

Positive Care Solutions Ltd

Head Office

Inspection report

Lowry Mill, Lees Street
Manchester
M27 6DB
Tel: 01615924491

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

This was the first time we had inspected and rated this service. We rated it as requires improvement overall because improvements were required in relation to the safe and well led key questions. However, we did find that the service was effective, caring and responsive.

We rated the service as requires improvement because:


- The provider did not have a restraint reduction programme in place which is a national requirement for all services using physical interventions in response to disturbed behaviour by people with a learning disability and/or autism.
- The provider's systems for training staff and monitoring compliance in relation to mental health legislation such as the Mental Capacity Act and the Mental Health Act were not fully embedded.
- Records did not always show how all agencies involved with an individual's care had been involved in their care planning where this would have been appropriate.
- Notifiable incidents had not always been shared with CQC in accordance with regulatory requirements.
- The provider's governance systems had not highlighted the issues we identified in relation to the care records and the lack of adequate safeguards in relation to the use of physical interventions.

However:

- Staffing levels on each shift enabled staff to give each young person the time they needed as teams were not short-staffed.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment of young people's needs and in collaboration with young people using the service and, where appropriate, their families and carers.
- The provider evaluated the quality of care they provided and made improvements on an ongoing basis.
- The teams included or had access to the full range of specialists required to meet the needs of the young people using the service. Managers ensured that these staff received adequate supervision and appraisal.
- Staff treated young people using the service with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They actively involved young people using the service and, where appropriate, their families and carers in care decisions.
- The service was easy to access. The criteria for referral to the service did not exclude young people who would have benefitted from care and the service had no waiting list at the time of our inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist community mental health services for children and young people	Requires Improvement 	See summary above for details.

Summary of findings

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Summary of this inspection

Background to Head Office

Positive Care Solutions Limited is a community-based organisation offering mental health care and psychosocial support to young people with complex needs, aged between 11 and 25, within supported tenancy accommodation commissioned by Local Authorities across northwest England. The interventions offered to the young people included social support, assistance with personal care if required, and a bespoke package of mental health support provided by healthcare professionals where needed.

At the time of our inspection the service was supporting young people in various geographical locations across northwest England and had an administrative base in Manchester, which was the provider's only registered location (Head Office). The service was registered with CQC at this location on 3 January 2020 and the provider is registered to provide one regulated activity: Treatment of disease, disorder or injury. There was a registered manager in post at the time of our inspection. This was the first inspection of this service since it was registered.

What people who use the service say

We spoke to five of the young people who were either currently using or had recently used the service and two parents of young people who had recently been discharged from the service. The young people told us that they felt well supported by staff and they were fully involved in their care. They said they felt safe and had not experienced any abuse or discrimination from staff. Young people described how staff were supporting them to do things they enjoyed and to work towards personal goals, for example in education or employment. Relatives also told us that they were happy with the service, although one person also raised some specific concerns about staffing pressures and a lack of professional boundaries having been an issue in the past. Several of the young people and their relatives said that the service was the most supportive they had ever experienced.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- spoke with the registered manager, the clinical lead and other members of the senior leadership team at the provider's office base
- reviewed the care records and medicine administration records of all the young people receiving care from the service at the time of our inspection
- visited four of the properties where young people were being supported by the service and observed how staff were caring for them
- spoke with three of the young people at their homes
- spoke with a further two young people and two relatives on the telephone
- spoke with two support workers, two senior support workers and one area manager
- received feedback from three commissioning case managers
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Summary of this inspection

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

- The service must ensure it monitors the use of physical interventions and has a programme in place to minimise use in line with national guidance. (Regulation 17(2)(a))
- The service must ensure that incidents are reported to CQC in accordance with the requirements of the Care Quality Commission (Registration) Regulations 2009 (Regulation 18 Notification of other incidents)

Action the service **SHOULD** take to improve:

- The service should ensure that record keeping in relation to physical interventions includes details of the de-escalation techniques attempted in order to try to prevent the need for physical restraint.
- The service should ensure that its internal monitoring of the use of the Mental Capacity Act is strengthened, staff training on the Mental Capacity Act fully supports them to understand the application of the Act to their work and improvements are made in the documentation of capacity assessments and best interests decision making where young people lack decision making capacity.
- The service should ensure that staff receive training on the Mental Health Act and its code of practice, which could potentially apply to the care of the young people they are supporting.
- The service should ensure that multi-agency care planning in relation to positive risk taking is always clearly documented in the individual's records and kept under regular review.
- The service should ensure that information relating to physical interventions and other restrictive practices is removed from individuals' positive behaviour support plans where this does not form part of the individual's plan of care.
- The service should ensure that staff receive training to support them in communicating effectively with all the young people they are supporting before starting to work with them.
- The service should consider how staff can be further supported to consistently use positive and inclusive language relating to the young people they are supporting, including when referring to behaviour they have found challenging.
- The service should consider how they can formalise their feedback processes for young people and their relatives to ensure that young people's views are sought and taken into account as comprehensively as possible.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Specialist community mental health services for children and young people

Requires Improvement



Safe	Requires Improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Requires Improvement	

Are Specialist community mental health services for children and young people safe?

Requires Improvement



Safe and clean environments

This service did not have any clinical premises where patients received care as the service was being provided entirely within young people's homes.

Staff completed and regularly updated thorough risk assessments which included assessment of environmental risks to young people using the service and removed or reduced any risks they identified. Health and safety issues were documented by staff using the provider's online staff portal and were followed up by the management team. The service received regular health and safety inspection reports from the provider of each young person's accommodation, providing assurance that the houses were free from environmental and other health and safety risks.

Staff always followed infection control guidelines, including handwashing. We observed staff complying with good practice in relation to infection prevention and control during our visits to the houses. Staff also prompted young people using the service to maintain good hygiene practices, for example washing their hands before preparing food. Risk assessments had been carried out by the provider in relation to infection prevention and control risks, for example risks relating to COVID-19.

The service did not provide any equipment to the young people. The health and safety reports they received from the housing providers of each young person's accommodation provided assurance that equipment was provided to maintain environmental safety, including fire extinguishers and carbon monoxide detectors, which were regularly tested and serviced if required.

Safe staffing

The service had enough staff, who knew the young people using the service and received basic training to keep them safe from avoidable harm. The number of young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each young person the time they needed.

The service had enough staff to keep the young people safe. The registered manager told us that the initial assessment of each individual's needs was used to determine the safe staffing levels needed to support that young person and we

Specialist community mental health services for children and young people

Requires Improvement



saw that each of the young people being supported by the service had a bespoke staff team rather than the provider having a set staffing structure. This contributed to the highly individualised care the provider was able to offer to the individuals they were supporting. The manager also told us that the service were aware of their limitations and refused to take care packages where they were not able to meet needs safely.

The staff teams we observed during the inspection were staffed to full capacity as assessed by the provider as required to meet the individual's needs. Staff told us that they could request a review of the minimum safe staffing levels if they felt the young person's needs had changed and the registered manager confirmed that staffing levels for each young person were reviewed and adjusted on an ongoing basis as young people's needs changed. We saw evidence of effective joint working between frontline staff, the service's senior leadership team and external stakeholders such as commissioners and care coordinators to ensure the service could respond to individuals' fluctuating needs with appropriate staffing levels.

The service's staffing model required all staff working with the young people to be sourced through a particular third party staffing provider. The provider ensured that young people using the service had a consistent staff team who could get to know them and understand their needs. The young people we spoke with told us that they worked with staff who knew them well and they were able to build positive relationships with their support workers.

Managers made sure all staff had a full induction and understood the service before starting their shift. All staff had to complete the Positive Care Solutions full mandatory training programme (which was a mixture of e-learning and some face-to-face training in physical interventions, first aid and managing medicines), complete an orientation to the service and work a shadow shift before starting to work with the young people. All the staff we spoke with told us that they had been through this induction process and it had equipped them with the knowledge and skills they needed to work safely with the young people they were supporting.

The service had low turnover rates. Although the staff were recruited via a staffing agency, they worked full time for the service and each young person had a consistent and stable staff team.

Managers supported staff who needed time off for ill health. Staff told us that they felt well supported by the provider if they needed time off due to sickness. Levels of sickness were monitored by the provider and were low in the 12 months prior to our inspection.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The provider's training data showed that over 90% of support workers, 100% of senior support workers and 100% of area managers were up to date with most of their mandatory training modules. The only exceptions to this were physical interventions training (89% of support workers) and the Care Certificate (64% of support workers). However, we also saw evidence that 100% of the 28 staff members working regular shifts for the provider at the time we inspected were up to date with their physical interventions training.

The mandatory training programme was comprehensive and met the needs of the young people and staff. All staff were required to complete a programme of training which included safeguarding, infection prevention and control, physical interventions, first aid and management of medicines. Staff also received the Oliver Magowan mandatory training which is a national requirement for all healthcare staff working with young people with a learning disability and/or autism. Staff told us that the training they received supported them to meet the needs of the individuals they were working with and to provide them with safe care. Managers monitored mandatory training and alerted staff when they needed to update their training.

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Requires Improvement



Assessing and managing risk to young people using the service and staff

Staff assessed and managed risks to young people using the service and themselves. They responded promptly to sudden deterioration in an individual's health. When necessary, staff worked with young people using the service and their families and carers to develop crisis plans. Staff followed good personal safety protocols. However, the service did not fully comply with best practice in relation to the use of restrictive interventions.

Assessment of individual risks

Staff completed risk assessments for each young person using the service on admission and reviewed these regularly, including after any incident. The risk assessment was an in-house template which had been developed by service's safeguarding and compliance lead. The registered manager told us that this was based on national best practice guidance on the assessment of clinical risk and the records showed that clinical risks were being identified and planned for appropriately. The registered manager told us that risk assessments were reviewed every six weeks at a minimum and following any incident involving the young person.

Staff could recognise when to develop and use crisis plans according to individual need. The registered manager told us that everyone's positive behaviour support plan included information on how staff would support them if their mental health deteriorated or they were in crisis, and all the records we reviewed did include this information. We saw evidence that crisis plans were developed in collaboration with the young people, who were encouraged to identify and plan for the management of their own triggers and signs of deterioration.

Management of individual risks

Staff responded promptly to any sudden deterioration in an individual's health. The records showed that individuals' mental and physical health needs were assessed, regularly reviewed and young people were supported to receive physical and mental health care as needed, including when urgent situations arose. Staff received training, which met Restraint Reduction Network standards, in de-escalation of conflict and physical interventions.

We saw examples of positive risk taking in care records, which were individualised and targeted at meeting the individual's assessed needs. However, documentation in relation to capacity and decision making was unclear at times.

Staff followed clear personal safety protocols, including for lone working. The staff we spoke with told us that they never had to work alone, there was always at least two staff members on a shift including at night and over the weekend. Staff told us that the training they had received, for example on de-escalation and physical interventions, supported them to work safely with the young people they were working with.

Use of restrictive interventions

Due to the nature of the service, the provider's staff were using restrictive interventions at times in response to disturbed behaviour, in order to prevent injury to the young person, staff or others.

Levels of restrictive interventions were low (32 episodes of unplanned physical restraint since the service registered with CQC in January 2020). Staff told us that they made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only when these failed and there was no other way to keep the young person or others safe. However, this was not consistently being recorded in each young person's incident reports. Following the inspection, the provider told us they had adapted their record keeping system to prompt staff to document the different levels of de-escalation techniques which were used in response to disturbed behaviour.

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Requires Improvement



Staff received training in responding to disturbed behaviour which was approved by the Restraint Reduction Network, and the staff we spoke with told us this training supported them to respond safely to disturbed behaviour.

All the young people had a positive behaviour support plan which described in detail their preferred ways of being supported and included individualised de-escalation tactics for staff to work with prior to using hands on restraint.

However, due to these plans being developed from a template document, all the plans included a section on physical restraint which included pre-written details of how restraint should be used, even when this was not a safe response for the individual. The registered manager and staff told us that they knew which individuals should not be physically restrained, we saw no evidence of young people being restrained inappropriately and the young people we spoke with did not raise any concerns about the use of restrictive interventions by staff. However, the presence of this irrelevant section within some plans posed a risk that these individuals would not be supported in a safe and person-centred way in a crisis situation. Since the inspection the provider has told us that they have now removed all pre-written information from the positive behaviour support plans of all the young people they are supporting.

Staff understood the Mental Capacity Act definition of restraint and worked within it. The staff we spoke with were aware of the circumstances which would give rise to a deprivation of an individual's liberty as defined by the Mental Capacity Act. We saw evidence on the records that staff identified concerns about deprivation of liberty appropriately and the provider escalated these to the relevant Local Authority so the correct legal authorisations were put in place prior to planned restrictions being imposed on the young people.

Staff did not use rapid tranquillisation, seclusion or long-term segregation, which would have been inappropriate in this type of service.

Safeguarding

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had a safeguarding lead who staff were able to contact for advice.

Staff received training on how to recognise and report abuse at a level appropriate for their role. All the staff we spoke with told us they had received safeguarding training and they were able to describe how they would identify signs of abuse and the process they would follow to report this in accordance with the provider's policy. We saw evidence from incident reports that staff were identifying and reporting safeguarding concerns internally as required.

Staff kept up-to-date with their safeguarding training. 100% of senior support workers, 100% of area managers and 93% of support workers were up to date with their safeguarding training at the time of our inspection. Staff were trained in relation to safeguarding to the level required by national guidance on safeguarding training for staff working directly with children and adults at risk.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received training on equality, diversity and inclusion and could describe how they supported individuals in a non-discriminatory way, which was supportive of their individual needs.

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Requires Improvement



Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The training staff received in relation to safeguarding children and adults at risk supported them to identify and manage safeguarding risks relating to the young people they were supporting. The registered manager told us that they had positive working relationships with the Local Authority Designated Officers (LADOs) for safeguarding in all the local areas where they were supporting young people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The registered manager showed us the staff portal which all staff had access to from their work laptops and mobile phones. This included a facility for reporting safeguarding concerns which were then reported on to the relevant local authority by a member of the senior management team. The management team had an on-call rota which ensured that there were always two or three managers available for staff to contact for advice, including at night and at the weekend.

We saw evidence that, where safeguarding concerns had been raised, the provider reported these appropriately to the relevant local authority safeguarding team (and the police where a crime had been alleged) and took other necessary action to protect the young person involved, including suspending staff from work pending the outcome of investigations. However, we found that concerns about abuse and incidents which were reported to the police were not always being reported to CQC as required.

Where young people had been assessed as lacking decision-making capacity, and there were risks to their safety leading to restrictions on their freedom to go out unaccompanied, any deprivation of their liberty had the correct legal authorisation in place and this was stored on their records so as to be clearly highlighted to all staff working with that person. The young people affected were aware when these restrictions were in place and told us they felt involved by staff in relation to the restrictions.

Staff access to essential information

Staff kept records of young people's care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we noted in some areas that improvements were needed in documentation.

Patient notes were mostly comprehensive and all staff could access them easily. Records were stored online in shared folders which staff could access remotely and each young person also had paper records at their property. All the records we reviewed were up to date and complete and the staff we spoke with knew what the up to date care plans were for the young people they were working with.

Records were stored securely. The electronic records were password protected and the paper records were being stored in locked cabinets within locked staff rooms at all the homes we visited.

Medicines management

The service used systems and processes to safely administer, record and store medicines.

Staff followed systems and processes to administer medicines safely. The provider's staff did not prescribe any medicines as part of the service, which was based around psychosocial support and nursing/psychology interventions. Staff described how they supported young people with taking their medicines in a person-centred way and the records showed that medicines were being managed safely within the service. Staff received training in the safe management of medicines and had their competency assessed before being allowed to handle medicines as part of their role.

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Requires Improvement 

Staff reviewed each person's medicines regularly and provided advice to young people about their medicines. The support workers and senior support workers we spoke with described how they familiarised themselves with the medicines the young person was taking by reviewing online information and took the time to speak with the young people about their medicines on an ongoing basis. The young people we spoke with told us that they understood what medicines they were taking and why, and that they had received support from staff in relation to their medicines.

Staff completed medicines records accurately and kept them up-to-date. We reviewed the medication administration records for all young people using this service at the time of our inspection and we did not identify any administration or record-keeping errors. The provider audited the medicines administration records and action plans were generated where the audit had identified issues. We saw evidence that these actions were promptly implemented, for example through discussion with staff.

Staff stored and managed all medicines safely. Medicines were stored within locked cabinets in the locked staff offices in all the houses we visited. Staff told us that the senior support worker on each shift was responsible for holding the keys to the staff room and medicine cabinet. Medicines were clearly labelled with the prescribing information which included the individual's name, the medicine prescribed, the dose and the frequency of administration. Staff told us that they transcribed this information to the individual's medication administration record and we did not identify any transcribing errors on the records we reviewed.

Staff learned from incidents to improve practice. For example, where minor issues with the medicine administration records had been identified through audit, we saw evidence that action was taken to address the lessons learned with staff to prevent a recurrence. Several members of the provider's senior leadership team were signed up to receive medicines safety alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the manager told us that these would be disseminated to all staff as needed.

The service ensured young people's behaviour was not controlled by excessive and inappropriate use of medicines. The registered manager described how medicines prescribed to be taken on an 'as required' (PRN) basis were monitored through regular audits of the medication administration records.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. The registered manager told us that, at the time of our inspection, they were not supporting any young people who were taking medication which had physical health effects which required ongoing monitoring. He said they had previously and this was managed safely through partnership working with the person's community mental health team (which had the primary responsibility as the prescribing authority for ensuring this ongoing monitoring took place).

Track record on safety

The service had a good track record on safety.

There had been no incidents leading to serious injury or death of a young person using this service since they first registered with CQC.

Reporting incidents and learning from when things go wrong

The service managed safety incidents well overall. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

Specialist community mental health services for children and young people

Requires Improvement



Staff knew what incidents to report and how to report them. The support workers and senior support workers we spoke with were able to appropriately describe what should be reported as an incident and they knew how to report incidents using the provider's online portal, which they could access from their work laptops and mobile phones. Staff raised concerns and reported incidents and near misses in line with provider policy. However, we identified some incidents which should have been notified to CQC and this had not been done at the time the incident occurred. The provider advised us that this had been due to a lack of clarity around which types of incidents should be notified due to the complexity of the service. This has now been clarified which should ensure incidents are notified correctly going forwards.

No never events had occurred within the service since registration.

No incidents had occurred since the service registered with CQC that required them to provide information to young people using the service or their families in accordance with the duty of candour. The registered manager told us that the training staff received on incident reporting as part of their induction included information about the duty of candour and the staff we spoke with were aware of the requirement to be open and transparent with young people if untoward incidents occurred.

Managers debriefed and supported staff after any serious incident. We spoke to some staff who had been involved in incidents and they told us they felt well supported by the provider afterwards.

Managers investigated incidents thoroughly. Young people using the service and their families were involved in these investigations. The registered manager confirmed that he and the clinical lead would conduct incident investigations, which would involve the young person if appropriate and any family members involved in their care. He said the focus would be on collaborative working with the young person and staff to identify what happened and how a recurrence could be prevented.

Staff received feedback from investigation of incidents. The staff members we spoke with told us that they received feedback about lessons learned from incidents and they were able to give examples of incidents they had been involved in and changes that had been made to both their personal practice and organisational procedures because of learning from incidents.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us and we saw in meeting minutes that they had regular staff meetings and one of the standard agenda items at these meetings was lessons learned from incidents.

There was evidence that changes had been made because of learning from incidents. For example, formerly ligature risk training was only provided to staff working with a young person with known ligature risks. However, the service then supported a young person who unexpectedly attempted to self-harm through ligature. As a result of the learning from this incident, the provider expanded the availability of ligature risk training to all staff in recognition of the fact that ligature risks could potentially arise for any young person using the service at any time.

Specialist community mental health services for children and young people

Requires Improvement



Are Specialist community mental health services for children and young people effective?

Good



Assessment of needs and planning of care

Staff assessed the mental health and social care needs of all young people using the service. They worked with the young people and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs and were highly personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each person using the service. Each person's records included an assessment of their holistic needs, including their mental health needs, which was person-centred and individualised. This included both information received from the service from which the young person was referred and information gained from a comprehensive assessment which the clinical lead, therapy lead and registered manager carried out collaboratively with the young person and any relative or carer they wanted to be involved. The registered manager told us that the initial assessment was carried out over several sessions with the young person to ensure their holistic individual needs were fully identified.

Staff made sure that patients had a full physical health assessment and they knew about any physical health problems. The comprehensive assessment included identification of any physical health conditions the young person was experiencing and any other support needs they had in relation to their physical health. The registered manager explained that an individual with significant or complex physical health needs would not be suitable for their service so a physical examination did not form part of the initial assessment process - physical health needs would be identified from information shared by other professionals and any issues reported by the young person.

Staff developed a comprehensive care plan for each young person that met their mental and physical health needs. Each young person had a care plan and a separate positive behaviour support plan which set out their assessed needs and the care and support to be provided to meet those needs in a detailed and person-centred way. The positive behaviour support plans provided detailed guidance for staff on indicators that the individual's mood or mental state may be deteriorating, triggers for distressed behaviour and the individual's preferred ways of being supported by staff.

Staff regularly reviewed and updated care plans when young people's needs changed. Plans were reviewed and updated six-weekly by staff and more frequently if warranted, for example following an incident. We saw evidence on the records that plans were being updated when young people's needs changed.

Care plans were personalised, holistic and recovery-orientated. All the care plans and positive behaviour support plans we reviewed were of a high standard – person-centred, individualised and reflective of the assessed needs, preferences and personal goals of the young person. The young people we spoke with told us how involved they felt in how their care was planned and delivered and how they felt seen and supported as an individual by the service.

Best practice in treatment and care

Staff provided a range of treatment and care for young people using the service based on national guidance and best practice. They ensured that young people had good access to physical healthcare and supported them to live healthier lives. Staff monitored outcomes for young people using the service on an ongoing basis and shared this information regularly with the commissioners of their care.

Specialist community mental health services for children and young people

Requires Improvement



Staff provided a range of care and treatment suitable for young people using the service. Each person was being supported in a bespoke and person-centred way depending on their assessed needs. The registered manager described how each person's package of care was built around their needs and would involve psychosocial support from a team of support staff, psychotherapeutic interventions provided by the clinical and therapy leads and/or self-employed counsellors contracted by the service, joint working with a mentoring support service and potentially other interventions such as occupational therapy as needed.

Staff delivered care in line with best practice and national guidance. The registered manager told us that the service's model of care was developed in accordance with National Institute for Health and Clinical Excellence guidance on the treatment of mental health conditions and working with behaviour that challenges. The model was based around interventions in thirteen areas which included, for example, social interaction and inclusion, substance misuse and addiction, sexualised behaviour and child sexual exploitation risks, criminalised behaviour, aggression and risk to others and self-harm risks. The support provided included joint working with other stakeholders where warranted by the individual's needs in these areas, for example youth offending and probation services, the individual's social work team and specialist substance misuse services.

Staff made sure young people had support for their physical health needs, either from their GP or community services. Staff described how they supported young people to access healthcare services and how they shared information with young people's GPs. The young people we spoke with told us that staff helped them to access healthcare as and when they needed it.

Staff supported young people to live healthier lives by supporting them to take part in programmes or giving advice. Staff described, and care plans showed, how young people were supported to live healthy lives in a person-centred way, for example by identifying healthy food which met the individual's taste preferences and cultural needs. We observed staff supporting young people to undertake health-promoting activities, for example going to the gym. The young people we spoke with told us that staff were supporting them to live healthy lives, for example by giving advice about healthy diet, helping them to access services like substance misuse and smoking cessation and supporting them to undertake healthy activities which they enjoyed such as exercise.

The service used an internal process to assess and record the severity of patient conditions and care and treatment outcomes rather than nationally recognised rating scales. The registered manager told us that, due to the nature of the service, their interventions were targeted at supporting the young person with a specific, immediate need, for example reducing incidences of aggression or self-harm, or increasing community engagement and positive social interactions. The service submitted weekly reports to the commissioners of each young person's care which enabled the outcomes for the young people to be monitored both internally and by external stakeholders.

Staff used technology to support patients. There was a staff laptop at each person's home and staff had work mobile phones. They could access each young person's records, which were stored on shared drives, from both the laptop and their phones.

The registered manager told us that the clinical lead (a registered mental health nurse) also carried out clinical audits which enabled them to monitor the effectiveness of the service.

Specialist community mental health services for children and young people

Requires Improvement



Skilled staff to deliver care

The provider's staff team included or had access to the full range of specialists required to meet the needs of young people under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of young people using the service. The registered manager described how the service's model of care enabled them to access allied health professionals to support the individual as needed, for example psychologists and occupational therapists. The day to day support provided to the young people was by healthcare support workers and senior support workers but the service's clinical lead (a registered mental health nurse) had oversight of this and provided the support staff with supervision and guidance.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the young people in their care. The provider's recruitment process ensured that staff were appropriately skilled for their role and had relevant work experience. The interview questions had been designed collaboratively with young people using the service, which was an example of good practice.

Managers gave each new member of staff a full induction to the service before they started work. As well as the mandatory training programme all new staff were required to complete, new staff also completed a shadow shift at the home of the young person they would be supporting during which they were familiarised with the medicines storage, record keeping and incident reporting systems. All the staff we spoke with confirmed that they had received this induction.

Managers supported staff through regular, constructive one to one supervision sessions and annual appraisals of their work. For all staff groups over 80% of staff were up to date with their supervisions and appraisals except for area managers' appraisals where 50% of staff were up to date (due to one member of staff not having received an appraisal).

Managers made sure staff attended regular team meetings or could access information from those they could not attend. Team meetings took place monthly and staff were able to dial into the meetings remotely if they could not attend in person. The team meetings were minuted and copies of the minutes were shared with staff who could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The registered manager described how staff supervision and appraisals included an exploration of any training needs with the member or staff. We also saw evidence that training needs were identified during the investigation of untoward incidents and promptly addressed with the relevant staff members.

Managers made sure staff received any specialist training required for their role. The registered manager told us that staff were supported to access additional training as needed by the assessed needs of the young person they were working with, for example staff working with one young person with a significant history of trauma all undertook some additional training on trauma recovery. All the staff members we spoke with confirmed they had received all the training they needed to work effectively with the young people they were supporting.

Managers recognised poor performance, could identify the reasons and dealt with these.

Specialist community mental health services for children and young people

Requires Improvement



Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit young people using the service. They supported each other to make sure young people had no gaps in their care. They had effective working relationships with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss young people using the service and improve their care. The registered manager told us that each young person's care was reviewed by a multi-disciplinary team which included the senior leadership team (including the clinical and therapeutic leads), their allocated mentor (a separate service directly contracted by Positive Care Solutions) and their allocated therapist at least every six weeks, more frequently if the individual's changing needs warranted this. We reviewed minutes of these meetings which confirmed this.

Staff had effective working relationships with external teams and organisations. The registered manager told us that regular multi-agency meetings were held to review the support being provided to each young person, these would include input from external stakeholders including social services, any community CAMHS team working with the young person, their GP and their commissioners and care coordinators. These meetings were taking place at least bi-monthly and, for some young people, as frequently as fortnightly. Senior managers from the service were also included in the formal Care Programme Approach (CPA) and Looked After Child (LAC) reviews which were taking place in relation to some of the young people in their care. We also sought feedback from external stakeholders, which was mostly positive.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff were able to access support to understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. However, staff had not received training on the Mental Health Act.

Staff did not receive training on the Mental Health Act and the Mental Health Act code of practice. The service was not providing support to anyone who was detained under the Mental Health Act or subject to a Community Treatment Order at the time of our inspection and had not done so since registration. The registered manager said it was possible that they may do so in the future, but this was unlikely. However, as the service was supporting young people subject to the Care Programme Approach and those potentially at risk of crisis or admission under the Mental Health Act, this training would be relevant for staff.

Staff knew how and when to ask for support in relation to the Mental Health Act. The staff members we spoke with told us that they would raise any queries about the application of the Mental Health Act to the care of the young people they were supporting with the safeguarding lead.

Young people using the service had easy access to information about independent mental health advocacy. The young people we spoke with said they had contact with an advocate regularly and this person supported them to make their views and preferences heard.

Good practice in applying the Mental Capacity Act

Staff supported young people to make decisions on their care for themselves. Staff assessed and recorded consent and capacity or competence for young people who might have impaired mental capacity or competence. However, not all staff could demonstrate a clear understanding of the Mental Capacity Act and records of capacity assessments and decision making in young people's best interests were not always clear.

Staff received and kept up-to-date with training in the Mental Capacity Act. The provider's training data showed that 93% of support workers, 100% of senior support workers and 100% of area managers were up to date with their Mental

Specialist community mental health services for children and young people

Requires Improvement



Capacity Act training. The registered manager told us that this training also included an overview of the law on consent and how this would apply to children and young people. However, not all the staff we spoke with were able to clearly explain the principles underlying the Mental Capacity Act and how these would apply to the young people they were supporting. Following the inspection the provider told us that they have increased the competency testing of staff to ensure the learning from their Mental Capacity Act training is embedded in their practice.

Staff we spoke with knew where to get accurate advice on Mental Capacity Act. The staff we spoke with said they would access this from the safeguarding lead if they were unsure whether the person they were supporting had the capacity to make a particular decision.

Staff gave young people all possible support to make specific decisions for themselves before deciding they did not have the capacity to do so. Young people's care plans and positive behaviour support plans included individualised detail about the young people's preferred ways to communicate and guidance for staff on how to support them to make decisions for themselves. The young people we spoke with said they felt like they could make their own decisions about their care. Where restrictive practices were used without the individual's consent, we either saw specific legal authorisation for this on young people's records or that they were being used as a last resort to prevent harm to the individual or others.

Staff assessed and recorded capacity to consent. Capacity assessments were included on all the records we reviewed. However, capacity assessments were not always dated and therefore it was not possible to ascertain how specific and relevant they were.

When staff assessed patients as not having capacity, they made decisions in their best interests and considered their wishes, feelings, culture and history. Some of the young people being supported by the service lacked the capacity to make decisions about certain aspects of their care and as a result there were restrictions imposed by the service which amounted to a deprivation of liberty. Where this was the case there was legal authority for these restrictions to be imposed and a copy of this was stored on the individual's care records where staff could easily access it.

The service was not carrying out any formal audits of the application of the Mental Capacity Act at the time of our inspection.

Are Specialist community mental health services for children and young people caring?

Good



Kindness, privacy, dignity, respect, compassion and support

Staff treated young people with compassion and kindness. They understood the individual needs of young people using the service and supported young people to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for young people. We saw positive, person-centred and appropriate interactions between staff and the young people they were caring for during our visits to the young people's homes to observe care. Young people using the service appeared comfortable with staff and interactions between them were relaxed, friendly and sometimes light-hearted, but also professional.

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Requires Improvement



We saw in care records occasions where staff members had referred to distressed behaviour exhibited by young people using the service as “kicking off”, which raised potential concerns about the culture within the service relating to young people exhibiting behavioural signs of distress. The provider has told us that, since the inspection, they have started to develop further training for all new and existing staff members to support them in using positive and inclusive language at all times when speaking with and about young people using the service.

Staff gave patients help, emotional support and advice when they needed it. The young people we spoke with told us that they felt well supported by staff and they were able to talk to their staff team about things that were bothering them.

Staff supported young people using the service to understand and manage their own care treatment or condition. The young people we spoke with said that staff explained things to them in the ways they understood and they were supported to take care of themselves as much as possible.

Staff directed young people using the service to other services and supported them to access those services if they needed help. The records showed that young people were being supported to access a range of other helpful services including additional health and social care support, community activities and educational and employment opportunities. The service worked in partnership with a mentoring service which supported young people to engage with a wide range of activities in accordance with their needs and preferences.

Young people using the service said staff treated them well and behaved kindly. The young people we spoke with highly praised staff in relation to how kind and supportive they were. Several young people told us that this was the most supportive service they had ever worked with and they gave us examples of how this support had enabled them to make positive changes in their lives.

Staff understood and respected the individual needs of each young person they were supporting. We observed staff members interacting with the young people they were caring for and it was apparent that staff members knew the young people well and were working with them in a person-centred way. Young people using the service told us that staff treated them as an individual and listened to them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards young people using the service. All the staff we spoke with were aware of the provider’s whistleblowing policy and said they would feel comfortable to use this if they saw a colleague doing anything they felt was wrong. We saw evidence from the incident reports of staff raising concerns, for example about the use of restraint which was not in accordance with the training staff received on using physical interventions to manage aggression.

Staff followed policy to keep young people’s personal information confidential. Staff received training in the safe handling of information and both paper and electronic records were being managed appropriately at all the houses we visited to observe care.

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Specialist community mental health services for children and young people

Requires Improvement



Involvement of young people using the service

Staff involved the young people and gave them access to their care plans. It was apparent from the care plans and positive behaviour support plans that they had been developed collaboratively with the young people. The young people we spoke with told us that staff worked with them to support them in the ways they needed.

Staff made sure young people understood their care and treatment (and sometimes found ways to communicate with young people who had communication difficulties). As each young person had a small, dedicated staff team, staff had the time to make sure the young person understood the support which was being offered and the reasons for this. Young people's preferred ways of communicating including, for example, Makaton signing, were included within their positive behaviour support plans. However, at the time of our inspection staff were not receiving training from the provider in using Makaton. We raised this with them and in response they immediately arranged some Makaton training for staff, prioritising staff members who were supporting the individual who used Makaton. Young people were given written information about the service which was also available in an easy read format. Following the inspection, the provider told us that they have also supported a young person to communicate through partnership working with a local service provider for Deaf people.

Staff involved the young people in decisions about the service, when appropriate. Some of the questions used in the interviews for support workers and senior support workers had been designed by the young people. The provider developed information sheets for the young people about new staff members, which was a positive way of helping the young people to feel empowered and comfortable within their own homes.

Young people could give feedback on the service and their treatment and staff supported them to do this. House meetings were held regularly at each property with the young person and their staff where any concerns could be raised by the individual in relation to their care.

Staff made sure the young people could access advocacy services. The registered manager said that the service liaised with local advocacy providers to ensure the young people using their service could access advocacy as required. The young people we spoke with told us that they had been able to access advocacy when they needed to.

Involvement of families and carers

Staff supported, informed and involved families or carers. The relatives we spoke with told us that staff were approachable and kept them informed about how their relative was doing. Relatives of young people using the service were supported to spend time with them in a flexible and person-centred way, informed by the individual's care plan.

There was no formalised method for gaining feedback from relatives and carers such as a survey, but the relatives we spoke with said they had been given opportunities to give feedback on the care their relative was receiving. The registered manager told us that, as the business grew, they would develop more formalised methods of gaining feedback from young people using the service and their relatives or carers.

Staff did not offer carers information on how to find the carer's assessment. The registered manager told us that they felt this responsibility would sit more with social services than with their service. The carers we spoke with told us that they did already have information about this when their relative started using the service and they felt confident the service would have supported them in relation to this if needed.

Specialist community mental health services for children and young people

Requires Improvement



Are Specialist community mental health services for children and young people responsive?

Good



Access and waiting times

The service was easy to access. Its referral criteria did not exclude young people who would have benefitted from care. Young people did not wait too long to start treatment. The service ensured that young people who would benefit from care from another agency made a smooth transition.

The service had clear criteria to describe which young people they would offer services to. There was no waiting list for the service at the time of our inspection due to the nature of the service. Staff saw all new referrals quickly and within commissioners' target times.

Staff tried to engage with young people who found it difficult, or were reluctant, to seek support from mental health services. The registered manager told us that the initial assessment process was a lengthy and detailed assessment which involved multiple attempts to engage the young person in the package of support offered while building a rapport with them.

Young people had a great deal of flexibility and choice in how the service was provided to them. Once they were receiving support from the service this was done through a bespoke package of 24/7 care based on their assessed needs.

Staff supported young people when they were referred, transferred between services, or needed physical health care. The registered manager described how information was shared and young people were supported during the transition away from receiving support from the service. Young people using the service told us that staff supported them to access their appointments with other healthcare providers such as their community mental health team, GP and dentist as needed.

Facilities that promote comfort, dignity and privacy

The provider did not have any treatment facilities as young people were supported within their own homes and in the community by the service.

Meeting the needs of all young people who use the service

The service met the needs of all the young people – including those with a protected characteristic. Staff helped the young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled young people and those with communication needs or other specific needs. The records we saw included person-centred and individualised needs assessments and care plans which set out how these needs would be met. These included needs arising from protected characteristics such as cultural needs and needs due to disability.

Staff made sure the young people could access information on treatment, local services, their rights and how to complain. Written information was provided to every young person using the service in a format which was accessible to them, which included a summary of the services the provider was offering and how to raise concerns about their care.

Specialist community mental health services for children and young people

Requires Improvement



Managers made sure staff and young people using the service could access interpreters or signers when needed. The registered manager told us that the service would provide all the support required by the young person to enable them to communicate with staff to the best of their ability, including interpreters. Staff had not received training in using Makaton signing although some of the young people did have this as an identified preferred method of communication on their care plan. However, this was arranged immediately when we raised the issue with the provider.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Young people using the service, relatives and carers knew how to complain or raise concerns. The young people we spoke with told us that they had no complaints about their care but they would feel comfortable raising concerns with the staff they knew well if they ever needed to. The relatives we spoke with also told us that they would feel able to complain about the service if they were not happy with any aspect of their relative's care.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they were aware of the provider's procedure for handling complaints. The staff portal, which all staff had access to from their work laptops and mobile phones, included a facility for staff to report complaints which would then be flagged for investigation by a member of the management team.

Due to the small size of the service they had not received sufficient numbers of complaints to carry out any data analysis or identification of themes in relation to complaints. However, we saw that where concerns were raised by young people using the service these were fully investigated and action was taken to address any lessons learned.

Are Specialist community mental health services for children and young people well-led?

Requires Improvement



Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for young people using the service and staff.

We found the registered manager and other members of the senior leadership team to be knowledgeable and skilled in the management of a service providing targeted social support to vulnerable young people with complex needs. All the senior staff we spoke with came across as being passionate about their work and committed to providing a high quality service, with the needs of the young people being of central importance to all aspects of the service. Staff told us that the senior managers were approachable and accessible, including out of office hours.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The registered manager told us that the service's vision was to become a leading organisation within northwest England for supporting children and vulnerable adults, enhancing change and supporting development.

Specialist community mental health services for children and young people

Requires Improvement



The service values were:

- Providing a supportive service, day and night
- Always being there for each other, personally and professionally
- Using our real life experiences in everything we do
- Never giving up on people, no matter how challenging it may get.

All the staff members we spoke with were engaged with the service's overall ethos of providing consistent and positive support, building real relationships and providing targeted and individualised support to enhance the development, overall wellbeing and life opportunities of the young people they were supporting. The registered manager said that the senior leadership team was planning an all staff event which would focus on engaging staff with the organisation's vision and values more explicitly.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All the staff we spoke with told us that they felt respected and valued by local managers and the senior leadership team. None of the staff we spoke with raised any concerns about equality, diversity and inclusion not being respected within the organisation. Everyone we spoke with said they would feel able to raise concerns without fear of experiencing discrimination as a result. Staff told us that they felt they had opportunities for career progression within the organisation.

All the staff we spoke with said that there was a positive and happy culture within the staff teams, which was inclusive of the young people they were supporting, and the records we saw corroborated this. The provider carried out a staff survey to gain feedback from staff. At the time of our inspection there had been minimal uptake of this by staff, but the registered manager described the work which was planned to increase staff engagement in the survey to make this a more effective tool for gaining feedback from colleagues.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were largely managed well.

The provider had governance processes in place including outcome monitoring which was overseen by the young people's commissioners. They were also carrying out a range of audits in relation to various aspects of record keeping, management of medicines and health and safety checks at the young people's homes. Improvement actions identified from the audits were documented in an action log on the provider's online portal, which was monitored by the senior management team until fully completed.

The service had recently launched an internal quality improvement programme which mirrored the CQC key lines of enquiry and aimed to provide annual assurance that they were compliant with the Regulations and providing safe, effective, caring, responsive and well-led support to young people.

The outcomes of quality monitoring processes as well as other key indicators of safety and quality were reviewed by the provider's senior leadership team at monthly quality management meetings.

Specialist community mental health services for children and young people

Requires Improvement



However, we also identified some gaps in the provider's governance processes including a lack of training and audits on the application of mental health legislation to the service and insufficiently robust governance in relation to the use of restrictive interventions.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The senior leadership team maintained a register of the key risks to the quality and safety of the service and monitored this on an ongoing basis.

The monthly quality management meetings included ongoing review of issues relating to organisational and individual risks and we could see from the minutes of the meetings over time how the sharing of information about quality and risk contributed to the support being provided to the young people the service was working with.

We identified some concerns in relation to how records were made of the use of physical interventions by staff. Staff were recording the use of physical interventions both in incident reports and on individuals' care records. However, these records did not always include sufficient detail to evidence that these restrictive interventions were used in line with the Mental Health code of practice. The code of practice states that, where a person restricts a patient's movement, or uses (or threatens to use) force then that should be used for no longer than necessary to prevent harm to the person or to others, be a proportionate response to that harm, and be the least restrictive option. Since the inspection, the provider has told us that they have amended their restraint policy and template positive behaviour support plans to ensure they are fully person-centred and compliant with the Mental Health Act.

The provider did not have a restrictive interventions reduction programme, which is a national requirement in relation to the management of behaviour that challenges when working with people with a learning disability and/or autism. Following the inspection the provider told us that they have now developed a restraint reduction policy and they are formalising a restrictive interventions reduction programme to provide oversight of their compliance with national best practice in minimising the use of restrictive practices in care.

Information management

Staff collected data about outcomes and performance and engaged actively in quality improvement activities.

Due to the small size of the service at the point of inspection, outcomes were being monitored on an individual basis rather than through the collection and analysis of data. However, we saw evidence that the provider was developing its systems on an ongoing basis so as to introduce more data-driven monitoring and improvement work as the business grew.

Engagement

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area.

Specialist community mental health services for children and young people

Requires Improvement



The registered manager described positive multi-agency working in relation to the care of all the young people they were supporting at the time of our inspection. We saw evidence in the records of collaborative working which involved all agencies involved with each young person, which was led by a named care co-ordinator and we could see how the service contributed meaningfully to this. We spoke with commissioning case managers, most of whom said the young people whose care they were commissioning were being positively supported by the service.

Learning, continuous improvement and innovation

The provider was asked to give examples of innovative practice and they gave several examples of how they have used information technology to improve their standards of care. For example, two mobile phone applications had been developed for use by the management team to be in continuous contact with the staff working with the young people, which supported their governance processes, staff performance monitoring and staff wellbeing through support being readily available to them.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The service must ensure it monitors the use of physical interventions and has a programme in place to minimise use in line with national guidance. (Regulation 17(2)(a))

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The service must ensure that incidents are reported to CQC in accordance with the requirements of the Care Quality Commission (Registration) Regulations 2009. (Regulation 18 Notification of other incidents)