Good

Sheffield Health and Social Care NHS Foundation Trust

Substance misuse services

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAHXK	Fulwood House	Drug (Opiate) Service	S1 4JP
TAHXK	Fulwood House	Drug (Non-opiates) Service	S1 4RH
TAHXK	Fulwood House	Alcohol Service	S1 4RH
TAHFC	Michael Carlisle Centre	Burbage ward	S11 9BF

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Outstanding** 
Are services well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated substance misuse services as good because:

- All areas were clean, well maintained and offered good facilities for the provision of services. Clients and staff told us they felt safe using the service. Services sharing locations had separate entrances for their clients.
- Staff had good knowledge of safeguarding procedures and made appropriate referrals. There were beneficial links with the local authority safeguarding team who provided guidance and training to support the service.
- Clients received care and treatment underpinned by best practice. Clinical staff demonstrated a good working knowledge of guidance and treatment options for drug and alcohol users. They received weekly continuous professional development and could access specialist training relevant to service delivery.
- Partnership arrangements ensured a multidisciplinary approach. Staff had formed effective external working relationships with the local recovery community and mutual aid groups. This provided clients with further support and activities during and after their treatment with the service.
- Clients spoke positively of the service; they felt involved in their treatment options and told us the staff team treated them with kindness and respect. We observed positive interactions between staff and clients in clinics and group sessions. Staff understood the needs of their clients and used this to build positive relationships with them.
- Staff ensured that it was easy for people to access the service. Waiting times to access and begin treatment were better than national averages. People could attend for assessment at the opiate, non-opiate and alcohol services without an appointment. Staff were able to provide flexible appointment times.
- The alcohol service had developed and updated an online screening tool for monitoring alcohol intake, which allowed health and social care professionals in Sheffield to make direct referrals into both the alcohol and the non opiate service.
- Services provided a range of clinics and access to specialist staff to meet people's needs and preferences, offering choice and continuity of care. This included home detoxification, wound care clinics, clinics for those using performance enhancing drugs and inpatient detoxification.

However:

- Staff in the opiate service did not use appropriate areas to activate urine tests and dispose of clinical waste. Instead, they used consulting rooms that were not fit for this purpose. This meant that staff and clients were exposed to an avoidable infection control risk.
- Staff did not always update risk assessment records and management plans using the trust's recognised risk assessment tool following changes in a person's circumstances or following a multi-disciplinary team review. Risk plans did not include agreed actions staff would take if a client missed an appointment or dropped out of treatment unexpectedly.
- Clients did not always have care plans that were holistic, or recovery orientated. Some concentrated solely on appointment attendance and maintenance of treatment. Clinical staff did not routinely audit the quality of clients' care records.
- Services received over 500 telephone calls a day and had difficulty managing the volume of daily telephone calls. This meant that clients and professionals experienced delays when trying to contact the service.
- Services were not able to monitor their team's performance adequately at local level. Trust figures showed staff were not compliant with mandatory training and the recording of supervision compliance. There was a need to improve the mechanism for recording training and supervision sessions.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff in the opiate service did not consider infection control procedures when using client consulting rooms to activate drug screening tests and dispose of clinical waste.
- Staff had not created a risk assessment and risk management plan for each client open to the service using the trust's new risk assessment tool. This meant updates following reviews and multidisciplinary meetings were contained within the contemporaneous clinical records. Although staff were in the process of transferring clients to the new risk assessment format, over a third of clients did not have updated risk assessments and risk management plans using this process.
- Risk plans did not show if staff had agreed with clients any actions they would take or who they should contact if a client missed an appointment or dropped out of treatment unexpectedly.
- Trust figures showed not all staff were compliant with the trust's mandatory training requirements.
- A few items of equipment were out of date at each location, such as syringes and wound dressings.
- Staff kept bins used for the safe disposal of needles on the clinic room floor and did not follow good practice in signing and dating bins on assembly.

However:

- Staff and clients said they felt safe accessing the service and that staff were quick to deal with any problems arising. Services sharing locations had separate entrances.
- Staff were knowledgeable about safeguarding matters and knew how to raise concerns. They received annual safeguarding training from the local authority and had close links with a dedicated worker.
- Services provided harm minimisation advice appropriate to the client's needs throughout their treatment.
- There were sufficient staff to provide care and treatment for clients. Managers were able to access agency staff to cover sickness levels and staff vacancies.

Summary of findings

- The service understood the requirements of the trust's duty of candour policy.

Are services effective?

Good

We rated effective as good because:

- Clients received care and treatment underpinned by best practice, and had access to psychosocial therapies, physical health clinics and group work sessions.
- Partnership arrangements ensured a multidisciplinary approach. Interagency work with the local recovery community and mutual aid provided clients with further support and activities. Staff had formed effective working relationships with external agencies to support clients during and after their treatment with the service.
- Staff offered clients immunisations and screening for blood borne viruses. There was a care pathway in place with the acute hospital should a client need further support and treatment
- The non opiate service recruited and trained ambassadors (people who had previously used the service) to support and inspire newer clients.
- Staff received weekly continuous professional development suitable for their role. Nurses were encouraged to become non-medical prescribers and undertake training in psychosocial interventions to enhance their skills.
- Staff had an in depth knowledge of issues affecting clients' wellbeing. They made appropriate onward referrals for physical and mental health issues.

However:

- Not all care plans were holistic and recovery focused. Some concentrated solely on appointment attendance and maintenance of treatment.
- Clinical staff did not routinely audit the quality of clients' care records.

Are services caring?

Good

We rated caring as good because:

- Clients reported positive interactions with staff and praised them for being caring and respectful. Staff offered emotional as well as practical support.

Summary of findings

- Clients were involved in decisions about their care and treatment.
- Clients had the opportunity to provide feedback about their service. Questionnaires were available at each site in the reception area.
- Clients were encouraged to include families and carers in their treatment and care, if they so wished.

However:

- Staff did not record whether clients had been offered and accepted a copy of their care plan.

Are services responsive to people's needs?

Outstanding ☆

We rated responsive as outstanding because:

- Waiting times to access and begin treatment were better than national averages.
- The opiate service, non-opiate service and alcohol service operated a drop in assessment system. This meant that people could attend for assessment without an appointment and offered individuals flexibility and choice.
- The alcohol service had devised and updated an online screening tool for health and social care workers to use with clients that resulted in direct referrals and a speedy appointment system.
- Services were proactive in understanding the needs of a diverse community and providing care for people who had complex needs or who were in vulnerable circumstances.
- Services provided a range of clinics and access to specialist staff to meet people's needs and preferences, offering choice and continuity of care. This included home detoxification, wound care clinics, clinics for those using performance enhancing drugs and inpatient detoxification.
- Services had established links with mutual aid and recovery support groups in the local community, enabling outreach work into services and allowing in reach into services. This ensured their clients had a support network in place in readiness for discharge from the service.
- The service investigated complaints in an open and transparent manner. Staff learned from complaints and made improvements to the way they provided care and treatment.

However:

Summary of findings

- The service struggled to deal with the volume of calls they received on a daily basis. This meant that clients and professionals experienced delays when trying to contact the service

Are services well-led?

Good

We rated well led as good because:

- Staff had a good awareness of the trust's visions and values and knew who the senior managers were.
- Staff at the Fitzwilliam Centre were positive about their local managers and felt well supported. Staff morale was high and staff told us they felt well supported by their peers and multi-disciplinary colleagues.
- Managers sought to improve staff morale and unify their teams during periods of change.
- Staff contributed ideas for innovations that improved the quality of the services.
- Staff had opportunities to give feedback on the service and felt able to raise concerns without fear of victimisation.

However:

- Managers were unable to use some of the trust's systems to extract information about their team's performance. They had developed local systems to monitor key performance indicators but this data was different from that supplied by the trust.

Summary of findings

Information about the service

Sheffield Health and Social Care NHS Foundation Trust provided community substance misuse services for the city of Sheffield. The service comprises three separate contracts:

Drug (Non opiate) service

The service operated from Sidney Street, which was in the city centre.

The service offered assessment, support and interventions to people using any non-opiate drug. Non-Opiate drugs include cannabis, amphetamines, steroids, cocaine and crack cocaine and new psychoactive substances (formerly known as 'legal highs'). It provided outreach in other services and communities across the city. Individuals could self-refer by telephone or in person. Individuals who self-referred by drop-in were assessed immediately. Any professional such as a GP, social worker, pharmacist or probation worker, could also make a referral.

In October 2016, there were 187 clients engaged in structured psychosocial interventions with the service.

Alcohol service

The service operated from Sidney Street, which was in the city centre.

The service successfully re tendered and won the contract for a restructured model in October 2016. The service provided assessment of drinking habits, support, advice and information to anyone aged 18 and over wanting to make changes to their drinking habits. The service also provided advice and support to people affected by someone else's drinking. It was a citywide service linking in to NHS hospitals, community mental health teams, prisons, and rehabilitation placements.

Individuals could self-refer by telephone or in person. Individuals who self-referred by drop-in were assessed immediately. Any professional such as a GP, social worker, pharmacist or probation worker, could also make a referral.

In October 2016, there were 990 clients engaged with the service.

Drug (Opiates) Service

The service operated from the Fitzwilliam Centre, which was in the city centre.

The Drug (Opiates) service offered assessment, support and interventions to people aged 18 and over who were using any opiate drug. These included naturally occurring opiates like heroin and morphine and synthetic (man-made) opiates like methadone and buprenorphine. It was a citywide service linking in to NHS hospitals, community mental health teams, prisons, and rehabilitation placements.

In October 2016, there were 1924 clients actively engaged with the service.

Inpatient detoxification (Burbage Ward)

The substance misuse service provided alcohol and drug inpatient detoxification to people aged 18 and over. They had access to five inpatient detoxification beds located on Burbage Ward at the Michael Carlisle Centre.

Sheffield Health and Social Care NHS Foundation Trust was last inspected 27 October 2014. The Care Quality Commission did not inspect substance misuse services as part of this process at that time.

Our inspection team

Chair: Beatrice Fraenkel, Chairman, Mersey Care NHS Foundation Trust

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Jenny Jones, Inspection Manager Care Quality Commission

Summary of findings

The team that inspected the substance misuse service comprised two Care Quality Commission inspectors, a consultant psychiatrist and a registered mental health nurse.

Why we carried out this inspection

We inspected this core 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 these services, asked a range of other organisations for information and sought feedback from clients.

During the inspection visit, the inspection team:

- visited all the substance misuse sites, looked at the quality of the environment and observed how staff were caring for patients
- spoke with 21 clients who were using the service and collected feedback from 12 clients using comment cards
- spoke with the service managers for each site
- spoke with 23 other staff members; including administrative staff, doctors, key workers and nurses
- spoke with the assistant clinical director with responsibility for these services
- attended and observed an alcohol clinic, a multi-disciplinary meeting, a physical healthcare clinic, a safeguarding meeting and a steroid clinic
- looked at 30 treatment records of clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 21 clients who used the substance misuse service.

Clients said they felt safe while at the service and that they could ask for help if they needed it. They spoke positively about the service they were receiving. They told us that staff were approachable and empathic. They felt supported in their recovery on a practical and emotional level making it easier for them to engage honestly with their keyworker.

Feedback from an ambassador volunteer was positive. Ambassadors were people who have been through the service and graduated from a training programme to become mentors to other clients. They told us how the service had changed their lives and how they had been able to aspire to improve the quality of their life and gain employment.

Four clients told us they found it difficult to contact the services by telephone as the lines were often engaged.

We received twelve comments cards about the services, which were all positive.

Summary of findings

Good practice

Alcohol service – the digital alcohol-screening tool available to other Sheffield health and social care professionals enabled them to refer clients immediately. The service responded quickly, often with same day appointments.

Non-opiate service – ran a clinic for clients using performance and image enhancing drugs (commonly known as steroids). Clients had their hormone levels monitored to check they were within safe limits. This enabled staff to give appropriate harm reduction advice.

The opiate service – ran a wound management clinic and outreach service for those clients with venous problems. Clients attended the clinic regularly therefore avoiding unnecessary infections and the need to over prescribe antibiotics. The clinic had won a poster presentation from the Royal College of General Practitioners

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff only use designated clinical rooms to carry out clinical procedures and adhere to infection control procedures.
- The trust must ensure that staff document and update client risk and risk management plans using the correct tools in the electronic records.

Action the provider SHOULD take to improve

- The trust should ensure that the service deals efficiently with the volume of daily telephone calls received. Clients and other professionals must be able to contact the service with the minimum of delays.
- The provider should ensure that all staff receive mandatory training in line with trust policy.
- The provider should ensure that all clients have up to date, person-centred care plans that are personalised, holistic and focus on recovery from substance misuse and treatment.
- The provider should ensure that risk management plans include actions staff should take if a person missed an appointment.
- The provider should ensure that routine quality audits of care records are undertaken.
- The provider should ensure that processes are in place that allows for the submission of accurate information and data about key performance issues.
- The provider should ensure that equipment at each location is in date.
- The provider should ensure that bins used for the safe disposal of needles are assembled and used in line with good practice and infection control procedures.

Sheffield Health and Social Care NHS Foundation Trust

Substance misuse services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Drug (opiate) Service	Fulwood House
Alcohol Service	Fulwood House
Drug (non-opiate) Service	Fulwood House
Burbage Ward	Michael Carlisle Centre

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

If a client's mental health were to deteriorate, staff were aware of whom to contact. Some of the nursing staff were trained as registered mental health nurses, which meant that they were aware of signs and symptoms of mental health problems.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had 20% compliance with the trust's mandatory training requirement for the Mental Capacity Act. However, they had an understanding of the core principles of mental capacity. Staff were aware the trust had a policy on the Mental Capacity Act and could refer to it if necessary. The mental capacity of clients using illicit drugs can vary and staff understood that clients sometimes temporarily lacked capacity. Staff discussed clients' capacity at multidisciplinary meetings if the need arose. The consultant psychiatrist would conduct capacity assessments if necessary.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Staff and clients told us they felt safe at both the Fitzwilliam Centre and Sidney Street services. Five clients from the Fitzwilliam Centre told us that sometimes there were disputes between clients in the waiting area but staff managed these well.

The environment was clean and well-maintained with up to date cleaning schedules. We saw domestic staff cleaning the base locations each day of opening and clients told us the premises were always clean and tidy. Both locations had up to date health and safety assessments, fire risk assessments and legionella assessments. There were appropriate arrangements in place for the collection and disposal of clinical waste. The service had carried out appropriate health and safety checks on equipment and electrical testing. There was a contract for servicing medical devices, such as breathalysers.

Clinic rooms at the Fitzwilliam Centre were suitable for purpose, although the clinic room at Sidney Street was small and did not contain an examination couch. Staff checked emergency equipment and medication regularly. The services kept stocks of naloxone and adrenaline on site. These were medicines used in emergencies. The medicine fridge was clean and staff checked the fridge temperature and ambient temperature daily to ensure that medication remained fit for use. There were no controlled drugs kept at either site. Staff had access to protective personal equipment, for example, gloves and aprons as required.

There were small quantities of out of date equipment at each location, such as syringes & wound dressings. We brought this to the attention of staff who immediately disposed of these items.

Staff kept bins used for the safe disposal of needles on the clinic room floor and did not follow good practice in signing and dating bins on assembly. We brought this to the attention of staff who rectified the situation immediately.

The Fitzwilliam Centre had numerous consulting rooms. Some of these rooms contained carpets and did not have wipe clean surfaces or hand washing facilities. Staff used the consulting rooms to carry out urine tests and dispose of clinical waste. This meant that staff and clients were exposed to an avoidable infection control risk.

Consulting rooms, reception areas and toilets had alarm points enabling staff and clients to summon help if required. The opiate service had CCTV installed in an area where reception staff did not have a clear line of sight. This allowed staff to monitor the safety of their clients. At Sidney Street, there were separate entrances and reception areas for clients who used non-opiates and clients who wished to change their drinking habits. On Burbage ward, the environment was clean and well maintained. Clients we spoke with undergoing detoxification said they felt safe. Ward staff monitored the equipment and clinic room, which were suitable for purpose.

Safe staffing

The non-opiate service and the alcohol service had individual service managers. Both managers were responsible for the opiate service. The Burbage ward manager oversaw the detoxification beds on Burbage ward. As a whole, the services employed 105 staff. There were two full time consultant psychiatrists, one full time speciality doctor and two full time junior doctors who provided cover across all the substance misuse locations, including the inpatient ward. In addition, the trust employed general practitioners, contracted to provide specific weekly clinics at the opiate service. This meant clients always had access to a doctor if needed.

Each service comprised a nurse team leader, key workers, nurses, administrative and building support staff. The opiate service also employed social workers as part of their team.

The non-opiate service had two ambassador volunteers at the time of our inspection. These were former clients who were free of illicit substances or alcohol use and had successfully completed the ambassador training programme. Their position was to support newer clients and act as positive role models. In addition, there were four carer ambassadors to support families of clients.

Patients undergoing a detoxification on Burbage ward told us staff were visible and very approachable. The substance

Requires improvement

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misuse consultant psychiatrist was responsible for care, treatment, and prescribing during their admission. Patients told us they maintained regular one to ones with their named nurse from the substance misuse service during their inpatient admission.

There was minimal use of bank or agency staff as the existing staff team across the services covered shortfalls where possible. The alcohol service had used agency staff to cover a social worker vacancy. The non-opiate service used agency staff to cover high sickness levels among administrative staff. There was one staff vacancy, which the service had just filled. Staff sickness rates as at 31 July 2016 was 11.4%. This was considerably higher than the trust average sickness rates of six per cent and mainly affected services at Sidney Street. Service managers were monitoring sickness levels. Staff turnover was low at just over seven per cent and no themes were evident.

Both the alcohol service and opiate service were clinic oriented and staff did not hold individual caseloads. The non-opiate staff team saw clients who either booked an appointment or self-referred into the service that day.

All staff we spoke with felt that workloads were manageable. Clients told us that the service rarely cancelled appointments and if they did, staff would offer a rescheduled date. The opiate service had a duty officer available for clients who either missed or needed to rearrange clinic appointments.

Staff were not up to date with mandatory training, however, not all elements of mandatory training applied to the service. Figures supplied by the trust as of October 2016 showed an average mandatory training compliance of 45% against the trust target of 75%. It was not clear from the figures supplied if this included the training that did not apply to the service. The areas of lowest compliance were dementia awareness (2.4%) and medicines management (3.3%). The service provided evidence during the inspection that showed staff were compliant with the majority of mandatory training. In addition, the service held twice-weekly continuous professional development training, which included life support training and accessed annual safeguarding training provided by the local authority. Service managers told us they had prioritised training relevant to providing care and treatment in substance misuse services. They produced an action plan whereby staff were booked onto future training sessions to meet trust target compliance rates. The services expected staff to be compliant with trust targets by December 2016.

Assessing and managing risk to patients and staff

Staff completed a risk assessment for clients entering into treatment. They did this at the initial comprehensive assessment. Staff used the trust electronic risk assessment rather than an assessment specific to substance misuse. This meant the quality of the risk assessment was dependent on the recording/documentation skills of the nurse as the template used did not guide and support staff to consider all domains of risk associated with substance misuse. For example, risks relating to debts, self-care or conflicts with others.

Comprehensive assessments included treatment history, physical health, mental health, self-harm, harm to others, exploitation, children and childcare, injecting, poly drug use, sexual behaviour and blood borne viruses. The risk assessment contained a plan detailing how staff and clients would manage risks.

All clients had a risk assessment. The service introduced a new risk assessment process in January 2016, whereby staff recorded clients' risks using the trust wide risk assessment. We reviewed 30 client care records of which four did not contain up to date risk assessments and risk management plans in this format. We saw one risk assessment contained in the comprehensive assessment and reviews of risk in progress notes rather than updating the risk assessment itself. If staff had concerns about the level of risk associated with a client, they would discuss this at the weekly multi-disciplinary meeting and document it in the progress notes. They did not subsequently update the risk assessment. Staff also discussed client risks at the daily flash meetings.

The business and performance manager monitored weekly how many risk assessments staff had updated. They provided staff with a daily report highlighting those clients due a risk assessment update using the new process. The services had an action plan for all clients to have an up to date risk assessment by the end of March 2017. They confirmed that out of 2519 clients requiring risk assessments, 877 (34.8%) did not have up to date risk

Requires improvement

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assessments or risk management plans using this process. This meant that staff could not always use the risk assessment or management plans as a reference point as updated information was recorded elsewhere.

Clients undertaking a drug or alcohol detoxification all had up to date risk assessments. Patients with known very complex physical health conditions, which staff considered too high risk to be managed on a mental health ward, had their needs managed by the acute hospital. The ward manager for Burbage Ward told us their team worked closely with the community substance misuse team to ensure safe care and treatment for patients undergoing detoxification.

There was a specific policy and protocol for staff to follow if clients missed their appointments, which included welfare checks and outreach if staff had particular concerns for their safety. However, the risk management plans did not include agreed actions, such as who the client wanted them to contact if they missed an appointment or dropped out of treatment.

Harm minimisation information was evident throughout the services. All locations we visited had harm minimisation posters displayed and accessible leaflets. Staff documented in clients' care records they had given clients harm reduction advice although they did not specify what the advice was.

Clients could access a needle exchange service at either the Fitzwilliam Centre or Sidney Street. This enabled clients who injected drugs to obtain clean equipment and dispose of used needles. Clients who shared any type of injecting equipment were at risk of contracting blood borne viruses. Accessing a needle exchange for clean equipment helped reduce this risk, protected the wider community, and gave staff the opportunity to give harm reduction advice.

The alcohol service provided prescribing for clients with alcohol issues as well as community and inpatient detoxification. There were clear guidelines for clinicians to follow when clients underwent a community detoxification.

The opiate service provided prescribing for clients with opiate addictions. Substitute prescribing is a clinical intervention with a primary focus to reduce and replace illicit opiate use. Substitute prescribing aims to reduce harm and improve the health and psychological wellbeing of the person. The clinical team did not provide a dispensing service onsite. Staff arranged for clients to collect their medication from their preferred pharmacy. Medications for substitute opiate prescribing are controlled drugs. They have a value on the black market and are therefore at risk of being diverted. Clinicians reduced the risk of diversion by prescribing under a regime where the dispenser at a pharmacy watches clients take their medication. All new clients began treatment following this process. The doctor reviewed the need for supervised consumption in the multi-disciplinary team meetings and with the client at their quarterly medical review.

If children or adults take substitute opiate medication, such as methadone, which their doctor has not prescribed it can result in death or accidental poisoning. The service advised clients to keep medications out of reach and ask their key worker for a safer storage box.

Pharmacy staff contacted the opiate service when a client missed collecting their opiate substitute medication for three days. This was because the client would be at increased risk of overdose due to reduced tolerance levels after this period.

Staff informed the client's GP of any alcohol or opiate substitute prescribing. This reduced the possibility of a client obtaining substitute prescribing from more than one trust, which would be harmful to the client and community if diverted elsewhere.

We reviewed the storage of prescriptions at both locations. Prescriptions at all locations were securely stored with an effective audit trail maintained by administrative staff. Prescribers we spoke with said they followed the standard operating procedure for signing prescriptions. They did not always evidence they had carried out the necessary checks when prescribing for clients usually seen by a different prescriber. This meant there was no record that clinicians had followed procedure.

There was an effective lone working policy to protect staff when out in the community. Staff held outreach clinics in host environments, which meant they were not isolated or lone working. In addition, staff carried out outreach work at a time that meant they returned to base within working hours rather than at the end of a day.

The services had clear processes in place for reporting safeguarding concerns. Staff had a good understanding of procedures and were confident in applying the trust's

Requires improvement

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policy. The local authority safeguarding lead worked closely with the substance misuse services, providing staff with training, advice and guidance. They were confident in the ability of staff to report safeguarding issues.

Track record on safety

There had been one serious incident in the opiate prescribing service in the 12 months leading up to our inspection and none in the alcohol or non-opiate service. The trust carried out an investigation into the incident. Staff received feedback about the incident that recommended closer working and better communication between services within the trust as a learning point. This led to the service implementing changes to their working practice.

Reporting incidents and learning from when things go wrong

Staff knew what the trust considered an incident and how to report it. There was a system in place to ensure that investigations were undertaken where it was necessary The services discussed any learning following investigation through multi-disciplinary team meetings, emails and staff team meetings. Teams had made changes because of feedback. A recent incident led to a staff debrief and learning around supporting clients with emerging mental health issues.

Duty of Candour

The trust has a duty of candour policy and staff were aware of this and the requirements.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We reviewed 30 client care and treatment records. Staff completed a comprehensive assessment with clients at their first appointment, within both services. The assessment explored their current situation, historical details of drug and or alcohol use and previous treatment, physical and mental health needs, family, social circumstances and motivation to change. This helped the worker to identify their client's strengths and resources as well as focus on their current needs. Following this process, staff and clients worked together to develop plans for their care and treatment.

At the alcohol service, keyworkers used the alcohol use disorders identification test to assess if their client had a problem with alcohol dependence. Any client who scored above 15 using this tool then completed the severity of alcohol dependence questionnaire. This allowed workers to offer the right type of interventions to their clients. Both of these tools were evidence based and followed good practice guidance.

The trust had introduced new collaborative care plans. These encouraged staff to work in partnership with clients to put their views at the centre of their treatment. Staff used these care plans for all new clients entering treatment. We saw staff had used a person centred approach in 20 care plans. These all contained goals and actions that were personalised, holistic and recovery oriented. The remaining ten care plans were of variable quality. Six of these care plans were personalised but mainly focused on goals directly relating to maintaining substitute-prescribing treatment. The remaining care plans although personalised had limited details. The electronic records did not indicate that staff had offered clients a copy of their care plan. Although there was the option to print a copy of the plan, there was no identified space on the form for staff to record they had done so. This meant that it was difficult to ascertain if staff had given clients a copy of their care plan or not without going through the client's entire notes.

The drugs services used patient group directives, which allowed nurses to administer a course of vaccinations to protect clients from blood borne viruses. There was a care pathway with the hepatology department at a local acute hospital for clients requiring further treatment.

On Burbage ward, the consultant from the substance misuse services had facilitated the clients' admission. If they needed to review medicine or make amendments, they could do this remotely due to the electronic prescribing facility. The consultant reviewed clients on the day of admission and then prescribed the required medications. Assessments were comprehensive, including details of substance misuse history and previous access to treatment and detoxification. There was detail regarding the level of dependency and any associated physical health complications associated with the substance misuse. Motivation and long-term care planning was recorded. One client's care plan recommended a six month residential rehabilitation. Plans were in place for the client's admission to the recommended accommodation post detox. Staff had supported the client to visit the placement during the admission.

Clients signed a contract agreeing to the terms of admission on Burbage Ward. This clearly stated they could not bring alcohol or drugs onto the premises and the use of non-prescribed substances would result in discharge. Clients told us they understood the ward would not tolerate drugs and alcohol.

We reviewed two care plans for prescribing and coping with inpatient alcohol detoxification on Burbage Ward. These care plans were not written in a way that showed client involvement. However, they were clear about the care provided and detailed interventions required. Clients told us they felt involved in the drawing up of their care plans and that they had discussed possible risks with the admitting staff. Two clients had pinned a copy of their care plan on their bedroom walls.

The trust held client records electronically, which meant staff at all locations had access to blood results and records specific to patients within the trust. The trust ensured clients records remained confidential and staff viewed them appropriately. The electronic system generated a warning if staff from another service viewed records without good cause and produced an audit trail that the trust followed up.

Best practice in treatment and care

Staff had a clear knowledge of best practice in treatment and care. The services had medicines management policies and procedures in place, including prescribing and detoxification guidance that staff followed. The opiate service prescribed medications as recommended by the

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Department of Health guidelines on clinical management for drug misuse and dependence. Clinicians conducted face-to-face appointments with clients starting a prescribing regime and staff screened for drug use routinely throughout treatment.

Clinicians prescribed the medicine thiamine for clients with alcohol dependency. This was best practice because people who drink heavily over a long period often have low levels of thiamine (also called vitamin B1). Lack of thiamine can lead to a condition that affects the brain and nervous system. The alcohol service followed national institute for health and care excellence guidance on the use of acamprosate for clients, which helps reduce the craving for alcohol. This medicine was prescribed immediately following detoxification if appropriate.

During the initial assessment, key workers referred any clients with perceived physical healthcare needs for further assessment by a nurse. Across the services, staff regularly communicated with clients' GPs about their physical health. Nurses monitored those clients using the service to change their drinking habits; this included taking blood samples for tests to monitor potential physical health problems related to prescribed medicines.In the opiate and non-opiate service, staff checked injection sites for infection and viability for those clients who injected drugs and provided a wound care clinic. Staff at the opiate service carried out cardiac monitoring on site to check for potential heart abnormalities in those clients prescribed high doses of methadone. Clients attending the steroid clinic at the non-opiate service had blood samples taken. This was so staff could monitor if clients' hormone levels fell within an acceptable range and give necessary harm reduction advice.

On Burbage ward, clients told us physical health screening on admission was very thorough. They said nursing staff and doctors provided the right care and treatment for any existing physical health conditions. We saw that cardiac monitoring was undertaken and patients received withdrawal support and assessment for blood borne viruses.

Best practice in the use of medication in drug dependence treatment details the need for treatment to focus on recovery rather than maintenance on medication. The Strang Report 2012 (commissioned by the National Treatment Agency) highlighted that recovery relies on broader achievements in health and social functioning and not just a clinical focus. We saw evidence of goals and interventions relating to recovery beyond medication in 20 records. The remainder contained goals relating to becoming stable on medication and attending appointments but regularly offered and encouraged clients to engage with psychosocial treatment.

The Department of Health's guidance states that treatment for drug misuse should always involve a psychosocial component. Staff used recognised treatment approaches combined with medication to engage and support their clients' recovery. Clients had access to structured psychosocial interventions with specialist key workers. Psychosocial interventions included cognitive behavioural therapy, contingency management, motivational interviewing, brief focused solutions therapy and mapping techniques. In addition, nurses provided informal psychosocial interventions to clients whose attendance and drug use meant they were not ready for a structured approach. Interventions also include support for employment, housing and benefits.

The non-opiate service used ambassadors to make recovery visible to client. They help to improve understanding, heighten people's treatment ambitions and motivate them to work towards recovery.

Changes and progress of client using the services were measured using treatment outcome profiles. The treatment outcome profile was a monitoring instrument developed by the national treatment agency for staff to use throughout treatment. The services were required to submit data routinely for all clients accessing the service to Public Health England.

For the year ending 30 September 2016 the alcohol service had 30.6% of clients discharging successfully from treatment (national average 39.3%). In the same period, the opiate service had 3.9% of opiate using clients discharging successfully from treatment (national average 6.8%). The non-opiate service had achieved 37.3% successful discharges for non-opiate using client (national average 40%).

The services acknowledged that the quality of data captured to inform the national drug treatment monitoring system or the national alcohol monitoring system had resulted in lower than national average rates. As a result, they had implemented prompts in clients' electronic

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records, which meant staff could not move forward without first completing essential data. Staff received a weekly newsletter, which highlighted the relevance of this data and why it needed completing.

The service has participated in nine clinical audits for the trust. Four were specific to substance misuse:

- Nalmefene - To ensure that it was prescribed to accordance with guidance
- Assessment in specialist services for alcohol dependence and treatment of assisted withdrawals - To check if current practice complied with NICE guidance (CG115)
- Quality and outcome of the alcohol and substance misuse inpatient detox - To improve the quality and outcome of the alcohol and substance misuse inpatient detox
- Audit on electrocardiogram monitoring in high dose methadone patients - To determine whether patient on high dose methadone prescription had regular electrocardiogram monitoring every six months and to see if electrocardiogram monitoring was discussed and look at various reasons why it was not done.

The business and performance manager monitored the quality of data across the services. However, other monitoring, for example, audits on the quality of documentation in care records did not take place.

Skilled staff to deliver care

A range of health and social care professionals provided input to the service and supported clients. These included consultant psychiatrists, specialist general practitioners, nurses and nurse prescribers, psychosocial intervention workers, drug and alcohol keyworkers, social workers, administrative and support staff.

Staff told us their managers supported them in relevant requests for additional training needs, for example, dual diagnosis training. Some nurses had received 16 weeks training in cognitive behavioural therapy, which took place at a local university and was to a recognised standard. This enabled nurses to provide their clients with informal psychosocial interventions. Nurses training to become non-medical prescribers told us they received support and regular supervision from the consultant psychiatrists and doctors working within the opiate service. Ambassadors underwent courses in peer mentoring and tackling substance misuse.

The clinical director was proactive in encouraging professional development for staff at all services, with weekly sessions available at both locations. For example, this training included serious incidents, the administration of emergency medications and new psychoactive substances.

Staff received effective supervision both formally and informally including clinical supervision where required. The trust reported a compliance rate of 60% for each location across the core service for the year ending 31 July 2016, but recognised the need to improve the mechanism for recording completed supervision sessions. The service managers and staff we spoke with all reported having supervision in line with trust requirements. The supervision compliance rate was 84% at the time of the inspection based on figures supplied by the service.

The service held a weekly team meeting which including discussions around operational developments, safeguarding, bed list review and inpatient detox, discharges, concerns about specific clients, and client involvement. Managers and medical staff attended a weekly meeting. We looked at minutes from several meetings held during the last three months. Minutes showed standard items on the agenda included discussions around staffing, environmental and equipment issues, safeguarding and incidents and complaints.

Compliance with annual appraisal was high overall. Non-medical staff had a 94% compliance rate and the compliance for all medical staff was 100%. This meant that service managers were able to support staff with their professional development to provide quality care and treatment for patients. There were structures in place for service managers to manage performance within their teams. No staff were currently being performance managed.

Multi-disciplinary and inter-agency team work

The clinical team held regular and effective weekly multidisciplinary meetings to review clients with complex needs in order to move their treatment forward. There was also a monthly safeguarding adults meeting to review progress on current safeguarding concerns across the whole service. There was good evidence of effective relationships and input from social services.

We saw that staff had an in depth knowledge and understanding of the issues their clients faced. These

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clinical meeting included in depth discussions about assessment feedback, prescription changes, illicit use/ relapse risks, safeguarding, mental health and physical health needs and referrals. Staff recorded the discussion briefly in the care records. However, the records did not fully reflect the quality of the discussion.

Each weekday morning staff attended a flash meeting. This was so they could discuss staffing levels, incidents or safeguarding issues and identify follow up action. For example, when staff were sick or absent, their work was identified and reallocated ensuring clients' needs were met.

Staff helped and supported clients with their social needs as part of their recovery, making referrals to outside organisations as needed. The services worked closely with probation, social services, pharmacies, local general practitioners, local housing associations and mutual aid groups.

There were effective working relationships with other teams in the organisation, for example community mental health teams, mental health crisis teams, mental health acute inpatient wards and the hepatology department at the local acute hospital.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff did not receive training in the Mental Health Act as it was not a mandatory requirement. However, staff had an understanding of mental health. We saw reference to mental health in clients' care records and communication between the service and the community mental health teams.

If a client's mental health were to deteriorate, staff knew whom to contact. Some of the nursing staff were trained registered mental health nurses, which meant that they were aware of signs and symptoms of mental health problems.

Good practice in applying the Mental Capacity Act

Staff we spoke with generally had an understanding of the principles of the Mental Capacity Act and were aware of the trust policy. Staff had low compliance with the mandatory training on the Mental Capacity Act. The service managers had requested the trust provide training that was more relevant to the needs of the service as the focus of the existing training was primarily on older people. The trust was currently rolling out the revised training to staff.

Staff were aware of the policy on the Mental Capacity Act and could refer to it. Mental capacity can be temporarily impaired in those clients who had recently used illicit substances. Staff provided examples of clients being intoxicated. If a patient attended the service intoxicated or under the influence of substances, staff would postpone any decisions until they regained capacity. Staff discussed clients' capacity at multidisciplinary meetings if the need arose. The consultant psychiatrist in the service would conduct capacity assessments if necessary.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

We observed staff from all services treating clients with dignity, respect and with consideration to their confidentiality Staff showed a supportive and caring attitude towards their clients. They talked about clients in a respectful manner. There were sufficient interview rooms at both locations for staff to carry out key work sessions with their clients.

Clients consented to us attending clinics at each of the services. Staff were friendly and knowledgeable and took time to listen and respond to the needs of clients. We saw staff give clients relevant harm reduction advice on each occasion and offer practical and emotional support. Staff had a wealth of local knowledge about resources available in the community to support clients' needs.

We spoke with 21 clients. They were mostly positive about the treatment they were receiving and the care they received from staff. Clients told us that staff were helpful, supportive, respectful and showed they cared about helping with their recovery. Five clients told us they had trouble contacting services by telephone. One client said telephone contact was especially bad on Mondays.

We spoke with an ambassador for the non-opiate service. This is someone who has graduated from using the service and undertaken specific training to become mentors to other clients. They told us how the service has changed their life and how they had recently achieved their goal of finding employment.

The involvement of people in the care that they receive

We viewed client records, which showed that clients were involved in their care plans and in decisions about their treatment options. Clients told us they feel involved in decisions regarding treatment options for example detoxification, harm minimising options and accessing support services. They were aware of what was in their care plan as their key worker or nurse displayed their plan on a computer screen for them to see during their appointment. Seven clients said staff had given them a copy of their care plan.

During the admission process, all clients received an information pack specific to the service they were accessing. This provided them with information around treatment choices, prescriptions, attending appointments, drug and alcohol screening, confidentiality, child safety, opening times, acceptable standards of conduct and client feedback.

Four clients told us family members attended the service and supported them in their treatment. Staff told us how supporting carers could sometimes be problematic, as clients did not always want their relatives or carers to be involved in their treatment. The services offered carer support and encouraged family involvement using carer ambassadors to promote this. Reconnecting with family and building bridges helped in supporting recovery.

The services sought client feedback through family and friends questionnaires, which were located in reception areas at each location.

Are services responsive to people's needs?

Outstanding ☆

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

Clients could self -refer into the opiate, alcohol and non opiate services either by drop in or booking an appointment. In addition, health and social care practitioners could make referrals for clients. The opiate service provided referrals into the service with appointments for triage and assessment within seven days.

The substance misuse services all had better than the national average access into treatment times for the year ending 30 September 2016. In the opiate service 0.7% of patient waited over three weeks from referral to treatment start against national average of 1.7% waiting over three weeks for opiate interventions. The service told us any delay in starting treatment occurred when clients did not attend their initial appointment. In the alcohol service, no patients waited over three weeks from referral to treatment start against national average of 2.8% waiting over three weeks for alcohol interventions. The proportion of patients dropping out of treatment within 12 weeks of referral for opiate users, alcohol users and non-opiate users was lower than national average comparisons.

When a patient completed treatment, staff gradually reduced their contact with the client. They gave clients information on how they could return to treatment if needed. The current contracts did not include an aftercare provision; this was met by referral into mutual aid and recovery groups in the community.

Staff took measures to re-engage clients who unexpectedly dropped out of their treatment. They did this through liaising with pharmacies, GPs and other involved professionals and attempting contact with the client via phone and letter. Staff sent out letters to clients offering them new appointments if they still required support. The service would arrange for outreach or police welfare checks if there was a concern for a client's safety following a period of disengagement.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of interview rooms, treatment rooms, group rooms and clinical rooms and a needle exchange available at both locations.

Each service displayed a wide range of leaflets available covering all aspects of care associated with substance misuse for example, medication, and physical health, types of abuse, mental health, sexual health, sleep hygiene and self-harm. There were leaflets signposting clients and carers to other community services such as alcoholics anonymous and narcotics anonymous as well as groups facilitated by the service. Information about the services was readily available on the internet, including fact sheets about community detoxification and types of medication as well as a social media link for clients to access a shared support group.

The opiate service facilitated a women's recovery group. The non-opiate service ran the service user ambassador program and carer group. The alcohol and opiate services facilitated 'SMART' recovery groups, which was good practice. They also facilitated a client led therapeutic knitting group. Staff told us the repetitive nature of knitting acted as a self-soothing tool and helped clients manage their emotions, stress and anxiety. During September, services participated in national recovery month, to promote treatment, support and recovery from addiction.

Staff respected clients' confidentiality wishes. There were clear information sharing agreements in place between the client and the service. Clients signed consent forms specific to each agency or person with whom the service wanted to share information. Clients could withhold their consent and staff respected their wishes. Services advised clients to share their mobile contact details so key workers could send them text reminders about their appointments.

Meeting the needs of all people who use the service

The service received about 500 telephone calls a day and struggled to deal with this high volume. This figure included repeat calls. This led to delays for clients and professionals wanting to contact the service. However, the trust was working on this issue before we inspected the service. There was a business plan to improve communications. This included better automation, increased capacity and an increase in staff. Four clients said they felt frustrated by the length of time it took to make contact with the service. Delays in answering the phone could place clients at risk if contact with keyworkers did not take place in a timely fashion.

Are services responsive to people's needs?

Outstanding ☆

By responsive, we mean that services are organised so that they meet people's needs.

There was a Saturday morning telephone service available to clients for anyone who needed to speak with a healthcare professional. Clients accessing the opiate service who had prescribing issues mainly used this service.

Nurses provided clients with venous problems a wound management clinic, dealing with deep vein thrombosis, cellulitis, leg ulcers and poor tissue viability. The clinic had good levels of client attendance and compliance, which led to a reduced need to prescribe antibiotics to treat infections. The clinic had won a poster presentation from the Royal College of General Practitioners. The service also provided outreach wound care dressing for vulnerable clients at a host environment.

The alcohol service had adapted and revised the alcohol audit tool into a visual, easy to use, online alcohol-screening tool. This was for Sheffield health and social worker to use with their clients when considering a referral to the service. This allowed workers to make immediate referrals into the service, and led to staff being able to offer clients same day appointments.

The non-opiate service operated a mobile needle exchange three times a week in geographically isolated areas. In addition, outreach workers delivered harm reduction advice at pharmacies and charitable organisation for vulnerable people. There was a student pathway, with the service attending and providing advice during fresher's week. The service also delivered drugs awareness training sessions at local acute hospitals.

All service areas offered instant access. Staff could offer clients who chose to drop in triage and assessment immediately or book an appointment at time that suited the client. All services offered late night opening hours for clients who would struggle to make appointments during normal working hours.

The non-opiate service ran a late night 'juice' clinic for clients using performance and image enhancing drugs. Clients could have a blood screen to test if their hormone levels fell within acceptable ranges. This provided staff with the opportunity to give appropriate harm reduction advice and help monitor and prevent clients' physical and mental health deteriorating. The clinic attracted new clients on a regular basis and was well attended by existing clients. The 'juice' clinic was one of a few clinics nationwide that provided this level of service.

The opiate service held a weekly women's recovery group and had links with the street working women's project and women's mutual aid groups.

There was a monthly multi-agency pregnancy and assessment group meeting and appropriate pathways with social services and midwives for pregnant clients.

Listening to and learning from concerns and complaints

The substance misuse services received two formal complaints during the 12 months leading up to the inspection. Both complaints were investigated and upheld. The service managers discussed the procedure for investigating complaints within trust time frames and actions taken following investigation. Staff received learning from complaints by email or at team meetings. If a member of staff needed individual feedback this happened during supervision.

Overall, the substance misuse received 18 formal compliments from clients during the last 12 months.

Services at each location displayed posters informing patients what steps they needed to take if they had a complaint and had leaflets readily available in reception for client use.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

Sheffield Health and Social Care NHS Foundation Trust stated their vision was to be recognised nationally as a leading provider of high quality health and social care services and to be recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. Their aim was to be the first choice for service users, their families and commissioners.

The trust identified the following values essential in achieving this aim:

- respect
- compassion
- partnership
- accountability
- fairness
- ambition.

Staff were aware of the trust's values and worked towards achieving these on a daily basis. Most staff knew who the manager for the specialist services was and told us that they had visited both locations in the past six month. Staff were positive about the support they received from their local managers.

Good governance

Commissioners set the performance framework and contract requirements for each location. The design of individual services was very specific and they were performance managed on delivering certain outcomes. These included the number of clients accessing the service, waiting times, the number of assessments undertaken, successful psychosocial interventions and the number of clients not attending appointments.

The trust had systems in place to monitor and assess how the services performed in relation to compliance targets for mandatory training and supervision. However, at local level managers were unable to use some of the trust's systems to extract information about their team's performance. This meant that although they had an overview of how their services were performing, they could not easily produce the data to evidence this. During our inspection, they managed to produce up to date figures using locally developed methods of monitoring performance. This information differed from the data provided by the trust and highlighted the need for improved monitoring of key performance indicators. We received assurances from the clinical director this would happen.

Staff were able to describe how they reported and learnt from incidents. The services investigated and monitored incidents and complaints appropriately. They held regular clinical governance meetings to discuss incidents and inform staff of lessons learnt.

Leadership, morale and staff engagement

Staff morale was variable. The opiate service had a positive, strong and supportive team. They had faced significant change and challenge brought about by tendering processes and the introduction of trust wide electronic records. Staff felt supported by their local team managers and by senior managers. Sickness rates in the team were lower than the trust average. The team comprised longstanding staff and had a low staff turnover rate.

We found staff morale in the non-opiate service and alcohol service was low. However, staff were professional and dedicated to providing a caring service. The alcohol service was going through a significant period of change due to successful retendering to deliver a new alcohol treatment model. The new model required fewer staff and the service was currently going through a period of consultation. The non-opiate service was based at the same location as the alcohol service and staff morale was low among some staff. This was due to the introduction of new working practices and high levels of sickness. The service managers were monitoring team morale, and sought staff feedback to address concerns.

Staff were aware of the whistleblowing process and felt they could raise concerns without fear of victimisation.

Commitment to quality improvement and innovation

It was clear the services encouraged staff to develop innovative practice that was recovery focused and improved access to treatment. The service was currently contributing to a research project undertaken by a leading expert in recovery capital at a local university.

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 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arises from carrying out the regulated activity. How the regulation was not being met: Staff did not always implement the new risk assessment system in a timely manner. This was a breach of: Regulation 17 2 (b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and equipment must be suitable for the purpose for which they are being used. The registered person must, in relation to such equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

Staff handled urine samples provided by clients and disposed of clinical waste in consulting rooms. These should only be handled within an appropriate clinic environment.

This was a breach of:

Regulation 15 (1) (C) and 15 (2)