East Sussex STAR Service

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated East Sussex STAR as good because:

- The areas where clients were seen were safe and clean. The service provided safe care. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- The service provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.

However:

- Staff did not always submit notifications to the Care Quality Commission about incidents that were reported to the police.
- Caseloads were high. The average caseload for staff was approximately 70 clients. Staff said that the high caseloads meant that they could not always give clients the time they needed.
- Vacancies and high sickness absence in Hastings meant the service was often short staffed. The number of changes to service delivery and management during the previous 12 months had affected staff morale. Staff said they were stressed and under pressure because of the staffing levels.
- Staff were unable to locate the cleaning logs to demonstrate that medical equipment was cleaned regularly.
- The boilers in both services did not work properly and some areas of the environment were tired and in need of repair.
- Care plans were mixed across Eastbourne and Hastings. In Hastings, staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Care plans were less personalised in Eastbourne.
- There were no recognised scales to measure opiate withdrawal in any of the 14 care records reviewed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good	

Summary of findings

Contents

Good

East Sussex STAR

Services we looked at
Community-based substance misuse services

Summary of this inspection

Background to East Sussex STAR Service

East Sussex STAR was awarded a new five-year contract in June 2019. The service provides specialist community treatment and support for adults affected by substance misuse who live in East Sussex. Most of the referrals into the service are self-referrals.

There are two hubs based in East Sussex, one in Eastbourne and the other in Hastings.

Staff also saw clients from rural areas at a satellite service. The service used a remote consult service to reduce barriers to clients accessing treatment. Remote consult meant that doctors used a video link to provide consultations for clients who were unable to attend a face to face appointment.

East Sussex STAR offers a range of services including initial advice; assessment; prescribed medicine for alcohol and opiate detoxification; naloxone dispensing and harm minimisation including needle exchange and testing for blood borne viruses. Clients could attend group recovery programmes; one to one keyworking sessions and doctor and nurse clinics.

The service was working in partnership with other agencies including social services, probation, GPs, pharmacies and supported housing.

East Sussex STAR has been registered with CQC since 23 November 2018. The service is registered to provide the regulated activity: treatment of disease, disorder and injury. There is a registered manager at the service.

This was the first time the service has been inspected using the new ratings methodology for substance misuse service, since registering as an individual location.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one inspection manager, one assistant inspector, two specialist advisers with knowledge and experience of working within substance misuse and one expert by experience.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- 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 stakeholders for feedback.

During the inspection visit, the inspection team:

- visited the services in Eastbourne and Hastings, looked at the quality of the environment and observed how staff were caring for clients
- spoke with 14 clients who were using the service

Summary of this inspection

- spoke with the service manager, registered manager, locality leads and team leaders
- spoke with 10 other staff members; including doctor, nurses, recovery workers, prescription admin worker, data analyst and volunteer
- observed two nurse assessments
- observed two induction assessments
- received feedback about the service from a commissioner of the service
- looked at environment including the clinic room and the needle exchange
- attended and observed a morning meeting and a clinical review meeting
- observed an initial assessment and a keyworking appointment
- looked at 14 care and treatment records of clients
- reviewed three incidents and two learning from death tools and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Client feedback about the service was largely positive. They said that staff were compassionate and caring and the service was welcoming. Some clients said they had to wait longer than expected to receive medically assisted treatment.

Results of the most recent survey between January and March 2019 were generally positive. The survey showed that 70% of clients rated the service as very good and 27% rated the service as good. Ninety-four per cent of clients said that the service was accessible and 89% said that the service provided them with what they wanted. However, only 55% of clients said that they had been asked for their views on the service they received.

Comments from the survey included making it quicker for clients to start medically assisted treatment, reduce waiting times and a request for text reminds for appointments. Other comments said that they had no complaints and they wouldn't change anything at all.

Comments from the service user bulletin included a request for the service to be more flexible with appointments and have a clearly marked feedback box that was checked weekly.

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?

Good

We rated safe as good because:

- All areas where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff knew the clients and received basic training to keep them safe from avoidable harm.
- Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer and record medicines. Staff regularly reviewed the effects of medicines on each client's physical health. In addition to consultants, the service had non-medical prescribers in post.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support

However:

- The service reported individual caseloads ranged between 30 and 70 clients, dependent upon complexity. Staff said that caseloads had increased because of covering long term sickness absence and vacancies. They said that high caseloads affected time available for clients and stress levels. Data provided by the service said that in October, the average caseload was 48.
- Vacancies and high sickness absence in Hastings meant the service was often short staffed. Staff said they were stressed and under pressure because of the staffing levels.
- Staff reported cleaning the medical equipment after each use. However, they were unable to locate the cleaning logs to evidence this.

Summary of this inspection

- The boilers in both services did not work properly. Staff used electric heaters as an interim measure whilst waiting for repairs.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans in Hastings reflected the assessed needs, were personalised, holistic and recovery-oriented. Care plans in Eastbourne were less personalised.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes for alcohol dependence. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and knew what to do if a client's capacity to make decisions about their care might be impaired.

However:

- The detail in care plans was mixed. In Hastings, staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Care plans were less personalised in Eastbourne.
- There were no recognised withdrawal scales such as the clinical opiate withdrawal scale (COWS) or clinical institute withdrawal assessment of alcohol scale (CIWA-r) in any of the records reviewed.

Summary of this inspection

- Staff said that some opportunities for face to face training was discouraged because of staff shortages in Hastings.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.
- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The number of changes to service delivery and management during the previous 12 months had affected staff morale. There was high vacancy and sickness absence. Staff said they were stressed and under pressure because of the staffing levels.
- Staff were not always able to attend face to face training because of staffing numbers and change of venue for classroom training.
- Staff did not always submit notifications to the Care Quality Commission about incidents that were reported to the police.

However:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. A new service manager had recently been appointed, and they were visible in the service and approachable for clients and staff.
- A recent change to the provider's vision and values meant that staff did not all know and understood them. However, staff understood their role within a client's recovery.
- Most staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider had a Mental Capacity Act policy. Staff completed mandatory Mental Capacity Act training. Staff rearranged appointments if clients attended the service under the influence, so that they had capacity to make informed decisions about their treatment. Staff knew who to contact for advice or guidance.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Good	Good	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Good

Safe and clean environment

Safety of the facility layout

The clinic rooms, reception areas and rooms where staff saw clients were safe, clean and well maintained. Areas most used by staff at both Eastbourne and Hastings were tired and in need of some repair. The boilers in both services did not work properly and there was a leak in staff office in Eastbourne. Missing glass from a fire door in Eastbourne was replaced during the inspection.

There was an intercom entry system and clients and visitors were expected to sign in and out. Both services were based over several floors. The ground floor in Hastings consisted stairs and a lift to the rest of the building. Key pads were fitted to areas for staff only or where staff should accompany clients. Clients in Hastings were seen on the first and second floor. Access to the service was by a small lift or stairs. Although narrow, the lift and corridors were accessible for people with poor mobility.

In Eastbourne, the ground floor was accessible and had group and therapy spaces and a disabled toilet. The clinic room and drug testing room were located on the ground floor. The meeting rooms on the first floor were used for counselling sessions. Clients with issues with mobility were seen on the ground floor.

The health and safety processes were in good order. The service recorded monthly and six-monthly health and safety assessments which fed into the risk register. Staff completed weekly fire alarm checks and six-monthly evacuation drills.

Staff were issued with call alarms that were linked to panels in corridors to display where the alarm had been raised. There were fixed alarms in the reception area. Closed circuit television screens were located behind the reception desk and were observed throughout the day.

Maintenance, cleanliness and infection control

Areas that clients had access to were clean, comfortable and well-maintained.

The provider had an infection control policy. Staff adhered to infection control principles including the disposal of clinical waste. Each service had a well-equipped clinic room with the necessary equipment to carry out physical examinations. Staff reported cleaning the medical equipment after each use. However, they were unable to locate the cleaning logs.

Safe staffing

Staffing levels and mix

The service had sought the leanest management structure to maximise front line workers and recruit specialist posts.

Staffing had been calculated based on caseloads. Data provided by the service reported caseloads of 552 at Hastings; 373 at Eastbourne and 246 for rural areas. The service reported individual caseloads ranged between 30 and 70 clients, dependent upon complexity. Staff said that caseloads had increased because of covering long term

sickness absence and vacancies. They said that high caseloads affected time available for clients and stress levels. Data provided by the service said that in October, the average caseload was 48.

Data provided by the service showed a 54% vacancy rate. Nine members of staff had left the service in the previous 12 months. Staff said many had left because of the changes to service delivery in the new contract. They said they were managing at current staffing levels, but it was not sustainable. Managers were aware of the challenges and were actively recruiting to vacancies. The vacancies for a non-medical prescriber and three recovery workers across both sites was being advertised. Three recovery workers had been recruited and were waiting for their start dates.

The prescribing doctor worked across both sites. The service had recently appointed an alcohol detoxification specialist nurse. There were three full time non-medical prescribers across both sites. The agency non-medical prescriber was due to finish working at the service the week of our inspection. Staff said managers did not always tell them about actions taken in response to vacancies.

Data provided before the inspection showed a 46% sickness absence rate. A performance report showed that 66 and 54 working days had been lost respectively because of short term and long-term sickness absence. The report showed that the equivalent of 5.5 full time posts had been lost due to sickness absence. The overall monthly sickness rate for short and long-term absence was 8.82%.

Staff worked across the county to ensure enough cover at both services. The criminal justice and alcohol team leader roles worked across both sites. However, staff told us that the service was often short staffed. They said that they were unable to give clients the time they needed because of their additional work due to staff shortages. Staff said they avoided cancelling groups where possible. However, some groups had recently had to be cancelled at Hastings because of staff shortages.

Where possible, the service used agency staff to provide admin and reception cover, but rarely for recovery workers. The service had experienced challenges maintaining agency staff for the reception area because of the nature of the service. Recovery workers in Hastings were on a duty rota to provide reception cover half a day a week. They said that duty and reception cover responsibilities affected the time available to see clients.

Clients had access to staff to support their physical and mental health. A non-medical prescriber and wellbeing nurse were available daily.

Mandatory training

Data provided by the service showed a compliance rate between 86% and 96% with sector and core training. The service had identified actions to address any gaps.

Assessment of service user risk

The service used a combined risk assessment and care plan. Risk assessments were present in all 14 records reviewed. However, the detail in the risk assessments was mixed. The eight risk assessments reviewed in Hastings were more comprehensive than those reviewed in Eastbourne. One client record in Eastbourne did not evidence medical input for a client for some time, despite the complexity of their needs.

Risk assessments at Hastings were particularly robust for clients with mental health issues. Staff completed joint assessments with the community mental health team. We saw evidence of the consultant seeing clients where there was concern of escalating risk. There was evidence of contingency management plans and exit plans if clients dropped out of treatment. Staff discussed risk during the morning meeting and clinical governance meetings in both Eastbourne and Hastings.

Staff used a range of recognised tools to measure and monitor risk. Staff completed the treatment outcome profile to monitor progress. In line with National Institute of Health and Care Excellence guidance, nurses completed the alcohol use disorders identification test (AUDIT) and the severity of alcohol dependency questionnaire (SADQ) to assess dependence. However, there were no recognised withdrawal scales such as the clinical opiate withdrawal scale (COWS) or clinical institute withdrawal assessment of alcohol scale (CIWA-r) in any of the records reviewed.

The provider had recently changed their prescribing policy to a more individualised approach, based on their new values. The policy was being embedded at the time of our inspection.

Staff followed local operational procedures for clients who persistently missed appointments. The service priority was to encourage clients to attend their appointments using a variety of approaches. Strategies included text reminders and the option of alternative venues to facilitate maximum

engagement. The service reimbursed travel costs for clients attending appointments during their period of titration. Staff sometimes held client prescriptions at the service to encourage attendance of appointments and medical reviews.

Clients were expected to attend medical reviews a minimum of three monthly, sooner if risk increased. Staff completed a review in absence with the prescriber to agree a formulate response if a client did not attend a medical review. A clinical decision was made during the meeting about whether it was safe to continue to prescribe. The regional lead consultant had to sign off on any decision that it was too unsafe to continue to prescribe.

Staff reviewed the effects of medicine on clients' physical health in line with National Institute of Health and Care Excellence (NICE) guidance. The service provided electro cardiogram tests for clients who were prescribed high doses of opiate substitute treatment. Wellbeing nurses provided blood borne virus testing, vaccinations and basic physical health checks. The service planned to offer a phlebotomy service.

The service responded to and shared information and alerts about dangerous or contaminated drugs. Staff shared information about alerts with local services including the homeless shelter. Staff provided harm reduction information to clients and provided naloxone to reduce the risk of overdose.

Management of service user risk

Staff followed the lone working policy when conducting home visits or seeing clients away from the service.

Staff provided harm minimisation advice and made clients aware of the risks of continued substance use.

Staff recognised and responded to warning signs and deterioration in clients' health. Staff worked closely with other health professionals including the local mental health team, GPs and pharmacies.

Safeguarding

Staff completed mandatory safeguarding training. Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff gave examples of how to recognise signs of abuse. Staff recorded safeguarding information in a dedicated section on clients' electronic records.

The service had recently created the post of a family worker to improve links with midwifery and children's services. The service issued clients with children with a lockable box to store their medicines. The service did not offer take out medicine for clients who had children under the age of five years.

Staff worked effectively with other agencies to safeguard clients. Staff contacted the local authority safeguarding team for advice and completed referrals where appropriate.

There was a safeguarding lead at the service who staff could contact for advice. The lead monitored clients with safeguarding concerns and attended quarterly regional safeguarding forums. Staff attended child protection meetings and multi-agency risk assessment conferences. The registered manager was a board member for local safeguarding partnerships for adults and children.

Safeguarding information was visibly displayed in the reception areas.

Staff access to essential information

All client records were electronic. Staff uploaded paper records, for example GP summaries, onto the client's electronic record.

Prescription information was also available via the electronic care records.

Medicines management

Staff followed good practice in medicines management. Policies and procedures for medicine management was in line with national guidance.

There was a well-equipped clinic room with the necessary equipment to carry out physical examinations. Staff reported cleaning the medical equipment after each use. However, they were unable to locate the cleaning logs for inspectors.

Medicines were appropriately stored, and staff completed daily temperature checks to make sure that medicines were kept at the recommended temperature.

The consultant worked across both sites. The non-medical prescribers at each service meant that there was increased access to clients accessing prescribed treatment.

Good

Community-based substance misuse services

Non-medical prescribers are healthcare professionals who have completed additional training and qualifications so that they can independently prescribe from a limited formulary of medicines.

Staff requested a medical summary from a client's GP before commencing medically assisted treatment to ensure safe prescribing.

An administrator processed repeat and instalment prescriptions. Blank prescription forms and those waiting to be signed were stored securely. There had been an increase in the number of mistakes concerning prescriptions because of staff shortages.

Contracted pharmacies provided direct supervision for new clients who were prescribed opioid substitute medicine. There was a service level agreement and protocols in place for pharmacists to share information on risk and changes in presentation with the service.

Supervised consumption and take out of medicines was based on clinical need. Staff reviewed the effects of prescribed medicines on client's physical health in line with National Institute for Health and Care Excellence guidance. The service completed electrocardiogram tests for clients who were prescribed a high dose of opiate substitute medicine.

There was a well-stocked needle exchange in line with National Institute for Health and Care Excellence guidance. Harm reduction information was displayed in the service and available for clients to take away.

Staff dispensed naloxone for clients who used opiates to reduce the risk of drug related deaths. Naloxone reverses the effects of an opiate overdose. Staff had been trained to use naloxone. We heard examples where staff had administered naloxone when a client had overdosed near the service.

Track record on safety

Within the previous 12 months, the service had not had any incidents that met the provider's criteria for a serious incident. The service had submitted 20 notifications for the unexpected death of a client in the previous 12 months. We saw that the service completed investigations into the death of clients to see if any lessons could be learned.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how incidents should be reported. Incidents were reported on an online reporting tool. Details of incidents were cascaded to local and regional managers. The safeguarding lead reviewed safeguarding incidents. Local managers reviewed incidents, assigned actions and closed when appropriate. We reviewed three incidents and saw that processes to review and close had been followed.

Staff discussed incidents during the morning meetings. Actions were agreed during the meeting to manage risk to staff and clients following an incident.

The service had recruited a regional quality and governance lead and regional learning culture lead to standardise their approach to auditing and learning from incidents.

Staff contacted their sub contracted pharmacy manager to follow up on pharmacy incidents within a specified time frame.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

The service used a service user plan which was a combined risk assessment and care plan.

We reviewed 14 client care records. There was evidence of a comprehensive assessment in 13 of the 14 records reviewed. Assessments included discussion about physical and mental health, substance misuse and safeguarding.

Care plans were personalised and recovery focused in eight of the care plans reviewed. Eight care records were fully completed and showed evidence of client's wishes about treatment and recovery goals. There was evidence of multi-disciplinary working and liaising with other professionals in the same eight records. However, there was missing information about client goals, strengths and resources in six of the records reviewed. The same six

records did not detail evidence of multi-disciplinary discussions. There was evidence of contingency management and exit plans if a client left treatment early in eight of the records reviewed.

Eleven of the 14 clients we spoke with said they had been actively involved in planning their care and treatment. Three clients told us they had not been offered a copy of their care plan.

Staff tried to arrange induction assessments and prescribing assessments back to back to avoid any delay. We observed two nurse assessments and two induction assessments. Staff were welcoming and demonstrated respect to clients. They gave a clear explanation of treatment options, rights, confidentiality, consent and acknowledged the client's wishes. Staff discussed safeguarding and arranged a home visit for a client who had children. Staff were open and supportive about the reason for the visit. There were clear discussions about forward planning, support available and contingency plans if problems occurred, for example, if the client experienced any withdrawal symptoms.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the clients. Interventions delivered were in line with guidance from the National Institute for Health and Care Excellence and the Drug misuse and dependence: UK guidelines on clinical management. These included needle exchange, medically assisted treatment, group work, psycho-social interventions, blood borne virus testing and counselling. Wellbeing nurses provided hepatitis B vaccinations. The service had a higher than national average for providing hepatitis B vaccinations. Wellbeing nurses checked client's injecting sites and signposted them to appropriate wound care.

Staff supported clients to lead healthy lives by providing support with issues related to substance misuse. This included administering Pabrinex. Pabrinex is an injection that contains vitamins B and C. It is used to treat symptoms that can be caused by a lack of these vitamins that is often associated with excessive alcohol use. Staff issued foodbank vouchers. The service offered a weekly breakfast club to encourage engagement and regular eating.

Following the success of a recent pilot, the service planned to implement a service for people who were prescribed dependence forming medicines from their GP.

The service had a dual diagnosis working together agreement with the local mental health team. Staff completed joint assessments with the community mental health team to ensure that the needs of clients were fully met.

The service offered an arrest referral service. Arrest referral is an intervention aimed at people who have been arrested and whose offences may be linked to drug use. Staff offered four arrest referral assessments per week.

Staff reviewed policies during clinical meetings to ensure staff knowledge and understanding.

Skilled staff to deliver care

All staff completed a comprehensive induction. Staff completed mandatory training and shadowed all staff and aspects of the service as part of their induction. The lead nurse arranged inductions for nursing staff.

Managers received a monthly supervision and appraisal compliance report. We reviewed two supervision records which were detailed and comprehensive. Data provided by the service showed 23% compliance rate for appraisals. Managers explained that the reason for the low compliance was due to the recent introduction of a pilot for mini-appraisals. These took place several times during the year, instead of one appraisal at the end of the year. We saw an example of a mini appraisal which contained detailed notes and actions.

Managers discussed learning and development needs during staff supervision. Staff told us that they had been unable to attend classroom training because of staff shortages.

The non-medical prescriber attended a monthly forum for non-medical prescribers employed by the provider.

Managers gave examples where poor staff performance was managed.

Data provided by the service showed that 73 of 74 staff had a disclosure barring check in place. A disclosure barring check was in progress for the remaining member of staff. The service had completed a risk assessment and they were not lone working with clients in the interim period.

The service employed a volunteer co-ordinator. Data provided by the service showed that 37 volunteers were employed by the service. All volunteers had a disclosure barring check in place. Volunteers completed mandatory

training. We spoke with a volunteer who said that they had also completed additional peer support training with a local recovery alliance. Some of the volunteers were volunteer counsellors.

There were plans to employ recovery motivators with lived experience and promote visible recovery.

Multi-disciplinary and inter-agency team work

Staff worked closely with other health professionals including the community mental health teams, children and family services, social workers, GPs and criminal justice services. Staff with lead roles including safeguarding, dual diagnosis and domestic abuse attended multi-agency meetings. Staff arranged joint assessments with specialist health professionals where appropriate. Staff worked closely with support services to ensure client needs were met and encourage engagement in their treatment. The Hastings service had a dual diagnosis working together agreement with the local mental health service.

The service contributed to local multi-agency meetings including the joint action group, cuckooing, modern slavery and the safeguarding children liaison group. Cuckooing is a form of crime in which drug dealers take over the home of a vulnerable person to use it as a base for drug dealing.

The test on arrest team attended the custody suite to identify and support clients in the criminal justice system into treatment.

There were regular multi-disciplinary team meetings. Staff attended the morning meeting which included updates about incidents, risks, safeguarding, clinical cover, groups, staff absences, duty cover, reception cover, joint assessments and clients who were in hospital. We observed two of these meetings which were well organised, comprehensive and engaged staff. There was a monthly clinical meeting for staff to discuss complex and high-risk clients.

Good practice in applying the Mental Capacity Act

The service had a policy on the Mental Capacity Act. Staff completed mandatory Mental Capacity Act e-learning training. Data showed that 86% of staff had completed level one in the Mental Capacity Act and 87% of staff had completed level two. The service had identified actions to address where training was outstanding.

Staff showed understanding of the Mental Capacity Act and knew where they could go for advice or support. A registered mental health nurse was the dual diagnosis lead for the service.

Staff completed decision-based assessments and presumed capacity unless stated. Staff asked clients to return to the service later that day if their capacity was affected by their substance use. Staff contacted the community mental health team if a client lacked capacity because of their mental health.

Staff discussed treatment options with clients and confirmed that they consented to care and treatment.

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We observed staff interacting with clients in a caring, compassionate and respectful way. Staff were welcoming and showed a genuine interest in the client's wellbeing. Staff were non-judgemental and spoke about clients with dignity and respect during the clinical meeting. Staff considered additional support available for clients to ensure their needs were fully met.

Clients said that staff were kind, caring and supportive. They said that staff were approachable and treated them with dignity and respect. They said that staff were responsive and provided practical and emotional support.

Staff said they felt able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients.

Staff explained the confidentiality policy to clients during assessments. Staff maintained client confidentiality of information.

Involvement in care

Involvement of service users

Good

Community-based substance misuse services

There was a weekly service user forum. The Eastbourne service had set up a 'moving on' group. The service user forum in Hastings was looking at ways to improve the building.

We observed staff clearly explaining treatment options and expectations during assessments. Staff made sure that clients had understood what had been discussed. Clients were encouraged to be involved in making decisions about their treatment.

The service had a contract with a national provider for interpreting services. Staff also used a language line, for telephone interpreting services. Staff could source signers for clients if required.

There was no dedicated advocacy support associated with the service. However, staff empowered and supported clients and families access to appropriate support. Staff worked closely with other support agencies including the recovery alliance and the family and carer team.

Staff completed a service user plan for all clients. The detail in the 14 records reviewed was mixed. Eight records had detailed information about the client's preferences, recovery capital and goals. However, the remaining six records contained limited information.

There were suggestion boxes and feedback forms located in the reception areas. A poster was displayed in the Eastbourne service showing the results of the last service user survey. Comments from the survey included: 'I wouldn't change anything at all' and '…ensure that people know that initial induction is a group and not a one to one appointment'.

Results from the latest survey were largely positive and showed that 70% of clients rated the service as very good and 27% rated the service as good. Questions in the survey included: accessibility of service; if the client had trust in the team member who was supporting them; if they had been asked their views on the service they had received and if they would like to be involved in improving their own and others' experiences of the service and if so, how would they like to be involved. Responses to accessibility and trusting team members was 92% and 94% respectively. However, only 55% said they had been asked for their views on the service they had received. 69% of clients responded that they would like to be involved in developing the service.

The latest service user bulletin dated June 2019 included a 'you said, we did' section with actions for the service user council to form a small action group to look at the needs of the Eastbourne and Hastings services. The bulletin also included a section entitled 'what can you do' and a 'keep, chuck, add or change' article. Comments from the bulletin included a request for the service to be more flexible with appointments and for the Hastings service to promote a 'following on' group.

Involvement of families and carers

There was a dedicated family worker to engage with families and improve links with midwifery and children's services. Families and carers were involved in clients care, if clients had given permission. Staff referred families and carers to the local family and carer team for support.

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

Good

Access, waiting times and discharge

There was a clear referral and assessment pathway for clients to be considered for medically assisted treatment. The service was commissioned to accept referrals for people who lived in east Sussex. Most referrals received by the service were self-referrals. The service accepted referrals from professionals including GPs, probation, prisons and social services.

The service had a target for clients to receive treatment within 21 days of referral. Data provided by the service showed that this target had been met for clients who had referred in for support with their drug use between April and June. The data showed that 1% of clients who had referred in for support for their alcohol use had to wait more than three weeks during the same period.

Managers allocated referrals to recovery workers based on need and capacity. As part of the new contract, the service had introduced dedicated alcohol, opiate and criminal justice recovery workers.

Good

Community-based substance misuse services

There was a daily drop in service available so that people could access the service at any time for advice, information or referral. The service offered two evening clinics and was open on a Saturday morning to meet the needs of employed clients.

Staff, including the medical team, saw clients in a range of settings, including home visits where appropriate, to reduce barriers to treatment. Staff signposted clients to appropriate agencies whose needs could not be met by the service.

The service provided weekly satellite services in rural areas to actively engage hard to reach clients and people who were reluctant to engage in treatment because of the perceived stigma associated with substance misuse. There were plans to use a converted bus to provide an outreach service for people who were unable to attend the service.

The ambulatory detoxification nurse worked closely with recovery workers to provide a joined-up care pathway for alcohol users. Data provided by the service showed that seven of nine clients had successfully completed their ambulatory detox in the previous three months. The service was working on a contract to provide home care cover at night to support people to complete alcohol detoxes in their home environment.

We observed staff discussing strategies to contact clients who seemed to be disengaging from the service. Strategies to attempt to re-engage clients included home visits, telephone calls, flexibility of appointment time and venue and text messages. Clients could contact the service at any time using an out of hours telephone number.

Discharge and transfers of care

Recovery plans reflected the diverse and complex needs of clients. Care records showed consideration and referral to other support services. The family liaison worker worked closely with midwives and children and families services. The dual diagnosis lead worked closely and completed joint assessments with the community mental health teams.

Staff considered contingency management and unplanned exit in eight of the care records reviewed. Staff completed a discharge checklist signed off by team leaders prior to all discharges. The form considered risks including safeguarding and criminal justice.

Staff discussed client risk and need during the morning meeting and monthly clinical meeting. Discussions included referrals and transfers between services. Staff discussed clients who had been admitted or were due to be discharged from hospital. Staff discussed clients who appeared to be disengaging from the service and agreed strategies to manage. The criminal justice worker ensured a smooth transition into the community for clients who had been released from prison.

The medically assisted treatment policy referred staff to the local operational policy for actions to take if clients stopped attending medical appointments.

The service had discharged 331, 270 and 203 clients in Hastings, Eastbourne and in rural satellite clinics respectively in the previous 12 months. The service had an average 20% unplanned discharge rate between April and June 2019.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms to see clients for medical reviews, one to one appointments or group work. There was a comfortable reception and waiting area with clean, well maintained equipment.

There was a room that could be used by parents who attended the service with children.

Service users' engagement with the wider community

The reception area had a good range of information leaflets and posters about support groups, breakfast clubs and a recovery cafe which was partially funded by the service.

The café had a space for work related to their recovery. Other support services and mutual aid groups could use the space free of charge. All money gained from the café was reinvested into recovery work.

Graduation ceremonies for clients who had completed treatment were held at the café each month. All food provided at the ceremony was free of charge.

Meeting the needs of all people who use the service

There was 95% compliance with training in equality, diversion and inclusion. Staff showed an understanding of the potential issues facing vulnerable groups.

The service offered satellite clinics to try to engage older alcohol clients and provide treatment in a less stigmatised

setting. The service was investigating the possibility of using a converted bus to provide advice, support and treatment away from the service. There was a remote consult service to reduce barriers to clients accessing or engaging in treatment.

The service provided an evening and weekend service to meet the needs of clients unable to attend the service during normal working hours. The Hastings service provided a breakfast club for clients once a week.

The service had recently trialled a dependency forming medicine project to identify and support GPs. The service planned to introduce a permanent service based on the positive results of the pilot.

There was a free phone number that clients could use to contact staff outside normal working hours. In response to client surveys, a service user engagement centre was due to be introduced in November 2019. The service would provide a single point of contact for clients to provide immediate support.

The provider delivered unconscious bias workshops to their board of trustees. The provider supported 'Pride' events and used social media to publicise their support for LGBT equality and inclusion.

The providers website included the browse aloud application. Browse Aloud is assistive technology software that adds text to speech functionality to websites. The facility is also available in a range of different languages.

Listening to and learning from concerns and complaints

The service had a compliments and complaints policy. A comments box and feedback forms were in the waiting and reception areas.

Staff managed complaints at a local level where possible. Staff recorded complaints on the service electronic reporting system. Information was cascaded to managers to monitor and review. The service shared information about complaints with commissioners.

Data provided by the service should that five complaints had been received for Hastings in the 12 months up until August 2019. All five complaints had been upheld. No complaints were recorded for Eastbourne. One compliment had been recorded for the rural service for the same time period.

Complaints were escalated to the regional manager, when clients were unhappy with the outcome. Complaints made via the provider's website were cascaded to the regional manager.

Are community-based substance misuse services well-led?

Requires improvement

Leadership

The consultant provided clinical leadership for the service. The nursing staff included non-medical prescribers, registered mental health nurses and registered general nurses. Some staff said that a recent change in chief executive officer would mean greater collaboration.

Leaders had the skills, knowledge and experience to perform their roles. The service manager had been in post since August 2019. The locality leads' and team leaders had a good understanding of the service. They could explain clearly how the teams were working to provide high quality care. The organisation had a clear definition of recovery and this was shared and understood by staff.

Staff said local leaders were visible and supportive, but members of the executive team were rarely seen in Hastings. They said they had felt abandoned because of the constant changes to senior leaders. Staff in Hastings hoped that the recent recruitment of a service manager and locality lead would bring stability to the service.

Vision and strategy

There was a clear definition of recovery which was understood and shared by staff. Staff knowledge of the provider's vision and values was mixed because they had recently changed as part of the new contract. Some staff said that the new values had inspired them to incorporate these within their work.

The service had recently been through a period of restructure. The new chief executive had attended a recent staff engagement event. The event had been arranged to discuss recent changes and the new vision and values for the service. Staff said that they did not always have an opportunity to contribute to discussions about changes to the service.

Good

Community-based substance misuse services

Following a period of consultation, the service had introduced dedicated alcohol, opiate and criminal justice workers to enable staff to tailor their knowledge and better meet the needs of the clients. The roles were being embedded at the time of our inspection.

There were specialist leads including safeguarding, domestic abuse and dual diagnosis who provided advice and support to staff.

Culture

Staff said that they felt respected and supported by their local leaders and teams. Most staff in Hastings said that the recent recruitment of a locality lead and service manager had begun to improve staff morale. Staff said that the local management were supportive and had a good relationship with the team. However, they felt increased stress due to staff shortages and said that they were not encouraged to attend class room training because of this. Staff felt their caseloads were high and were concerned that they were unable to give clients the time they needed.

Staff appraisals included conversations about career development and how it could be supported. We saw examples of discussions about career development in the appraisals reviewed. The service had supported staff career development. Three nurses had completed non-medical prescriber training and the service supported recovery workers to become trained in complementary therapies.

We heard examples how the service had responded proactively to allegations of bullying and harassment.

The provider was reviewing their recruitment policies for new employees and support with existing staff with disabilities. Staff recruitment processes assessed values as well as competency.

Governance

Managers used a weekly performance report to monitor staffing, vacancies and caseloads. There was a locality lead at each service who had oversight of staff performance. Managers and locality leads recognised the impact of sickness on caseloads and gave examples where they had actively followed the provider's policy to manage sickness absence. There was active recruitment underway. Three vacancies had been recruited to and the remaining vacancies were being advertised. The service had recently introduced dedicated workers to work with alcohol, opiate and criminal justice clients to reduce workload and encourage team specialisms.

The service used key performance indicators set by their commissioners to gauge performance and productivity. There was a clear governance structure to ensure the safe running of the service. A working group reviewed clinical policy. Policies and procedures were regularly reviewed to make sure they were relevant and in line with national guidance.

The medically assisted treatment policy detailed staff responsibilities to monitor, support and review clients during the initial stages of being prescribed opiate substitute medicine. The policy detailed actions for staff to take if clients did not pick up their prescription. The policy referred staff to implement the local operational policy if a client stopped attending medical reviews.

There was a clear framework of what should be discussed at the service, manager or director level to make sure that essential information including learning from incidents and complaints was shared. There were regular local and regional meetings to discuss risk, clinical reviews, safeguarding, incidents, performance and governance.

The service quality improvement plan gathered information for governance meetings. Issues identified during the monthly senior governance meeting were cascaded to local team governance meetings.

The service co-chaired a joint governance meeting with the community mental health team under the dual diagnosis pathway. The cluster lead nurse attended the Controlled Drugs Local Intelligence Network (CD-LIN) with arrangements in place to report all medicines management incidents to representatives from the clinical commissioning group.

Treatment outcomes, learning from deaths and quality audit findings informed the service improvement quality plan. Managers completed investigations into all drug or alcohol related deaths to identify learning and recommendations to reduce these incidents.

Staff confirmed that they were involved in one audit per quarter for risk assessments and care plans. Nurses completed monthly clinical audits. The data analysts provided weekly reports of local performance information, including caseloads, medical reviews and client contact.

The service had commenced a deep dive audit of prison releases for East Sussex because there was limited shared monitoring processes in place. The purpose of the audit was to highlight strengths, acknowledge poor performance and practice and seek to improve these areas. The audit was actioned because of figures provided by Public Health England about people who had been discharged from prison accessing treatment.

The service met regularly with and submitted reports to their local commissioners. This included monitoring of key performance indicators such as client successful treatment completion, unplanned discharges, re-presentations and incidents. Feedback from the commissioner about the service was positive.

Staff did not always submit notifications to the Care Quality Commission about incidents that were reported to the police. We reviewed a spreadsheet printed from the electronic database that recorded that eight incidents had required police attendance at Eastbourne since January 2019. CQC records showed that we had received a notification for two incidents. Staff had not submitted a notification to CQC for an incident that required police attendance the day before our inspection.

Staff worked closely with other teams, both within the provider and external, to meet the needs of the clients.

Staff were aware of the provider's whistle blowing policy.

The provider completed an annual organisation-wide online staff survey on an annual basis. The results of the survey were unavailable for inspectors.

Management of risk, issues and performance

The service had a clear quality assurance management and performance framework in place. Clinical governance was embedded throughout the integrated governance structure with oversight from medicines management, reducing mortality groups and doctors' meetings.

Staff discussed risk during team meetings and local risk registers fed into the corporate risk register. The service had a business contingency plan that identified what actions should be taken to ensure that a service was maintained for clients, for example, in the event of adverse weather. Managers had considered the potential impact of the exit of the United Kingdom from the European Union on medicines and staffing.

Managers monitored sickness and absence rates. Managers were addressing the high sickness and absence rate at the Hastings service.

Staff said that changes to service delivery had not impacted negatively on the care and treatment offered to clients.

Information management

Staff had access to appropriate equipment and technology needed for their work. The information technology structure generally worked well although there were occasional issues with the internet signal in Hastings.

Information governance systems included confidentiality of client records. The service was moving to paperless records. Staff uploaded paper documents including GP summaries and assessment tools onto the client's electronic record.

Managers had access to information to support them with their role. They received a weekly report with information about performance of the service and client care. Managers and staff had oversight of dashboards to monitor caseload, risk, recovery plans and clients' care and treatment.

Engagement

There was a service user involvement group at the service. The service completed regular surveys with clients. Clients were invited to provide feedback and suggestions using the comments box in the waiting area. The provider produced a quarterly bulletin for clients. Clients who had completed treatment attended a graduation ceremony arranged by the service.

Learning, continuous improvement and innovation

The service worked closely with GPs to support people who were prescribed high levels of dependence forming medicines. During a recent pilot, staff had provided telephone intervention for people who were prescribed high levels of these medicines. Of the 235 people worked with, 70 had detoxed completely and 65 had reduced to safer levels. Feedback from the pilot included improved quality of life and sleep levels.

Good

Community-based substance misuse services

The service offered a contingency management scheme where clients who provided a negative drug screen were issued vouchers. Staff issued vouchers to clients who participated in hepatitis C surveys.

Outstanding practice and areas for improvement

Outstanding practice

The dependency forming medicines project team had been nominated for the Primary Care Team of the Year for their work in supporting people reduce or detox from such medicines.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that appropriate notifications are submitted to the Care Quality Commission without delay. (Registration Regulation 18)

Action the provider SHOULD take to improve

- The provider should manage staff vacancies and absence so that staff shortages do not negatively impact on the service, staff morale or staff ability to attend training.
- The provider should monitor and review staff caseloads so that they are able to give clients the time they need.
- The provider should ensure that cleaning logs for medical equipment are up to date and available for staff.
- The provider should act to repair the boilers and make appropriate repairs to improve the environment.
- The provider should ensure that client records are personalised, holistic and recovery orientated in both Hastings and Eastbourne.
- The provider should ensure that staff use recognised withdrawal scales for opiate using clients.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents Care Quality Commission (Registration) Regulations 2009 (Part 4) The provider did not always notify the Commission without delay about an incident that was reported to, or investigated by, the police. This was a breach of Registration Regulation 18 (1) (f)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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