MOSAIC

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

We felt this was an excellent, well run service for children and young adults. Children and young adults needs were clearly at the centre of care delivery. The service continued to develop and respond to local need. There was a culture of learning and improvement throughout the service which was supported and encouraged by managers.

The service was based within a large modern building that had good health and safety arrangements. Arrangements were in place to manage environmental and clinical risks.

Staff were skilled, responsive to need and client focussed. Assessments and care plans were thorough and detailed, with clearly defined outcomes. Staff used best practice in planning treatment and care. There were evidence based psychological approaches used throughout the service and access to counselling and complementary therapies.

Staff were respectful and supportive towards clients. Service user participation and feedback was actively sought. There was an accredited training programme for peer support workers who were previous clients to work within the service. Peer support workers described ongoing support and development.

Summary of findings

There were clear referral pathways into the service and discharge/transfer pathways, including transitional planning for young adults moving to adult services. Staff worked flexibly, offering evening appointments and treatment groups.

The service had well established links with young carers' organisations. A therapeutic support worker had been employed to link with a local dog shelter with opportunities for dog walking and social contact.

The service had a clear organisational and team vision. Managers ensured that information about the service was communicated through the wider organisation and that information from the organisation was communicated to the team. Staff were encouraged and supported to develop skills and gain qualifications.

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Background to MOSAIC

Mosaic is a substance misuse service for young people under the age of 26 run by Stockport Metropolitan Borough Council. The service was part of the wider children's integration of services under "Stockport Family".

Services provided are

- Treatment service
- Education and schools based service
- Family service
- Complementary therapies
- Multi-agency support and liaison
- Counselling

The service was previously registered at a different location. The service moved address in 2015 and was re-registered. At the previous location the service was inspected on 14 February 2013 and 21 August 2013 and was found to be meeting all the standards that were inspected at that time.

Our inspection team

The team that inspected the service comprised CQC inspector Andrea Tipping (inspection lead) and one other CQC inspector.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

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

During the inspection visit, the inspection team:

- visited this location, looked at the quality of the physical environment, and observed how staff were caring for people who used the service
- spoke with six people who were using the service
- spoke with one carer of a person using the service
- spoke with the registered manager and the team managers
- spoke with nine other staff members who worked within the service, including nurses, social workers, family and schools team members
- spoke with six peer support volunteers
- spoke with the prescribing clinic doctor
- looked at five care and treatment records for people who used the service
- looked at four personnel and supervision files
- looked at policies, procedures, annual reports and other documents relating to the running of the service
- requested feedback from key stakeholders and commissioners for the service.

Summary of this inspection

What people who use the service say

We received positive feedback about the service from clients. We reviewed the most recent annual service user participation survey which reported from April 2014 to March 2015. Feedback was received from 72 participants who were positive about the service. This included evaluations from children of substance misusing parents who commented on positive aspects of the service, including activities that reduced social isolation, structured work and increased understanding of substance use. Other themes from children attending activities were that the service had helped in reducing isolation, having respite and time away from difficult situations, talking to and meeting other children living with similar situations and increasing confidence.

There was also parental and carer feedback about the family service. Positive evaluations regarding being welcomed, keyworkers, care plans and emotional and practical support were received from all participants.

Groupwork evaluation highlighted specific themes around meeting others, problem solving, confidence building and the group facilitators. The evidence informed think family programme received end of course feedback. This included understanding more how substance use impacts on children and importance of parenting and routine. There were a number of personal, highly positive comments regarding reinforcing a need to change and making decisions about substance use.

There were evaluations received for treatment work, which included clients attending for prescribing clinics and individual therapies. All clients felt welcomed, found staff caring and respectful, felt staff listened and explained well, with all giving a positive overall rating of the service.

There were also a number of compliments noted in the evaluation report from carers, clients and other professionals.

We received feedback from commissioners who said that the quality of service from Mosaic was of a high standard and flexible to meet the needs of complex and challenging young people. There was also positive feedback about the staff, noting they were proactive and committed to engaging and building strong therapeutic relationships with young people.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service was based within a large modern building which had good health and safety arrangements.
- Clinic rooms were clean and well organised, with medication fridge temperatures and medical devices checked.
- Staffing levels were well maintained and there was no use of bank, agency or locum staffing needed.
- Staff had received a comprehensive induction when they commenced employment and mandatory training at annual intervals thereafter.
- Staff undertook comprehensive risk assessments at initial assessment and these were reviewed regularly.
- There were procedures in place for lone working and evening appointments.
- There were arrangements in place with dispensing chemists, including supervised consumption arrangements.
- There had been no serious incidents in the last twelve months.
- Information and learning from incidents was shared with the team.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff completed thorough holistic and recovery focussed assessments.
- Staff completed physical health assessments.
- Records were stored safely and accessible to those who needed them.
- Staff used best practice in planning treatment and care.
- Evidence based psychological approaches were used throughout the service.
- Staff measured treatment outcomes and reported on these.
- There was a skilled multidisciplinary staff team.
- All staff received an annual performance review and received regular supervision.
- Staff maintained good relationships with workers in many other agencies including the voluntary sector and carers organisations.

Summary of this inspection

- Staff had been trained in and demonstrated good application of the Mental Capacity Act.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were respectful and supportive towards clients.
- Clients described staff as being positive and having good attitudes.
- Clients knew who their keyworker was and would see them consistently.
- Service user participation and feedback was actively sought.
- There was an accredited training programme for peer support workers who were previous clients to work within the service.
- Clients and peer support workers had been involved in the design of the building.
- Clients told us they were involved in setting their own treatment plans and direction of care.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There were clear referral pathways into the service.
- There were no waiting lists at the time of this inspection.
- Allocations were discussed weekly and allocated to the most appropriate keyworker.
- Team managers checked all service discharges, including scrutinising client records where they did not attend.
- Staff worked flexibly, offering evening appointments and treatment groups.
- There was a range of interview rooms and rooms for group work and complementary therapies.
- Staff linked in to other organisations to allow early identification of children and young people requiring support.
- The service had devised an emergency care pathway to offer support to children or young people whose substance use had brought them into contact with emergency services.
- The service had well established links with young carers' organisations.
- Written information had been devised in two formats which could be understood by young adults or younger children.
- A therapeutic support worker had been employed to link with a local dog shelter with opportunities for dog walking and social contact.

Summary of this inspection

- The service had a clear complaints procedure which was included in information packs and outlined in the waiting room.
- The service had used other methods successfully to capture feedback from clients.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had a clear organisational and team vision.
- Managers ensured that information about the service was communicated through the wider organisation and that information from the organisation was communicated to the team.
- Staff described managers as available and accessible when needed.
- There was a culture of learning and improvement throughout the teams.
- Staff were encouraged and supported to develop skills and gain qualifications.
- Sickness and absence rates were low and staff retention was good.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

There was clear understanding of the Mental Capacity Act and its application to the service. Staff had been trained in and were aware of the Mental Capacity Act (MCA). All clients were supported to make their own decisions in terms of their care plan. Staff were aware of the ages where the MCA was applicable and the Gillick principles for children.

There was no use of Deprivation of Liberty safeguards in this service.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Mosaic was based within a large modern building with other children's services. The building was extensively modernised prior to teams moving in with input from the different services that were based there. The team were based on the first floor and shared a large open plan office with several other children's services, including school nurses and youth offending services. Offices were accessed via electronic key fob. The main client areas were accessed via a welcoming reception area with two waiting areas. All interview rooms and clinic rooms were clean, with comfortable well maintained furniture. Several rooms had close circuit television cameras available if needed. There were no wall mounted call points but staff could use pendant alarms on request. Staff told us they would arrange joint interviews if there was a risk identified in relation to an appointment or interview. Clients would tell reception staff if they felt unwell or anxious and the reception area provided good observation of both waiting rooms.

There were two clinic rooms. One was used for consultation and the other was used for clinical interventions including physical health examinations, blood tests and vaccinations. Both rooms had desks and chairs for consultation and examination couches. The hepatitis B vaccines were stored in a locked fridge. The temperature of the fridge was checked daily to ensure medicines were stored at correct temperatures. Emergency medication in case of a reaction to vaccines was stored in an emergency cupboard and these were in date. Urine and saliva testing kits were also used within the service to ensure safe prescribing and these were ordered in small quantities to ensure they were used before the expiry dates.

Infection control audits were completed regularly and any actions completed. One of the nurses in the team led on infection control measures. Cleaning cupboards were tidy and organised, with equipment colour coded. Cleaning rotas were completed on a daily basis. There was sharps bin provision and a clinical waste contract for the removal of clinical waste. This was all in line with infection control requirements. Nurses used aprons and gloves when handling urine specimens or taking bloods.

Safety checks on electrical equipment were carried out when the team moved and when new equipment was ordered prior to use. A medical devices monitoring sheet was maintained by one of the nurses.

Safe staffing

The current staffing for the whole team was 26 staff in total, eight staff who worked for the treatment team, eight staff in the family team, six staff based with the school based team, one counsellor, two team managers and one senior manager.

These staff figures had been calculated in line with data regarding service need and caseload management.

Caseloads varied depending on the team involved and level of input needed. Staff felt their caseloads were manageable and these were regularly reviewed during supervision and weekly allocation meetings.

Staff arranged cover when planning annual leave and managers would arrange cover in the event of sickness. There was no use of bank/agency staff within this service.

Staff were all up to date with mandatory training, including health and safety awareness and safeguarding.

Assessing and managing risk to people who use the service and staff

Substance misuse services

Staff undertook an initial risk assessment at assessment. This was the trust approved risk assessment tool for over 18 year olds, and the young person's risk assessment for under 18 year olds.

These were updated regularly following appointments and we saw comprehensively completed assessments in five case files. Clients were involved in completing risk assessments and risk management plans. Risk assessments covered risks of violence, self harm, neglect, risks associated with substance use and harm minimisation, offending and home circumstances including children.

All staff were knowledgeable about adult and child safeguarding concerns and would refer these onto the local authority teams as needed. Staff were aware of the safeguarding contacts within the organisation. All treatment and family team staff followed the local authority safeguarding policy. School based staff reported safeguarding using the individual school's policy.

There were good local working procedures for lone working where staff undertook home visits including risk assessments and a calling in system. For staff working extended hours, seeing clients outside normal working hours within the building, there were staff on duty in the reception area and a buddy system was in place.

Fire safety assessments were completed when the team moved location. All staff had attended a fire safety briefing in the building.

Environmental risk assessments had been completed for the new building and client areas. These captured all the risks and controls in place.

Health and safety meetings had been held on a weekly basis for all the teams in the new building so that any issues or concerns were addressed.

Staff maintained good links with local dispensing chemists with one specific pharmacy used for most supervised consumption. Supervised consumption is where staff at the pharmacy dispensed a daily dose of a substance and ensure it was taken within the pharmacy. This reduced the potential for overdose or diversion of medication for selling. A list was sent from this pharmacy each week with information about prescription collections. This alerted the staff if anyone had not picked up medication for three or more days because they would then need to see a prescriber to re-start medication. Other chemists were telephoned to check if service users had been picking up their medicine. It was highlighted by the service to commissioners that there was a need for supervised buprenorphine dispensing arrangements, similar to existing arrangements for supervised methadone consumption arrangements which were already in place. There were three chemists in different areas of the town trained to deliver supervised buprenorphine medication.

Track record on safety

There had been no serious incidents reported in the last twelve months.

Reporting incidents and learning from when things go wrong

Staff were aware of the incident reporting procedure and we saw examples of these in terms of reporting if a client had attended and was intoxicated or aggressive and also trips/falls being reported.

Managers analysed the forms to ensure that any appropriate actions/changes were put in place immediately within the service. The local authority undertook a broader analysis of incidents. Integrated children's services were represented and feedback/lessons learnt were received about incidents that had occurred in other services.

Information and learning was shared within the team through team meetings and emails.

The team had been involved in two serious case reviews in the last twelve months and managers outlined a comprehensive process for staff who worked as part of the review teams outlining how this was supported. As part of reviews, if there were issues that the service may learn from, even if this was not specifically about the service, this learning was passed on to the team or working practices changed as a result. These reviews had not been published at the time of inspection.

A multi-agency review had taken place in the town two years ago into child sexual exploitation and the risks of this. One of the service workers was already in post as child sexual exploitation worker, seeing children affected and training staff in other services about potential exploitation. The review helped to enhance & embed the role & underpinned further training delivery to colleagues and

other agencies, some of which was delivered in partnership with domestic abuse and child sexual exploitation team colleagues. This was an example of learning and taking actions based on review findings.

Duty of candour

All staff were aware of responsibilities under the Duty of Candour. Staff told us that if mistakes or errors occurred, an immediate apology was offered. There had been no serious investigations in the last twelve months involving a more formal process.

Are substance misuse services effective? (for example, treatment is effective)

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

We reviewed five case records from the team. In all of these, there was evidence of a comprehensive initial assessment including risk assessment and ongoing records of treatment. Treatment plans were detailed, holistic and recovery focussed. Clients had been involved in the completion of these and plans were personalised to each client's circumstances and aims for treatment. All plans were signed and commented on by clients. These also included contingency plans in the event of unexpected exit from treatment. We saw evidence of liaison and multidisciplinary work with a wide range of other agencies, including child and family teams, looked after children's services, youth offending services, education providers, school nurses and young carers organisations.

Treatment staff were trained to undertake a basic health assessment: height, weight, blood pressure and spirometry testing. This was part of a wider public health initiative. Clients consent was sought for a standard letter detailing findings to be sent to their GP. We saw evidence of comprehensive physical health checks, including health promotion advice, and these were offered to all clients. Blood borne virus checks were offered and hepatitis A and B vaccination provided if needed. There were referral pathways for hepatitis C treatment if required.

Records were stored in a paper based format, although care plans and some documents were completed electronically. We found copies of all electronic information in the paper client record.

Best practice in treatment and care

Staff told us of the research and evidence base for approaches and treatments that they used. This included formal guidance such as National Institute for Health and Care Excellence (NICE) guidance and National Treatment Agency tools and guidance. The service also worked with a focus on children and families and used the common assessment framework where consent was given to offer early intervention to families and multi-agency support before their problems escalated. Staff identified key research papers and books that underpinned approaches, for example, family work. The prescribing doctor kept up to date through supervision and professional development with new treatment approaches, for example, Public Health England recommendations regarding pharmacological treatments for alcohol craving. There was a culture of innovation and continuous learning evident throughout the service.

Psychological approaches offered include motivational enhancement, structured treatment in the form of 1:1 and group work and relapse prevention work and ongoing support.

The treatment team offered structured evidence based interventions to young people under 18 and those aged 18-25, including treatment programmes as a part of statutory orders for young offenders aged 18-25.

The team provided pharmacological interventions for clients who were dependent on opiates. This included substitute medication to help clients manage their withdrawal symptoms and reduce their illicit opiate use, like methadone, and a similar medication, buprenorphine, known as an partial agonist, which blocks the clients from feeling any effect if they use another opiate on top of their prescribed medication. They also prescribed medication to help clients reduce their craving for alcohol like acamprosate. The prescribing doctor also initiated and monitored relapse prevention medications to prevent clients from using alcohol in the form of disulfiram and naltrexone. If clients drank alcohol when they were prescribed disulfiram, they would become physically unwell, which reduced the likelihood of them repeating the behaviour in the future. The service prescribed relapse prevention medication for opiate use in the form of naltrexone. Naltrexone has a full blocking effect, which prevented clients feeling the effect of the opiate. This reduced the likelihood of them using in the future because

they feel no effect from the substance. Naltrexone was also being prescribed to reduce alcohol cravings. Both disulfiram and naltrexone were recognised in the NICE guidelines for alcohol use to support abstinence.

A nurse within the team specialised in community alcohol detoxification with clear protocols and procedures for this. This involved close liaison with the client's GP for prescribing and daily monitoring visits. A screening tool for withdrawal effects was used at each visit and physical observations taken. Written information regarding the process, withdrawal symptoms and dealing with cravings was given. A clear care plan including contingency planning was devised with the client. There were clear pathways within the service for accessing inpatient detoxification or longer term rehabilitation programmes and maintaining links with clients who were transferred to services.

The family team received referrals from a number of agencies including social care/safeguarding, families, self referrals, substance use teams and schools and the school based service.

The team provided face to face and group work sessions for children affected by a significant others substance misuse. Interventions offered include counselling, motivational interviewing, attachment based interventions and solution based therapy. Interventions were provided to improve resilience, increase support networks, and coping strategies. The team aimed to engage the whole family where possible.

The family parent/carer service aimed to provide support for adults affected by or concerned by substance misuse, predominantly concerns about substance use by children and offering support to grandparents who have become primary carers due to parental substance misuse. They ran the community reinforcement & family training evidence based programme for parents/carers. A further programme was the "think family" programme, which was an intensive six month programme involving parents and children if appropriate. The aim of the programme was to help parents understand how their use affected children and to identify and develop strategies that reduced harm, built resilience and safeguarded children.

The schools based team offered education, brief interventions, overdose prevention advice, relapse prevention and harm reduction strategies. Referrals were predominantly made by schools, then self referrals and referrals by other agencies for example Accident and Emergency departments, school nurses, parents or family team. If more intensive treatment was required, a referral was made to the treatment team and the school team worker would often arrange a joint introduction session at the school. Further intervention may then be arranged at the team base but if this was difficult further sessions were arranged at the school. Schools based staff also provided some training to children and staff within their designated schools.

Counselling was available for clients to self refer to in addition to their treatment package. A counsellor was based at the service for four days per week. A mindfulness group ran weekly with clients and carers attending.

The service measured outcomes through annual reports for the school and family teams and outcome data for treatment was collated through the national data collection by the national data treatment monitoring service (NDTMS).

Outcomes for children seen by the family team were measured using pre and post intervention self assessment. Children reported feeling more confident in terms of their own ability to cope and knowledge in terms of their parents substance use and there were also improvements noted in children's self assessment of home life and school life.

Feedback from adults seen by the family team showed that 80% of adults reported positive change in family relationships and communication. Positive change was also noted in wider areas of life such as improved support networks, social life and employment .

There were outcomes measured for both adults and children who engaged in the think family group work programme. Retention rates were good, with two thirds of parents, totalling 49 adults who completed or were still receiving intervention. High levels of positive outcomes were reported in terms of reducing effect of drug/alcohol use on family life, communication and support within the family, problem solving and emotional and physical health issues.

Treatment team data was submitted to the NDTMS and reports used to identify trends. For example, data for alcohol related admissions in under 18 year olds was

available from 2012/13 in data reporting on alcohol indicating a high level of risk locally and this led to the development of the referral pathway with the local A&E department.

Figures for young people under the age of 18 were summarised in regular reports to the service, the most recent was key data for 2015-2016. Figures for young people over 18 were reported as adult treatment figures and merged with adult substance use services, which meant that extrapolation of key data for this service was difficult.

Skilled staff to deliver care

The team had staff from a variety of backgrounds and disciplines. This included nursing, social work and psychology backgrounds. All staff had further training and education within substance misuse, for example, diplomas in substance misuse work. The prescribing doctor was a GP with a specialist interest in substance use, and had a postgraduate substance use qualification.

Many staff had gained further qualifications which consolidated their skills and expertise, for example, in family work. Two members of staff were just completing formal training, one in social work and one in occupational therapy, to develop their skills and knowledge. A member of staff had been recently seconded from the service for 12 months to complete improving access to psychological therapies training, with the aim of improving skills in providing structured interventions for low mood and anxiety and other common mental health difficulties within the service.

There was a continuous drive to learning and service enhancement. For example, all staff had recently attended a one day bespoke educational session about new psychoactive substances. All family team staff had received training to run the group work programme.

Managers said that new NICE guidance was communicated to all staff via emails and team meetings and staff were expected to keep up to date with research evidence and clinical practice relating to their area of work.

Staff we spoke to described a comprehensive induction programme prior to starting work. Peer mentors undertook an accredited training programme with supervision and support prior to placement work.

All staff had an annual performance review and the level of staff who had undertaken this in the previous twelve months was 100%.

Staff received regular supervision and we were able to review four supervision records. These were comprehensive and covered caseload management and safeguarding issues.

Staff attended weekly team meetings.

Multidisciplinary and inter-agency team work

The service was part of a multiagency, integrated approach to children's services. This influenced the move of location, to be based with other children's services. The service was based with other specialist teams such as youth offending services but also with other local authority and healthcare based teams. Within the teams, there was close joint working evident, for example, clients seen at school who required treatment services and treatment team referrals for family support for carers of clients in treatment.

The family team maintained good links with child and family social services teams and adult services. If families were referred and there was familial substance use identified an automatic referral to the service is made. They also linked with young carers and voluntary organisations who provided support.

School based workers attended "team around the child" meetings or child protection conferences as needed. They were allocated to specific schools and had made good relationships with teachers and educational staff and school nurses.

Treatment team workers maintained good relationships with other children's services and with other healthcare providers. There were effective links with local child and adolescent mental health services and adult mental health community teams.

Several team workers had specific duties which required specific multiagency working. The tier 2 co-ordinator received automatic referrals for young people under 18 presenting to the local accident and emergency department with issues relating to substance use. They had developed good relationships with individuals within the department. One of the treatment team workers had extensive knowledge and training in child sexual exploitation (CSE) and was the CSE lead within the team.

They carried a caseload of clients affected by CSE and had also developed close working relationships with safeguarding agencies, care providers and agencies and the police.

Staff took a lead on other specialist areas such as mental health, looked after children and domestic abuse. This enabled staff to attend relevant meetings to ensure they were working in partnership with other agencies and taking relevant referrals. For example, a member of staff was linked to multi agency risk assessment conferences (MARAC) which is a multiagency approach to domestic abuse. They were proactive in checking all the referrals sent through a shared system that were being discussed at forthcoming meetings. Staff identified referrals where alcohol and drug use was a significant factor and contact was made to offer support. There was a clear multiagency pathway for this.

Mosaic staff provide training to other agencies and teams, both within the wider children's services and to other agencies, for example, midwifery services.

There were information sharing agreements and protocols in place. Staff were aware of sensitivity of information they held. When the service had first moved to a building shared with other teams there had been occasions where information was requested verbally by other teams' members. A process had been put in place whereby a written request was made explaining why information was needed.

When clients were first assessed, a comprehensive consent form was completed detailing any information sharing. The consent and confidentiality form was completed before any assessment was started. The confidentiality statement regarding safeguarding and risk was part of this discussion.

Adherence to the MHA (if relevant)

The service did not have detained patients

Good practice in applying the MCA (if people currently using the service have capacity, do staff know what to do if the situation changes?)

Staff had been trained in and were aware of the Mental Capacity Act (MCA). All clients were supported to make their own decisions in terms of their care plan. Staff were aware of the ages where the MCA was applicable and the Gillick principles for children.

Staff described situations where the case worker may have a different opinion than the client in terms of future outcomes. Clients with capacity were able to make their own decisions even if these seemed unwise.

The team described working in partnership with parents, social workers and mental health practitioners in the client's best interests if deemed as lacking capacity. Capacity was noted to occasionally be an issue in relation to clients presenting in an intoxicated state and often treatment decisions could wait until the client regained capacity and was in a position to consider information in relation to treatment decisions. Staff were able to seek more specialist advice within the overall integrated service in relation to capacity issues if needed.

Equality and human rights

Staff that we spoke with demonstrated a good understanding of equality and diversity issues. Staff were aware of issues which may affect young people, for example in terms of sexuality, and were able to talk sensitively of situations they had managed.

Management of transition arrangements, referral and discharge

A comprehensive transitional pathway was in place for clients who required transfer to adult services. This involved a period of joint working with both the provider and adult services and joint contingency planning with the client whilst transferring. Transition could be delayed or extended if necessary because of complex needs or intensive treatment being undertaken.

Within the school based team, a process was devised for occasional sessional support where children were discharged from active treatment but were still vulnerable, for example, because of home arrangements.

Are substance misuse services caring?

Kindness, dignity, respect and support

We witnessed respectful and supportive interactions by staff during this inspection. Clients told us that they found the service welcoming and felt they were treated well by everyone they came into contact with, including reception

staff. Reception staff were felt to be welcoming and discreet, and several clients knew their names. Clients all reported they were offered a drink when they arrived and felt this was a nice way to be greeted.

We spoke to six clients. Staff were described as positive, having a good attitude, helping clients feel empowered and motivated. There was also a theme of not feeling judged and that staff were always positive even if setbacks had occurred. Staff were noted to be flexible in terms of appointment times and responsive if extra support was needed. All clients knew their key worker and were positive about the input they received and the consistency of seeing the same worker.

Treatments offered had included complementary therapies, counselling and additional support, for example, pet therapy. Clients had valued being able to access complementary therapies including acupuncture and mindfulness training.

Clients referred to the holistic nature of the service, noting that they had been helped with information in relation to education, employment and other agencies by key workers. Staff empowered clients using the service and showed determination and creativity to overcome obstacles to delivering care.

We spoke to one carer who had been referred for support themselves when their family member had accessed treatment. They were positive about the care their relative received and their experience of the service and had also been offered and taken up several complementary therapies themselves.

The involvement of people in the care they receive

The most recent service user participation report 2015 was reviewed. Evaluations from 20 children of substance misusing parents indicated all found their keyworker helpful. All commented on positive aspects of the service, including activities that reduced social isolation, structured work and increased understanding of substance use. When asked what could be improved, 65% of participants could not identify any improvements with the remaining suggesting more activity/trips. Ten percent of participants suggested they would have preferred extended contact with the service. Evaluations were also received from ten children who attended regularly run activities and days out during the year. Positive feedback was received from all, with particular themes around reducing isolation, having respite and time away from difficult situations, talking to and meeting other children living with similar situations and increasing confidence.

There were 13 parents/carers who gave feedback about the family service. Positive evaluations regarding being welcomed, keyworkers, care plans and emotional and practical support were received from all participants.

The CRAFT (community reinforcement and family training) family group work programme received 14 participant evaluations. These were positive with specific themes around meeting others, problem solving, confidence building and the group facilitators. The think family group-work programme received end of course feedback including understanding more how substance use impacts on children and importance of parenting and routine, there were a number of personal, highly positive comments regarding reinforcing a need to change and making decisions about substance use.

There were 15 evaluations received for 1:1 treatment work. All of these reported that people felt welcome, found staff caring and respectful, felt staff listened and explained well, with all giving a positive overall rating of the service.

There were also a number of compliments noted in the evaluation report from carers, clients and other professionals.

All clients we spoke with said they were asked for feedback or suggestions regularly.

Several past clients had been recruited through the service to provide peer mentor support or to deliver training. Peer mentor trainees and substantive recruits who we spoke with felt well supported during training and once working. Peer support workers felt strongly about having the opportunity to work with a service that had helped them and being able to give something back. One peer mentor was involved in an open drop in group that ran and there were aims for this to be peer user led in future. There were further plans for peer mentors to be involved in staff interviews.

A great deal of consideration had been put into the design of the new premises to ensure that it would meet the needs of clients. Managers consulted with and sought staff and client feedback in the design of the reception. Peer mentors made decisions on the signage and visits to the building

prior to moving in. A flip chart was placed in the old premises reception to ask what clients liked about reception. Changes and adaptations were then made prior to moving location.

Each room in the new building had been designed with clients in mind and with input from service users and peer mentors. For example, the rainbow room was specifically for sessions with children and play therapy. This was decorated in neutral tones, with low comfortable furniture, therapy dolls, a wide range of toys for different ages in good condition and arts and crafts equipment.

Clients told us they were involved in their own treatment plans and setting their own aims for the future, both in terms of substance use and other life changes, for example, employment or education. Confidentiality policies were clearly understood and talked through, although two service users felt some unease about the shared waiting areas.

Are substance misuse services responsive to people's needs?
(for example, to feedback?)

Access and discharge

The service accepted referrals from a number of sources, including self-referrals. There was close working evident both within the different teams of the service and with other children's services and health and welfare services.

The annual figures up to March 2015 showed the school based service received 366 referrals, saw 291 young people for assessment and engaged in a planned intervention with 499 young people .

Annual figures up to March 2015 for the family team showed that there were 100 new referrals for children with substance misusing parents and that intervention was provided for 127 children (including some children referred prior to the reporting period).

Figures for adults seen by the family team over the same time period showed that there were 104 new referrals. Of these referrals, 75 received interventions or continued support from the team with a further 37 clients who were referred prior to the review period.

The service had a transitional pathway for clients who moved to adult substance misuse services. This involves ensuring consent for information sharing, joint handover meetings and a period of shared care planning including contingency planning. There was flexibility within the pathway for clients to continue comprehensive treatment with Mosaic if transfer may have a negative impact and for longer transitional planning if there were more complex needs.

The treatment team accepted referrals from other children and family services, education services, youth justice services, health and mental health services and self or family referrals.

Allocations were discussed in weekly team meetings. However if an urgent referral was received, allocation would be made on the same day the referral was received. Where possible, clients would be allocated to the most appropriate member of staff such as those identified as child sexual exploitation risk allocated to the lead for CSE cases. Priority was given to pregnant clients and those needing prescribing services. Each case was discussed individually in the team meetings to identify level of risk and priority.

The team managers checked all case closures to ensure the case management policy had been adhered to. This included making sure that the service user had been given three appointments if they had not attended and depending on risk that other services had been contacted such as probation services to see if a joint meeting could be arranged if clients were attending their service. They would also check that a seven day closure letter had been sent before closing the case.

Treatment discharge data was collated and reported to identify themes and trends. Figures for 2015 were reviewed. Just over a third of young people referred did not attend or engage with the service. There was a comprehensive policy outlining actions to be taken if clients indicated they no longer wished to engage, including offering support literature, delivering harm reduction advice, flexible arrangements to encourage engagement (for example, alternative venues), joint working if the client was referred by another service and re-referral processes and follow up. Risks were also reviewed in terms of safeguarding and other agency involvement and information sharing needed. The service had strategies to prevent missed appointments, including letter, text or email reminders and

offering diaries and written reminders. There were also arrangements in place for unplanned discharge (for example clients being detained in custody) and clients moving out of area.

The service provided flexible options, for example, evening appointments for clients who could not attend during the day due to employment or education. Structured treatment group work programmes were also often run in the evenings. There were peer support groups which met regularly at the service, including an early evening group for female clients only.

There was no waiting list for treatment at the time of inspection.

The facilities promote recovery, comfort, dignity and confidentiality

The service was based within a new purpose designed building with other integrated children's services. There was a large welcoming reception area and all clients were greeted and offered a drink whilst waiting. The reception desk had been designed to ensure that there was no screen between visitors and staff, but that confidential information and screens were housed below the desk so that these could not be seen. There were two waiting areas which were used by several different teams. Both rooms had clean, contemporary furniture. Information on notice boards was up to date and included harm reduction information, sexual health information and advice including the local service contact details and advocacy and complaints advice. Additional rooms were available near the waiting area if clients are too distressed or anxious to wait in the waiting area.

A corridor then led on to interview rooms and other rooms used by the service. There was a large group-work room which contained chairs which could be arranged to suit group numbers and purpose and soft lighting in the form of lamps. There was a counselling and complementary therapy room, decorated in soft tones and with comfortable furniture which could be adapted to suit the situation. There was also plenty of space to sit on the floor if clients or children preferred. The rainbow room had soft furniture and a variety of different aged toys in good condition and arts and craft equipment. The room layout was adaptable to suit different ages and needs.

A large conference room had a dividing partition so that this could be converted into two smaller meeting rooms. The large room was sometimes used for multidisciplinary meetings and case conferences or for training.

Interview rooms contained comfortable chairs and a low table for discussions, desks were available in the corners for teams who used these during sessions. All rooms had natural light and air conditioning was available throughout.

There were a number of smaller rooms designated as supervision rooms for staff use, but which could also be used as interview rooms if the need arose.

Meeting the needs of all people who use the service

The team manager attended several panels to ensure that Mosaic was responsive to the needs of the population of Stockport. The integrated children's panel discussed cases known to the service and other hard to reach young people who were using substances and the panel looked at improving access and engagement with young people into the services that would meet their needs.

The service had responded to an increase in the number of looked after children (LAC) and care leavers being referred for substance use and not being motivated to attend by providing a link worker for care leavers and LAC. The link worker had attended all the LAC and care leaver's team meetings to outline their role and build relationships. The link worker met with young people where they felt most at ease and would undertake outreach visits to engage the young person and build a rapport.

The service responded to recommendations in the Hidden Harm 2004 report by investing in the "think family" programme. This incorporated a group for parents focusing on how substance use affected children. Alongside this group children of substance using parents were allocated a worker to undertake therapeutic interventions around their worries.

The service had devised an emergency care pathway relating to both young people aged up to 18 years. The pathway had started in 2010 as a result of the service receiving no referrals from the emergency department but knowledge that clients and young people were attending intoxicated or with drug or alcohol related injuries/ reasons.The acute hospital emergency department staff referred all young people who had presented under the influence of drugs/alcohol. The Tier 2 co-ordinator within

the service assessed referrals and gathered information from other systems to make a decision on risk. The level of risk determined what action was taken, for example, referring to other agencies or accepting for assessment.

Senior leads and team managers attended the multiagency allocation panel which included social care, health and other key services. The referrals were from the multiagency safeguarding hub and a decision was made at the panel which service was most appropriate to undertake a common assessment framework assessment and which could lead to the team around the child (TAC) process. Mosaic led on some TAC meetings.

The service worked in partnership with other services to provide opportunities for service users for example an organisation which offers art groups and activities and young carers associations.

The service had worked well in ensuring information met the needs of both children and adults. For example, there were two separate leaflets outlining the counselling service, one for young adults and one for children. Both contained similar information but with different wording, examples and graphics to suit different client groups.

A therapeutic support worker was employed who worked in partnership with a local animal shelter. This enabled clients to attend the shelter and take the dogs walking. This could be part of engaging a client, part of their treatment or recovery. This was a successful part of the service and was led by evidence regarding the benefit of pet therapy for service users with mental health and/or substance use issues.

A counsellor who also provided complementary therapies was employed within the service. They provided acupuncture, mindfulness and one to one therapies as part of clients care plans.

Mosaic offered a flexible approach for clients which included one to one sessions, home visits, group work and late night appointments. There was always a member of staff available if clients needed urgent support either by telephone or dropping into the service.

Each member of staff had their own work mobile. This was due to some clients feeling more comfortable phoning or texting their worker direct. Clients diagnosed with autistic spectrum conditions or anxiety who preferred not speaking on the phone could use text messages. Workers could text appointments and check to see how the client was between sessions. We witnessed one phone call with a client who could not attend where the care plans and current progress were reviewed over the phone instead with the client's agreement.

All clients were given an information pack with details of the services on offer within Mosaic. This information was discussed with the client in the first session.

There was access to interpreters if they were needed and information leaflets could be sourced in different languages. Easy read information was available for those clients with learning disability or literacy needs.

Listening to and learning from concerns and complaints

The service had information displayed in the waiting areas which advised how to complain. The complaints procedure linked into Stockport Metropolitan Borough Council's overall complaints resolution. There were two staff who worked within the complaints resolution service.

In the last two years, the service had received two formal compliments addressed to the council and no complaints. There were cards and informal thank you messages displayed in the team offices.

The service had developed innovative ways to ensure that they gathered client's feedback. This included the use of cards in the waiting room, feedback questionnaires and posters displayed in the waiting room and flipchart comment pages.

Are substance misuse services well-led?

Vision and values

The service was part of the wider children's integration of services under "Stockport Family" which had a clear set of visions and values. These were to ensuring young people

•are given the very best start in life by their parents and carers

•enjoy good health and receive the services they need to become as independent as possible and to achieve the best health outcomes

•are well prepared for adulthood and engage in education, employment and training

•are supported in contributing to their community

•live safely and happily within their families.

The service had its own further overarching aim of reducing the harm caused to children, young people and families affected by substance misuse.

Staff knew the visions and values of the organisation and the service. They spoke of the work that they were doing and how this was improving children's and familie's lives.

The service had a business plan outlining aims and objectives for the service, potential risks to the service and possible future issues and plans.

Good governance

The service fitted into the overall governance of the integrated children's services run by the local metropolitan borough council. The service had weekly team meetings and management meetings. These fed into the integrated children's service quarterly wider management group meetings for all managers and senior management group meetings for the service managers. There was a newly formed senior leadership team which the service manager was a representative for. Staff represented the service at multi-agency safeguarding meetings, clinical governance, risk and child sexual exploitation forums.

The service benefitted from having a registered manager and team managers who had worked within the service for a number of years. Feedback about the registered manager and team managers was unanimously positive.

Managers knew their staff well. They were available and accessible when needed. Managers were based in the open plan office and senior leads sat with their teams which enabled an open culture. Managers provided regular supervision and organised team meetings. They ensured staff were aware of information they needed through verbal communication with their teams, meetings and use of emails. There was a culture of continuous learning and improvement, both in terms of lessons learnt but also in the sharing of good practice and treatment evidence. This was seen in the focus on new psychoactive substances, treatment approaches advised by the National Treatment Agency and the development of expertise in child sexual exploitation. Staff were supported to gain knowledge both through structured in house training but also via the gaining of formal qualifications.

The team produced outcome data and annual reports for the different stakeholders involved in the service, for example, local authority and education services. These broke down data in terms of referrals, complexity, substances used, aims for intervention, interventions offered and outcomes at discharge. Data was also provided to the national data treatment monitoring service with bespoke reports received allowing for analysis of key areas/ trends for improvement.

Leadership, morale and staff engagement

Sickness and absence rates in the service were low, with one team member on longer term absence. The retention of staff within the service was high with most of the team having been in the service for over six years.

Prior to the inspection, the provider had identified no concerns which needed to be reported to any professional bodies with regards to staff conduct. There were no grievances being pursued, no disciplinary proceedings, no performance management monitoring and there were no allegations of bullying or harassment.

There had been no whistleblowing information received. Staff described feeling able to raise concerns without fear of victimisation.

The morale in the team was described by staff as good, despite staff noting a period of transformational change and the uncertainty and stress that this could cause. Staff felt the move to a location with other teams had been largely positive, with some concerns about being based in a shared building and the large open offices being less conducive to having discussions within the teams without being overheard. However staff noted that there were supervision rooms and private rooms throughout the building and they would use these as needed.

Staff described good communication and support within their smaller teams and across the service.

There were opportunities for professional development and all staff described being supported to develop their expertise.

Commitment to quality improvement and innovation

It was notable that during a wider transformation programme undertaken to integrate children's services that this service used the opportunity to look at improvements

that could be made and was fully involved in plans for the building and environment of the new location. The service also ensured there were opportunities to involve clients, staff and carers in this.

There is a continual focus on service improvement and development, an example of this is that each member of staff had attended a one day course or a three day course on restorative practice. This is an approach based on building relationships and conflict resolution.

Outstanding practice and areas for improvement

Outstanding practice

The service ensured that staff were constantly updating their skills and knowledge, for example, in training all staff about new psychoactive substances and therapeutic approaches. A member of staff had been recently seconded from the service for 12 months to complete improving access to psychological therapies (IAPT) training, with the aim of improving skills in providing structured interventions for low mood and anxiety and other common mental health difficulties within the service.

The family service links with carer organisations had included team activity days and residential holidays for children who are young carers and the feedback for this was extremely positive. The service offered to adults, particularly parents, was also excellent and this was often offered alongside treatment for children/young adults.

The development of a pathway from A&E for those under 18 seen in crisis was innovative and responsive to local need. The evidence showed that this was working well.

The schools based team was an example of innovative practice and was clearly valued by all stakeholders, a reflection of the value placed in this service was that it was funded by every secondary school in the catchment area.

Areas for improvement

Action the provider MUST take to improve

None

Action the provider SHOULD take to improve

None