Grosvenor House

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Spectrum employed a range of multidisciplinary professionals to deliver treatment and care to clients in the Inspiring Recovery service. They all demonstrated a good understanding of the Spectrum mission, vision and values. Staff received a comprehensive induction, and appropriate training for the role, as well as managerial and clinical supervision and appraisal. They were supported by senior managers, who were visible and actively involved in the operational delivery of the service.
- Clients, relatives and carers we spoke with told us that Spectrum staff, including the doctors, nurses and recovery workers, were kind, polite and respectful to them. We observed recovery workers and nurses maintaining the clients' privacy and dignity in their approach with clients and treating them with empathy and encouraging them to achieve their goals.
- All treatment was underpinned by national guidance and staff had a good understanding of the best practice guidance that was appropriate with regard

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to prescribing, physical health care, detoxification and access to psychosocial interventions. There was a regular audit programme for medication and record keeping.

- Clinic rooms were clean and tidy and had the necessary equipment. Staff followed procedures to manage and prevent the spread of infections. All staff knew how to report incidents and could describe what types of occurrences they would report. Staff could escalate their concerns to the local risk register and these were reviewed at the joint clinical governance meetings. Feedback from all incidents was shared in team meetings and in other communications.
- Clients did not have to wait to access clinical treatment and staff were proactive in their approach towards supporting clients in discharging from substance misuse services. All transitions were seamless between the stages of recovery. Clients saw the service as one seamless system that delivered their care and treatment as the Inspiring Recovery service.
- All clients knew how to complain. The service responded to complaints in a timely manner, investigated where appropriate and any identified learning was cascaded to the teams. Spectrum gathered individual and joint feedback on the care and treatment provided in the Inspiring Recovery services and used this feedback, along with the complaints and compliments information, to inform the service delivery and design.

However, we also found the following issues that the service provider needs to improve:

- Whilst Spectrum had a number of audits and health checks to monitor the safety and effectiveness of the service, we identified issues relating to the assessment and management of risk, including risks relating to safeguarding children.
- Documentation was not completed consistently and staff did not always follow policies and procedures. Where clients did not attend for their appointment in shared care, the positive-engagement procedure was not always followed. This procedure supported the recovery workers in managing the risks associated with the client not attending the service, for example the risk of overdose.
- The care plan documentation and recording in the shared care practices was inconsistent, the recovery goals agreed with clients were not always specific and time bound and there was not always evidence that the client had been offered a copy. The recovery workers had to input information on to two client information systems and duplicate their work. It was in these shared care services where the majority of these concerns were identified.
- All clients were not aware of the late night and early morning treatment provision available across the service. Clients told us that Also, the complaints information leaflet did not contain information on how to complain to the Parliamentary and Health Service Ombudsman.

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Background to Grosvenor House

Grosvenor House is one of 8 locations registered by the provider Spectrum Community Health CIC as of October 2016. This location was registered by the provider on the 12 April 2011. The location has a registered manager and a nominated Individual.

Spectrum Community Health CIC is sub-contracted by another service to work in partnership with them to deliver the service 'Inspiring Recovery' in the City of Wakefield's towns and boroughs. The substance misuse services are commissioned by Public Health England through the local authority.

Spectrum provide both the clinical services and the shared care element of the Inspiring Recovery service. Shared care is where treatment and support is offered in the local GP practices and is delivered in partnership between the GP and a recovery worker. This means that clients can attend their local GP service for their substance misuse appointments.

The Inspiring Recovery services are for adults aged 18years and over. Spectrum employ 24 staff to work in this service.

They provide the clinical services for the 1,680 clients who attend Inspiring Recovery. The clinical service provision includes the well-being services, blood borne virus and health screening, as well as detoxification and substitute prescribing for drug and alcohol dependence. This clinical provision is delivered by doctors, non-medical prescribers and nurses employed by Spectrum.

The clinical treatment is delivered from the main Grosvenor House site at Union Street in Wakefield and also from two satellite sites: one in Castleford and one in South Kirby. These three sites are known as the 'hubs.'

The shared care provision is delivered by recovery workers employed by Spectrum. There are currently 17 shared care practices that are included in the Inspiring Recovery provision. They offer treatment for opiate dependence only. However, the recovery workers in these practices will support clients with low level alcohol misuse or other substance misuse alongside their opiate dependence. The Spectrum recovery workers in these shared care practices co-ordinate all the clients care and treatment.

Spectrum, at the Grosvenor House location, has been inspected twice since it was registered in 2011. It was inspected on the 15 October 2012 and 10 February 2014 using the previous inspection methodology. On both these occasions the service was found to be meeting all the required standards inspected.

This inspection on the 12 September 2016 was the first time the service had been inspected using the latest Care Quality Commission inspection methodology and the updated Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection team

The team that inspected the service comprised of the lead CQC inspector Sharon Baines, two inspectors and a specialist substance misuse 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.

Summary of this inspection

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 about the clinical service provided at Grosvenor House.

During the inspection visit, the inspection team:

- visited three locations where the clinical service provides care and treatment, including a primary care GP setting, the main substance misuse service in Wakefield and one of the satellite substance misuse services in Castleford
- looked at the quality of the physical environment where clinical care and treatment was delivered at these three locations and observed how staff were caring for clients
- spoke with five clients
- spoke with the clinical operations manager who was the registered manager
- spoke with nine other staff members employed by the service provider, including a doctor, a specialist health visitor, team leaders, nurses and shared care workers
- spoke with one other manager who worked in the service but was employed by a different service provider
- received feedback about the service from the local commissioners via Public Health England, as well as other stakeholders including pharmacies and GPs.
- attended and observed a clinic with the doctor, a health and well-being clinic with the nurse and a clinic in the primary care setting with a key worker
- collected feedback using comment cards from 11 clients
- sought feedback from patients, relatives and carers and other organisations at a focus group
- looked at 12 care and treatment records for clients
- looked at five personnel records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

During our inspection we spoke with five clients and two relatives of people who used the Spectrum clinical service and the shared care services. We also received 11 comment cards from clients that were accessing these services. Most of the comments were positive and four identified areas where the service could improve. The clinical team also completed a patient experience survey in September 2015 and received 23 responses.

People who used the service spoke highly of these services and the Spectrum patient experience survey indicated a high level of client satisfaction. They told us that staff were polite, helpful and respectful and that they were always available when they needed support. They told us that they felt listened to, staff explained their treatment and that they were involved in the decisions about their care. They told us that they thought the environment was clean.

However, all the people who we spoke with that used the Spectrum clinical services at the Wakefield hub raised concerns that they felt intimidated when they attended for their clinical appointment. This was because the access to the building was around the back of the building and other clients congregating around the doorway.

Summary of this inspection

Three of the comments we received and one of the records we reviewed for the shared care services said that they struggled to get to appointments due to work commitments as the shared care services did not provide an evening appointment provision.

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 and risk management plans for clients in the shared care setting were either not present, could not be found at the time of the inspection, or did not reflect the contemporaneous notes.
- Child safeguarding information was not sufficient and child safeguarding risk was not always managed appropriately.
- Caseloads were not always managed effectively by the care co-ordinators, for example procedures to help engage clients and manage risk were not always followed.

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

- Clinic rooms at the substance misuse services were observed to be clean and tidy and had the necessary equipment including an examination couch, blood pressure monitors and weighing scales.
- Staff followed the procedures in the Spectrum infection prevention policy including hand washing and hand care, use of protective clothing, safe handling of sharps and the management of clinical waste.
- Staff mandatory training compliance was above 95%.
- All staff knew how to report incidents and could describe what types of occurrences they would report. Feedback from incidents was shared in team meetings and in other communications.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All treatment was underpinned by national guidance and staff had a good understanding of the best practice guidance that was appropriate with regard to prescribing, physical health care, detoxification and access to psychosocial interventions.
- There was a regular audit programme in place for medication and record keeping.
- There was a range of multi-disciplinary professionals delivering treatment and care to clients in the Inspiring Recovery service.

Summary of this inspection

- Staff received a comprehensive induction, appropriate training for the role, as well as managerial and clinical supervision and appraisal
- All transitions were seamless and clients saw Inspiring Recovery as one service.

However, we also found the following issues that the service provider needs to improve:

- Documentation to record the clients' goals in the shared care records was used inconsistently: some used a plan called the 'goal getter,' others used a recovery plan and all used the contemporaneous notes. The objectives recorded in this documentation we observed were not always specific or time bound.
- The service did not have audit arrangements in place to monitor the application of the Mental Capacity Act.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients, relatives and carers we spoke with told us that Spectrum staff, including the doctors, nurses and recovery workers, were kind, polite and respectful to them.
- During the inspection we observed recovery workers and nurses maintaining the clients' privacy and dignity in their approach and treating clients with empathy whilst encouraging them to achieve their goals.
- The care and treatment records showed that confidentiality and information sharing was discussed by the recovery workers and this was reviewed.
- During our inspection we spoke with people who used the service and they told us that they felt involved in their treatment and care. They told us that their treatment options were discussed with them.
- Spectrum gathered individual and joint feedback on the care and treatment provided in the Inspiring Recovery services and used this feedback to inform the service delivery and design.

However, we also found the following issues that the service provider needs to improve:

- Not all the plans known as the 'goal getter' or recovery plans that we reviewed for clients in the shared care practices were signed by the client, or had confirmation that the client had been offered a copy.

Summary of this inspection

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients did not have to wait to access any of the services provided by Spectrum.Waiting times to access the wider Inspiring Recovery services for assessment or treatment were no more than three weeks.
- Discussions around caseloads and discharges were recorded in the shared care team meeting minutes.
- There was lots of information available for clients including information on medication, the risk of overdose, consent and information sharing and how to complain.
- Information was available in easy read formats for clients and staff had access to interpreters through a language line.
- All clients knew how to complain. The service responded to complaints in a timely manner, investigated where appropriate and any identified learning was cascaded to the teams.

However, we also found the following issues that the service provider needs to improve:

- The positive engagement procedure was not always followed where clients did not attend appointments in the shared care services.
- The complaints information leaflet did not contain information on how to complain to the Parliamentary and Health Service Ombudsman
- All clients were not aware of the late night and early morning treatment provision available across the service.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff employed by Spectrum demonstrated a good understanding of the Spectrum mission, vision and values.
- Staff told us that senior managers from Spectrum's executive team regularly visited the service. We observed that the clinical operations manager was visible in all areas of the service and was actively involved in the operational delivery.
- There was a process in place for staff to submit their concerns to the local risk register.
- Staff reported that they felt that the team was open to sharing ideas and that they could raise concerns without fear of victimisation.

Summary of this inspection

However, we also found the following issues that the service provider needs to improve:

- Not all Spectrum policies had been reviewed and it was unclear whether some policies applied to Spectrum staff or the Inspiring Recovery service.
- Not all the joint systems in place between Spectrum and the contract holder that delivered Inspiring Recovery supported staff in fulfilling their role, for example having to use two electronic client recording systems.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is a piece of legislation which enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves.

Training on the Mental Capacity Act level one was mandatory for all staff and level two was mandatory for all staff with direct client contact. All staff that were required to complete this training had done so.

Spectrum had guidance for staff regarding the application of the Mental Capacity Act and the Independent Mental Capacity Advocates in their Safeguarding Adult Policy. However, this was still in draft format.

All the staff we spoke with had a good understanding of the Mental Capacity Act, including the five statutory principles, and the application of the Act within their role.

Staff referred to the draft guidance in our discussions and confirmed that if they needed any advice on decisions around capacity they knew where to access it.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Spectrum were not the lease holders for any of the premises they worked from and did not have direct responsibility. However, they worked in partnership with the accountable organisations to ensure the environments were safe and clean. For example, at the three hubs, Spectrum had agreed some responsibilities which included the management of the clinic rooms, infection control and clinical waste.

Spectrum had an up to date health and safety assessment, which had been internally ratified by the provider's risk and assurance department. All staff had received the health, safety and welfare training and at the time of the inspection the service was resourcing additional health and safety risk management training. All staff had received the mandatory fire awareness training and there were identified fire wardens, who were clearly displayed on notice boards throughout the building.

We observed the clinic rooms at the substance misuse services to be clean and tidy. The rooms had the necessary equipment including an examination couch, blood pressure monitors and weighing scales.

At the main hub at Union Street in Wakefield, there was a defibrillator machine and sufficient pads, which all nurses were trained to use and there was always a nurse on site. Adrenaline, epinephrine auto injectors and naloxone were all in date and kept in a grab bag for easy access in case of an emergency. These were checked regularly and the checks recorded.

All staff had completed the mandatory infection control level one and level two training. Staff followed the procedures in the Spectrum infection prevention and control standard precautions policy, approved by the quality assurance and patient safety committee in February 2016. This included hand washing and hand care, use of protective clothing, safe handling of sharps and the management of clinical waste. We observed adequate hand washing facilities and adequate signage in place in the clinic rooms.

An integrated pollution control environment audit was carried out on the 26 January 2016 by an external infection and prevention control lead. They found Grosvenor House was assessed as 100% compliant with general environment, patient's immediate area, dirty and waste disposal, storage areas and clean utility / treatment rooms and hand hygiene facilities. However, areas for improvements were identified, including ensuring that equipment had the necessary 'I'm Clean' stickers and use of temporary closures on the sharps safety bins. These actions had been completed. A legionella risk assessment was completed annually and was last completed April 2016. Spectrum were responsible for the contract for clinical waste collection, this included used equipment from the needle exchange.

Safe staffing

The staffing numbers for Spectrum were agreed in consultation with the lead provider for the Inspiring Recovery services. The numbers of clinical staff and Spectrum recovery workers were allocated according the number of staff required to meet the commissioned service provision.

Consideration was also given regarding the number of people with the appropriate skills to provide substance misuse services across all of the hubs and in shared care.

At the time of the inspection, there were 24 staff working for Spectrum across the three hubs and the 17 shared care GP

practices. These staff included substance misuse detoxification nurses, health and well-being nurses, doctors, and non-medical prescribers and recovery workers.

The service was managed by a clinical operations manager and two team leaders: one team leader for well-being and one team leader for shared care.

At the time of the inspection the caseload across the 17 shared care GP practices was 266. There were 4.4 whole time equivalent band 6 recovery workers and two whole time equivalent band 4 recovery workers employed to work with these 266 clients. The shared care team leader held a small caseload of 10 clients. This meant that the recovery workers in the shared practices held a caseload of 40 clients. However, the caseloads were not split evenly and the band 6 recovery workers had higher caseloads of approximately 60 clients across the shared care practices and were given the more complex cases. These shared care recovery workers were the care co-ordinators for the clients.

The manager had the authority to increase staff as required. Staffing numbers had been increased in shared care in January 2016. This was initially in response to higher caseloads of over 75 clients for each worker and the staff unable to complete the clients reviews every 12 weeks. This was on the local risk register. Initially, staffing was increased to the temporary recruitment of a 0.6 whole time equivalent staff member and, following a review in July 2016, this temporary recovery worker was employed in the 0.4 whole time equivalent permanent shared care post. The recovery workers told us that they felt that these caseloads were now more manageable. However, we found that clients on some shared care caseloads were not managed safely and effectively, for example all procedures, like positive engagement and risk assessments and other documentation was not always completed. Positive engagement is where the service uses proactive methods to support clients to attend the service. This may include contacting the client or other agencies like the pharmacy that may see the client more frequently, changing the dispensing arrangements of the client's prescription, or prescribing a client's medication at an appointment only.

As of the 24 June 2016 there were 1592 patients accessing the services provided by Spectrum Health Care CIC. There were 15 prescribing clinics across the three hubs, seeing 195 patients on average per week for prescribing and review of recovery plan. These doctors did not hold a caseload. This included nine sessions provided by four doctors and the rest by four non-medical prescribers. Staff felt that the time to see a client in the prescribing clinic, which was 15 minutes for a review, or a 30 minute appointment for more complex clients or a start/restart on medication, was sufficient. The prescribers also had an hour slot of protected time to review clients' treatment and sign their prescriptions for substitute medication.

There were sufficient staff to meet the needs of the clients with regard to detoxification from substances and for addressing the clients' physical health needs. The detoxification nurses and well-being nurses did not carry a permanent caseload. There were three detoxification clinics in which two whole time equivalent band 6 nurses saw 15 patients on average per week for prescribing reviews, alcohol and opiate detoxifications and home visits as required. There were also three whole time equivalent band 6 well-being nurses providing 13 drop-in clinics, for example to screen for blood borne viruses and to vaccinate for hepatitis B and review other physical and mental health conditions and make appropriate referrals. The health and well-being team leader supported these nurses.

The service also employed one full time health visitor and one whole time equivalent midwife seconded from acute trust, who worked with a social worker from the local authority to make up a small team that supported families with more complex needs.

Spectrum reported a total permanent staff sickness of 8% overall and a substantive staff turnover of 10%, as at 24 June 2016 at this location. They reported no qualified nurse vacancies and key workers vacancies as of this date. This equated to just two members of staff who had periods of sickness in the last 12 months.

Staff told us that prescribing clinics were not cancelled and were always covered, including by the clinical operations manager who was a non-medical prescriber. Of the total of 53 shifts that required cover by bank or agency staff in the last three months, as at 24 June 2016, all were covered. However, the service used just two regular Spectrum bank staff to fill these sessions to ensure consistency for the clients, one of whom was now in permanent employment at the service. There was no bank or agency cover for the well-being clinics but rather than cancel them completely, the service would try to cover alternative clinics.

Substance misuse services

Staff mandatory training was completed and monitored with weekly updates provided to staff. Staff compliance was above 95%. Mandatory training included: fire awareness, basic life support, information governance, infection control level one and two, health and safety and well-being, conflict resolution, moving and handling people and loads, equality and diversity, safeguarding children level one, two and three and safeguarding adults level one and two, Mental Capacity Act level one and two, and Prevent level one, two and three training. Prevent training is designed to safeguard people and communities from the threat of radicalisation and supporting terrorism in line with the government's Prevent strategy.

The provider had a policy document in relation to the fit and proper person test and a recruitment policy that it adhered to in order to ensure its staff were of good character, had sufficient health to be able to fulfil their role with reasonable adjustments and had the appropriate skills, knowledge and experience to complete their roles. Spectrum supplied data which confirmed that all of the Spectrum staff working at this location had a current disclosure and barring service check, as at 24 June 2016. This check ensures that employees are safe to work with the clients in the service. The disclosure and barring service information was present in all five personnel files reviewed.

Assessing and managing risk to clients and staff

We reviewed 12 clients' records: six records of clients who were accessing the hubs and six shared care clients.

The care co-ordinators oversaw the care and treatment. This included assessing the client, agreeing a plan with the client to managing identified risks and reviewing the situation every 12 weeks, or sooner where change had occurred.

The care co-coordinators in the substance misuse hubs, including Union Street in Wakefield, South Kirby and Castleford, were employed by Spectrum's partner organisation. Therefore in the six records we reviewed for clients attending the hubs, we reviewed the clinical input only from the Spectrum doctors, non-medical prescribers and nurses.

In three of these six client records that we reviewed where clients who attended the hubs received a substitute prescription for their opiate dependence, we noted that risk was identified in the prescribers consultations with clients, including non-engagement, polydrug-use and safeguarding. In the prescribing notes we observed on the system, information was recorded consistently with the action taken, including harm minimisation information given and changes to prescribing decisions to reduce the risk of overdose for example when a client had not been attending.

The other three records we reviewed for the hub were for clients who had completed an alcohol detoxification. In these records, the nurse had discussed with clients the risk in relation to the safety of the alcohol detoxification. This included identifying the level of intervention required and additional support for the client at home during the detoxification.

Four of the clients in the twelve records we reviewed had accessed support from the well-being nurse at the hubs for conditions like deep vein thrombosis and hepatitis C that are linked to injecting substances. One of the clients was referred to review their physical health due to an increase in their ongoing increased alcohol use and associated ill-health. We observed harm minimisation and appropriate referrals to other services, for example to hepatology. However, this was recorded in the contemporaneous notes rather than in the care co-ordinators overarching care plan or risk management plan.

There was evidence of conversations between the Spectrum prescribers, detoxification nurses and well-being nurses. All consultations, including care and risk management plans, were recorded in the contemporaneous notes. There was no evidence of any joint review meetings to discuss care and risk management in the client records that we looked at, either every 12 weeks in line with national guidance or more often for the clients with more complex, changing needs.

The care co-ordinators in the shared care GP practices were the band 6 and band 4 recovery workers employed by Spectrum. Therefore we reviewed all the information in the six shared care records that were relevant to the role of the care co-ordinator. In these shared care records, we observed current risk assessments in four of the client records that we reviewed. The risk assessments were tick box assessments and included the client's substance misuse, mental health, forensic history, housing status, level of suicidal intent, neglect, child care issues that involved social services, and unsafe sexual practice. However, we observed risk management plans in just two of the client records, only one of which identified the

client's current presenting needs. We found that there were no clear actions taken in response to identified risks and no dates or identified responsibilities to mitigate or manage risks in the other records.

There had been no safeguarding concerns or safeguarding alerts received in relation to the service in the past 12 months, as at 20 June 2016. There was a named safeguarding lead for adults and children. This was the specialist health visitor. There were also two named safeguarding experts within Spectrum to support staff.

We observed Spectrum's safeguarding children policy which was reviewed and agreed in August 2016, which detailed the services and staff responsibilities with regard to safeguarding children in the service. The Spectrum safeguarding adults policy was still in draft format and included the types of abuse and the services and staff's role with regard to domestic abuse and the multi-agency risk assessment conference, multi-agency public protection, hate crime, human trafficking, the prevent (anti-terrorism) and mental capacity. Safeguarding representatives from Spectrum also attended the local safeguarding board meetings. Spectrum was represented at the local multi-agency risk assessment conferences and the multi-agency public protection arrangements in relation to safeguarding children, adults and the community.

All staff knew about the safeguarding policies and where to access help and support in relation to safeguarding. They had also completed the relevant training in safeguarding children levels one to three for relevant roles, the prevent anti-terrorist training and mental capacity level one and two training. Staff told us that there were a low number of referrals. In the substance misuse hubs the safeguarding referrals would generally be completed by the care co-ordinator in the partnership organisation but the clinician would be informed. All staff could approach the safeguarding lead to discuss a family and we saw evidence of this in three of the client records that we reviewed. However, these were families that were already either subject to safeguarding or involved with the specialist workers in the family team.

However, in the shared care service, the records we reviewed where the clients had children, the risk assessments did not reflect the current situation for the client and their children. There were no current risk management plans with regard to safeguarding the children and the children's names and details were either not recorded or could not be found in the record at the time of the inspection.

Similarly, in two records we reviewed for clients attending the hub, the details of the children in the contemporaneous notes at the clients reviews or appointments were limited and did not include any names or ages of family members, or any detail of the children's contact with significant others. Whilst this was the responsibility of the care co-ordinator, there was no evidence in these records that the prescribers could assure themselves regarding the safety of the children. It is important that doctors or nurses prescribing medication have accessible and accurate information for when they prescribe a controlled drug like Methadone. This is because they will make decisions around prescribing based on risk or potential risk. The advice that they may offer the client, for example safe storage of medication information, will also be based on risk.

We notified the service immediately about the records where the clients in shared care had not been attending the service and had responsibility for children. The clinical operations manager looked into these cases immediately and brought it to the attention of the workers. The importance of risk assessing and risk management was re-visited with the team, the allocation of complex cases was reviewed, safeguarding level three training has been arranged for November 2016 and will be rolled out to all Spectrum staff and the use of the quality audit tool was increased by 50%. In addition, Spectrum had already commenced a piece of work to complete an audit of compliance document alongside the 'procedure for family assessment within Inspiring Recovery' to ensure that safeguarding the children and early intervention had an increased focus in the clients' treatment.

Clients signed a clinical treatment contract when they entered the Inspiring Recovery service, which clients and staff had to agree and sign. This included appointment attendance and drug testing, the client's responsibility for their children whilst they were on the premises, the client's responsibility for their prescription and a warning regarding the consequences of the use of inappropriate behaviour, like verbal or physical abuse, or drug dealing.

The clinical service at Grosvenor House followed the Spectrum medicines management policy, This included

consent to treatment, storage of medication, the role and the accountability of the prescriber, including non-medical prescribers, prescribing and the management of prescriptions.

Inspiring Recovery worked in partnership with 57 pharmacies that were responsible for dispensing the substitute medication like methadone or buprenorphine. They completed additional checks where clients were on supervised consumption around a client's intoxication prior to dispensing the medication and also help to re-engage clients when they were not attending appointments. They also notified the service where a client had missed their medication and required a reassessment in order to reduce the likelihood of an overdose.

Urine or swab tests were completed to see if a client was using other substances on top of their prescribed medication where a client was starting in the Inspiring Recovery service or where a prescriber was reviewing a client's medication. A care co-ordinator in Inspiring Recovery could also test a client if they had concerns. Breathalysers were also used to determine the client's use of alcohol.

The Spectrum staff in all settings were expected to review the level of presenting risk in relation to the prescribing regimes for opiate dependent clients and the level of risk would impact on the level of supervised consumption for the prescribed substitute medication. Initiation onto a substitute prescription, like methadone or buprenorphine, using other substances on top of the prescribed medication and poor attendance would mean that a client would be prescribed a regime for daily supervised prescription collection. Daily supervised collection means that a client has to attend the pharmacy on a daily basis for their medication. A pharmacist can assess a client's general appearance, intoxication and is often a key role to identifying new risks and reporting them back to the service where there are concerns. Where a client was more stable on their medication and risk was low, they could be on a regime that required less supervision and less frequent collection. However, we noted that two shared care clients who had not been seen for a number of months and had children and other risk factors, had not had their medication regime reviewed considering any potential increased risk.

A recent medicines management audit had been completed by the service prior to the inspection which focused on seven key areas to ensure staff were handling medicines in a safe and effective manner. The outcome of the audit was positive and areas where improvement could be made were detailed in an ongoing action plan. During our inspection we observed that vaccines were stored at the correct temperature and the cold chain, a process for maintaining the temperatures of the vaccines, was followed. We also observed a clinic session where a staff member discussed safe storage of medication and locked medication boxes with a client.

All staff received conflict resolution training and compliance was 100%. Spectrum followed a joint policy for positive behaviour management with its integrated partner service. This included de-escalation techniques, risk assessment, health and safety protocols, incident reporting and lone working procedures. Spectrum had a workforce services policy (lone working) that detailed the role of managers and staff. This was effective from 2013 and due for review in March 2016. There was no evidence that this policy had been reviewed, though the information contained in it was appropriate.

We observed the 'client information leaflet: alcohol, drugs and driving that detailed the clients responsibilities with regard to the client notifying the Driver and Vehicle Licensing Agency and the services responsibility to notify the Driving and Vehicle and Licensing Authority and/or the police should they become aware that the client continued to drive when they had been advised not to. The client had to sign to agree that they had received this information. We also observed a prescriber discuss this with a client as the client was on controlled medication.

Track record on safety

There were no serious incidents requiring investigation raised from the location in the last 12 months prior to the 24th June 2016. However, in 2015 just prior to this reporting period, there were five incidents relating to two clients taking legal highs within a 2 week period. One client was arrested and one client needed to have their level of consciousness monitored.

An investigation was completed and the clinical operations manager called a multi-agency meeting to identify whether it was a wider issue. It was discovered that there had been an increase in the amount of diazepam and the legal high

'spice' in the locality. Following these incidents, Spectrum's emergency equipment was reviewed and it was identified that a timer was required to support the administration of an antidote, as well as additional pads for the defibrillator.

There were 16 notifications between 1 June 2015 and 31 May 2016 to the Care Quality Commission for this provider regarding deaths of clients who had been in contact with the service. However, there were no concerns regarding the provider in the most recent report from the coroner's office (April 2013 – September 2013) in relation to preventing future deaths.

The service was not involved in any serious case reviews in the 12 months prior to the 20 June 2016.

Reporting incidents and learning from when things go wrong

All the staff we spoke with knew what types of occurrences should be reported as incidents. Staff gave good examples of the types of incidents that had occurred, including a client overdose, a fridge error and issues with the finger prick blood spot testing equipment. The clinical operations manager told us that all staff could report incidents but in all cases staff would report incidents to their line manager to discuss the incident. Staff told us that there was no formal debrief following incidents but they were supported by the managers following incidents.

There was an incident reporting policy. Spectrum used an electronic reporting system to record all incidents, complaints and concerns. However, the service they were working in partnership with used a different system. Therefore, Spectrum had agreed to use the partner organisation's system to record incidents, which would be populated on to their system by the quality team.

Incidents were investigated by the clinical operations manager and issues or identified learning was shared at the clinical governance meetings and the managers meetings. The team leaders who attended these meetings then fed relevant information, learning and actions to their teams. Whilst there was no standard agenda for all the team meetings, we observed for both the shared care teams and the well-being teams examples of where action was taken as a result of an incident. For example, the purchasing of a new fridge and the future monitoring of the fridge, to ensure the vaccines were stored at the correct temperature.

Following a client's death, the service notified the Care Quality Commission where this was appropriate, recorded the incident on their own electronic recording systems and completed a detailed root cause analysis. We reviewed four detailed root cause analysis reports following clients' deaths, which included a chronology, sharing good practice, lessons learned and recommendations and arrangements to share the learning. Outcomes from the root cause analysis for each death were shared in a number of management forums including the clinical governance meeting and actions were managed through the clinical governance framework.

As there was a joint governance structure shared between Spectrum and the partner organisation that delivered the Inspiring Recovery service, this meant that the best practice, lessons learnt and actions for incidents, including deaths, was also shared and implemented across all the substance misuse services and staff in the locality.

Duty of candour

Staff had access and were aware of the Spectrum being open and duty of candour policy, ratified in August 2016 by the quality assurance and patient safety committee. The root cause analyses completed following a death in the service also contained a duty of candour section to ensure adherence to the duty of candour regulation with clients and their relatives/carers. All staff described an open and transparent approach towards their clients following all incidents, not just those appropriate for the application of the duty of candour. Staff told us that following any incidents, clients were spoken to personally and informed of the outcome following investigation where appropriate.

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

Assessment of needs and planning of care

The comprehensive assessments in the Inspiring Recovery services were completed by Spectrum's partner provider when the client first accessed treatment.

However, we reviewed the client records with regard to the clinical assessment completed by the Spectrum clinical staff. In the records we reviewed, we saw evidence of initial clinical assessments at appointments with doctors, nurses and alcohol detoxification nurses for clients in the hubs. For example, all four wellbeing assessments we observed

completed by the well-being nurse assessed clients but also provided them with advice, choice and ideas on improving or maintaining their physical and mental health. The three alcohol detoxification assessments we observed included the completion of the alcohol use disorder identification test and the severity of alcohol dependence questionnaire to identify the level of dependence on alcohol and the type of intervention required. The clinical assessments completed by doctors and non-medical prescribers were also detailed and included assessments of the client's physical and mental health and social circumstances.

We reviewed 12 clients' records: six records of clients who were accessing the hubs and six shared care clients.

All the records we reviewed for opiate clients receiving treatment at the hubs contained a treatment plan which was reviewed every 12 weeks or more frequently where risk identified this, or if someone had started on substitute medication. The treatment plans for the alcohol detoxifications completed were clear and had an inbuilt review of treatment on day three.

Of the six records we reviewed for clients accessing shared care, four had either a current recovery plan or an alternative plan used by the service known as a 'goal getter' plan. The documentation that was used was inconsistent but the clinical operations manager told us that the service was moving to use the recovery plan document.

Staff confirmed that the recovery plan document in shared care should be reviewed every 12 weeks. In three of the client records there was no evidence that this documentation had been used to review the clients' care and treatment every 12 weeks, or when the risk changed. However, there was evidence in the contemporaneous notes that the patient objectives and risk was reviewed at each appointment. Appointments in shared care were every two to six weeks depending on the agreed recovery plan and clients risk. Some client's records had a detailed structured entry, whereas others did not.

The goals in the recovery plan, 'goal getter' document or in the contemporaneous records, were not always specific, measurable, achievable and realistic and time bound. Examples included, "for the client to reduce their use of alcohol or to think about hepatitis C".

There was evidence in most records of referrals or signposting to other recovery focussed services for counselling, activities, employment or peer support.

Client records were electronic and access to the electronic systems was password protected. Information systems, governance and the policies and procedures were included in the staff induction. Spectrum used two electronic client recording systems to document client care. One system was the overarching recording system used by all the workers in the Inspiring Recovery services to record client care and treatment, including in the three hubs. However, in shared care, the recovery workers had to use the GP practice electronic recording system to record the client care and treatment. They would use paper copies of the recovery plan and other care co-ordination documents like the information sharing agreement and have these scanned on to the overarching information system used by the Inspiring Recovery service. Also some documents like the risk assessment document had to be completed on the Inspiring Recovery electronic recording system. Staff complained that they had to duplicate the information a number of times. This meant that there was the risk that some documents were not transferred from one system to another, or in a timely manner. We found some documents that had not been scanned onto the system following appointments. Therefore information was not always available to staff when required.

Best practice in treatment and care

We reviewed the specialist substance misuse prescribing policy and the shared care contract in relation to prescribing for opiate dependence and medicines management. The policy and contract were underpinned by National Institute for Health and Care Excellence guidance and Public Health England evidence based standards.

Clients receiving support for their opiate dependence were offered a choice of medication between methadone and buprenorphine and relapse prevention medication, like naltrexone to prevent a relapse. Clients' medication was reviewed every 12 weeks in the hubs, or more frequently if they had started treatment, were reducing or had complex needs with high risk. Clients were given harm minimisation advice, offered blood borne virus testing, immunisation and signposted to treatment and referred or signposted to structured psychosocial support and mutual aid. Staff were able to quote the best practice guidance that was

appropriate to the treatment and care delivered, including the National Institute of Health and Care Excellence (2007) clinical guideline 52 for opioid detoxification and the Department of Health (England) (2007) Drug misuse and dependence: UK guidelines on clinical management and the development of administrations.

We also reviewed the specialist alcohol prescribing guidelines and the alcohol treatment provision, as well as three records for clients who had completed an alcohol detoxification in the community. All clients accessing the service for their alcohol misuse had a comprehensive assessment using evidence based screening tools including the alcohol use disorder identification test, the severity assessment and dependency questionnaire and a liver function test. Only clients that had low level dependency, low risk of seizures and family or carer support, were able to complete a community alcohol detoxification. A reducing dose of chloroziazapozide medication was prescribed for the client assist with the safe withdrawal from alcohol. Relapse prevention medication was prescribed post community alcohol detoxification and clients were encouraged to engage in relapse prevention therapy, motivational enhancement therapy and were encouraged to attend community mutual aid recovery groups. The policy and staff confirmed that this treatment was in line with NHS National Treatment Agency Review of Effective Treatment for Alcohol, as well as the National Institute of Health and Care Excellence (2010) Clinical Guideline 100: 'Alcohol-use disorders: Diagnosis and clinical management of alcohol related physical complications' and National Institute for Health and Care Excellence (2011) Clinical Guideline 115: 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.'

We observed evidence based map work with clients in the shared care GP practices that was used to enable the clients to visually track their progress, including the goal planner/recovery plan. These were based on the Public Health England, International Treatment Effectiveness Programme link node mapping (mind mapping) manuals.

Spectrum offered smoking cessation, which is a comprehensive support programme and use of nicotine replacement therapy. In all 12 records we reviewed, clients had been offered smoking cessation.

All clients were offered a wellbeing screen by the well-being nurses, including a physical and mental health screen, advice and information and an onward referral to an appropriate service, for example the GP, Hepatology, or sexual health.

There was a regular audit programme in place for medication and record keeping. The service regularly undertook a health check to ensure all aspects of care are reviewed. Included in the health check was the review of clients' recovery and management plans, consent, risk assessment and National Drug Treatment Monitoring System data and the associated action plan. We also observed an alcohol detoxification audit, a hepatitis B audit and a medicine management audit that had been completed. Other audits completed by the service included a hand washing audit, a patient group directive audit and a fridge temperature audit. Outcomes of the audits were fed back in team meetings.

Client progress and changes were measured using the treatment outcome profile. This is a monitoring tool developed by the National Treatment Agency for staff to use throughout treatment and reported through the National Drug Treatment Monitoring System. Public Health England gathers these statistics and provides local and national data. Discharge outcomes were also monitored by the service.

Skilled staff to deliver care

There was a range of multi-disciplinary professionals employed by Spectrum to deliver treatment and care to clients in the Inspiring Recovery service. This included doctors, non-medical prescriber, general medical nurses that were employed as health and well-being nurses and nurses that were responsible for supporting clients to detoxify from alcohol or opiates. These staff members predominantly worked in the substance misuse hubs, including the main service at Union Street in Wakefield, South Kirby and Castleford.

Recovery workers were employed in the shared care practices by Spectrum and they worked in partnership with the GP to holistic, recovery focussed treatment and care in the primary care setting.

Pregnant clients attending the service, or those with children under the age of 18, could access support from the specialist midwife and specialist health visitor, as well as

the specialist social worker who was employed by the local authority. This team worked across all the substance misuse services and offered advice and support to the all the Spectrum and Inspiring Recovery team.

In the 12 months prior to the 24 June 2016, 89% of permanent non-medical staff had an appraisal and all permanent non-medical staff had a named person that provided regular supervision. Staff confirmed that they received management supervision within the timescales set in the supervision policy of every three months. Most staff received management supervision more frequently than this and generally every six weeks. Staff told us that a doctor delivered a weekly group clinical supervision and staff also received regular clinical supervision from an appropriate supervisor, for example the non-medical prescribers received supervision from the doctors and the doctors received supervision from the clinical lead or externally. Team meetings were also used as opportunity to discuss clients, best practice and challenges. We observed detailed discussions in the team meeting minutes.

All staff completed a staff induction at the start their employment and we observed the comprehensive induction checklist that was sent to the new starter with their offer letter and start date. This was completed by the employee with the support of their line manager over the new employee's first three months.

The human resources department managed and monitored the clinical staff registration and the continuous professional development required for their registration. The service checked the electronic staff record daily to ensure that all the nurses registrations with the Nursing and Midwifery Council were current and for the alerts when registrations were due for renewal. All the doctors had been revalidated.

We reviewed five staff personnel records which were complete with the information required including sickness information, disclosure and barring checks and information regarding the employee's qualifications and recruitment information in line with the recruitment policy.

At the time of the inspection, over 95% of staff had completed the Spectrum mandatory training. In addition to this training, staff told us that specialist training was also available to ensure that had the right skills, knowledge and experience to fulfil their role. Most staff told us that this was easy to access and said that they were also supported with study leave. Specialist training included immunisation training, non-medical prescribing, motivational interviewing and the advanced practitioner certificate in cognitive behavioural techniques.

The doctors had completed the level one and two Royal College of General Practitioners specialist training in substance misuse.

The clinical operations manager and one of the team leaders had completed 12 sessions of a leadership course.

Multidisciplinary and inter-agency team work

Spectrum worked in partnership with the main substance misuse contract holder in order to deliver the specialist substance misuse services, Inspiring Recovery, across the Wakefield locality and to meet the requirements of the commissioned service provision and targets. We saw evidence in all the records that we had reviewed that demonstrated this partnership approach. This included the well-being nurses, specialist health visitor and detox nurses liaising with the partner treatment provider regarding a client's care and treatment. The doctor we spoke to confirmed that the multi-disciplinary team met regularly to discuss complex cases and these discussions were documented in the notes by the Inspiring Recovery worker from the partnership service. We also saw evidence of case discussions in the team meeting minutes for both teams.

Inspiring Recovery worked in partnership with of 57 dispensing pharmacies that were responsible for the dispensing of the substitute medication prescribed by Spectrum. Staff reported these relationships to be positive with agreed pathways.

Spectrum also worked in partnership with the 17 shared care GPs at their practices. We observed the contract that underpinned the partnership approach between Spectrum and the GPs at these practices to deliver substance misuse care and treatment. We saw evidence that the shared care workers completed regular prescribing reviews with the GPs in these shared care practices.

Staff at Spectrum confirmed that they had a good relationship with GPs, pharmacies, as well as other recovery services including homeless services, organisations to support relatives and carers, mutual aid groups like Alcoholics Anonymous, Narcotics Anonymous and SMART (self-management and recovery training), as well as other local community services.

The health visitor and specialist midwife offered additional family support and had built good relationships with relevant services including the early help hub, local safeguarding teams, maternity services and sexual health services.

Good practice in applying the MCA

The Mental Capacity Act 2005 is a piece of legislation which enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves.

Training on the Mental Capacity Act level one was mandatory for all clinical staff and level two was mandatory for all staff who worked with clients. All staff that were required to complete this training had done so, and refresher training was scheduled.

The service had guidance for staff regarding the application of the Mental Capacity Act and the Independent Mental Capacity Advocates in their Safeguarding Adult Policy. However, this was still in draft format.

All the staff we spoke with had a good understanding of the Mental Capacity Act, including the five statutory principles, and the application of the Act within their role. They gave examples where they would consider a client's capacity where they were intoxicated to consent to treatment or to receive their prescription for medication and the action that they would take. Staff told us that concerns regarding capacity that were not a consequence of intoxication or medication were rare.

Staff referred to the draft guidance in our discussions and confirmed that if they needed any advice on decisions around capacity they would discuss this with the safeguarding lead, or the specialist social worker and refer to the Local Authority. Staff confirmed that they would record decisions around capacity in the client's care records.

At the time of the inspection, Spectrum did not have arrangements to monitor the application of the Mental Capacity Act.

Equality and human rights

Spectrum submitted the policy they used called the 'core approach to equality and human rights' as the document that underpinned the Inspiring Recovery approach to equality and diversity. This included the approach of the staff employed to work in the Inspiring Recovery service by Spectrum. However, this was not a Spectrum policy but a document that their partner substance misuse partner authored and ratified through their own governance procedures and there was no evidence that this had been agreed with Spectrum.

Equality and diversity training was mandatory for all staff and 92% of staff had completed the e-learning training.

The service worked in a person centred way with clients from a range of different backgrounds and with clients who had protected characteristics. During our inspection we observed that staff worked in a way to ensure that all clients received equality treatment and access to services.

Management of transition arrangements, referral and discharge

Clients accessed treatment for their substance misuse through dropping in to one of the hubs, or they could be referred by their GP, other agency or professional. Clients were assessed by the staff in the partner organisation with Spectrum that delivered the Inspiring Recovery service. Following this assessment, clients were offered clinical appointments with the doctor and/or nurses as required addressing their treatment needs.

Clients who were dependent on opiates were no longer able to access shared care directly. They had to start treatment in one of the hubs and were transferred into shared care when they became more stable and met specific criteria, including engaging well with a treatment regime, attending regularly, no illicit substance misuse and generally low risk. The shared care criteria and pathway were being developed to ensure a smooth transition for clients between the 3 hubs and shared care.

When clients were discharged from receiving pharmacological treatment, like an alcohol detoxification and relapse prevention medication, they could continue to receive ongoing psychosocial interventions from recovery workers in the Inspiring Recovery service employed by Spectrum's partner agency. All transitions were seamless despite, for example, clinical workers and recovery workers in the hubs working for different organisations to deliver the Inspiring Recovery service. Clients saw the Inspiring Recovery service as one service that delivered their care and treatment.

Substance misuse services

Post recovery, clients were encouraged to become a service user representative supporting individual care and the development of services, and were signposted appropriately.

Are substance misuse services caring?

Kindness, dignity, respect and support

We spoke with clients who used the Inspiring Recovery service and they told us that Spectrum staff, including the doctors, nurses and recovery workers, were kind, polite and respectful to them.

Relatives and carers also confirmed that they were also treated in this way.

During the inspection we observed interventions with clients where staff demonstrated these behaviours, treating clients with empathy and encouraging them to achieve their goals. We also saw how recovery workers and nurses maintained the clients' privacy and dignity in their approach with clients and staff gave us additional examples from their practice of this. Such as?

We also observed one of the well-being nurses accompany a client to the GP appointment for a physical health need in order to support them to attend. We were told by staff that they attempted to do this for clients where there was an identified need and when resources allowed it.

We observed the confidentiality agreement used by the integrated service that all clients completed and this was used by the Spectrum recovery workers in the shared care GP practices. The shared care records showed that confidentiality and information sharing was discussed by the recovery workers and this was reviewed. Clients signed to agree who they gave consent for the service to share their information with and the type of information that could be shared.

This confidentiality agreement included information about how each client's information would be used by Spectrum clinical services whilst the client attended the substance misuse services. This also included information regarding the sharing of information with the National Drug Monitoring Treatment System and the reason for this. Clients told us that they were encouraged to share information with other professionals and agencies by the staff in the clinical teams and in shared care, as well as with relatives and carers, who could support them throughout their treatment.

The involvement of clients in the care they receive

During our inspection we spoke with people who used the service and they told us that they felt involved in their treatment and care and that the treatment options were discussed with them. The clients we spoke to said that they knew what their recovery goals were and they described goals that were individual to them. Relatives and carers also confirmed that they were encouraged to be involved in the client's treatment and staff discussed client care with them in general terms or in detail, depending on whether consent was given by the client. We observed a clinic session in which the staff member asked the client about their medium and long-term goals and discussed treatment options. All staff told us that they discussed the range of prescribing and treatment options available to clients.

Of the six shared care records we reviewed we observed that four of the care plans or the goal getter documents had been signed by the client and three of the documents had a tick-box to confirm whether the client had been offered a copy of the care plan. These were ticked on all three records. However, on the other three records it was unclear if the client had been offered a copy of their 'goal getter' plan or care plan.

Staff at the service confirmed that they encouraged clients' relatives and carers to engage with a locally commissioned support group that works in association with the Inspiring Recovery substance misuse services.

The service had contacts at various local advocacy services that could be accessed.

Spectrum's patient experience service report was completed in September 2015 to gain feedback from clients who accessed their services. The results indicated a high level of satisfaction with the care received by clients with all but two areas reaching 100% satisfaction. Areas identified where improvements could be made included access to the building and a client feeling rushed. The service used this feedback from clients to inform the service delivery and design, along with joint feedback that

was gathered quarterly along with the friends and family test on patient experience of the Inspiring Recovery services as a whole, not just Spectrum. All client feedback was circulated to staff and clients in a newsletter.

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

Access and discharge

Spectrum worked with adults aged 18 years and over who were misusing alcohol or drugs. Clients could drop in to the hubs to access support, or could be referred by their GP or other services. They worked with all clients who referred internally within the Inspiring Recovery services who had already had a comprehensive assessment to identify their support needs.

At the time of the inspection, there were 266 clients accessing the 17 shared care services and 1592 clients in opiate prescribing treatment across the three hubs. As of the 1July 2015 and 30 June 2016, the average length of time in treatment across the Inspiring Recovery services delivered by Spectrum and the organisation that was the lead contract holder was 5.8 years for clients who used opiates and 1.2 years for clients who used other substances including alcohol, with 48% of clients accessing services for six years or more. This was above the national average. Spectrum worked with the contract holder and the commissioners to reduce the length of time clients were in treatment.

Length of time in treatment was a key performance indicator set by the service commissioners. Other key performance indicators included wait times, planned discharges and the number of representations back into the service.

There was no waits to access any of the Spectrum service at the time of the inspection and clients did not have to wait above three weeks to access the Inspiring Recovery services for assessment, or to start treatment.

The Inspiring Recovery service submitted data to the National Drug Treatment Monitoring System, which local and national commissioners use to compare substance misuse services and their outcomes. This was joint data for the main contract holder and Spectrum. Planned completions for clients from treatment, where clients do not represent back to the service within six months, is one of the outcomes that is used to measure the success of a service. Between 1 January 2015 and 31 January 2016 the planned completion rate for clients was 5.9% of the total client population. This was similar to other community substance misuse services nationally. However, Inspiring Recovery was performing higher than the national average for clients completing treatment who were using non-opiate substances or alcohol.

Locally, Spectrum collected data to monitor the shared care outcomes with regard to client completions from treatment. In the quarter prior to the inspection, there were eight (24%) planned exits from treatment in the shared care services and these clients did not represent back into treatment within six months. There were 25 unplanned exits where the client just stopped attending for their appointments at the GP practice and the recovery worker was unable to contact them. Discussions around caseloads and discharges were recorded in the shared care team meeting minutes.

The commissioners considered the service to perform well on qualitative and quantitative outcomes as measured by National Drug Treatment Monitoring System, contract management and client feedback.

The service had a positive engagement procedure to follow where clients did not attend appointments and this was guidance for staff on what action to take. However, this was currently still being embedded in the service and the procedure was not followed for two of the clients in shared care whose care and treatment was reviewed.

The facilities promote recovery, comfort, dignity and confidentiality

Clinic rooms were available for staff at the mainstream Grosvenor House substance misuse service on Union Street in Wakefield, as well as at the hubs in Castleford and South Kirby. There was sufficient clinic space to accommodate a number of prescribing clinics and well-being clinics at the same time. A clinic room was also made available at the GP shared care practices for the recovery workers to see their clients in the primary care setting. All rooms were adequately sound proofed to ensure conversations were confidential. All intimate procedures were carried out in a private room to ensure privacy and dignity to service users.

Substance misuse services

We observed information available for clients on the risk of overdose from alcohol, opiates and psychoactive substances, as well as information on medication including chlorodiazapoxide, accamprosate, disulfiram, nalmafine and naltrexone and a client guide to an alcohol detox.

Leaflets were also available for clients regarding complaints, compliments and general feedback. However, the complaints information leaflet did not contain information on how to complaint to the Parliamentary and Health Service Ombudsman.

Meeting the needs of all clients

The staff resources had been streamlined to provide appropriate support, including prescribing, detoxification and well-being provision, at each hub across the district to enable equitable access for all patients regardless of geographical constraints.

Spectrum provided one late night prescribing clinic per month across the three hubs for people who worked or who were unable to attend between the usual working hours of 9am to 5pm. Service provision at all locations was Monday to Friday. Late night and early morning service provision in the shared care services was dependent on the GP surgery opening hours. There was no weekend provision and this was not required in the service specification.

Whilst three of the clients we spoke with confirmed that the service did try to be flexible and to meet their needs when they were booking appointments, we received three comment cards and noted information in a client care record that clients who were working found it difficult to access treatment. This was predominantly in the shared care services where clients accessing were more likely to be stable and in work. Therefore not all clients were aware of the late night or early morning treatment provision available across the service.

Spectrum was reliant on the buildings it delivered treatment from, including the substance misuse hubs and the GP practices, being equipped for disabled access. If the premises could not accommodate people requiring disabled access, or the client had a mental health or social problem that prevented them from attending the service in the short-term, then the nurses and the shared care recovery workers would work with the client on an outreach basis, either at an alternative venue or in their home.

Leaflets and information was available in easy-read formats. Staff told us that they had easy access to language line to provide information and advice and to facilitate their appointments with people who did not speak English or who spoke limited English. Staff confirmed that they asked clients how they would like staff to communicate with them and gave examples of using language line with the population of clients from Eastern Europe who were currently accessing the local substance misuse services. Access to British sign language interpreters could be sourced when required.

Listening to and learning from concerns and complaints

Two formal complaints and two informal complaints were made in the 12 months prior to the 24 June 2016. Spectrum defined a complaint as any expression of dissatisfaction about any aspect of the care they provided. None of these were upheld and none were referred to the Parliamentary and Health Service Ombudsman.

Spectrum's complaints policy and its complaints standard operating procedure described the complaints pathways and procedures to be used by staff to ensure a quick resolution for the complainant. The policy also gave guidance on ensuring that lessons were learnt and shared across the organisation to improve standards of care and prevent or minimize any recurrence.

Staff told us that they understood the complaints policy and would always try to support the client and resolve the complaint locally first. However, this would still be logged as a complaint.

Formal complaints would be sent to the clinical operations managers for investigation, with the complaint allocated a priority. The priority scale would dictate the timescale for response in accordance with the policy. The quality assurance and patient safety committee oversaw this process and the chief nurse had the final sign off of the complaint.

The number of complaints, trends and changes in service delivery were all monitored by the service and the lessons learnt were shared across the service via the integrated clinical governance board. They were then cascaded via team meetings and emails.

Substance misuse services

Staff told us that feedback was given to both staff and clients following a complaint, including lessons learnt. Staff usually received this feedback through team meetings and supervision.

Posters and leaflets were available in the services so that clients and relatives were aware of how to give feedback and raise concerns.

Four compliments were received by the provider in the last 12 months, which included gratitude for staff supporting them in their recovery and helping them access treatment in the acute setting.

Are substance misuse services well-led?

Vision and values

Spectrum's mission statement stated:

- We are a healthcare service delivering care to all, including vulnerable adults and young people. Our services are delivered with respect and dignity in a professional and personal way by empowering our clients and pushing the boundaries, challenging stigma and exclusion in our communities.

Spectrum's vision stated:

- We aspire to achieve the best health and wellbeing outcomes for our clients and place individuals, families, carers and communities on the road to rehabilitation, recovery and integration.

Spectrum's values included:

- Environment: Being with like-minded people, who have mutual respect, working to the same goals within a safe, compassionate and friendly environment.
- Valued with the right reward and recognition: Through trust and support, we are rewarded and feel appreciated, encouraging us to develop our skills and our potential (with a bit o' tea and cake).
- Our Passion is making a Difference: Passion that drives us to care and commit ourselves to making a positive difference to the quality of people's lives.

Staff employed by Spectrum and working in the clinical services and shared care demonstrated a good understanding of the Spectrum mission, vision and values. Staff paraphrased their values and mission as 'quality without compromise' and 'every contact counts. ' and they could describe the service values to the inspection team. Staff demonstrated the values in their behaviours, including in the caring and compassionate client interaction we observed and also in our discussions, where they discussed their role in supporting and empowering clients to change and improve their lives. The vision and values of the clinical service was communicated via the staff newsletter, as well as through supervision and appraisals.

Spectrum's values complimented the shared values agreed with their partner organisation to deliver the treatment and care in partnership service Inspiring Recovery, which included 'support, enable and empower.' The clinical operations manager confirmed that having these shared values specific to inspiring recovery, supported the partnership arrangements, future planning and in understanding the challenges and achieving solutions for the whole service.

Staff told us that senior managers from Spectrum's executive team regularly visited the service. We also observed that the clinical operations manager was visible in all areas of the service and was actively involved in the operational delivery of the service.

Good governance

The Inspiring Recovery services were delivered in partnership by Spectrum and another organisation that was the lead contract holder. This organisation subcontracted to Spectrum. To ensure that service delivery was cohesive and seamless, governance arrangements, for example policies and procedures, incidents and deaths, were all reviewed by managers of both organisations at the integrated clinical governance board. Spectrum used its own policies and procedures, though not all had been reviewed as required in the policy, for example the Spectrum lone working policy. Spectrum also followed the lead contract holder's policies and procedures but there was no evidence in these policies that they applied to Spectrum staff or Inspiring Recovery as a whole, for example the equality and human rights policy.

There were governance arrangements in the Inspiring Recovery services where duplicate systems were used, including the incident reporting systems and the electronic client records. Whilst no concerns were raised about the incident recording systems, staff in shared care complained

that they had to duplicate the information a number of times on both systems. Therefore, not all the joint systems in place between Spectrum and the contract holder that delivered Inspiring Recovery supported staff in fulfilling their role. Some documents that had not been scanned on following appointments were found when we informed staff that they were not in the record. Therefore information was not always available to staff when required.

There were systems to ensure that staff complied with mandatory training and received management and clinical supervision and annual appraisals. Staff could access advice and support in child and adult safeguarding.

There were systems to ensure that clinical audits, as well as medication and record audits took place regularly. We observed action plans in relation to the records audit, which included reviewing family support documentation, recovery plans and risk management plans. However, despite these audits, we identified issues in these areas in the shared care files we reviewed. The registered manager acknowledged that there were ongoing actions to be completed to improve the quality of the documentation to ensure clients and children were safe. Also, there were no audit arrangements in place to monitor the application of the Mental Capacity Act.

Systems were in place to monitor complaints and incidents across the service and these were investigated where appropriate. Lessons learnt and best practice was cascaded to the teams via team meetings and supervision. This information, as well as client and staff feedback, was used to inform service provision.

The key performance indicators for the service were set by the service commissioners. Each quarter the provider inputted into the joint Inspiring Recovery report on the service performance against the key performance indicators.

All staff told us that they could raise issues and discuss with their managers in team meetings and in supervision. The registered manager told us that there was an escalation process in place where items could be submitted onto the local risk register.

We observed the local risk register that identified three risks for the clinical provision at Grosvenor House. The risks included reduced staffing levels impacting on caseloads and meeting performance targets and the implementation and development of new pathways that could impact unexpectedly service delivery. We observed appropriate actions, reviews and control measures for each of these risks.

Leadership, morale and staff engagement

Sickness and absence rates were on average at 8.1% as of June 2016. This equated to two staff members in the 12 months prior to that date.

There were no reported bullying and harassment cases. Staff felt able to report their concerns when needed without fear of victimisation. All staff were aware of the organisation's whistleblowing policy and told us that they felt confident in using this if needed.

Morale was variable. Staff spoke positively about their role working with the clients attending the service and were passionate about their work and most staff were enthusiastic and positive about working at Spectrum in the Inspiring Recovery Service. However, a couple of staff reported that they had periods where they felt stressed and unhappy working in the service, particularly around the significant staffing reductions due to reduction in contract value. This was reflected in the Spectrum staff survey that was completed in September 2015, where on the whole the staff response was positive about the organisation, their role and feeling valued. The majority of staff said that they would still be working for Spectrum in the next 12 months and were likely to recommend the service to family and friend as a place to work, or if they needed to receive care. However, approximately two or three respondents out of the 15 respondents that replied (13% to 20%) that were negative about feeling valued by the service, the conditions of their employment, the culture in the service, management communication and the support they received. The service had an action plan in response to the survey that had been most recently reviewed in July 2016.

Staff reported that they felt that the team was open to sharing ideas. Staff told us that they could share ideas in the team meeting and we saw examples in the team meeting minutes of this, particularly around supporting patients but also suggestions for service improvements. The annual reviews completed with staff were considered by the clinical operations manager as an opportunity to

focus staff on the business plan and their own personal development and responsibility in achieving the challenges of the contract, which was in line with some of the objectives of the staff survey action plan.

Commitment to quality improvement and innovation

Spectrum was involved in a district wide continuous professional development programme which had been developed to ensure the sharing of best and current practice, enabling them to disseminate new working practices and involving primary care in the service delivery.

Spectrum had developed referral pathways at each hub for clients requiring Hepatology, which included a referral letter template on the electronic system, for clients to access treatment.

Spectrum was in the process of exploring the use of technology to support mobile working in order to allow staff to access the systems remotely, ensuring that the most up to date information on the client is available to support their clients' ongoing recovery.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is sufficient information gathered to assess risk and that all risk is assessed and managed effectively, including risks to children.

Action the provider SHOULD take to improve

- The provider should ensure that the recovery workers who hold caseloads can manage the clients care and treatment effectively and are able to complete all the tasks required.
- The provider should ensure that care plan documentation and recording in the shared care practices is consistent, that goals are specific and time bound and that there is evidence that the client has been offered a copy.
- The provider should ensure that they have robust monitoring arrangements in place to ensure that staff follow policies and procedures and that treatment is safe and effective.
- The provider should review the content of their complaints information leaflet.
- The provider should ensure that all clients are aware of the late night and early morning treatment provision available across the service to support clients who find it difficult to attend.
- The provider should ensure that the policies and procedures and joint systems employed to deliver the Inspiring Recovery service, support staff to fulfil their role and are reviewed in the required timescales.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment must be provided in a safe way for service users. The registered person must ensure that there is sufficient information gathered to assess risk and that all risk is assessed and managed effectively, including risks to children. Regulation 12 (2) (a) (b)