EDP Drug & Alcohol Services Bideford hub

Quality Report

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Date of inspection visit: 2 April 2019
Date of publication: 14/06/2019

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
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.

Summary of findings

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

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

Overall summary

We rated EDP – Bideford hub as **requires improvement** overall because:

- Staff were not always managing risk to clients. Clients who had been using the service prior to April 2018 did not have a disengagement plan in place. A disengagement plan details what the client expects from staff when they disengage from the service or do not attend appointments, for example by contacting their next of kin. This meant that if a client disengaged with the service staff might not know who to contact including relatives, carers or health professionals and others involved in the clients care to make them aware this had happened. Three out of six records reviewed did not contain a risk management plan. Risk management plans did not refer to crisis planning.
- Staff were not always developing detailed recovery plans which included client's goals and what treatment they were receiving. At the time of the inspection, the provider had not started the newly developed local care planning audit.
- Staff did not ensure that clients received a comprehensive assessment of physical health needs from the client's GP or other relevant health professional. Staff were not including client's physical health needs when developing recovery plans. The provider did not have a physical health monitoring policy and staff were concerned that physical health monitoring was not comprehensive. Only clients who were prescribed medication by the service or undergoing home detoxification had their physical health checked.
- Staff were not carrying out or referring clients for blood borne virus (BBV) testing. Clients should have been offered BBV testing on-site or referred to their local GP for testing but 0% of clients had been tested referred in the 12 months prior to this inspection.
- In the Barnstaple clinic, staff were not adhering to infection control principles when testing urine samples. The urine testing facilities were not being used appropriately by staff. When the clinic room was in use, staff were testing urine samples in the kitchen. Staff were disposing of used sample pots in the clinical waste bin in the clinic room without emptying the contents fully. The dedicated toilet for urine testing did not contain a clinical waste bin or an area to test urine samples.
- The provider did not have a robust recruitment process to ensure all staff had an up-to-date Disclosure and Barring Service (DBS) certificate in place. The human resources (HR) department was responsible for ensuring staff had a valid DBS certificate and had not realised when a number of staff DBS certificates had expired. Managers did not have oversight of this process.
- Staff were not recording informal complaints. This meant that managers could not be assured that complaints were actioned fully, and complaints could not be analysed to determine themes or trends.
- Some needles used for the needle exchange service were out of date in the Bideford clinic.

However:

- The clinical assessment service staff assessed risk at the point of assessment. When clients were allocated a recovery navigator, they would then complete a comprehensive assessment. The comprehensive assessment included completing a risk assessment and incorporated information received from the client's GP at the point of referral. Clients requiring a prescription received a face to face assessment with the service's doctors or non-medical prescribing nurses.
- The clinical assessment service were completing initial assessments with clients within two weeks of receiving a referral. Urgent client referrals were seen promptly.

Summary of findings

High risk clients were prioritised, for example pregnant women and opiate-users. Staff monitored clients on the waiting list to detect increase in level of risk or need.

- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care, treatment or condition.
- Staff felt respected, supported and valued by management. Staff and clients described a change in culture in the last six months and felt optimistic and positive about the future direction of the organisation. Managers had introduced initiatives to improve morale such as arranging team away days.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Requires improvement 	EDP – Bideford hub is a substance misuse service providing support to clients in the community.

Summary of findings

Contents

Requires improvement

EDP Drug & Alcohol Services Bideford hub

Services we looked at

Community-based substance misuse services

Summary of this inspection

Background to EDP Drug & Alcohol Services Bideford hub

xEDP Drug & Alcohol Services are a charity that provide a range of substance misuse services to adults over 18 in Devon and Dorset.

In April 2018, EDP Drug & Alcohol Services took over the contract to provide community substance misuse services in Devon. EDP and other organisations such as Devon Doctors and Devon Partnership NHS trust formed a partnership to provide these services. This partnership is known as the Together Drug & Alcohol Service.

Devon County Council commission the Together Drug & Alcohol Service to provide services across Devon. There are three registered locations across the county:

- Bideford hub
- Newton Abbott hub
- Exeter hub

In addition to the three registered locations, there are a number of satellite locations clients can access.

Bideford hub is a community substance misuse service providing support to clients aged 18 and above across North Devon. At the time of the inspection the service had a registered manager in place. The registered manager is also responsible for managing a team who cover East and Mid Devon however these staff did not have a physical base.

The service has a dedicated team to respond to referrals and complete initial assessments. The clinical assessment team (CAS) cover all areas of the county and had a team leader managing this team.

Bideford hub is registered as a location under EDP Drug & Alcohol Services to provide the regulated activity for treatment of disease, injury or disorder. This was the first comprehensive inspection since registering with the Care Quality Commission in October 2018.

Following the inspection of Bideford hub on 2 April 2019, inspections took place at Newton Abbott hub and Exeter hub. These reports are published separately.

Our inspection team

The team that inspected the service comprised two inspectors and a specialist advisor who has professional experience of substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

To 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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service in Bideford, looked at the quality of the environment and observed how staff were caring for clients
- reviewed the clinic room in Bideford and Barnstaple
- spoke with two clients who were using the service
- spoke with the registered manager
- spoke with nine other staff members; including two nurses, one non-medical prescriber, three recovery navigators, the community development lead, the clinical assessment service (CAS) team leader and the two team leaders for the service
- attended and observed one medication review meeting
- looked at six care and treatment records of clients
- looked at five staff personnel files and
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to two clients currently using the service. They described staff as positive and helpful. Clients told us that their needs were being met. This included a referral to mental health services when needed. We were told that staff followed up with them when they missed appointments and that they receive a reminder text or phone call. Clients said that the groups were helpful and that it provides a safe and supportive environment for them. Clients described an improvement in the service they received following the new contract. They said that the service was more organised and that it was quicker to get treatment and speak to staff. Clients commented that there was no longer tea and coffee facilities and that the water dispenser had been removed from the waiting area.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- Staff were not always managing risk to clients. The clinical assessment service (CAS) were completing initial disengagement plans for all newly referred clients, however staff were not routinely updating or developing plans with current clients. This meant that if a client disengaged with the service staff might not know who to contact including relatives, carers or health professionals and others involved in the clients care to make them aware this had happened.
- Clients did not always have a detailed risk management plan in place and did not include reference to crisis planning. Client's risks were identified but ways to mitigate the risk were not always included. Only three out of six records reviewed contained a risk management plan.
- Staff were not ensuring that all clients were having their physical health checked regularly. The provider did not have a physical health monitoring policy and staff were concerned that physical health monitoring was not comprehensive. Only clients who were prescribed medication by the service or undergoing home detoxification had their physical health checked.
- Out of 39 staff, ten did not have an active Disclosure and Barring Service (DBS) certificate. This included staff based at Bideford and the Mid & East Devon team. Four out of 11 clinical staff did not have an active DBS certificate. This is because they were out of date.
- In the Barnstaple clinic, staff were not adhering to infection control principles when testing urine samples. The urine testing facilities were not being used appropriately by staff. Staff were transporting urine samples from the toilet and testing the sample on the kitchen counter. Staff were discarding used sample pots in the waste bin the clinic room but not emptying them fully, causing the room to smell of urine. The dedicated toilet for urine testing did not contain a clinical waste bin or an area to test urine samples.
- Some needles used for the needle exchange service were out of date in the Bideford clinic.

However:

- The clinical assessment service staff assessed risk at the point of assessment. When clients were allocated a recovery

Summary of this inspection

navigator, they would then complete a comprehensive assessment. The comprehensive assessment included completing a risk assessment and incorporated information received from the client's GP at the point of referral. Clients requiring a prescription received a face to face assessment with the service's doctors or non-medical prescribing nurses.

- Staff had policies, procedures and training related to medication and medicines management including prescribing, detoxification, assessing people's tolerance to medication and take-home medication such as naloxone.
- Staff understood local authority safeguarding processes. Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. The service had a safeguarding lead and staff could contact them for advice and guidance.
- Serious incidents were investigated, and any lessons learned shared with staff. Staff were offered debriefs following incidents and we were provided details of changes to practice following investigation of incidents.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Staff did not always develop recovery plans that met clients' needs identified during assessment. Three out of five care records did not contain recovery plans. Recovery plans that had been developed contained client's identified needs but did not contain details on how clients would meet their goals or what treatment they were receiving.
- The service did not complete comprehensive assessments of physical health needs and concerns. Staff did not develop recovery plans in response to known or identified physical health concerns. Prescribing staff relied on GP assessment of physical health but the service did not have a comprehensive process in place to ensure this was taking place and physical health needs were being met.
- In the 12 months prior to the inspection 0% of clients had been offered or referred for blood borne virus (BBV) testing. Staff were trained to complete blood borne virus testing but had not offered testing to clients. Clients should have been referred to their local GP for BBV testing but 0% of clients had been referred in the 12 months prior to this inspection.

However:

- Clients undergoing an alcohol home detoxification were receiving adequate physical health monitoring.

Summary of this inspection

- All staff received regular supervision and were supported to further develop their skills through personal development plans. Volunteers and peer mentors were recruited, trained and supported by a manager.
- Staff provided a range of treatment and care for clients based on national guidance and best practice. Staff used nationally recognised tools to monitor withdrawal symptoms for clients undergoing detoxification.

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, treatment or condition.
- Staff adhered to and understood clear confidentiality policies and maintained the confidentiality of information about clients.
- Staff directed clients to other services when appropriate and, if required, supported them to access those services.

Are services responsive?

Good

We rated responsive as **good** because:

- Clients could access services easily. Referral criteria did not exclude people who would have benefitted from care.
- The service employed a hospital liaison worker who worked with clients who presented at the local hospital. They supported and encouraged them to engage with the service and liaised with other relevant agencies, such as police and mental health teams.
- The assessment team completed initial assessments with clients within two weeks of receiving a referral. Urgent client referrals were seen promptly. High risk clients were prioritised for example pregnant women and clients who misused opiates. Staff monitored clients on the waiting list to detect increase in level of risk or need.
- Staff demonstrated an understanding of the potential issues facing vulnerable groups such as those experiencing domestic abuse or sex workers.

However:

- Staff were not recording informal, verbal complaints raised by clients. This meant that managers could not be assured that complaints were actioned fully, and complaints could not be analysed to determine themes or trends.

Summary of this inspection

Are services well-led?

Requires improvement 

We rated well-led as **requirements improvement** because:

- The provider had some gaps in the governance process. The provider's risk register did not include staff not offering blood borne virus testing or that clients had not been referred to their local GP for testing. Managers had not ensured that staff were completing or reviewing disengagement plans for all clients. Managers had not ensured that staff were completing risk management plans for all clients or that recovery plans were developed that met clients' needs identified during assessment. Managers had not embedded a local care planning audit.
- The provider did not have a robust process to ensure staff had an up-to-date Disclosure and Barring Service (DBS) certificate in place. The human resources (HR) department was responsible for ensuring staff had a valid DBS certificate and had not realised when a number of staff DBS certificates had expired. Managers did not have oversight of this process.
- The provider was in the process of updating their clinical policies. For example, the prescribing 'Did Not Attend' (DNA) policy was still in draft form. The provider was in the process of updating all policies due to the recent change in contract. Some staff were unaware that there were updated clinical policies.

However:

- Staff felt respected, supported and valued by management. Staff and clients described a change in culture in the last six months and felt optimistic and positive about the future direction of the organisation.
- Leaders had the skills, knowledge and expertise to perform their roles. The registered manager had a good understanding of the service they managed and could explain how the team were working to provide high quality care.
- Leaders were visible in the service and approachable for staff. Staff knew by name who the clinical leads, service manager and CEO were and how to contact them directly.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood and discharged their roles and responsibilities under the Mental Capacity Act 2005. Staff received training and knew where to go to seek advice and guidance if they needed it. Staff gave examples of supporting clients during mental capacity assessments and how to support a client who lacked capacity to make decisions about their treatment.

Requires improvement

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Requires improvement

Safe and clean environment

- The entrance to the Bideford hub was bare and unwelcoming. There were no signs or posters on the walls. Clients accessed the service via a buzzer and were instructed to first floor, which is where the service is located. There was no reception area but there was a small waiting room on the first floor.
- Rooms were clean, and clients had access to a number of private rooms to meet staff in. There were rooms for one to one meeting, group rooms, a clinic room and a needle exchange.
- There were communal toilets that were also used to conduct urine testing. There were hand-washing posters displayed and a clinical waste bin available.
- In the Barnstaple clinic, the facilities for urine testing were not being used appropriately by staff and staff were not always adhering to infection control principles. The dedicated toilet for drug testing did not have a clinical waste bin or space to test samples. When the clinic room was in use, staff transported the urine sample to the kitchen to test it. Staff were discarding used sample pots in the clinical waste bin in the clinic room but did not always empty the contents first. This meant that the clinic room smelt of urine.

Safe staffing

- Not all staff had an active DBS certificate. Out of 39 staff, ten did not have an active DBS certificate. This included staff based at Bideford and the Mid & East Devon team. Four out of 11 clinical staff did not have an active DBS certificate. This is because they were out of date. Staff had signed disclaimer forms whilst waiting to receive an up-to-date certificate back from the Disclosure and Barring Service. Staff without valid DBS who do not have a disclosure do not have unsupervised contact with service users.
- The service had enough staff to meet the needs of clients. Clients and staff told us that sessions were not cancelled due to staff absences.
- The service provided a range of staff including team leaders, nurses, recovery navigators including those for and the criminal justice system, a doctor and non-medical prescriber. Staff and managers told us that a cap on caseloads had recently been introduced which had reduced caseload sizes to 50. Staff felt that this had reduced the levels of stress being experienced. Managers monitored caseloads in supervision.
- Since December 2018, there had been three recovery navigators on long-term sick. Their caseloads had been covered by agency staff. There was one vacancy for a non-medical prescribing nurse, but these hours were covered by an agency worker on a long-term contract.
- Staff received mandatory training in a range of formats including e-learning and
- to face training. At the time of the inspection 87% of staff based at the Bideford hub had completed their mandatory training. Only 67% of the staff in the East & Mid Devon team had completed their mandatory training however this was a smaller team. There were three staff who had not completed all mandatory training.

- Staff followed good lone-working procedures. The manager and staff told us that typically clients were not seen in their own homes.

Assessing and managing risk to clients and staff

- The clinical assessment service staff assessed risk at the point of assessment. When clients were allocated a recovery navigator, they would then complete a comprehensive assessment. The comprehensive assessment included completing a risk assessment and incorporated information received from the client's GP at the point of referral. Clients requiring a prescription received a face to face assessment with the service's doctors or non-medical prescribing nurses.
- The clinical assessment team (CAS) monitored people on the waiting lists to detect changes in level of risk. The CAS team managed referrals to the service and completed a brief assessment within 24 hours. A member of the CAS team contacted clients over the telephone within two weeks of the brief assessment to complete a comprehensive needs and risk assessment. Clients who preferred a face to face meeting were invited to one of the service sites for their assessment.
- All six client care and treatment records reviewed across the service contained a risk assessment. Risk assessments were updated following an incident or a change in circumstances, for example if a client disclosed further substance misuse. However, staff did not consistently complete risk management plans relevant to the needs of the client. Of the six client care records we reviewed, three did not contain a risk management plan. Those records which did contain risk management plans did not have them stored in the same place. Some staff were using the risk management plan in the records whereas others were writing it at the end of the risk assessment or in the clinical notes. Client's risk management plans did not always include details on how to mitigate or manage the risks and did not refer to crisis planning.
- The clinical assessment service team had completed disengagement plans for clients who had been referred to the service since the new contract. However, clients that had been on caseload prior to this provider did not consistently have plans in place. This meant that if a client disengaged with the service staff might not know who to contact including relatives, carers or health professionals and others involved in the clients care to make them aware this had happened. All clients who had disengaged from treatment were discussed with the team leader, who would review the case before a decision was made to discharge the person. The service did not have a sufficiently robust policy outlining the expectations on staff in the event of somebody failing to engage in their treatment for example the prescribing 'did not attend' policy was in draft form.
- Staff ensured that clients were aware of the risk of continued substance misuse and encouraged harm minimisation. This was evidenced during the observation of client's medication review with the nurse. Harm minimisation was discussed at all appointments and clients were offered naloxone and training on how to use this. Harm minimisation aims to address alcohol and other drug issues by reducing the harmful effects of alcohol and other drugs on individuals.
- Staff ensured prescriptions were sent to local pharmacies or collected by the client from the service and had arrangements in place to ensure clients received medication on weekends and bank holidays. Staff had formed close working relationships with the pharmacies so that they would be informed if the client did not collect their prescription as normal or if they had a specific concern about a client. However, recovery plans did not always reflect this.
- The service had a process in place for staff to follow if a client gave their medication to a third party. Keyworkers assessed risks through one to one sessions and discussed outcomes with prescribers.

Safeguarding

- Staff understood local authority safeguarding processes. Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. The service had a safeguarding lead and staff could contact them for advice and guidance.
- Staff had received safeguarding training and knew how to identify adults and children at risk of, or suffering, harm. However, staff told us that the training was not specific to their client group.
- Staff recorded safeguarding concerns appropriately in clients records and ensured that this was updated regularly. Staff discussed safeguarding concerns at the daily team meeting to ensure all staff had been

updated. Staff had taken appropriate action to ensure that safeguarding referrals were being made to the local authority and clients were supported through the process.

Staff access to essential information

- Staff used a secure electronic system for client's care and treatment records. All relevant staff had a log-in and accessed the system when required. Staff were using the system to record recovery plans in multiple formats. Managers confirmed they were aware of the concern and had been working to try and reduce the number of forms used.

Medicines management

- Prior to 1 April 2019 the contract for the clinical prescribing practice was held by Devon Doctors. During the inspection this responsibility had been taken over by Together Drug & Alcohol services. As such some policies were still under review.
- Staff had relevant policies, procedures and training related to medication and medicines management including prescribing, detoxification, assessing people's tolerance to medication and take-home medication such as naloxone. The clinical policies relating to medicines management had recently been distributed to staff and not all staff had read the updated policies. However, all staff were aware of relevant guidelines such as the National Institute for Health and Care Excellence and the Drug misuse and dependence: UK guidelines on clinical management' (2017), known as the orange book.
- Staff followed good practice in medicines management including transport, storage, dispensing, administration, medicines reconciliation, recording and disposal. Doctors and non-medical prescribers at the service prescribed in line with the National Institute for Health and Care Excellence guidelines, including methadone for the management of opioid dependence. Non-medical prescribers had access to the 'Drug misuse and dependence: UK guidelines on clinical management' (2017) and the service's prescribing policies.
- Recovery navigators told us that they would book clients in to see GPs for health checks if they felt it was necessary and clients told us that they were escorted by their recovery navigator if necessary. The nursing staff we spoke with told us that they used to offer physical health monitoring clinics but that these had stopped. They told us that they planned to reintroduce these in the future.
- The clinic in Bideford had out of date needles for the needle exchange service.
- Staff were storing naloxone in the clinic room which was locked. Naloxone was not readily available in all areas of the service. Naloxone is an emergency medication used to counter the effects of opioid overdose.

Track record on safety

- The service reported 22 serious incidents in the past 12 months. These incidents were unexpected client deaths, for example due to a substance overdose.
- All client deaths were reviewed at a serious incident review panel. Staff also attend the local authority's 'drug related and avoidable death' review meetings.

Reporting incidents and learning from when things go wrong

- All staff knew which incidents to report and how to do this on the electronic system. Learning from incidents was shared across the service locally through supervision and team meetings.
- Staff described examples of recent learning from incidents and how their practice had changed as a result. Following an incident with a prescription, weekly checks with the local pharmacists were introduced to ensure clients were not being prescribed the same medication twice following a missed collection and when restarting treatment.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- The inspection team examined six sets of client care and treatment records. Three out of six records reviewed were not holistic or detailed. They did not include a reference to harm reduction. No recovery plan identified physical health as a need despite some clients having a known illness such as chronic

obstructive pulmonary disease (COPD). All recovery plans had an identified need such as pharmacological intervention or psychosocial intervention but did not contain details on the treatment, support being offered or goals the client wanted to achieve.

Best practice in treatment and care

- Clinical staff used nationally recognised tools to assess the acuity of client's withdrawal symptoms. The service used the Clinical Institute Withdrawal Assessment for alcohol scale (CIWA), Alcohol Use Disorders Identification Tool (AUDIT) and Severity of Alcohol Dependence Questionnaire (SADQ) appropriately when supporting clients during a community alcohol detoxification.
- Clients were offered a range of care and treatment for example medication support, detoxification treatment, groups and one to one session. These included mutual aid partnership approaches (such as Alcoholics Anonymous), relapse prevention techniques, harm minimisation and a range of psychosocial intervention groups. These interventions were in line with guidelines from the National Institute for Health and Care Excellence. Clients said that the groups were helpful and that it provides a safe and supportive environment for them.
- Staff arranged for clients to have health tests that they would need, such as an electrocardiogram to monitor their heart if prescribed over 100ml of methadone. This would monitor their heart for any abnormalities and was in line with Department of Health, 2007; Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care, Royal College of General Practitioners, 2011. Clients undergoing alcohol detoxification treatment at home had their physical health monitored by a nurse and staff recognised signs of deterioration.
- Staff supported clients to live healthier lifestyles with guidance and information forming part of each appointment and group work. The waiting room had leaflets to ensure clients had the information they needed, and staff could refer to other services as they needed to.
- Staff recorded outcomes for clients using the treatment outcome profile (TOPs) at regular intervals at the start, during and at discharge of treatment.
- Staff provided information to Public Health England through the national drug monitoring system. This helped staff to compare progress with other areas in the country with a similar demographic and to look at areas for improvement.
- In the 12 months prior to the inspection 0% of clients had been offered blood borne virus testing. Staff were trained to complete BBV testing but the clinics did not have the correct equipment to carry out tests. Clients should have been referred to their local GP for BBV testing but 0% of clients had been referred in the 12 months prior to this inspection.

Skilled staff to deliver care

- Staff completed a range of learning to meet their needs. Managers provided all staff with an induction and staff completed mandatory training as part of this. Following this, one to one sessions were used to support staff in identifying training relevant to their current post. The service had recently introduced a new competency-based induction program. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.
- Staff identified their learning needs and special interests and created individual development plans as part of their appraisal.
- Managers gave examples of poor staff performance and how this had been managed locally with support from the human resources team.
- The service had one nominated member of staff to recruit and train volunteers. Volunteers were trained and supported by relevant staff to take on roles such as supporting groups and meeting and greeting clients when they came in to reception.
- Staff told us that they received regular supervision and appraisal, and this was documented within personnel files. Staff were provided supervision and debriefs following facilitation of group sessions and incidents. We reviewed five electronic staff files which contained supervision notes, probation meeting minutes and absence management forms. All five staff files evidenced that staff were receiving regular supervision meetings.

Multi-disciplinary and inter-agency team work

- The staff team had the right skills and qualifications to support clients using the service. This included doctors, non-medical prescribers who were nurses, team leaders,

recovery navigators and healthcare assistants. The service also provided support to clients within the criminal justice. We saw from the client records that a multi-disciplinary approach had been taken to support clients and this was recorded appropriately.

- Staff had regular team meetings and minutes were available for staff unable to attend. Where appropriate, police and other agencies attended the weekly multi-disciplinary team meeting. Agenda items included staffing, safeguarding, policy and procedure updates and client feedback.
- Staff discharged clients when care and treatment was no longer required, and we saw evidence in supervision records of managers supporting these decisions. Clients could drop in to the service when they needed to even if they had been discharged so that they always had somewhere to go at difficult times.
- The service had shared care agreements in place with local GPs and pharmacies. This ensured that clients could access support from each service and utilise the different skills of staff at each service.

Good practice in applying the Mental Capacity Act

- Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and gave examples of when a client's capacity may fluctuate, for example when they were under the influence of alcohol. All staff were required to complete training in the Mental Capacity Act 2005. However, staff commented that the training was not tailored to the client group for example substances affecting capacity. At the time of the inspection 100% of staff had completed training in the Mental Capacity Act.

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff treated clients with dignity and respect and took a non-judgemental approach to the support they provided. Clients we spoke with all mentioned this and the fact that staff were caring, kind and supportive. Staff stated they could raise concerns about disrespectful, discriminatory or abusive behaviour towards clients and would feel listened to and taken seriously.
- Clients and volunteers who had previously been clients of the service told us that staff went above and beyond to support them, such as accompanying them to GP appointments, court and other important meetings.
- Staff adhered to and understood clear confidentiality policies and maintained the confidentiality of information about clients. Client electronic records showed prompts on the main screen if a client had stated not to share information with an individual such as a member of their family or partner. Client records also showed a consent to share information document, showing which agencies, the client had given permission for EDP to share their information with.

Involvement in care

- All clients we spoke with said they were supported to understand their care and treatment and manage their condition.
- Clients could access independent advocacy services and information about this was available on the noticeboards. Staff signposted clients to other service user organisations locally for support.
- The service had recently developed a role for a community development lead and part of the responsibilities of the role was to create a client forum to involve clients in development of the service. However, the meetings had not yet taken place.
- Not all clients had a recovery plan that demonstrated the client's preferences, recovery capital and goals.

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

Good

Access and discharge

- The service actively engaged with commissioners, social care, the voluntary sector and other relevant stakeholders to ensure services were planned, developed and delivered to meet the needs of the local population.

Requires improvement

Community-based substance misuse services

- The assessment team used a red, amber, green rating system, based on risk, to prioritise allocation of clients to recovery navigators' caseloads. Clients on the waitlist were sent a letter containing harm reduction advice, and an offer of access to a weekly drop in and the needle exchange service. The letter also included information on mutual aid groups and a card with access to an online tool for psychosocial interventions.
- The service was accessible to all who needed it and took account of clients' individual needs. The assessment team referred to an exception list for those who could not be assessed via the telephone, such as those who were homeless. Clients who met the criteria for this list were allocated to a caseload and offered a face to face assessment. The service utilised a worker who was part-funded by the street homeless team to facilitate outreach work with clients. Clients without a home could access services via the Exeter site or satellite hubs located in the city centre.
- The service had clear pathways for clients which were explained during the first appointment. However, staff could be flexible to meet the individual needs of clients to ensure they received treatment promptly. This could include a home visit or an appointment within another setting in the community.
- The service told us they used a 'no wrong front door approach' and accepted referrals from any source and completed an assessment or signposted individuals as necessary. The service employed a hospital liaison worker who worked with clients who presented at the local hospital. They supported and encouraged them to engage with the service and liaised with other relevant agencies, such as police and mental health teams.
- Staff referred clients for additional support to mental health services as required, ensuring that they received appropriate care and treatment and worked in partnership with those agencies. Team leaders from the service attended regular dual diagnosis meetings with the local mental health team.
- The service had a process for staff to follow if clients did not attend their appointments. This included contacting the pharmacy the client used, using emergency contact details and if more than two appointments were missed the client's prescription would be suspended.
- All discharges were signed off by the management team to ensure that discharge was appropriate and that there was a clear aftercare plan in place. The service was monitored through the National Drug Treatment Monitoring System which reports on representations following discharge from treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had accessible interview and group rooms to see people in, which were well equipped and fit for purpose.
- The front door was locked, and a staff member controlled entry into and out of the building. However, the entrance was bare and had minimal signage to instruct clients were to go and how to access the service, which was located on the first floor.
- The service utilised four floors and there was a disabled parking space with ramp access to the ground floor. The service ensured that clients that could not use stairs had access to group rooms, consulting rooms and the clinic on the ground floor.
- Interview and clinical rooms had adequate soundproofing and privacy.

Clients' engagement with the wider community

- The service had good links with local rehabilitation and detoxification units.
- Clients were offered volunteer opportunities to become recovery navigators following treatment and a set period of abstinence from substances.

Meeting the needs of all people who use the service

- The service had specialist teams and workers to support the most vulnerable and complex clients. This included a criminal justice team, family, transition, and outreach workers.
- Clients could access evening sessions if required and a duty worker was able to attend drop in sessions. Due to its rural location the service offered service from satellite locations across the county to ensure accessibility of the service.
- Staff demonstrated an understanding of the potential issues facing vulnerable groups e.g. Lesbian Gay Bisexual Transgender (LGBT), black and minority ethnic, older people, people experiencing domestic abuse and sex workers and offered appropriate support. This included creating multiagency relationships with relevant charities, such as the Mayday trust, community services, and attending local pride marches.

Requires improvement

Community-based substance misuse services

- Staff reported good links with midwifery services and held monthly pregnant service user groups.
- Clients reported that treatment and care was never cancelled, and staff would ensure they were always seen by a member of the team when they needed support or were in crisis. The service provided a duty clinic for clients to access support outside of planned sessions.

Listening to and learning from concerns and complaints

- There was a complaints policy in place and clients and staff were aware of the process for complaints. Staff would attempt to resolve any complaints informally initially and refer these on to managers if they could not be resolved. However, staff were not recording informal complaints. This meant that managers could not be assured that complaints were actioned fully, and complaints could not be analysed to determine themes or trends.
- The service logged formal complaints within their incident recording system which included details of investigation outcomes and lessons learned. Multidisciplinary team meetings included discussion around complaints and compliments as a standing agenda item.
- There were posters detailing how clients could complain in all sites except the Barnstaple clinic.
- In the previous 12 months the service had received three formal complaints.

Are community-based substance misuse services well-led?

Requires improvement

Leadership

- Managers had the skills, knowledge and experience to perform their roles. All managers and team leaders were in the process of completing management training. They demonstrated a good understanding of the clients the service supported and the difficulties that staff sometimes faced. They talked with confidence about the service and the standards expected in the level of care staff were delivering.
- The manager and team leaders had a visible presence in the service and staff could approach them at any time for advice, guidance and emotional support if they needed it.
- The organisation had a clear definition of recovery and this was shared and understood by all staff.

Vision and strategy

- Staff strove to empower clients to be successful, to make positive changes and to take back control over their lives. Staff demonstrated this through the care and support they provided to clients. All staff knew what their role was within the organisation and the boundaries of that role when working with clients.
- The senior management team had revised the organisations mission statement, values and vision following the new contract and this had been disseminated to all staff.
- Managers understood the budgets they needed to work to while still meeting the key performance indicators that had been set by commissioners.
- The senior management team gave staff the opportunity to contribute to discussions about the strategy of the service for example nursing staff had been approached to write operational policies such as the blood borne testing policy.

Culture

- All staff we spoke with felt respected, supported and valued by management. Staff and clients described a change in culture in the last six months and felt optimistic and positive about the future direction of the organisation. Managers had introduced initiatives to improve morale such as arranging team away days.
- The staff group felt positive and satisfied in their roles. Staff members felt they could approach colleagues for support and that they worked well as a team and could challenge each other professionally during case discussions.

Governance

- The provider had some gaps in the governance process. The provider's risk register did not include that staff were not offering blood borne virus testing or referring clients to their local GP for testing. Managers had not ensured that staff were completing disengagement

plans for all clients. Managers had not ensured that staff were completing risk management plans for all clients and that recovery plans were developed that met clients' needs identified during assessment.

- The provider did not have a robust and comprehensive local care planning audit programme. Managers received a report stating the number of open care plans. A local care planning audit had not been embedded to ensure managers had oversight of the quality and detail in care plans.
- The provider was in the process of updating their clinical policies. For example, the prescribing 'Did Not Attend' policy was in draft form and the needle exchange policy was not in place. The provider was in the process of updating clinical policies following a change in contract. Some staff were unaware that there were updated clinical policies but were using the 'Drug misuse and dependence: UK guidelines on clinical management' (2017) in line with national guidance.
- A nurse's forum and prescribers' meetings were in place to ensure oversight of medicines management across the services.
- There was a clear framework of what must be discussed at a team and provider level in team meetings to ensure that essential information such as learning from incidents and complaints, was shared and discussed.
- Staff had implemented recommendations from reviews of incidents and complaints. For example, following an incident in one of the services the provider implemented a new risk assessment training.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the clients. For example, team leaders from the service attended regular dual diagnosis meetings with the local mental health team and attended multi-agency case working for pregnant women which recovery navigators attended.
- Staff were aware of the organisation's whistleblowing policy and how to access it.

Management of risk, issues and performance

- The provider did not have a robust process to ensure all staff had an up-to-date Disclosure and Barring Service (DBS) certificate in place. Staff who worked for the previous provider did not have their DBS status checked when the contract changed. This meant that at the time of the inspection 10 out of 39 staff did not have an up to date DBS certificate. Local managers did not have oversight of this at a local level and relied on the human resources (HR) department. We raised this at the time of inspection and HR advised that staff that did not have an in-date DBS certificate work unsupervised if they signed a disclaimer stating that had not committed an offence since the previous checks.
- Managers did not have full access to staff personnel files as these were held centrally with the HR department. Managers had limited access to electronic and paper records which showed supervision, appraisal and sickness records. In Bideford, we reviewed five staff records, one did not contain an appraisal record.
- The provider did not ensure that all clients had robust risk management plans and disengagement plans. Risk management plans were found to be missing or were completed in an incorrect form. Managers did not ensure that staff were adhering to the risk management policy.
- Managers maintained and had access to the risk register for all services. However, not all identified risks were detailed. For example, the lack of oversight on some staff DBS certificate status and that the service had not offered or referred clients for BBV testing in the past 12 months.

Information management

- Staff had access to equipment and technology they needed to do their work. Computer systems worked well, and staff had access to laptops. The service had a lead administrator and data officer who supported staff with IT issues.
- The service collected data for both their own use to develop the service and to add to the national recording for substance misuse services. The use of data was explained to clients on entry in to the service and all details were anonymised. Managers understood the importance of confidentiality agreements when sharing information and data. Policies were in place to ensure clients information remained confidential and this was stored securely on an electronic system.
- Managers had a dashboard which gave them an overview of the performance of the service and the staff. Information was easy to access in a timely manner and accurate which helped managers to identify areas for improvement and discuss them at regular managers meetings.

Requires improvement

Community-based substance misuse services

- The service had developed information sharing protocols with external organisations including the local authority, probation and mental health services.

Engagement

- Staff, clients and carers had access to up-to-date information about the work of the service. This could be accessed through the organisation's website, social media and via leaflets and posters.
- Clients and carers could give feedback on the service they received. Feedback forms and boxes were available in reception/waiting rooms areas and they could speak to managers on request.
- Managers engaged with other organisations such as commissioners, local GPs, pharmacists and the probation service.
- Staff told us they could meet with members of the provider's senior leadership team to give feedback and attend meetings.

Learning, continuous improvement and innovation

- The service had recently appointed a community development lead whose role was to involve clients in the development of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clients have a disengagement plan that is regularly reviewed. (Regulation 12)
- The provider must ensure that all clients have a risk management plan in place. (Regulation 12)
- The provider must ensure the urine testing facilities in the Barnstaple clinic are used by staff appropriately, and that staff adhere to infection control principles. (Regulation 12)
- The provider must ensure that clients are regularly offered Blood Borne Virus testing and that the needles for the needles exchange service are in date. (Regulation 12)
- The provider must ensure that staff complete clear, detailed recovery plans with clients that include goals and details of the treatment being offered to the client. (Regulation 9)
- The provider must ensure there is oversight over the expiration of disclosure and barring service certificates for all staff. (Regulation 17)
- The provider must ensure that all known risks to service delivery are part of the risk register so a robust action plan can be developed. (Regulation 17)

Action the provider SHOULD take to improve

- The provider should ensure that staff consider client's physical health needs when developing recovery plans.
- The provider should ensure that managers record all complaints so that trends can be analysed and to ensure all complaints have been actioned appropriately.
- The provider should ensure that naloxone is readily available in the service.
- The provider should ensure that staff in the East & Mid Devon team complete all mandatory training.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not doing all that is reasonably practical to mitigate any such risks. Staff were not completing disengagement plans with clients who joined the service prior to April 2018. Staff were not always completing risk management plans as part of the risk assessment. The provider was not ensuring that the premises used by the service are safe to use for their intended purpose and are used in a safe way. In the clinic in Barnstaple, staff were using the kitchen to complete urine testing when the clinic room was in use. There were no facilities to complete urine testing in the dedicated toilet such as a shelf for testing or a clinical waste bin. The provider was not assessing the risk of, and preventing, detecting and controlling the spread of infections. In the clinic in Barnstaple, staff were discarding used sample pots in the clinic room waste bin without emptying first. The provider was not ensuring that there were sufficient quantities of equipment or medicines to ensure the safety of service users and to meet their needs. The clinic in Bideford was not offering blood borne virus testing to clients. The needle exchange service in Bideford contained out of date needles. This was a breach of Regulation 12 2(b)(d)(f)(h)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was not ensuring that staff completed a clear care and/or treatment plan, which includes agreed goals. Staff were not always detailing clear, agreed treatment and recovery goals in client's recovery plans. Staff were identifying a client's needs but not detailing how the service would support the client to meet this need. This was a breach of Regulation 9 3(a)(b)
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured all gaps in the governance processes had been identified. The provider did not have a robust recruitment process to ensure all staff had an up-to-date Disclosure and Barring Service (DBS) certificate in place. The provider did not ensure that the lack of blood borne virus (BBV) testing was added to the risk register. This was a breach of Regulation 17 2(a)(b)