked permission to go to different parts of a person's home, for example "Can I just pop this in the bathroom [person's name]" or when visiting they would ask "Can we come in [person's name]?", ensuring the person made their own decision to answer the door bell or decide where people were to sit. People who shared a home were encouraged to use all parts of the communal space as they wished. They were also able to choose to spend time alone in their rooms if they wanted to be by themselves. We observed staff knocked and waited for a response. One person's support plan contained statements about living with others that included the following agreements; 'Do not go into other people's rooms when they are not at home; knock before entering any room; leave communal areas clean and tidy and share chores fairly.'

A professional who worked alongside staff at The Brandon Trust told us, "I have also seen staff be forward thinking, responsive and exceptionally kind and caring not only to the people they support but also to their families as well. Staff go above and beyond to give a good service and have built up some really lovely genuine relationships with the individuals they support."

Comments from staff included, "We are not controlling them; but they can have our support if they need it", "Their care is all about consistency and quality of life", "It's about supporting people in the way they deserve" and "I love being with Brandon Trust, I love their values and I can't fault them, I just love my job."

When asked what they felt was the best thing about Brandon Trust a relative told us "I like the fact that they are treated with dignity and respect. I think they live a pretty good life." Another said, "[Person] is treated like any other person, [person] is now so independent"

Good

Is the service responsive?

Our findings

People were assessed to ensure their 'plans for life' were person centred and met their individual needs. Copies were available in people's homes and online. They included a community care assessment (CCA) that generated outcome based support plans. CCA's covered issues such as improving health and emotional well-being, quality of life, making a positive contribution, increasing choice and control, freedom from discrimination and harassment, economic well-being and managing personal dignity and respect.

Plans detailed how staff could support the person with a variety of needs including, eating and drinking, personal care, living with others, education and employment, emotional health and well-being, and complaints. Behavioural support plans detailed any behaviours of concern along with descriptions of 'base line' behaviour, possible triggers, proactive management and recovery and post incident behaviours. 'Base line' behaviour refers to the beginning measurement of a person's usual behaviour presentation.

Staff had handover meetings where they discussed people's current needs. Daily report sheets were completed, which contained details such as what the person had eaten, what activities they had undertaken, whether they had a shower, and any appointments they might have attended. Staff also used an aide memoir in the form of a daily handover checklist to remind them of the person's daily needs such as 'Check that [person] has in his rucksack emergency meds, wallet, money, bank card, bus pass, sandwiches and snacks.'

Some of the homes we visited were occupied by one person requiring one to one support. This meant that staff could get to know the person's needs well and were able to gain their trust. In one case a staff member stated that the person was being supported by a total of four support workers who had worked with them for between two and five years. This ensured both continuity and a good knowledge of their needs. One staff member told us they looked at people's support plans and felt that they were an accurate reflection of their needs. They said "I read everything; they're useful and you can add bits to update them."

The registered manager told us "We adapt to the needs of the people being supported, for example, we have some very small services of just one person being supported independently. We have had to go over many hurdles to get things right, for example when we have taken on people from other services and it took more than a year to accommodate and settle them appropriately."

The registered manager also told us "Some people have flourished from having 1:1 support but it is hard and intensive for the staff." Staff were supported by working shorter part time hours, sharing the support within a team. For one person, the larger team of support staff had also reduced the experience of attachment issues, enabling them to develop more relationships.

They added "The downside to one person living independently is a potential lack of motivation. In a house where three people share they are constantly trying new things and motivating each other to do things." This was an area the service was monitoring.

Plans for life contained details of interest's people followed and were actively involved in. People confirmed that they received support to access a range of activities outside of their homes such as attending employment, day centres, swimming, shopping, meals out, social events and visiting relatives. Activities also included having access to assistive technology to play computer games, learning games such as life skills software and communicators to help participate in 'songs or prayers'.

The service was compliant with the accessible information standard. The accessible information standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service had easy read and pictorial formats for all information. The service had also developed a lending library of assistive technology for people to access and decide if it was suitable to their needs. Examples of equipment people borrowed were mobile phones, digital cameras and 'inclusive technology' message communicators.

A registered manager told us "All services have access to on line Brandon Trust forms such as ABC charts (antecedent, behaviour and consequence). This is the biggest part of the training, to use these properly we need a start and an end if we as a group are going to improve the quality of life for people and support the staff."

Staff were knowledgeable about the needs of the people they supported. They could describe people's behaviours and communication styles and how they were able to best support them. For example, one staff member could state the triggers that usually prompted a change in one person's behaviour and the interventions they put in place. They said "[Person] sometimes needs a change of environment or to be kept busy; and not to get too hot." They confirmed they had received training in positive behavioural techniques and added "social interaction is on [person] terms."

Concerns and complaints were managed appropriately. One person told us they would speak to a member of staff if they were unhappy. Easy read versions of the complaints policy had been produced and a copy of one was on display in the office and in people's homes. The policy informed the person that they could send their complaint to the Local Government Ombudsman or Care Quality Commission if required. A relative told us, "Any concerns and complaints [they had] raised were taken seriously and dealt with promptly. They described the communication with the service as "Recently it's been very good."

Where appropriate people were supported to develop end of life plans. The registered manager told us that all people were offered an end of life plan. Not everyone wanted to complete an end of life plan and in one person's care and support plan it was noted that their power of attorney (the authority to act on behalf of another person) had made the decision not to complete a Brandon Trust plan, having already made separate arrangements.

Good

Is the service well-led?

Our findings

There were three registered managers in post. The Brandon Trust had a clear management and staffing structure in place. The registered managers were responsible for people in different locations and managed the day to day delivery of the service. A staff member said of their manager "We see [registered manager] all the time. You can always talk to [registered manager], or we can pop into the office anytime." They went on to say "The management? I think they are brilliant." However, one staff member had a different view of the management saying "It's okay; they sometimes try to save money and cut costs and there's too many managers and not enough workforce."

Staff were motivated by the enthusiasm and commitment of the management team. A staff member described the management team as "Good, positive, caring and understanding. They are concerned and care for the staff and the people we look after. There's a good atmosphere and culture; it's friendly and nobody is cowed." When asked if the Trust were good to work for a staff member replied "I haven't got a bad thing to say about them." Another staff member said "A fantastic company; I've had some great experiences. [Registered managers] have been fantastic, as have the team leaders. I have always been able to talk to them about any issues I've had."

People were encouraged to join the Members Board, be involved in Brandon Voices and form part of the interview panel of new senior managers. These groups helped to gather people's views, form policy making and involve everyone in a collective ownership of projects. Inclusivity is a key element to the ethos of The Brandon Trust. Many of the Trust's policies had been produced in an easy read format that included pictorial representations, for example safeguarding, the Mental Capacity Act and complaints.

The Brandon Trust quality assurance programme was based on the 'key lines of enquiry (KLOE)' used by the Care Quality Commission. Services were audited to see if they are safe, effective, caring, responsive and well led. Each of these domains was audited throughout the year and action plans were put in place in response to findings. Team leaders and locality managers were involved in the auditing process and the system ensured that team leaders and managers from different localities checked the accuracy of each other's audits for objectivity. If the team leaders found the checks hard, they had it peer reviewed to highlight good areas and where to develop things.

It was brought in when the KLOE processes changed and they wanted to see where things had developed, and what still needed to be achieved. Guidance was then developed for all the teams to follow and there was a comprehensive monthly timetable of what to focus on. This was then rolled out continuously throughout the year.

The registered manager told us "Harsh marking makes consistency, we are constantly asking are we checking incident records, are we checking everything? We do the desktop review and then a visit to the service to make sure it is the same. We talk to the people who are using the service according to capacity and communication issues." One staff member described staff undertaking the quality assurance reviews as "Very diligent" and added "we are made aware of what needs to change," citing an improvement in

handover procedures following an audit finding.

There was evidence to suggest that people were engaged and involved at many levels. For example, a 'Driving up Quality' event was held annually, whereby people supported by Brandon Trust, their relatives and supporting health and social care agencies, board members and commissioners were invited to meet with managers and staff to celebrate any successes and discuss any issues they might have. A registered manager said "We focus on what the Trust does well, celebrate achievements and moving forward. We also acknowledge what isn't working and recognise what has to be done about it. It gives stakeholders an opportunity to comment on what we could do better." They said that staffing had been raised as an issue at last year's meeting and they felt that efforts made since had improved the staffing situation.

A registered manager stated that people had been involved in the interview process for the Trust's new chief executive and other staff appointments. They said that the Trust was currently recruiting people using the service as 'quality checkers' as part of their quality assurance programme. This was paid employment and a two day course was held for those who were interested in the position.

Some people had become members of the Brandon Members Board (made up of representatives from all areas). Members were actively involved in arranging a safety day for people with learning disabilities and were working on producing a health and safety video. Footage of the safety day was made available on the internet. Minutes of meetings held showed that issues discussed included internet safety, fire safety, quality checkers and a forthcoming 'Local Voices' meeting, where people could learn of any developments and raise any issues.

The Trust had formed an 'Accessible Policies Group' in order for people to be more involved in the writing of policies and procedures relevant to them. They were asked to check them and to make sure they were easily understood and gave good information.

The Brandon Trust actively sought ways to learn and improve the service they provided. A registered manager told us "If appropriate always ask the people who are receiving the support. What is it like to be supported? How would you raise a concern? We are continuously checking it out with people. You want everyone to experience a very good service and everyone to have the appropriate training." A professional who works alongside the staff told us "There have been times when I have had to address issues with senior management around the level of engagement between staff and the people they support. There have also been issues with staff using their mobile phones whilst on duty which again I have highlighted with senior management and they have looked at how to resolve this."

The Brandon Trust worked closely with health care professionals, commissioners and partnership organisations. One professional told us "I have always found the management in every level to be approachable and responsive. If I e-mail or call then I always get an acknowledgement or response. I feel that communication is good and that any issues are discussed and sorted in a timely and appropriate manner. Brandon Trust know that they can approach me at any time and equally I know that I can speak with them." 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 inform us of reportable events.