Compass - Lewisham Health and Wellbeing Service

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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.

Summary of findings

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 rated Compass – Lewisham Health and Wellbeing Service as requires improvement because:

- There had been a number of managers for the service, some of whom were managing the service for a short period. Staff reported that they had not felt supported by all managers and there had been inconsistency. There had been a high turnover of staff.
- There was no record of the learning from incidents being discussed and shared with staff in the service. The provider's incident matrix guided staff on when to report incidents. Identification and reporting of safeguarding issues and breaches of confidential information were not always reported as incidents. The incident matrix did not ensure that all events and incidents which should be reported as an incident were. The provider did not formally notify the Care Quality Commission of some incidents which it was legally required to.
- The governance system was not fully effective and did not integrate the provider's policies with the operational safety, quality and performance of the service. Managers did not have all the information they required. There was no accessible system to have oversight of the quality, safety and performance of the service.
- The service did not have a system for collating the feedback from young people, families or carers, to identify any themes or trends. This meant an important source of information that could drive improvement was missing.
- When people made complaints about the service, these were not always recorded or responded to as complaints. Senior managers did not have detailed information concerning complaints. The complaints policy did not contain an appeals process for complainants dissatisfied with a complaint investigation or outcome.
- Patient group directions for registered nurses to dispense medicines did not include the names of registered nurses authorised to do so. They did not follow legal or best practice requirements. The provider changed these immediately and confirmed no medicines had been dispensed.
- Information for young people was not always in an accessible format. There were no age appropriate or easy read versions of important information for young people with learning disabilities or reading difficulties.
- Staff did not measure and record the room temperatures where non-refrigerated medicines were stored. The effectiveness of non-refrigerated medicines may be affected if stored above the maximum temperature of 25 degrees.
- Staff lone working procedures were not known by all staff and had not been consistently followed.
- Staff and some managers did not have a full understanding of the duty of candour.
- Staff did not have a good understanding of the Mental Capacity Act 2005.

However, we also found the following areas of good practice:

- All young people in the service had a comprehensive assessment and risk assessment. These were detailed, included all aspects of young people's lives, and included all potential risks. Young people's wishes and preferences were explicit in their care plan and their risk management plans.
- Staff provided a range of interventions to support young people's sexual health, emotional and substance misuse issues. The interventions provided by staff followed best practice guidance from the Department of Health and the National Institute for Health and Care Excellence.

Summary of findings

- Staff displayed understanding, sensitivity and respect when talking about young people using the service. They provided practical and emotional support and ensured that young people were involved in, and directed, the level and type of support they needed.
- Staff were knowledgeable regarding potential risks to young people, including sexual abuse, gang involvement, child sexual exploitation and neglect.
- Staff undertook all mandatory training required. The mandatory training rate was 100%.
- Staff accompanied young people to other services for their first appointment when they required more support. This was particularly important when young people were attending adult services for the first time.

Summary of findings

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Background to Compass - Lewisham Health and Wellbeing Service

The provider took over this service in May 2018. The Care Quality Commission had not previously inspected this service.

Compass – Lewisham Health and Wellbeing Service is a community service for young people in the London Borough of Lewisham. The service provides early help for disadvantaged young people and families, universal services for the local population of young people, and targeted services for young people with specific needs.

The service provides interventions for young people in three specific areas: substance misuse, sexual health and emotional wellbeing. This includes providing outreach to schools and youth clubs.

The service provided by Compass – Lewisham Health and Wellbeing is for young people aged 10 – 19 years of age. The service is provided for young people up to 25 years of age when there is evidence they have additional needs.

The service is registered for the regulated activity: Treatment of Disease, Disorder or Injury.

The service had a registered manager in post.

Our inspection team

The team that inspected the service comprised a CQC inspector, a CQC assistant inspector and a specialist advisor, who is a consultant psychiatrist in addictions.

Why we carried out this inspection

We undertook an unannounced, comprehensive inspection of this service as part of our routine programme of inspecting registered services.

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, and had requested information from the provider about the service.

During the inspection visit, the inspection team:

- visited the service offices, where some young people were also seen
- spoke with the registered manager who was also the lead nurse for the provider
- spoke with five other staff members employed by the service provider, including the interim service manager, registered nurses, a counsellor and a health and wellbeing worker
- attended and observed a team meeting
- looked at eight care and treatment records for young people

Summary of this inspection

- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We did not speak with young people using the service during the inspection. This was due to the difficulties engaging young people using the service and the potential for inspection staff to put them off using the service.

The provider did not collate the feedback it received from young people, families or carers. This meant the provider did not have oversight of feedback about the service on an ongoing basis.

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?

Requires improvement 

We rated safe as requires improvement because:

- There was no record of the learning from incidents being discussed and shared with staff in the service.
- Patient group directions, for registered nurses to dispense medicines without a prescription, did not contain a list of registered nurses authorised to dispense medicines. This meant they did not follow legal requirements or best practice guidance. The service changed these immediately and confirmed no medicines had been dispensed since the service had opened.
- Staff did not measure and record the room temperatures where non-refrigerated medicines were stored. The effectiveness of non-refrigerated medicines may be affected if stored above the maximum temperature of 25 degrees.
- The procedures for lone working were not clear to all staff and had not been consistently followed.
- Staff and some managers did not have a full understanding of the duty of candour. They could not recall that when a mistake had been made they had to write to relevant persons to apologise. They did not describe keeping relevant persons updated on how such mistakes would be prevented in future. The registered manager informed us that the criteria for the duty of candour had not been met.

However, we also found:

- All young people in the service had comprehensive risk assessments. Young people's risk management plans were based on their risk assessments and focussed on minimising potential risks.
- Staff were required to complete safeguarding training as part of their induction. We were informed by the manager that this included PREVENT to raise awareness of young people's vulnerability to radicalisation
- Staff were knowledgeable regarding potential risks to young people, including sexual abuse, gang involvement, child sexual exploitation and neglect. Members of the team attended multiagency meetings, such as the critical risk safety panel and the missing, exploited and trafficked (MET) meeting.
- Staff undertook all mandatory training required. The mandatory training rate was 100%.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Staff provided a range of interventions to support young people's sexual health, emotional and substance misuse issues. The interventions provided by staff in these areas followed best practice guidance from the Department of Health and the National Institute for Health and Care Excellence.
- Staff completed a comprehensive assessment of young people who had been referred to the service. This assessment was detailed and incorporated their details of their personal, social and family life.
- Staff had undertaken a wide range of training so they could provide appropriate interventions for young people. Staff had been trained in psychological intervention techniques and had received training regarding sexual health and misuse of prescribed medicines.
- Staff had a good understanding of how to assess young peoples' competency. They understood Gillick competency and the Fraser guidelines.

However, we also found:

- Staff did not have a good understanding of the Mental Capacity Act 2005.

Are services caring?

Good

We rated caring as good because:

- Staff displayed understanding, sensitivity and respect when talking about young people using the service. They provided practical and emotional support to young people, and there were a number of cards from young people thanking the staff for the support they had provided.
- Staff accompanied young people to other services for their first appointment when they required more support. This was particularly important when young people were attending adult services for the first time.
- Young people's wishes and preferences were explicit in their care plan. Staff ensured that young people were involved in, and directed, the level and type of support they needed. Staff also involved families and carers when young people did not have legal competency or when young people consented to their involvement.
- Young people's risk management plans were individual and personalised and reflected their preferences and goals.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

Summary of this inspection

- The service recorded that one complaint had been received. Minutes of a team meeting recorded that complaints had been received regarding the late cancellation of appointments. These was no record that these were recorded as formal complaints. This meant that senior managers did not have detailed information concerning complaints.
- The complaints policy did not contain an appeals process for complainants dissatisfied with a complaint investigation or outcome.
- Information for young people was not always in an accessible format. There were no age appropriate versions or easy read versions of important information for young people with learning disabilities or reading difficulties.

However, we also found:

- The service had clear care pathways with other local services, particularly the child and adolescent mental health team and youth offending services.
- Staff understood the specific needs of young people with autism and physical disabilities and young people who identified as gay, lesbian or bisexual.
- Young people had a choice of where they could meet staff. This could be at the service offices, youth clubs, or at other services. School attenders could access the service at youth clubs in the evenings.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- There had been a number of managers for the service, some of whom were managing the service for a short period. Staff reported that they had not felt supported by all managers and there had been inconsistency. There had been a high turnover of staff.
- The provider's incident matrix guided staff on when to report incidents. Identification and reporting of safeguarding issues and breaches of confidential information were not always reported as incidents. Use of the providers incident matrix did not ensure that all events and incidents which should be reported as an incident were, or that the provider could monitor these effectively.
- The service had not made any statutory notifications concerning abuse or alleged abuse of young people to the Care Quality Commission. This was a legal requirement.
- The managers and team leader in the service did not always have all the information required to operate the service effectively. In addition to incomplete or incorrect performance

Summary of this inspection

data, information regarding the service was recorded in a number of different documents. Not all of these were available to managers all of the time. Accurate performance data for four months in 2018 had been collected at the time of the inspection. Information regarding the service was not collected in a way that enabled oversight of key indicators affecting the quality, safety and performance of the service. This included the absence of a system to regularly collect feedback from young people and their parents, to drive improvement.

However, we also found:

- Staff from the service attended local community events to promote the service and to raise awareness of the service. This work was also undertaken in schools. There were plans to expand the service to more youth clubs.
- Staff explained and provided information to young people regarding confidentiality and information sharing. If young people could not understand, this was explained to their parents or carers.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- All young people were supported to make decisions regarding the support the service provided. At their assessment, the young person had their competency assessed regarding what support they wanted from the service and what information about them could be shared. Specific questions regarding their referral to the service and what they hoped to achieve were included in the assessment of competency. When a young person was not competent, a parent or guardian provided consent on their behalf.
- The templates for the competency assessment and information sharing were detailed and comprehensive. However, this meant that some young people may have difficulty understanding some of the words and information. There were no easy-read or age appropriate templates. This meant some young people may be signing the templates indicating their consent without fully understanding all the information.
- All staff had undertaken training regarding the Gillick competency. Staff could describe in detail the elements of the Gillick competency test and the Fraser guidelines. Young peoples' records clearly recorded that their competency was thoroughly assessed regarding the support they would receive from the service. All staff had also undertaken training on the Mental Capacity Act 2005 (MCA). However, staff knowledge of the MCA was incomplete. They could not describe the five principles of the MCA.

Requires improvement

Substance misuse services

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

Are substance misuse services safe?

Requires improvement

Safe and clean environment

- Some young people met with staff at the service offices. Several rooms were available for appointments with young people. However, staff met most young people in youth clubs, which they visited weekly, or at other organisations.
- The entrance to the service offices was locked and access was controlled by staff. Closed-circuit television cameras were used in areas of the service used by young people.
- The service was clean and the seating and furniture in the service was in good condition. The waiting area had a clock, information leaflets and a water dispenser. Overall, the environment was well maintained.
- The service had a cleaning schedule.

Safe staffing

- In addition to the service manager, there were 12 full time posts. The vacancy rate was 38%, with five posts vacant. Four of these posts, including the nurse team leader and a counsellor, were filled by long term agency staff. The registered nurse vacant post was being advertised at the time of the inspection.
- Turnover of staff since the service opened 10 months earlier was 54%.
- Staff sickness was 1%.
- Staff worked during weekdays and met with young people during this time. Health and Wellbeing workers and registered nurses also visited a youth club once per week. There was sufficient staff to operate a duty rota at the service and to operate a rota for the youth clubs.
- The service used long term agency staff to cover vacancies and to provide consistency.
- The mandatory training completion rate was 100%. Mandatory training for staff included health and safety risk assessments, manual handling, infection control, information governance and basic life support.

Assessing and managing risk to clients and staff

- The inspection team looked at eight care records of young people using the service. Staff completed a risk assessment for all young people at their first appointment. When assessing potential risks, staff explored young people's home circumstances and peer group. Young people's risk assessments included the potential risk of harm to or from others, and included risks of emotional, physical, financial and sexual abuse, neglect and child exploitation.
- Staff used young people's risk assessments to develop risk management plans. These plans were based on the young person's views and identified events which would increase potential risks.
- Staff could describe how they would identify children at risk of harm. They described a wide range of potential risks including gang involvement, physical abuse, high risk sexual behaviours and sexual exploitation.
- Staff in the service had undertaken level 3 safeguarding children training and level 2 safeguarding adults training. They had also undertaken additional training

on female genital mutilation. Staff were required to complete safeguarding training as part of their induction. We were informed by the manager that this included PREVENT to raise awareness of young people's vulnerability to radicalisation. WRAP training was available, this was not mandatory training for staff.

- Staff worked effectively with other agencies to promote young people's safety and to share information. Staff attended child protection conferences and the critical risk safety panel. Staff also attended missing, exploited and trafficked (MET) meetings.
- The service had a safeguarding lead and all staff attended monthly reflective practice concerning safeguarding issues.
- Staff spent time working in the evenings at youth clubs. This involved staff arriving and leaving the youth clubs on their own. The provider had a lone working policy. However, not all staff were clear of the arrangements for lone working. The procedures for staff to call in, and to note their whereabouts on a board, had not been consistently followed. This had been raised in a service business meeting a month before the inspection. At the time of the inspection, some staff were not aware of the procedures when lone working.

Staff access to essential information

- Staff used an electronic notes system to record information regarding young people. When paper records were used, staff uploaded them onto the electronic notes system.

Medicines management

- Registered nurses in the service could dispense emergency contraception medicines and medicines to treat sexually transmitted infections. Registered nurses' competency to dispense these medicines was assessed by a GP with a special interest in sexual health, which was best practice.
- Nursing staff could use patient group directions (PGDs) to dispense these medicines. A PGD is a way for specific healthcare professionals to legally dispense a medicine without a doctors' prescription. However, the name and signature of the registered nurse authorised to dispense medicines was not kept with the PGDs. This was not in accordance with best practice guidance (Patient Group Directions, National Institute for Health and Care Excellence [NICE], 2013) or with The Human Medicines Regulations 2012. The service added this to the PGDs immediately and confirmed no medicines had been dispensed since the service had opened.
- The front page of each PGD recorded the updates that had been made to the PGD. However, these updates were not always dated. This did not follow the provider's policy and meant that there was no clear history of how the PGD had changed.
- Medicines were stored in cupboards at two youth clubs and in the service. Registered nurses checked these medicines weekly. This included recording the batch numbers and expiry dates of medicines. This was good practice. However, the temperature of the rooms where medicines were stored was not recorded. Non-refrigerated medicines should normally be stored at a maximum temperature of 25 degrees. If stored above this temperature, the effectiveness of the medicines may be affected.

Track record on safety

- There had been no serious incidents in the service since it had opened.
- In the event that a serious incident occurred, the provider would request the manager from a different service to investigate the incident. This would involve an investigation using root cause analysis to identify contributory factors. The provider's incident policy described the process to be followed.

Reporting incidents and learning from when things go wrong

- Twelve incidents had been reported in the service since it had opened. Ten of the 12 incidents reported were related to safeguarding. The provider had an incident matrix to assist staff with decision making and judgement regarding the seriousness of an event or incident. Prior to the inspection there had been no reported incidents for four months.
- All incidents were reviewed by the provider's senior management team and clinical governance committee. However, there was no record that incidents were discussed at the service team meetings. This limited the learning from incidents.

Requires improvement

Substance misuse services

- The service had recently commissioned an electronic incident reporting system. When operational, it was expected that this system would enable managers to capture, manage and monitor incidents more effectively.
- Staff and some managers did not have a full understanding of the duty of candour. Although the duty of candour was described in one of the providers' policies, at interview, senior managers could not recall the requirements to apologise in writing and to update relevant persons on actions taken to prevent repetition. However, the registered manager informed us that the threshold for the duty of candour had not been been met.

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

Requires improvement

Assessment of needs and planning of care

- Young people referred to the service had a comprehensive assessment of their needs. The assessment included information regarding the young person's family, relationships, personal and social functioning, emotional wellbeing, substance misuse and physical and sexual health. The areas covered in the assessment followed best practice guidance (Drug misuse prevention: Targeted interventions, NICE, 2017). Some young people also completed strengths and difficulties questionnaires to assist with identifying their needs.
- Staff developed care plans for young people based on their assessed needs. Young people's care plans were goal based and were specific, measurable, achievable and realistic.

Best practice in treatment and care

- The inspection team looked at eight young people's care records. The service provided brief interventions for young people with substance misuse or emotional difficulties. These interventions included psychosocial support or were based on cognitive behaviour therapy and motivational interviewing techniques. Young people were also able to engage in self-help via the provider's website with an online counselling service. For young people with moderate low mood, psychodynamic psychotherapy was provided by counsellors. All the interventions offered followed best practice guidance (Depression in children and young people: Identification and management, NICE, 2007; Drug misuse and dependence: UK guidelines on clinical management, Department of Health, 2017). Brief interventions were provided for six sessions. However, the number of sessions could be extended or reduced according to need. In April – July 2018, 200 young people started psychosocial interventions for their emotional wellbeing, and 42 young people had started counselling.
- For young people over 13 years of age seeking support regarding their sexual health, a range of support was available. The service worked with a pan-London organisation and Public Health England to be a distributor of free condoms to young people. The distribution of condoms took place in youth clubs in the evenings as part of an overall package of sexual health advice and interventions. This followed best practice (Sexually transmitted infections: condom distribution schemes, NICE, 2017). The 'clinic in a box' operated by the registered nurses in the service provided pregnancy testing, testing for specific sexually transmitted infections, emergency contraception, and sexual health advice and guidance. The range of sexual health interventions offered followed best practice guidance (Sexually transmitted infections and under-18 conceptions: Prevention, NICE, 2007). The 'clinic in a box' had been used by young people 61 times from April 2018 to July 2018.
- The service offered both universal and targeted interventions for young people. Universal interventions were offered to populations, and support workers provided educational groups at schools. Targeted interventions were offered to young people in local youth clubs in the evening. Staff could also meet with young people at the service and at partner agencies' services.

Monitoring and comparing treatment outcomes

- The service used the teen star as an outcome measure for young people using the service. The teen star is an outcome tool specifically used for young people with complex needs, including substance misuse.

- The service contributed information to the national drug treatment monitoring service. This service is operated by Public Health England and collects and collates substance misuse outcomes nationally.

Skilled staff to deliver care

- Staff had received a comprehensive induction when they started working in the service.
- Staff had undertaken training in cognitive behaviour techniques, solution-focused brief therapy and motivational interviewing techniques. Staff also had training on sexual health and the misuse of prescription medicines. Young people were allocated to staff members based on their needs and the staff member's skills. This meant that staff always worked with young people with the same type of needs.
- All staff received monthly supervision. Staff supervision records were structured and detailed. Staff supervision included a review of the care records of two young people.
- Recruitment processes were followed to ensure that all recruitment checks were completed before staff started working in the service. The recruitment checks included review of the staff member's education and work history and professional references. A disclosure and barring service (DBS) police check was received by the provider before staff started working in the service.
- Since the service opened, there had been some issues with staff performance in the service. These matters had been dealt with quickly and effectively.

Multidisciplinary and inter-agency team work

- Staff had access to information from the referrer when they assessed young people for the service. For example, staff had information from community mental health or youth offending services. Staff from the service also attended multi-agency meetings where some young people were discussed.
- Young people had an identified member of staff who would support them at each session they attended.
- All staff attended a weekly clinical meeting, where young people assessed for the service were discussed. Registered nurses and counsellors attended this meeting and could provide input into the support the young person may need. Staff also attended a monthly business meeting to discuss operational matters. A GP with a special interest in sexual health also provided input into the service monthly or more, as required.
- Staff attended a reflective practice group with a psychologist external to the provider.
- Staff in the service did not act as the lead professional for young people. They worked with other agencies to co-ordinate the support provided to young people. For example, the service worked with young people who were supervised by the youth offending service. Staff liaised with other services frequently to ensure that the support they provided was co-ordinated with and supportive of other services' input.
- Staff nominally worked with young people for 12 weeks, providing support at one meeting per fortnight. However, this could be tailored to weekly meetings, or the number of meetings could be extended. Young people could be referred to counsellors in the service and could access counselling within four to six weeks. When young people no longer required support, or required further support, they were discharged from the service. There were clear pathways for young people to be discharged to services, and staff in the service provided other services with relevant discharge information promptly.

Good practice in applying the MCA

- All young people were supported to make decisions regarding the support the service provided. At their assessment, the young person had their competency assessed regarding what support they wanted from the service and what information about them could be shared. Specific questions regarding their referral to the service and what they hoped to achieve were included in the assessment of competency. When a young person was not competent, a parent or guardian provided consent on their behalf.
- The templates for the competency assessment and information sharing were detailed and comprehensive. However, this meant that some young people may have difficulty understanding some of the words and information. There were no easy-read or age appropriate templates. This meant some young people may be signing the templates indicating their consent without fully understanding all the information.

Requires improvement

Substance misuse services

- All staff had undertaken training regarding the Gillick competency. Staff could describe in detail the elements of the Gillick competency test and the Fraser guidelines. Young persons' records clearly recorded that their competency was thoroughly assessed regarding the support they would receive from the service. All staff had also undertaken training on the Mental Capacity Act 2005 (MCA). However, staff knowledge of the MCA was incomplete. They could not describe the five principles of the MCA.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff spoke with enthusiasm and compassion regarding the young people they supported. They demonstrated understanding, sensitivity and respect for the young people using the service. Staff provided young people with practical and emotional support whilst they were using the service. There were a number of cards from young people thanking the staff for the support they had provided.
- Staff said that they would be able to raise concerns about colleagues' behaviour towards young people if they felt such behaviour was inappropriate. Staff did not consider there would be negative consequences for them if they raised concerns.
- Staff encouraged young people to access other services, when this was appropriate. Staff would accompany young people to other services for their first appointment when they required more support. This was particularly important when young people were attending adult services for the first time.
- The provider had a confidentiality policy and training regarding information governance was mandatory for all staff. Staff explained the importance of confidentiality to young people during their initial assessment at the service.

Involvement in care

- Young people's wishes and preferences were explicit in their care plan. Staff ensured that young people were involved in, and directed, the level and type of support they needed. Young people were encouraged to engage with the service and to understand and manage their problems. Staff adapted the way they communicated with young people to meet their preferences, such as providing motivational text messages.
- Young people's risk management plans were individual and personalised and reflected their preferences and goals.
- Staff actively engaged with families and carers when young people did not have legal competency or when young people consented to their involvement. This included working with the family to provide mediation.
- The provider was unable to provide comprehensive information regarding feedback they had received about the service from young people, carers or their families. Feedback forms and leaflets were used and there were individual examples of feedback praising the staff and the service. However, these were mainly from other professionals or related to educational sessions provided in schools. The lack of comprehensive feedback, provided over time, meant that the provider did not have oversight of feedback about the service on an ongoing basis. This meant an important source of information to drive improvement was missing.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access, waiting times and discharge

- Young people were referred to the service from a wide range of organisations. These included accident and emergency departments, social services, youth offending services, child and adolescent mental health services, schools and GPs. Young people could also refer themselves to the service.
- When the service was unable to meet the needs of a young person staff could refer them to a more appropriate service. Work with other agencies was

assisted by the service being represented at local multi-agency groups, including the early help panel. On some occasions, staff accompanied young people to other services.

- A key performance indicator was for staff to meet and assess a young person within five days of receiving the referral of the young person to the service. Performance information regarding how often the service achieved this was not available at the time of the inspection.

Discharges and transfers of care

- The service had clear care pathways with other local services. This included a significant number of young people referred from the service to child and adolescent mental health services or vice versa. Other care pathways included sexual health services providing more comprehensive screening and treatment than the service offered.
- The service had clear criteria for young people whose needs the service could meet. There were separate criteria for emotional health and wellbeing, sexual health and substance misuse. The criteria included young people where the service could support them but would also need to refer the person to a specialist service. Three months prior to the inspection, the service had started providing interventions to young people with suicidal ideas or who were self harming. Staff expressed concern that they did not have the skills to meet the needs of these young people. Following this, senior management considered the views of staff and worked with the commissioners and other local agencies to redirect these referrals to suitable services who could meet the needs of the service users.
- Staff in the service accompanied young people when they visited other agencies for the first time. This was particularly the case when young people first started attending or transitioning to adult services.

Meeting the needs of all people who use the service

- The service was provided for young people aged 10 – 19 years of age. However, young people with disabilities could access the service up to the age of 25 years.
- Staff understood the specific needs of vulnerable young people. This included young people with autism, physical disabilities and young people who identified as gay, lesbian or bisexual.
- Young people had a choice of where they met staff from the service. This could be at the service offices, youth clubs, or at other services. The service held evening clinics at youth clubs so school attenders could access services.
- The service used a telephone interpreting service when young people or their families could not speak English as a first language.
- Information for young people was not always in an accessible format. For example, the comprehensive assessment form used for young people contained four pages of information regarding consent and information sharing, for the young person to sign. There were no age appropriate versions or easy read versions for young people with learning disabilities or reading difficulties. Similarly, there were no alternatives to the complaints and compliments leaflet.

Listening to and learning from concerns and complaints

- The service had received one formal complaint since it had opened. This complaint was from a partner agency and the complaint was dealt with immediately. However, two months before the inspection, service business meeting minutes recorded other complaints received. These complaints were regarding appointments being cancelled by staff at the last minute. A further complaint concerned a refusal to share information due to a young person not consenting. These was no record that these were recorded as formal complaints. This meant that complaints, which should have been dealt with as formal complaints, were not. Senior managers did not have detailed information concerning complaints.
- The provider had a complaints policy which described how complaints were managed. However, the policy did not describe how a complainant could appeal the outcome of a complaint or how a complaint was investigated. The policy described the service approaching commissioners to 'arbitrate' if a complainant remained unhappy. The role of the commissioners of the service was not to arbitrate complaints. The provider should have had an internal procedure to review how complaints were investigated and their outcome.

Requires improvement

Substance misuse services

Are substance misuse services well-led?

Requires improvement

Leadership

- Leadership in the service had not been successful with the original service manager. Staff had felt unsupported and there was a high turnover of staff. There had been a number of interim service managers in the service in the two months before the inspection. On some occasions there was no service manager and another senior manager spent time at the service in addition to their other duties.
- The registered nurse team leader provided clinical leadership in the service. They were an agency member of staff and had significant nursing experience. However, they did not have specific nursing experience in sexual health, substance misuse or mental health. This limited the team leader's knowledge and ability to provide clinical leadership in these specific areas of work.
- In the months before the inspection, some business meeting minutes reflected an authoritarian leadership style in the service. Staff were told about changes in the service and instructed to undertake additional work in a way that was not supportive to staff.
- The interim service manager and registered nurse team leader had a good understanding of the service they managed. They were visible in the service and were approachable to staff.

Vision and strategy

- Staff understood the vision of the organisation to provide an effective, safe and user-led service. However, they felt unable to fully embrace this vision due to the recent changes in interim service managers and feelings of lack of support. Staff had also found it stressful supporting young people who were actively self harming or suicidal. The decision to support these young people had been made without fully involving staff or understanding their skills and experience. The decision to support these young people was changed again soon after. At the time of the inspection, the service was not supporting these young people. Staff were involved in discussions about some changes in the service.

Culture

- Staff felt unsupported and not listened to. Whilst staff spoke of job satisfaction working with young people and seeing their progress, they were not satisfied with their jobs. They were not positive and described the management approach at times as confrontational, inconsistent and lacking openness. However, it was clear that this only applied to some managers. Staff morale was low.

Governance

- There was a lack of clear structure at team meetings. Incidents, safeguarding referrals and complaints were not standing agenda items. This meant that review of these events and learning from them was not incorporated into the day to day operation of the service.
- There was a monitoring system for staff undertaking mandatory training and for recording incidents. However, information regarding these areas was held separately. In addition to medicines audits, care plan audits were undertaken each month and in each staff members' supervision. This information was also held separately. There was no system for formally monitoring that all staff had regular supervision. Information concerning staff and the work they undertook was not easily accessible in one place.
- Registered services are required to formally notify the Care Quality Commission (CQC) of certain incidents or events. One type of event is when staff in the service make a safeguarding children or adult referral to the local authority. Staff in the service had made several safeguarding children referrals since the service opened. The service had not notified CQC of these.

Management of risk, issues and performance

- The performance of the service was measured by specific activities and interventions undertaken by the service. These were aligned to metrics used by the

national drug treatment and monitoring service and to the service commissioned. Accurate data regarding service activity and performance had been collected for April – June 2018.

- The governance system was not fully effective and did not integrate the providers' policies with the operational safety, quality and performance of the service. Information regarding the service was not collected in a way that enabled oversight of key indicators affecting the quality, safety and performance of the service.
- The provider's' incident matrix was to assist staff with decision making and judgement regarding the seriousness of an event or incident. However, the incident matrix described some incidents or events as being managed by 'case management'. This meant staff were not required to complete an incident form. Events dealt with as 'case management' included identifying and reporting safeguarding issues. Breaches of confidential information did not require incident reporting if less than ten people were affected. Both safeguarding and disclosure of confidential information were items on the provider's clinical risk register. Use of the incident matrix did not ensure that staff reported all events and incidents, which meant the provider could monitor these effectively. Incidents that the provider was required to report in accordance with data protection law were not recorded as incidents.
- The provider maintained a clinical risk register for the service and this had been updated just prior to the inspection. An item on the risk register concerned medicines being stored at the correct temperature and being dispensed in accordance with standard operating procedures. The room temperatures where medicines were stored were not recorded and PGD documents had not been signed by authorised registered nurses. The measures recorded on the risk register to control the risks had not been effective. The risk register included a risk concerning outreach work and lone working. However, this did not reflect the lack of clarity staff had regarding lone working procedures at the time of the inspection. At the time of the inspection, there had been a high turnover of staff in the service and high use of agency staff. The risk register did not include the risk of lack of suitably skilled staff being available to operate the service.
- The risk registers for each of the youth clubs were almost all identical. They included potential risks regarding confrontation with parents and infection control. However, risks specific to individual youth clubs, such as increased risks of violence in an area were not recorded. The actions to minimise risks were not always practical. For example, risks to staff were to be mitigated by only working in daylight hours, or between nine am and five pm. The service only operated in youth clubs in the evenings.

Information management

- The collection of reliable information regarding the service had been problematic for several months. Senior managers had not been able to effectively monitor the quality and performance of the service due to incomplete or incorrect information. These issues had recently been identified and acted upon. However, as part of the remedial action taken, staff were required to input data for the previous three months for the second time. Staff had been provided with a very short time frame to complete this and had been a significant burden on staff time. However, we noted that additional resource and support was provided by the organisation's central services such as members of the quality assurance team, for example, the business systems analyst.
- The managers and team leader in the service did not always have all the information required to operate the service effectively. In addition to incomplete or incorrect data, information regarding the service was not available to managers all of the time.
- Staff stored all of the information required to provide support for young people electronically. This system could be accessed by all staff when they needed it.
- Staff explained and provided information to young people regarding confidentiality and information sharing. When assessed as competent, young people indicated who they consented the service to share information with. With young people who were not competent, parents or carers made these decisions.

Engagement

Requires improvement

Substance misuse services

- Young people, family members and other professionals had opportunities to feedback regarding the service. However, this feedback was not collated to identify themes and trends and areas for improvement.
- Staff from the service attended local community events to promote the service and to raise awareness of the service. This work was also undertaken in schools. There were plans to expand the service to more youth clubs. Young people had chosen a new name for the service.

Learning, continuous improvement and innovation

- The service did not take part in any research or innovative practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all events and incidents that should be reported as incidents are reported. The provider must ensure that there is a record that the learning from incidents is disseminated to staff.
- The provider must ensure that complaints and responses to complainants are appropriately handled and recorded. There must be a clear process for complainants to appeal the way a complaint has been investigated or the outcome.
- The provider must ensure that there is an integrated governance system which effectively records and reports on safety, quality and performance in the service, and which enables the provider to proactively identify risks and improve the quality and safety of the service. The provider must systematically seek and act on feedback from young people using the service.
- The provider must ensure that statutory notifications are made to the CQC.
- The provider must ensure that the temperature of rooms where medicines are stored are checked and recorded regularly.

Action the provider SHOULD take to improve

- The provider should ensure that there is consistent leadership from a service manager and that action is taken to address the recruitment and retention of staff.
- The provider should ensure that Patient Group Directions are developed and operated in accordance with best practice guidance and relevant legislation.
- The provider should review whether WRAP training should be mandatory training for staff at the service.
- The provider should ensure that procedures for lone working are understood and used by all staff.
- The provider should ensure that all managers have a full understanding of the requirements of the duty of candour.
- The provider should ensure that all staff have a detailed understanding of the Mental Capacity Act 2005.
- The provider should ensure that information for young people is age appropriate or otherwise meets their specific needs.

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	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The system for receiving, recording, handling and responding to complaints was not operated effectively. This was a breach of Regulation 16(2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service or to assess, monitor and mitigate the risks to the health, safety and welfare of young people using the service. The service did not effectively seek and act on feedback. This was a breach of Regulation 17(1)(2)(a)(b)(e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents When young people in the service disclosed allegations of abuse the service did not make statutory notifications to CQC. This was a breach of Regulation 18(1)(2)(e)

This section is primarily information for the provider

Enforcement actions

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.