Winstone House - Horizon

Quality Report

Winstone House
199 Church Street
Blackpool
Lancashire
FY1 3TG
Tel: 01253 205157
Website: www.horizonblackpool.uk

Date of inspection visit: 18 October to 19 October 2017
Date of publication: 30/01/2018

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 found the following issues that the service provider needs to improve:

- Client records including assessments, risk assessments, and recovery plans were poorly documented. Information was missing and records were not updated regularly. The electronic record system was not effective in supporting staff to record or locate client information. Information was difficult and time consuming to find. This meant that vital information to implement client care was not available.
- Client records had been transferred from the previous provider in April 2017. However, staff were unable to locate them within the electronic record. This meant that staff had to repeat assessments and plans unnecessarily. Staff were not able to complete this in a timely way. This had not been reported as an incident and therefore any future prevention was not clear.

Summary of findings

- Staff managerial and clinical supervision figures were low and did not meet the provider's target of every six to eight weeks. This meant that staff were not appropriately supervised in their roles.
- Staff did not understand the Mental Capacity Act, code of practice and best interest checklist procedure. Staff were unaware of how to assess capacity or how to act on the findings.

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

- Access to keyworkers, doctors and other disciplines was good. Staff were able to prioritise urgent needs and see clients the same day if necessary. There was also a psychologist newly in post who could provide therapy to clients with complex psychological issues.
- Clients gave excellent feedback on the attitude of staff and the service they receive. Clients stated that staff were flexible to meet their needs and caring. Clients felt the service had positively transformed their lives.
- Managers were visible within the service. Staff felt supported by them and that they could seek informal support at any time. Staff described managers as approachable and able to recognise caseload limitations.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		See overall summary

Summary of findings

Contents

Winstone House - Horizon

Services we looked at
;Substance misuse services

Summary of this inspection

Background to Winstone House - Horizon

Winstone House – Horizon provides community substance misuse services for the Blackpool area. The service is commissioned by the local authority as part of a wider service pathway. Winstone House – Horizon provides support for clients who have stabilised their substance misuse and require a psychosocial and clinical approach to their recovery, providing one to one keyworker sessions and access to group work. The wider pathway includes three other locations that provide;

- initial assessments and risk assessments of newly referred clients
- support for complex clients
- prescribing for detox and stabilisation
- support with abstinence
- volunteering opportunities
- employment and education options

The wider parent organisation fed into the service and provided some group work. This included:

- dependency emotional attachment programme groups
- reduction and motivation programme groups
- pre- dependency emotional attachment programme groups

The service was registered to provide the regulated activity of treatment for disease, disorder or injury. There was a registered manager in post.

The service had been registered since April 2017 and therefore had not previously been inspected.

Our inspection team

The team that inspected the service comprised CQC inspector Clare Fell (inspection lead) and a nurse specialist advisor.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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 asked other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- visited the location, looked at the quality of the physical environment and observed how staff were caring for clients
- spoke with 14 clients
- spoke with the registered manager and the integrated service manager
- spoke with six other staff members employed by the service provider, including nurses and support workers
- attended and observed two client group sessions
- collected feedback using comment cards from 42 clients
- looked at eight care and treatment records, including medicines records for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients described the service as much improved since changing location and provider in April 2017. Clients commented on the improved environment being bright, open and welcoming. Clients felt staff were friendly and non-judgemental in their approaches towards them. Clients described the service as flexible to meet their needs and that staff endeavoured to support them with a wide range of issues. Clients who attended group sessions were particularly complimentary regarding the support they received and the encouragement from the group facilitators. Clients remarked how the service had positively transformed their lives.

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 issues that the service provider needs to improve:

- Risk assessments were not always updated or fully completed in line with the organisations policy. Vital information had not been recorded or included in risk management plans.
- Some client information recorded prior to April 2017 could not be located on the electronic recording system. Staff and managers were not aware of how to access this information. This had not been reported as an incident and lessons learnt procedures had not been followed.
- Staff had limited time to complete the necessary documents for each client. This was due to a poor electronic record system and additional work of repeating documents. This meant that client records were not always fully completed or up to date.

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

- Access to doctors and non-medical prescribers was good. Urgent needs could be prioritised and addressed promptly. There was a doctor or non-medical prescriber available each working day.
- Mandatory training rates for staff were good. Staff training was easily accessible and relevant to their role. Staff described the training as good quality.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Comprehensive client assessments were not always completed to the expected standard. One client did not have an assessment and two assessments were poorly completed. This meant that key information relating to client's care and treatment was not recorded.
- Recovery plans were also not completed or were of poor quality. This meant that clients' goals, aims, views and treatment were not documented.

Summary of this inspection

- Client's physical health needs were poorly recorded. It was difficult to locate physical health information within the electronic record system. Information regarding client's physical health needs following referral into the service was not recorded well.
- Staff were not receiving formal supervision in line with the providers' policy. Supervision figures were low and staff reported a lack of consistent supervision.
- The electronic record system was not effective in supporting staff to record or locate client information. Information was difficult and time consuming to find.
- The Mental Capacity Act and code of practice was not well understood by staff. Staff did not understand how to proceed if a client lacked capacity. This included a lack of understanding of how to assess capacity and the best interest checklist. Staff were unaware of the capacity assessment form that was available.

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

- A psychologist had been appointed to work with clients on individual therapy and input into group sessions. The service was aware of the link between adverse childhood events and substance misuse.
- A substantial range of key performance indicators were used to measure the success of the service. Data was used to address issues in the service and make improvements.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff demonstrated respectful and caring attitudes towards clients at all times. Staff were friendly and welcoming whilst also having skills to challenge clients appropriately when needed.
- A family worker was employed to engage with families and carers of clients with substance misuse problems. Individual and group work sessions were available to anyone requesting this support. Informal information and advice was available as well as structured group sessions.
- Feedback from clients was gathered using a wide range of methods. Clients gave excellent feedback regarding the service they received and the attitude of staff. Client felt the service had improved their lives and that the staff had a positive and professional approach.

Summary of this inspection

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Access into the service was prompt and urgent referrals could be seen more quickly. There was an effective system in place to triage and assess new referrals. A duty system supported staff to allocate time for unexpected or urgent cases.
- The service targeted clients who found it difficult to engage with substance misuse services. Specific client groups were being supported to engage in substance misuse work.
- A more flexible approach to keyworker appointments had been adopted following negative feedback from clients. Future appointments are now booked at times convenient for the client.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- The lack of access to client information was not recorded as an incident and therefore procedures for learning lessons were not available. The implications of this were not detailed on the risk register.

However, we also found areas of good practice, which included:

- Staff described managers as having a visible presence within the service. Staff felt managers were approachable and easily accessible to offer clinical advice and support.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Despite staff being up to date with training in the Mental Capacity Act, staff lacked knowledge and understanding of the Mental Capacity Act and the five statutory principles. Mental Capacity Act training was mandatory and 83% of staff were compliant with this training module. However: staff were unclear regarding any actions or processes they would follow for clients who might have impaired capacity. Staff were unaware of how to complete a mental capacity assessment or how to follow the best interests checklist. There was a mental capacity assessment tool but staff were not aware of it. Staff said they would refer to another agency to complete the capacity assessment. This is not in line with the Mental Capacity Act or the mental capacity policy. Staff were not aware of the mental capacity policy or how to seek advice within the service.

The service was aware of the changing demographics of clients using the service. This included an increase in older people and people with complex mental and physical health needs. This meant that the likelihood of clients requiring a mental capacity assessment was increasing.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Interview rooms were not fitted with alarms. Staff had access to personal alarms but other staff, due to the layout of the building, could not always hear them. Interview rooms were located away from reception and office areas. Managers were aware of this and a contingency plan was in place:

- staff were encouraged to book interview rooms adjacent to one another
- higher risk clients were seen in pairs or a staff member waited nearby
- a costing plan for an alarm system had been requested and was awaiting approval.

The clinic room was clean and tidy with the appropriate hand washing facilities. There was an examination couch located in another larger room. There was a defibrillator that had been checked daily and a first aid kit containing up to date Naloxone, a medication used to reduce the effects of opiate overdose. The electro-cardiogram machine was being repaired and calibrated and was returned the following day in full working order.

All areas were clean and tidy and in a reasonable state of repair. There was a plan to redecorate some areas. We reviewed the cleaning roster, which demonstrated a regular cleaning routine was followed by staff.

Safe staffing

The service employed 11 keyworkers. There were no vacancies at Winstone House. The sickness rate for the wider service was four percent for the last 12 months, which is in line with the national average.

The service was restructured in April 2017 into three distinct pathways. Staffing levels for each pathway was estimated by examining the number and type of referrals.

The average caseload per keyworker was between 60 and 75 clients. Staff felt that staffing levels and caseloads were just about manageable. However: there was very little time for staff to address unexpected events or complete the paperwork for clients wishing to begin a detox. Staff described feeling rushed and not being able to fully complete assessments and recovery plans to a good standard. Staff felt this contributed to the number of poor and incomplete client records. Caseloads were regularly discussed informally with managers. Staff told us they were able to speak to managers if their caseloads were becoming unmanageable and that managers would consider delaying increasing caseloads.

There were no clients waiting to be allocated to a keyworker. Newly referred clients were assessed by the connect pathway. Clients were transferred to the dependency pathway if and when they needed this aspect of the service.

Cover for sickness, leave and vacant posts was managed within the team for short term absences. For longer term absence, there was access to bank staff. There had been no bank or agency staff used at Winstone House. One doctor was employed on a long term locum basis.

There was access to a doctor five days a week across the service as a whole. A doctor was available at the Winstone House site three days a week and a non-medical prescriber four times a week. Doctors and non-medical prescribers were also available at other sites within the service five days a week. Clients and staff confirmed that access to a doctor was prompt and urgent needs could be prioritised.

Substance misuse services

Staff had access to and received regular mandatory training that was relevant to their role. The average compliance with mandatory training was 86% for the last 12 months. There was no training module that fell below the CQC benchmark of 75% completion.

Assessing and managing risk to clients and staff

Risk assessments were not always updated or fully completed. We examined eight care records and five risk assessments were poorly completed. Risk management plans had not been completed and information such as child protection concerns was not included in the risk management plans. Risk assessments were partially completed and vital information was missing.

Plans for unexpected exit from treatment were vague and unclear. One client had been assessed as medium risk of disengagement but there was no risk management plan or recovery plan regarding how to manage this risk. There was a client disengagement protocol that staff followed in each instance. Staff were unable to access client information stored within the electronic record system prior to April 2017. Staff were attempting to reassess clients on an ongoing basis. This process was slow due to the reluctance of clients to explain their risk history again and staff's time constraints.

Staff were able to respond promptly to clients who were experiencing a crisis and in need of extra support. Clients felt they could easily speak to their keyworkers on the telephone or in person when they needed to. There was a duty system in place that allowed staff to address any unexpected issues raised by clients in the absence of the keyworker.

Safeguarding training had been completed by staff. Safeguarding adults training compliance was 92% and safeguarding children level one was 83%. The integrated service manager and safeguarding lead had completed safeguarding children level two and three. Staff were aware of particular safeguarding concerns and how to act on them. Staff described local processes of raising alerts with the police and local authority for both children and adult safeguarding concerns. Staff had access to a safeguarding lead who was available for advice and guidance for more complex issues. Staff were also aware of third sector organisations that were available to support clients who were experiencing domestic abuse and other issues.

The parent organisation had a lone worker policy. Local processes had been adapted to meet the needs of the service. This included ensuring all home visits were completed by two members of staff and that all staff returned to the building at the end of the working day. Due to the complex needs of the client group, senior staff members were required to complete home visits. These processes were embedded into the staff local induction procedure.

Medications were prescribed by doctors and non-medical prescribers and completed prescriptions were stored at one of the other services Harrowside, which provided part of the patient pathway. This was under the control of the prescribing administration team. Prescriptions were collected by each individual pharmacy and a copy of the prescription was stored on file for the purposes of auditing. Each location had an additional minimal supply of prescriptions sheets that were logged and accounted for. There was no medication stored at Winstone House apart from Naloxone, a drug to counteract the effects of opiate overdose.

Track record on safety

The service reported five serious incidents in the last six months. These were all deaths of clients who were in receipt of services. The service had investigated these deaths and was awaiting further information from the coroner regarding the causes of death.

The service had implemented a plan to reduce the number of client deaths. This included focussing on the most at risk clients who may also have complex physical health needs. These clients were being offered home visits to improve engagement. Other at risk client groups were being targeted by an outreach team. The service had adopted a flexible approach such as offering appointments at convenient times to clients. The service accepted referrals from a number of sources and was promoting the service within other local organisations. This meant that the number of clients referred into the service had increased over the last 12 months. Monthly referral rates from April 2017 to September 2017 had increased from 116 to 164 referrals per month.

Reporting incidents and learning from when things go wrong

Substance misuse services

Staff demonstrated a sound knowledge of the incident reporting system and could give examples of incidents that had been reported. Incidents reported included client medication or drug overdose, abuse to staff and loss of medication.

Not all incidents had been reported. The service had not reported the lack of access to client information as an incident. This meant that staff could not access client assessments and recovery plans that were created prior to April 2017.

Feedback to staff regarding investigations of incidents was delivered during team meetings. This included lessons learnt from client deaths and other incidents.

There was a policy in place that stated staff should receive a de-brief following a serious incident. The service had not reported any serious incidents other than the five reported client deaths.

Duty of candour

Staff were aware of the duty of candour policy and were able to describe situations where they had needed to apologise to service users. Staff confirmed they used an open and transparent approach when addressing these issues.

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 examined eight care records and not all had fully completed comprehensive assessments. One had not been completed at all. Two were poorly completed and lacked detail despite the clients being with the service for many months.

Not all recovery plans were completed to a good standard. One had not been completed at all. No information had been entered in relation to recovery goals, treatment options or clients' views. Four recovery plans had been poorly completed. There was no reference to strengths or goals or the clients' views. Information that was available was brief and lacked personal detail.

Information was missing from the electronic recording system and other information was difficult to find. Assessments and plans added to the system prior to April 2017 were not accessible to staff. Staff were unable to locate these documents and were attempting to recreate a number of plans and assessments. Other data such as physical health information was stored in a number of different locations within the electronic system that made it time consuming to find. Staff reported they had difficulty navigating the system and locating the correct information in a timely manner. However, client information that was available was stored securely on the electronic recording system. Staff could access the system using individual passwords.

Best practice in treatment and care

We examined five care records relating to the prescribing of medication. There was evidence of prescribing rationale documented in the doctor's review meeting notes. Clients that are more complex were seen more regularly and stable clients were seen approximately six to eight monthly. The prescribing of medication was with British national formulation limits. The doctor was aware of the national institute of health and care excellence guidance and demonstrated how this and other guidance was followed in practice.

The service had recently employed a psychologist. The role included delivering one to one psychology work to clients and offering staff supervision for individual client issues. Other roles included reviewing service polices and group work sessions to add a psychological perspective.

Key working staff offered clients support on aspects of care such as employment, housing and benefits. Clients described and we observed staff being available and actively involved in resolving social issues. Staff were aware of other local organisations were more specialist support could be sought. Staff knew how to refer and signpost clients to these organisations. This support was not always clearly documented in recovery plans.

Client's physical health care needs were not always clearly documented in the electronic recording system. Only two out of eight records examined demonstrated that physical healthcare had been assessed following referral into the service. Some of this information had been lost when the service transferred from another provider in April 2017. Client's ongoing physical healthcare needs were well

documented within daily entries and doctor review meetings for four records. This included information such as clients GP attendance and discussions with practitioners regarding physical health issues. Two records had partial information about physical health issues.

The service used key performance indicators to measure outcomes for clients. These included 67 measures such as,

- number of clients waiting more than two weeks for treatment
- number of clients successfully completing structured interventions
- number of clients successfully completing psychosocial interventions
- number of unplanned discharges
- number of clients completing detoxes

These figures were shared with commissioners and used to measure the progress of the service and plan for future developments and changes.

The service also collated treatment outcome profile figures for the national treatment agency for substance misuse. These figures are used to highlight national themes and trends in substance misuse and treatment.

Clinical staff engaged in various audits dependant on their roles. Keyworkers were involved in key performance indicator audits and treatment outcome profile audits. The safeguarding lead conducted audits around safeguarding referrals and actions.

Skilled staff to deliver care

The team consisted of the following disciplines:

- three non- medical prescribers and two substance misuse specialist doctors
- one psychologist (part-time)
- eleven keyworkers (including two nurses) and a part-time family worker
- one administrator and cleaner
- twelve volunteers with various roles

Staff were experienced and qualified for their roles. The service had a stable staff team who had worked in substance misuse for many years. Two keyworkers were nurses. One nurse was trained in mental health and another was dual trained in mental and general health. Other keyworkers were trained and had experience in counselling, social work and criminal justice. Both doctors had specialist training such as Royal College of General Practitioners substance misuse level one and two.

There was a triad supervision model in place. This meant that often clinical supervision was arranged with staff groups consisting of three different professionals. This allowed staff to offer advice and guidance from other perspectives. We reviewed the supervision figures for the last eight months. On average staff received two combined supervision sessions of both clinical and managerial supervision during the eight month period. One staff member had received no formal supervision and five had received only one supervision session in eight months. This was not in line with the provider's policy, which stated clinical supervision should be every six to eight weeks. Staff described infrequent supervision with large gaps in frequency. Caseload supervision was available although no figures were collated for this.

Staff were able to access managers for advice and support at any time. Staff gave each other informal peer support on a daily basis. Staff described working in a supportive environment.

Not all staff had received an annual appraisal due to the service opening in April 2017. Only one member of staff had completed the appraisal process. There was a plan for all staff to have been appraised before April 2018.

There were regular team meetings, which all staff could attend. These consisted of monthly update meetings, which included:

- updates from each pathway
- key performance indicator information and actions to address any challenges
- staffing updates (recruitment, sickness, appraisals and training)
- complaints and compliments

Specialist training was available to staff. Recent specialist training included toxic trio training (domestic abuse, mental health and substance misuse) and neglect training. One member of staff had completed non- medical

prescriber training. Staff were encouraged to discuss specialist training during supervision sessions. There was a process for applying for additional training that all staff had access to.

There had not been any instances of poor performance that needed addressing within the service. Managers gave appropriate examples of how poor performance had been addressed within another part of the service. This included involving the human resources department for specialist support. There was a policy in place with procedures and guidelines to follow.

Multidisciplinary and inter-agency team work

The majority of multidisciplinary meetings consisted of medication reviews attended by the doctor, keyworker and client. The service was finding it difficult to link in with mental health services and liaison between the two teams was in its infancy. Where necessary joint meetings were held with probation staff to discuss clients involved with the criminal justice system.

Other links and information sharing practices were good between the following services:

- GP's (client's medical information could be requested by email)
- pharmacies (telephone liaison between the service and pharmacy regarding missed doses of medication)
- a number of voluntary sector organisations dealing with social issues
- the police
- local accident and emergency department (hospital contact the service if a client is admitted to hospital)

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 were up to date with training in the Mental Capacity Act. Mental Capacity Act training was mandatory and 83% of staff were compliant with this training module. Despite this, staff lacked knowledge and understanding of the Mental Capacity Act and the five statutory principles. Staff could not describe any actions or processes they would follow for clients who might have impaired capacity. Staff did not know how to complete a mental capacity assessment or how to follow the best interests' checklist.

There was a mental capacity assessment tool but staff were unaware of this. Staff said they would refer to another agency to complete the capacity assessment. This is not in line with the Mental Capacity Act or the mental capacity policy. Staff were not aware of the mental capacity policy or how to seek advice within the service.

The service was aware of the changing demographics of clients using the service. This included an increase in older people and people with complex mental and physical health needs. This meant that the likelihood of clients requiring a mental capacity assessment were increasing.

Equality and human rights

Equality and diversity training was mandatory for all staff. Eighty three percent of staff had completed this module in the last 12 months. There was an equality and diversity policy available for staff to refer to.

Management of transition arrangements, referral and discharge

For clients newly referred into the service, another aspect of the service completed the initial assessment and agreed which pathway best suited the client's needs. This included a comprehensive assessment, health and wellbeing assessment and a risk assessment. Staff at Winstone House could add to these documents as further information was disclosed.

For clients approaching discharge there were recovery workers available to help clients who were abstinent or almost abstinent. Their role was to deliver aftercare support and to formulate an aftercare support plan.

Are substance misuse services caring?

Kindness, dignity, respect and support

We observed staff treating clients with respect and supporting them using positive approaches. Staff demonstrated appropriate skills to challenge clients when necessary. Staff maintained respectful and caring throughout the interactions we observed.

Clients reported staff were friendly and welcoming at all times. Clients felt that staff were flexible and approachable and endeavoured to do their best to meet clients' needs.

We observed staff demonstrating knowledge of individual client needs in their interactions with clients. The stable

staff team meant that clients had access to staff who were familiar with their circumstances. Many clients had been using the wider service for many years and were well known to staff. However, this information was not always evident within recovery plans.

Client confidentiality was maintained by the use of a secure electronic record system which was only accessible to staff.

The involvement of clients in the care they receive

Clients were not always involved in their recovery planning. Client's views were not clearly documented in recovery plans and copies of recovery plans were not routinely given to clients. Despite this clients reported feeling involved in their care and able to make decisions relating to their recovery.

There was good provision of support to families and carers of clients. A part-time family worker offered individual appointments and group sessions to carers. The group sessions were structured educational and support sessions following the community reinforcement and family training model.

Advocacy services were provided locally. Staff were aware of advocacy services and knew how to refer or signpost clients if necessary.

Clients were involved in making decisions about the future of the service. Feedback from clients had been sought regarding the structure of the service and the implementation of the current pathways. Client groups had been held and feedback used to implement change. Clients had complained that the previous provider had a rigid appointment system and a formal approach to engaging with clients. This feedback had been used to ensure that appointments were now made with clients at a mutually agreed time. Staff were encouraged to have a flexible and friendly approach towards clients.

Clients could also give feedback in a variety of other formats. This included:

- an email box
- comments boxes
- post group surveys
- verbally to staff
- social media comments
- formal complaints process
- thank you cards

We examined feedback from 30 clients from two group sessions and one thank you card. Feedback was positive from 29 clients who praised the service for being helpful, caring and informative.

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

Access and discharge

Another pathway within the service completed initial assessments. Feedback from clients and carers and monthly key performance indicators demonstrated that access into the service was prompt and without delay.

Clients with urgent needs could be seen quickly. There was a duty system in place, which allowed staff to complete any unplanned work. Clients described being able to speak to their keyworker the same day if needed and that other staff were always available. This could be both face to face and on the telephone.

The service actively sought to engage clients who were vulnerable and difficult to engage. A complex care team targeted clients who were homeless, pregnant, leaving prison, suffering chronic pain or living in hostels.

The service had a protocol in place regarding how to respond to clients who had disengaged from the service. This consisted of:

- offering a number of appointments either on the premises or at home
- contacting the referrer or GP for further information and liaison
- re-assessing any risks and using the outreach team if appropriate.

There were plans in place for a texting service to remind clients of upcoming appointments. It was hoped this would reduce the amount of clients missing their appointments.

Substance misuse services

All appointments were made with the clients input and booked around days and times that were suitable for the client. Future appointments were arranged during keyworker sessions and clients left with information for their next appointment.

Appointments were rarely cancelled or postponed by the service. This was due to low staff sickness and the flexible duty system. Staff and clients both confirmed that appointments were reliable and consistently ran on time.

The facilities promote recovery, comfort, dignity and confidentiality

There were an adequate number of interview rooms, a clinic room and urine sample room. There was a larger meeting room for group sessions.

Interview rooms had adequate soundproofing and conversations were not easily overheard.

There were lots of leaflets available on numerous relevant topics including:

- physical health issues
- treatments and medications
- harm reduction and preventing overdose
- safer injecting and drinking
- mutual aid groups
- complaints

Meeting the needs of all clients

The service was located on the first floor of a multi-use building. There was a stair lift for people with restricted mobility and a disabled access toilet. Home visits were offered to clients unable to leave their home or travel to the location.

Information leaflets were published in English and could be printed in other languages on request. The service had access to interpreter services for clients whose first language was not English.

Listening to and learning from concerns and complaints

There had been no complaints over the last five months. The service had received feedback via comment cards which had been considered and addressed where possible. Complaints and feedback were discussed at the monthly senior management meeting and analysed for themes and trends.

There was a complaints policy available to both staff and clients. The policy advised staff to discuss complaints informally with clients in an open and honest manner, apologising where necessary.

Clients had access to complaints leaflets and complaints policy visible in the waiting area. Clients confirmed they felt confident to raise complaints directly to staff in the first instance. Managers were planning to feedback complaints and comments information using a notice board.

Staff had a good understanding of the complaints process and knew how to seek advice and guidance. Feedback regarding complaints or informal concerns was cascaded to staff via team meetings. We saw evidence of action being taken in response to feedback.

Are substance misuse services well-led?

Vision and values

Horizon's vision for client's journeys was "from dependence to freedom". This reflected four service pathways, which were, connect, dependence, detox and freedom. This concept was clear to staff and clients as represented in the separate locations of each pathway. Staff were employed by Delphi Medical whose values were:

- person centred
- accessible
- sustainable
- accountable

A number of staff had been employed by the previous provider and were now newly employed by Delphi Medical. Senior managers had visited the service to promote the company values to the current staff team. Vision and values had been embedded into the interview and induction process to support future employees.

Substance misuse services

The head of integrated services and clinical service managers were a visible presence on a day to day basis. Other senior managers visit the service and cover for annual leave or other absences. Staff described managers as approachable and supportive.

Good governance

There was a governance structure in place to address performance and quality. This consisted of monthly team meetings attended by clinical staff and direct line managers. Issues raised at the team meeting could be discussed further at monthly Delphi managers meetings such as risk register, key performance indicators and policies. There was a Delphi senior leadership meeting which fed into the wider parent organisation. Matters such as risks and health and safety concerns could be discussed at this level.

Individual service issues could be placed on the risk register. Problems such as a lack of access to client records was not appropriately highlighted on the risk register or followed up via the incident reporting and governance structures.

The senior management team had oversight of mandatory training records for each staff member. Information was collated and highlighted when training modules were due for renewal. There was a morning each month set aside for staff to complete mandatory training modules. Training was readily available and easily accessible.

Staff were not receiving regular clinical or managerial supervision. Managers reported frequent caseload supervision was taking place but that this was not recorded or documented.

Staff spent time unnecessarily repeating client assessments or searching for documents and information within the electronic care record system. Managers were aware of the difficulties of the electronic system and had plans to streamline the system in the future. This included:

- reviewing the templates used
- reducing information being repeated and stored in different locations
- improving recording of consent documentation
- staff training.

Client electronic information that was not accessible to staff was not reported as an incident. Other incidents such as deaths and violent behaviour were reported appropriately. There was a process for incidents to be discussed at managers and governance meetings and any lessons learnt fed back to staff in team meetings.

The service used key performance indicators to gauge the performance of the team. These were produced monthly and shared with commissioners. Managers were aware of any variations in the figures and understood factors that impacted on the figures.

Staff described having adequate administrative support. Managers recognised that the administrative team might need to be increased in the future as the service becomes more established. The service had access to volunteers who had an interest in administrative duties and training.

Leadership, morale and staff engagement

A staff survey had recently been completed but the results were not available at the time of inspection.

Sickness and absence rates were low across the service. Managers reported low levels of sickness that were not work related. Managers followed the sickness policy and where necessary staff were monitored and reviewed regarding there absences.

There had been no bullying or harassment cases in the last 12 months. Managers were able to give examples of how difficulties between staff members had been addressed appropriately. Managers involved human resources where necessary in other areas of the service to ensure the correct procedures were followed.

Staff knew the whistleblowing policy and were able to describe the process well. Staff felt confident to raise concerns initially with their manager without fear of victimisation. Staff stated the regularly raised concerns during team meetings and other forums.

Morale across the service was reasonable and improving. Staff felt they had been through a series of changes and that a more settled period was ahead. Staff who had been employed by the previous employer were becoming more integrated in the service.

Staff described a supportive working atmosphere with other staff and managers. Staff felt they could easily seek advice and guidance on any clinical issue.

Substance misuse services

Staff were consulted on the new pathway design. Staff were asked their views on locations of services and which pathway they felt would best suit their skills and experience.

Commitment to quality improvement and innovation

The service was involved in collecting data for national audits that included:

- Hepatitis C screening
- deaths in custody
- dry blood spot testing
- national treatment agency for substance misuse.

The service was aware of the link between adverse childhood experiences and substance misuse. A psychologist had been employed to integrate this work within the service. The service was aware of local issues and gaps in provision of some mental health services. The psychologist was planning to provide one to one psychological therapy to clients and input into policies and service design.

The service had endeavoured to promote the service in the local area to clients and other agencies. A tram had been decorated by clients to educate people about the service. Clients involved in this project had gone on to form an art group, which was continuing. The promotion initiative had been successful as reflected in some of the key performance indicators. The number of direct referrals from GP's was reducing and referrals from third sector organisations was increasing. The service also noted a rise in referrals overall.

A recovery walk had been recently organised to celebrate recovery for clients and again promote the service. Managers recognised the previous model of fragmented services was not helpful and were hoping to improve the image and understanding of the organisation.

It was recognised that clients had difficulty accessing dental care and a dental bus had been arranged to visit the service. Clients were to be treated and made aware for the need for self-care, oral hygiene and dentistry. This was a joint initiative by the service and the British association of dental nurses.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clients have comprehensive and up to date assessments, recovery plans, and risk assessments. Assessments, recovery plans and risk assessments must be regularly reviewed and information must be used to inform each document. The provider must ensure that information is available to ensure risks to their health and safety are managed appropriately.
- The provider must ensure that all incidents are reported as per policy and any associated risks are addressed and mitigated in a timely way.
- The provider must ensure that all staff receive regular clinical and managerial supervision and that it is documented.
- The provider must ensure that staff understand the Mental Capacity Act and code of practice and apply this in practice where appropriate.
- The provider must ensure identified risks are addressed and mitigated in a timely way.

Action the provider SHOULD take to improve

- The provider should continue with plans to improve the electronic recording system.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: • The provider did not ensure that assessments and recovery plans were comprehensive and up to date. Information was inaccurate and not reviewed in line with the providers' policy. Regulation 9 (3) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: • The provider had not ensured that staff understood the Mental Capacity Act and code of practice Regulation 11 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • The provider had not ensured that risk assessments were recorded for all clients. They had not all been updated or fully completed in a timely manner. Regulation 12 (2)(a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: • The provider had not ensured that all incidents were reported in line with policy. • The provider had not ensured that identified risks were addressed and mitigated in a timely manner. Regulation 17(2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • The provider did not ensure that all staff were receiving an appropriate level of supervision. Regulation 18 (2) (a)