The Together Trust

The Together Trust Domiciliary Care Agency

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 28 September and 10 and 11 October 2016. The inspection was announced. We last inspected the service on 24 October 2013 when we found the service to be meeting the standards in relation to all regulations inspected. At this inspection we identified one breach of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was in relation to governance.

The service was registered to provide personal care to people living in their own homes. This included supported living schemes that were based across Greater Manchester and 'outreach' services provided across the Greater Manchester and Cheshire areas. The outreach services were provided to children and young people, and primarily consisted of support for them to access leisure activities outside of school hours. However, a small number of people using the outreach service also received regular support with personal care at home. At the time of our inspection, 10 people were being supported who lived in the supported living schemes. The outreach services were providing support to 84 people, although not all of these people were receiving support with the regulated activity of personal care.

There was a registered manager 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.

People using the service, relatives and carers we spoke with all told us they were very satisfied with the service provided by Together Trust. Relatives told us the service was responsive and listened to them.

People using the service were supported by consistent staff teams, which helped staff get to know people well. Some people supported by the outreach service had one regular support worker who worked with them, and people in the supported living services had small teams of regular staff. The provider ensured there was sufficient time for people to get to know new members of staff if they needed to introduce a new staff member to the teams.

The service had access to in-house professionals including a psychologist and speech and language therapist. Relatives told us input from such professionals had helped their family members progress and build confidence. Staff worked alongside these professionals to provide effective support to people that reduced the need for reactive strategies to behaviours that could challenge the service.

Staff worked in ways to help ensure people were provided with the care and support they needed in the least restrictive ways possible. Staff were positive about supporting people to develop their independence and to build their skills. This including using special support approaches that staff had received training in to help people engage in tasks such as preparing drinks or meals.

Staff told us they were well supported and received good quality training that supported them in carrying out their role effectively. We saw staff had been trained in a variety of topics, including training in autistic spectrum disorders, safeguarding, medicines and positive behavioural support. Staff received regular supervision that helped ensure their competence.

Staff were motivated and committed. They spoke positively about the people they provided support to and were proud of the progress they had supported people to make. Staff were consistently positive about Together Trust, who they told us were supportive and interested in providing effective person centred support.

Peoples' support plans were person centred and identified their needs, preferences, strengths, goals and interests. We saw staff had regularly reviewed and updated support plans to ensure they reflected peoples' current needs. However, we found one care plan contained contradictory information in relation to monitoring a person's weight. The registered manager told us they would ensure this detail was clarified.

The service had taken appropriate steps to manage risks to people's health and wellbeing. However, we saw such steps were not always clearly recorded in people's risk assessments, which would increase the risk that support, would not always be provided consistently and safely. The provider took prompt action to address this issue shortly after the inspection.

Staff were aware of their responsibilities in relation to safeguarding and told us they would be confident to report any concerns to a manager or team leader. We saw concerns had been reported to the local authority safeguarding teams as required. However, the service had not always notified CQC when they had made such referrals as is a legal requirement. The service did not have a clear recorded overview of safeguarding referrals made, which would make it more difficult to ensure such incidents were adequately monitored.

The service regularly gathered feedback from people who used the service. There were systems and processes in place to monitor and improve the quality and safety of the service. Whilst we were confident accidents and incidents were closely monitored within support teams, this information was not always easily identifiable from the information held within people's care files or the audit documentation.

Staff had received training in communication, and used communication aids such as pictures to help involve people in their care planning and to assist them to communicate effectively.

People took part in a range of activities including visiting the library, taking part in sporting activities and attending day services. Staff had explored voluntary opportunities for a person who had expressed an interest in gaining work skills.

There was a thorough process in place to help ensure only staff of suitable character were employed by 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.

Medicines were managed safely. There was sufficient information recorded to ensure staff were aware of when people required their medicines.

Thorough processes were in place to help ensure only people of suitable character were employed to work at the service.

Steps had been taken to ensure identified risks to people's health and wellbeing were minimised.

Is the service effective?

Good

The service was effective.

Staff monitored behaviours that challenged the service with support from in house behavioural support practitioners and psychologists. Effective strategies were devised to proactively reduce any incidences of behaviours that could challenge the service.

Staff received frequent supervision and felt well supported. Training was provided in a range of topic areas, including training to support effective methods of communication and supporting individuals to engage in activities and learn new skills. Staff told us training was of a good quality.

Staff had a good understanding of the principles of the Mental Capacity Act. Staff had considered ways in which they could provide support, which was the least restrictive option.

Is the service caring?

Good

The service was caring.

People using the service and relatives were consistently positive about the caring approach of staff. Relatives told us staff supported the whole family.

Consistent staff teams supported people, which helped staff

develop positive relationships with people and get to know them well. The provider ensured new members of staff received sufficient time to get to know people whilst working alongside existing staff.

Staff were positive about supporting people to be more independent. They discussed using training they had received in specific approaches to support, to help people build skills and increase their engagement in activities.

Is the service responsive?

Good

The service was responsive.

Support plans were person centred and contained information about people's preferences, strengths and support needs. Support plans were treated as 'live' documents that were regularly reviewed and updated by staff.

Relatives we spoke with were consistently positive about the services response to any concerns they might raise. They told us the service was responsive, listened to them and always acted when they said they would.

People were supported to take part in a variety of activities based on their needs and preferences. This included leisure activities and holidays. The service had also explored volunteering opportunities for a person who had expressed an interest in developing work skills.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Staff were consistently positive about the provider and the support they received. Staff were motivated and dedicated.

There were systems in place to monitor and improve the quality and safety of the service. However, overviews of key aspects of the service were not always readily available. This included overviews such as the number of falls an individual had sustained, or the status of safeguarding referrals made to the local authority.

The Together Trust Domiciliary Care Agency

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 28 September and 10/11 October 2016 and was announced. We gave the provider 48 hours' notice prior to our first day of inspection. This was as the location provides a domiciliary and supported living service and we needed to be sure someone would be available to assist our inspection.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience did not visit the service, but carried out phone calls to people using the service, relatives, and carers to gain their views.

Prior to the inspection, we reviewed information we held about the service. This included previous inspection reports and notifications that the service is required to send us about safeguarding, serious incidents and other significant events. We reviewed the Provider Information Return (PIR), which the service had completed before our inspection. 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.

As part of the inspection we visited the provider's head office and a satellite office at a supported living scheme in Bolton. We visited one person supported by the supported living service at their home. We were unable to visit other people due to either issues around provision of consent or because they were not available at the time of inspection.

In addition to the one person we visited at home, we spoke with five people who used the service by phone during the inspection. We also spoke with eighteen parents, carers and relatives by phone. We reviewed records relating to the care people received, including nine support plans, daily records and records of medicines administration. We also reviewed records related to the running of the service, including audits, policies and five staff personnel files. We spoke with eight staff during the inspection, and an additional four staff by phone shortly after the inspection site visit. We spoke with 12 staff, which included the registered manager, a senior manager, seven support workers/senior support workers, the operations manager and two team leaders.

We sought feedback from the local authority quality assurance team, Stockport safeguarding, Stockport Healthwatch, commissioners of the service and other professionals, such as social workers who had previous involvement with the service. We received feedback from one commissioner of services, which is discussed in the body of this report.

Good

Is the service safe?

Our findings

The registered manager told us there were set hours of support provided to people supported by the supported living service. These hours were agreed with commissioners of the service, and most services had 'contingency hours' available that could be used flexibly to meet people's needs. Staff we spoke with at some of the supported living services told us the services were 'short staffed'. The registered manager told us there was a lot of 'good will' amongst staff, which meant the existing staff teams would cover any gaps in the rotas as overtime. Staff we spoke with confirmed this was the case. The registered manager told us that agency staff were occasionally recruited, who went through the provider's full recruitment processes with the view to them becoming permanent members of staff.

The registered manager told us there was a continuous process of recruitment for staff working within the outreach service. The senior manager showed us a tool that had been developed to help calculate the required number of staff to meet the hours of support the service was providing. This indicated there was currently a surplus of staff hours available. The registered manager told us they rarely had to cancel any outreach calls due to staff absence as team leaders and managers were generally supernumerary to the staff on rota and could provide support if required. None of the relatives of people using the service we spoke with raised any concerns about missed or cancelled support visits.

Individual risk assessments had been completed that identified potential risks to people's health and wellbeing, as well as ways in which staff should act to reduce the likelihood or impact of any such risk. This included risks such as epilepsy, nutrition, choking and self-neglect. Specific risk assessments had been carried out when required, such as for risks presented for people who required assistance with moving and handling or for specific activities or trips that people were planning on attending. This demonstrated the service had identified, and acted to reduce the risk of harm to individuals. Staff showed an appreciation of the importance of supporting people to take managed risks. One staff member talked to us about supporting an individual on a trip that was seen as presenting potential risks. A risk assessment had been completed for the activity, which would help reduce any potential risks, and they told us; "You can't be completely risk averse."

Despite these positive examples in relation to risk management, two people's care files we looked at identified risks that had not been reflected in the risk assessments. One person had sustained a number of falls and there was no falls risk assessment in place. We were satisfied with the actions taken by the service to reduce risks in relation to this person falling, which included seeking advice from a number of health professionals including the GP and a physiotherapist. However, the registered manager acknowledged this risk should have been reflected in a risk assessment. The provider sent us a copy of the risk assessment that they had put in place for this person shortly after the inspection. The second person's support plan identified they were at risk of pressure sores, and contained information on how this risk was managed. We again found appropriate measures were in place to control this risk, although these were not clearly reflected in a risk assessment. The provider addressed this issue by producing a skin integrity management plan for this person during our visit.

We saw evidence that where appropriate, safeguarding concerns had been recorded and reported as required. Staff were aware of how to identify and report potential safeguarding concerns. They told us they would inform their team leader or the registered manager if they had any concerns in relation to a person's welfare. Staff we spoke with told us they had not had to raise any safeguarding concerns, but were confident their managers would take appropriate actions if they had any concerns. They were also aware they could approach other agencies such as the police, CQC, the local authority safeguarding team, or an individual's social worker if they had concerns they didn't feel able to raise within the organisation.

Robust procedures were followed to help ensure only staff of suitable character were recruited to work with the service. We saw all applicants completed an application form and a check was completed to ensure any gaps in employment history were adequately accounted for. References had been received and verified from previous employers, and there was suitable identification retained within staff personnel records. Disclosure and barring service (DBS) checks had been completed prior to staff taking up post. DBS checks highlight whether an applicant has any convictions or is barred from working with vulnerable people, and helps employers make safer recruitment decisions. We saw where information had been returned on DBS checks that a risk assessment had been completed. This demonstrated the service had considered whether the person was safe to work with people supported by the service, and whether any adjustments or restrictions were required to reduce any possible risks. One staff member told us they had found the recruitment process to take a long time, but said they thought this was positive as it demonstrated that the provider was being 'thorough' to make sure they employed the right staff.

Staff had received training in the safe administration of medicines and staff confirmed a manager had checked their competency. We reviewed medication administration records (MARs) and saw staff had completed most records with no gaps. One MAR we looked at had a missing signature. The registered manager was able to confirm this medicine had been administered by cross-referencing this record to the daily counts of medicines carried out by staff.

We saw there were protocols in place that provided staff with the information they would require in order to administer 'when required' (PRN) medicines, such as pain relief medicines and medicines for anxiety as needed. Where PRN medicines had been prescribed to help people manage anxiety or behaviours that challenge, we saw there were detailed protocols in place that had been regularly reviewed. This would help ensure such medicines were administered appropriately, and only when needed. We spoke with one staff member who supported a person who was prescribed a when required 'rescue medicine' that was administered in certain circumstances when they experienced an epileptic seizure. The staff member was aware of the guidelines in place detailing the specific times that this medicine should be administered. We saw the staff team had received training in epilepsy and the staff member confirmed the training had included instruction on how to administer this medicine safely.

Staff completed handover records between shifts at the supported living services. These records demonstrated staff undertook regular checks relating to the safety of the environment. For example, there were records of checks relating to fire safety, general maintenance, and fridge temperatures.

Good

Is the service effective?

Our findings

Some of the supported living services were set up as positive behavioural support (PBS) services. These services provided support to people with complex needs and behaviours that could challenge services. This included the provision of support to people who had previously been living in 'secure' hospital services. We saw these people had substantial packages of care in place, which included frequent input from the provider's in-house psychologist, speech and language therapist (SALT), behavioural support practitioner and occupational therapist (OT). There were regular multi-disciplinary-team meetings to review progress being made, one of which was taking place during our visit to this service.

We saw staff monitored any accidents or incidents closely in conjunction with the behavioural support practitioner and psychologist. We were shown charts used to monitor trends in people's behaviour that were used to identify positive steps being made, as well as where further coaching of staff or other interventions might be required. We spoke with the behavioural support practitioner who showed us that monitoring had indicated a recent increase in incidents for one person, which they had identified as being related to the introduction of new staff members. They told us this would be discussed at the MDT meeting that day to determine whether any strategies could be introduced to help reduce such incidents. We spoke with the team leader at the service who talked about using role plays, scripts and social stories as a way of supporting this person to manage their anxiety effectively. Social stories are ways of helping people with autistic spectrum disorders to learn social skills and effective ways to deal with certain situations. Staff told us such techniques had been very effective and resulted in a decrease in incidents. They also spoke about working with other members of the MDT to develop effective strategies for introducing new staff to the team, such as being aware of times of the day when the person was often in a more relaxed mood and introducing staff during activities that the individual enjoyed. The behavioural support practitioner discussed another instance where their monitoring had indicated that a person's behaviours could change at certain times of the day. They told us they determined this was related to times of the day they might require prompting to use the toilet, and following changes to their support guidelines they had seen a reduction in behaviours that challenged. This showed the service was working in a person centred way and using advice from a range of professionals to produce effective outcomes for individuals.

Staff had received training in managing behaviours that can challenge that was accredited by the British Institute of Learning Disabilities (BILD). We saw people had behavioural support plans in place where required and that these had been regularly reviewed and updated. These focussed on pro-active strategies, such as identifying changes to the environment or the way staff supported people to help reduce the need for further intervention. Active and re-active strategies were also identified to help ensure staff could respond effectively if pro-active strategies had not been successful. The registered manager told us physical intervention was rarely required and would only be used as a last resort. We reviewed incident records, which confirmed this. Incident records had been completed frequently, and generally documented minor incidents. Records demonstrated that staff had considered potential causes of any incidences of behaviours that challenged, and ways in which they could reduce the likelihood of a similar incident occurring in the future. More significant events had also been analysed by the in-house psychologist. This showed the service had a pro-active approach to learning from incidents to improve the care and support provided to

individuals.

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service was supporting three people who had an order from the Court of Protection authorising a deprivation of liberty (DoL). The orders had been received to authorise the individuals move to the service and to authorise restrictive practices detailed in their support plans. Other professionals had been involved in the review of the DoL authorisations to help ensure the restrictive practices were still necessary and in the individuals' best interests. Staff we spoke with were aware of the purpose of the court of protection orders and what they meant in relation to the individuals' care and support.

We found staff had a good knowledge of the principles of the MCA and they could provide us with positive examples of how they had acted in peoples' best interests to minimise the use of restrictive practices. For example, one support worker talked about the need to consider environmental factors in the reduction of behaviours that challenged, and spoke about how the person they supported (who had an authorised deprivation of liberty) was able to access a secure garden area independently, whilst remaining in the sight of the support worker. They told us this had benefitted the person as they enjoyed accessing the outdoors and it also allowed them space and time alone, which had a positive impact on their wellbeing. A team leader spoke about how staff had developed a less restrictive way of supporting an individual with their finances, which involved placing money in envelopes with names of activities or purchases for the forthcoming week written on them. Staff told us they would support people subject to an authorised DoL to access the community whenever they wished, and we saw evidence this was the case. We saw in one person's care file that they were administered a medicine 'when required' for indications relating to their behaviour. We saw use of the medicine had been monitored and it was documented that it was aimed to provide positive support to the individual to reduce the need for this medicine to be administered. This showed the service was working effectively to provide care that was the least restrictive option and supported people to retain as much freedom and independence as possible.

We saw details recorded in people's support plans in relation to consent were variable. Some support plans we reviewed contained detailed information about how staff should support people to make decisions themselves wherever possible. This included the use of communication aids, such as 'objects of reference' and pictorial aids for example. However, This information was not present in all support plans. However, records showed that where an individual lacked the capacity to provide consent to a decision that consideration had been given to ensuring the decision was made in the person's best interests and that relevant people were involved in the decision making process, including advocates where appropriate. Staff told us they would always try and involve people in decision making as far as was possible and would respect peoples' wishes.

Relatives we spoke with told us they thought staff had the required skills and knowledge to meet their family member's needs. Comments made included; "Staff know what they are doing and are kind and are respectful," "They are super and they are all very good. There is a team of six and they are all as good as each other," and; "I can't fault the support workers from Together Trust. They have done a lot of relevant training

and have invested a lot of energy in building [family member's] confidence up again."

We saw staff followed a schedule of induction training and completed an induction handbook during their first 12 weeks working at the service. The handbook covered policies, procedures and the training staff would undertake to meet the standards of the care certificate, as well as setting out tasks and goals. Staff told us they found the booklet helpful and told us they received regular supervision during their induction as well as being given time to shadow more experienced staff. The care certificate is a set of minimum standards that should be covered for any new care workers to ensure they have the required competence to care for people safely and effectively.

Staff we spoke with told us they felt they received sufficient training, and said the training was good quality. One staff member told us; "I've never had as in depth training as with the Together Trust." Another staff member said; "It's good. I enjoy the training. It's not like a tick-box exercise as with some other providers." One of the senior support workers we spoke with told us they had received recent training in how to provide staff supervision and described the training as 'fab'. Staff told us, and records confirmed that staff had received training in a variety of topic areas including; medicines; moving and handling; positive behavioural support; epilepsy; food hygiene; first aid and communication. The providers' services for younger people were 'autism accredited' by the national autistic society, and staff had received training in relation to autistic spectrum disorders. Training had also been provided to staff in providing active support. This is an approach to supporting people with a learning disability to engage in activities and everyday tasks, and to support the learning of new skills. Staff told us active support was well embedded in some of the supported living services, and we saw there had been discussions about how the approach could be adapted to suit the needs of people who required less support to engage in such tasks. Where required, staff had received additional training specific to supporting with particular needs in relation to their care and support, such as people who had a percutaneous endoscopic gastrostomy (PEG) or a tracheostomy. A PEG is a tube that is inserted into the stomach and often used to supply food and medicines to people who are unable to take them orally.

Staff told us they received regular monthly supervision that they found useful and supported them in carrying out their roles competently. Records confirmed that staff had received supervision on a regular basis, including weekly supervisions when a staff member first started in their role. This would help the provider ensure staff were competent and supported to carry out their job role to the expected standard. Records of supervisions showed discussions allowed for feedback to be given and received by the staff member, and areas for development and goals had been identified. We also saw supervisors had 'coached' staff in relation to the effective implementation of support approaches learnt about in training courses.

The support the service provided in relation to people's health varied between the outreach and supported living services. Where the service had a role to play in supporting people to access health services, we saw evidence people's health was monitored and referrals had been made to other services as required. For example, we saw staff had contacted the GP in relation to one person's weight loss and the person had also been seen by a dietician and speech and language therapist (SALT). There had also been discussion around involving the clinical psychologist in relation to this concern if physical causes of the weight loss were ruled out. People supported by the supported living service had a 'health action plan' or similar document in place that detailed that person's health care needs and goals, and how staff should support the service to meet any such needs. Detail was provided on other professionals involved in the person's care and any specific needs in relation to areas such as hearing, vision, mental health and epilepsy.

One relative told us; "'My [family member] has lost a lot of weight recently but it's not clear why… The support worker is really great and supports us as well as my [family member]. They are very careful to watch

what they eat and drink when they are out and to record that for us." We saw plans were in place to support and encourage people to eat healthy meals where this was an identified need. For example, one person's records stated the person wanted to lose weight, and that staff should positively frame healthier options, such as by discussing that home cooked food was 'tastier' than other processed foods. Staff recorded the food and drink people had received, and in the supported living services and they encouraged people to help draw up weekly meal planners. Staff monitored people's intake against any stated health aims, which were summarised on a weekly basis.

Good

Is the service caring?

Our findings

Relatives we spoke with were consistently positive about the caring and supportive relationship staff had developed with their family members. One relative said; "It's a brilliant service. They treat [family member] so well and are so kind to him. I have no worries at all." Another relative told us; "They always come home laughing. I don't feel that they are just taking my [family member] out and then not really caring about them," and a third relative said; "I can't speak too highly of the service. It's not just a job. You can tell that people really care." Relatives told us the service involved them in their family member's care and that the service was supportive of them as a family. One relative told us; "[Staff member] isn't just brilliant with [family member]; he has made a real difference to all the family. We look forward to seeing him because he is a ray of sunshine."

Although we were only able to speak with a small selection of people who used the service, those we did talk with were also positive about the support they received. One person said; "I feel safe with them [the staff]. They are my friends." A second person told us; "They [the staff] are nice. I like [staff member] very much," and a third person described the team leader as 'fabulous'. From speaking with staff it was apparent they had a good knowledge of the needs and preferences of the people they supported. The process of staff getting to know people well was enhanced through the provision of consistent staff teams, and the effective induction of new staff members. For example, one person supported by the outreach service had been supported by the same staff member for several years, and people in the supported living services had set staff teams. The provider was mindful of the impact the introduction of new staff could have and ensured new staff members had sufficient time to shadow more experienced staff and get to know the people they would be supporting. One relative told us; "Sadly the support worker who has been coming for a few years is leaving. But the way it's been handled is really good. The new support worker has been coming in tandem for quite a few weeks and this week will be the first time he's come single handed. Because [family member] has been going out with both of them, he'll accept the new person without question."

Staff had received training in communicating effectively with people who might have limited verbal communication. People's support needs in relation to communication were detailed in their support plans and some people had 'communications passports' in place, which provided information on non-verbal communications people used. Staff used various aids to communication including pictorial planners for activities and meals, use of social stories and picture exchange communication system (PECS), which is a method of communicating using pictures. One staff member we spoke with told us they thought the person they supported would benefit from staff receiving training in Makaton (a way of supporting communication through the use of signs and symbols), although that person could also communicate in other ways. They told us they were confident the provider would ensure staff received this training. One relative we spoke with told us; "[Family member] was struggling because they are not able to speak clearly, but Together Trust have really helped because they are putting in some speech therapy. It's made a big difference and I don't think [family member] is as isolated as he was."

Staff told us they would encourage people's independence by encouraging them to make choices, such as around food shopping and clothing, and by supporting people to build their skills. One staff member said;

"[Person] has a lot of help but is very capable. I try and build a relationship first and work out what they like doing. I try and make things fun and encourage them to be involved." Staff also talked about using task analysis and active support, which they had received training in, to help teach people new skills and engage them in activities. Task analysis involves breaking down day to day tasks into steps that the person is then supported to learn and engage in.

People told us staff were respectful, polite and respected their rights and dignity. Staff told us they would ensure curtains and doors were shut when assisting people with personal care, and support plans also prompted staff to respect people's privacy. For example one support plan prompted staff to leave the room when the person was speaking with friends or family on the phone, and instructed staff to ask permission before using a cup or other items in the person's home.

Support plans provided staff with information on people's cultural background, including any significant events they might celebrate. Staff we spoke with were aware of this information and what it meant in relation to the care and support they provided people with. Some staff had received training in human rights and equality and diversity. We spoke with one staff member who had recently completed the equality and diversity training, who told us; "[The training] really changes your perception. One exercise looked at prejudice. We did a lot of exercises; it really opened your eyes."

Good

Is the service responsive?

Our findings

Support plans for people using the supported living service were person centred and highlighted what people were able to do for themselves as well as areas where they would require support from staff. They outlined people's support needs in relation to a range of areas including health, mobility, sexuality, relationships, travel and emotional wellbeing. Staff had completed person centred planning tools that helped identify peoples' strengths, interests and people and places that were important to them. Staff completed daily records of care and support provided, which identified progress and achievements in relation to goals and outcomes identified in people's support plans. For example, we saw a person's increased involvement in choosing their meals using a picture communication system was highlighted. Another person's support plan identified an aim to save money to go on a holiday. Staff we spoke with were aware of peoples' goals as identified in their care plans, and were able to provide examples of support provided to help people achieve these aims.

Staff told us support plans would undergo a full review every six months. The support plans we looked at had been reviewed recently, although we found some information, such as guidance from health professional assessments was not always clear from the copies of support plans kept in the office. The registered manager told us this information would be contained in the copies kept at the individual's homes. We visited the satellite office at one of the supported living schemes and found such information was available to staff. We also looked at the support plans at the scheme and saw staff treated these as 'live documents', which staff had made regular updates and amendments to. This would help ensure the records were up-to-date and reflected any changes in the individuals' needs or preferences. One staff member told us; "We constantly update the support plans. Anyone can update them."

One person's support plan contained contradictory information in relation to the frequency their weight should be recorded, and in relation to when staff should seek further advice from a health professional in relation to weight loss. We requested and received additional information from the registered manager in relation to the care this person had received and were satisfied with the actions taken by staff. The registered manager said they would go back to the health professionals involved in this person's assessment to clarify the requirements in relation to the monitoring of their weight.

The registered manager told us people supported by the outreach service all lived with parents or other carers in their own homes. Support provided to young people was generally delivered outside school hours or at weekends and consisted primarily of support to access leisure opportunities. However, some people using this part of the service also received support in relation to personal care and nutrition for example. The support plans for people using the outreach service were less detailed than those for people receiving 24 hour support, and it was not always clear what the aims of the support sessions were, or what staff responsibilities were in relation to aspects of care, such as the administration of medicines. However, we saw evidence from the daily records that support sessions were planned flexibly to meet the preferences of the individuals on each occasion. People using the service also told us this was the case. For example, one person told us; "I'm very happy. They ask me what I want to do and we do it." Another person said; "'I do lots of things and I like shopping. Sometimes I might say I don't want to go and then [staff member] asks if I'm

alright, and sometimes I change my mind and then we go." We saw that for young people using the service, aims and outcomes from support sessions were identified and recorded against aims from the government initiative 'Every Child Matters'. This included supporting the person to be healthy, safe and to make a positive contribution. The registered manager told us people were supported on a consistent basis by the same staff member, and this was confirmed by people using the service and by staff. This would also help ensure staff were aware of people's needs and their responsibilities in relation to the person's care and support.

Staff told us the supported living service had provided support to several individuals who had transitioned from the provider's children's services. A team leader we spoke with told us one of the supported living services had been set up initially as a 'shared care' service, where support was shared between the individual's relatives and the service itself. This person was being supported wholly by the Together Trust at the time of our inspection, and the team leader spoke about how they had worked to help ensure the person had retained contact with their family members. This had included arranging social outings with the family and individual. We spoke with a senior support worker who talked about there being a very long planning and transition period for a person who was due to move to the service in the near future.

During our visit to the supported living scheme we saw one person was supported to attend a trampolining session. Staff told us another person was supported to go on regular trips to the library, a cycling session using adapted bikes and music workshops. At the time of our inspection, some people using the supported living service were being supported by staff on a holiday abroad. Staff had recorded planned activities each week and made a record of actual activities undertaken. These records showed people took part in various activities, including swimming, walking, baking, shopping, trips to the cinema and attending day services. Staff told us one person had expressed an interest in undertaking voluntary work, and they told us they were in the process of setting up a voluntary placement at the service's head office. One person told us; "'I'm very happy. I go to a disco every month. There's one tonight and we go ten pin bowling. Sometimes there might be a trip as well. I decide for myself what I want to do."

Relative's we spoke with told us the service was responsive to feedback and quick to act in relation to any concerns they might raise. One relative said; "What I really like about Together Trust is that if they say they are going to do something then they do it," and another told us; "We feel that it's all about team work. There is no 'us and them.' We've all got [family member's] best interests at heart so they are very responsive to any concerns we might have and we have confidence in this service." We saw regular feedback was sought from people using the service through pictorial format feedback forms completed on a weekly basis. There was a complaints policy that was also available in pictorial form to help people understand how they could raise a complaint if they wanted. The provider told us there had been one formal complaint made in the past year. The provider had responded to the complaint in a reasonable time and had met with the individual raising the complaint to discuss their concerns. The records indicated the individual had been satisfied with the response provided in relation to their concerns.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. The registered manager was responsible for the supported living and outreach services across Greater Manchester. They were also responsible for managing the provider's day services in Stockport and a service providing support to people at Bolton College, which were services that were not required to be registered with CQC. The registered manager was supported by an operations manager for the outreach service, and team leaders and senior support workers who had some management responsibilities for the supported living services. The registered manager told us they had had discussions with their manager as it was felt their remit may be becoming too broad as the service was growing in size. They told us they were considering registering some aspects of the service as separate locations with CQC in the future, to help ensure adequate management oversight. However, they told us the support they received from the Together Trust and their manager was 'fantastic'. They also told us they found the staff teams to be 'committed' and to have a 'strong work ethic'.

The staff we spoke with were motivated and told us they enjoyed their jobs and felt valued for the work they did. They were consistently positive about the provider and the support they received. Comments made by staff included; "I love my job. The Together Trust is the best company I've worked for. The training and support is fantastic and it's well organised;" "If you do something well you always get a lot of praise from the manager. I think Together Trust are really good;" and "I work hard to be a really good support worker; it's what I want to spend the rest of my life doing. I'm proud of how far we have come with [person], we've really worked hard with her. Together Trust is a fantastic company to work for, the best I've ever worked for. They are really professional."

Relatives and people we spoke with told us they found staff, including managers, listened to them and acted on any feedback they gave. We received feedback from a commissioner of the service who told us they found the service to be 'person centred and responsive.' One relative said; "I am sure it is well managed because things run like clockwork." Staff told us they were always able to approach a manager or team leader if they required any advice, and there was an on-call service that staff were able to access outside core hours. Records showed regular team meetings with staff took place, where discussions were held around individual's support needs, health and safety, policies and procedure, training and feedback from the registered manager's audit. This would help ensure staff were kept informed about changes in the service, were aware of their responsibilities and able to work together to implement improvements.

We found the provider had not submitted all required notifications to CQC. We found evidence of one safeguarding referral that had been made to the local authority, but not notified to CQC. It is important that services submit notifications to enable us to adequately monitor their performance, and to ensure they have taken appropriate actions in relation to safeguarding concerns for example.

Staff kept accurate records of care and support provided to people and any accidents or incidents. Team leaders completed weekly reports for the registered manager that provided details on a range of checks carried out within the services. This included checks of finances, medicines, health appointments, accidents and incidents, changes to support plans, training, supervision and summaries of support provided to

people. The registered manager reviewed these records and also completed quarterly audits focussing on different aspects of service provision. For example, we saw these audits had covered areas such as servicing and maintenance of equipment, support plans, activities, risk assessments, fire safety and training. The registered manager made recommendations based on their audits, which were fed back to team leaders as part of an action plan. We saw some of the quarterly audits were overdue by around one month at the time of our inspection. However, where this had occurred in previous months, the registered manager had completed multiple audits at the same time to ensure all areas had been sufficiently monitored and evaluated.

The registered manager told us records of accidents and incidents were passed to a health and safety manager who was able to provide information on and trends in relation to the frequency and number of accidents. However, we found that despite there being close monitoring of accidents and incidents at an individual level; overviews of all accidents (such as falls) or incidents for specific individuals' was not easily accessible. We also found the registered manager had not reviewed all incident forms, although such information was provided to the registered manager in summary form.

Staff told us the registered manager would be informed of any significant accidents or incidents at the first available opportunity, but also told us they needed to clarify when the registered manager would be required to review and sign off the actual accident/incident forms. The registered manager acknowledged that the overview of accidents and incidents at an intermediate level could be strengthened, and shortly after the inspection they informed us they were putting in place new procedures to enable such monitoring. We also found that safeguarding incidents were monitored within teams and were reported to the registered manager, but there was no service level overview of any safeguarding incidents. Although we were confident that safeguarding concerns were managed appropriately; this would make it more difficult for the registered manager to monitor safeguarding incidents within the service. The registered manager told us they would put a tracking document in place to help ensure adequate overview.

On the first day of our inspection we found not all information we requested was available. The service had recently opened a 'satellite office' for their outreach service in Bury. The service file and care records were not available at the registered office on our first day. The provider told us the manager for this service had taken the records to the satellite office to make copies, and these were later returned.

Systems and process in relation to the governance of the service had not been effective in identifying some of the issues we found during our inspection, such as shortfalls in some risk assessments, lack of a clear overview of safeguarding in the service, or the variability of information recorded in relation to seeking consent. The processes in relation to monitoring of accidents and incidents were also lacked clarity in some instances and the provider had not submitted all required notifications to the CQC.

This was a breach of Regulation 17(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager and provider were responsive to our feedback, and as a result of our enquiries they informed us of a number of immediate changes they had made. This included reviewing the organisations policies on falls and consent and introducing new forms to improve record keeping in relation to provision of certain aspects of care such as repositioning.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in relation to the monitoring of the quality and safety of the service were not always effective. Regulation 17(1)