County Durham Substance Misuse Service - Centre for Change

Quality Report

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

Ratings

Overall rating for this location	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 the service as requires improvement overall because:

- Staff did not always record safety-related information within clients' care records despite the potential serious risks associated with people with drug and alcohol addictions. We saw three care records which did not include risk assessments or risk management plans, one care record with an out of date risk assessment and four records which contained no evidence of advice given about the risks associated with the clients' treatment or harm reduction advice.
- Staff did not record sufficient information about clients who used the service which meant that care was not always person-centred or holistic and patients were not routinely involved in decisions about their care and treatment. Omissions in care records included recovery plans, equality and diversity information, clients' strengths, goals and motivation to change, alcohol dependency and discharge planning.
- Staff were not up to date with their mandatory training. Only 65% of staff had completed their e-learning training. The e-learning training included records management and equality and diversity and there was evidence the lack of training was having an impact as we identified gaps in care records in relation to client information, including equality and diversity considerations.

However, we found the following areas of good practice:

- There were sufficient numbers of skilled and experienced staff to deliver safe care and treatment. Staff received regular supervision, had access to specialist training, knew how to report incidents and handle complaints, engaged in clinical audits, made safeguarding referrals when appropriate, responded appropriately when clients' health suddenly deteriorated and were open and honest when things went wrong. Staff felt respected, valued and proud to work at the service and contributed ideas towards its future strategy.
- Staff treated clients in a kind, caring and compassionate manner. Staff supported clients during referrals and transfers between services. Clients were offered alternative treatment options if they were unable to comply with a particular treatment regime. Staff helped clients to understand and manage their care, treatment and condition using a variety of communication methods such as hearing loops, braille, easy read, other languages and large font when required.
- Staff monitored and addressed the physical healthcare of clients. Blood born virus testing was offered routinely to clients, staff offered advice on leading healthier lifestyles and referred clients to primary healthcare services when appropriate.
- The people who used the service were able to give feedback on the service they received. There were comments cards and boxes in each of the services' reception area, a complaints process, you said, we did noticeboards and people provided feedback through one of the service's third-party organisations. Clients had access to advocacy, signers, interpreters, an independent mental health advocate or mental capacity advocate when required. The service had a policy in place for dealing with clients who were late or missed their appointments which we found to be fair and reasonable in its approach.
- The service's range of care and intervention treatments followed national guidance on best practice. The service had effective pathways to other supporting services including local mental health services, bereavement and counselling services and veterans' services for people living with post-traumatic

Summary of findings

stress disorder. The service had no waiting lists, urgent referrals were prioritised and the service operated an open access system so clients could attend one of the services and commence their treatment the same day.

- Humankind had held the Equality North East 'Equality Standard Gold Award' since 2012, adapted its delivery to make information accessible to people with dyslexia, literacy issues, visual impairments and for whom English was not a first language.The service had its own equality and diversity champion and the service buildings were accessible. The service had been awarded an Investors in People accreditation. It was also working towards being accredited with a Better Health at Work award.
- The service proactively engaged with the local community. The Durham service run bi-monthly meetings with residents in the area and provided interventions and advice to students at the local university and colleges within County Durham. Staff attended police crime and commissioner events to provide advice to attendees about substance misuse.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Requires improvement 	

Summary of findings

Contents

Requires improvement

County Durham Substance Misuse Service: Centre for Change

Services we looked at

Substance misuse services

Summary of this inspection

Background to County Durham Substance Misuse Service - Centre for Change

The County Durham Substance Misuse Service: Centre for change is a community based substance misuse service which provides substitute prescribing and medical and psychosocial interventions for children and adults with alcohol and drug addictions.

At the time of our inspection visit in October 2018, the service comprised three locations:

- Saddler House in Bishop Auckland
- Ridgemont House in Peterlee
- Whinney Hill in Durham

Since 1 February 2018, the service has been provided by a new partnership of providers. Humankind are the lead provider for the service, and third-party organisations were responsible for interventions, programmes and community development in relation to recovery. The service's current contract is for two years.

Principles underpinning the service delivery model include;

- An integrated service team across the county and across service pathways
- Strong integration with stakeholders, promoting partnership and reducing duplication
- Engagement and co-production with service users, promoting local ownership of recovery
- Accessibility across recovery centres and a range of local community venues, ensuring the service is outward facing
- Utilising the knowledge, experience and skills of the service team to develop the service
- A Think Family approach across all elements of service delivery

The service's delivery model includes effective referral and assessment processes, including open access to support timely engagement with a range of service pathways and intervention packages. The service benefits from several single point of contact/liaison team members dedicated to key stakeholder groups including several criminal justice partners, GPs and local hospitals.

A range of proven pathways and interventions are being implemented across County Durham. These pathways and packages are tailored to local need and will be further developed with service users, service staff and stakeholders. Key delivery areas include:

- Effective recovery co-ordination and case management
- Criminal justice pathways working with partners across the criminal justice system, including Durham Police's diversion initiatives
- Integrated children, young people and families offer promoting shared working with Children's Services, Youth Offending Service and Adult Social Care
- Recovery Academy Durham – full-time structured programme, with weekly timetables individually created by service users
- Pro-active engagement with health partners (GPs, pharmacies, mental health and acute care) through the service's health, outreach, prevention and engagement team
- Supporting County Durham in Recovery to thrive and become an independent, sustainable recovery community organisation

Across County Durham the service partnership aims to create a positive culture of opportunity and ambition for service users and local communities, adopting an asset building approach which supports service users and their families within the communities where they live.

Prior to Humankind taking over the service, the service had not been previously inspected. The service had moved from a recovery-based centre delivery model across six county-wide sites to an outward facing, community delivery model based from three recovery centres with multiple satellite venues as mandated in the service specification.

Summary of this inspection

There had been a full service staff re-structure including formal job matching, consultation and new role deployment during the first three months of Humankind service delivery.

The service has been registered with the Care Quality Commission since 26 April 2018 to carry out the treatment of disorder, disease or injury. The service had a registered manager in place.

Our inspection team

The team that inspected the service comprised a Care Quality Commission inspector, three assistant inspectors and a specialist nurse with experience in the treatment of substance misuse acting as a specialist advisor to the Care Quality Commission.

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

Our inspection was unannounced which meant staff were unaware we were coming to inspect the service.

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information.

During the inspection visit, the inspection team:

- visited all three units at this location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with eight clients and two carers
- spoke with the three service managers
- spoke with 19 members other staff members, including nurses, non-medical prescribers, recovery co-ordinators and an administrator
- attended and observed two flash meetings at the Bishop Auckland and Durham services which were short, focussed meetings to discuss any progress and developments
- looked at 15 clients' care and treatment records
- looked at the medicines management arrangements for service

Summary of this inspection

What people who use the service say

People who used the service said staff were always kind, treated them with dignity and respect, were compassionate and supportive. They also said that staff helped them to understand and manage their care treatment and condition.

Clients felt staff went the extra mile. Staff collected clients from their homes, drove them to see their GP and supported them during their consultation and actively helped find accommodation for homeless clients.

Clients said that they were given clear and sufficient information to enable them to make informed decisions about their care and treatment. They also said they felt involved in decisions about planning their care and treatment.

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 did not always record safety information within clients' care records. We saw three care records which did not include risk assessments or risk management plans, one care record with an out of date risk assessment and four records which contained no evidence of advice given about the risks associated with the clients' treatment or harm reduction advice.
- Staff were not up to date with their mandatory training. Only 65% of staff had completed their e-learning training. The e-learning training included records management and equality and diversity and there was evidence the lack of training was having an impact as we identified gaps in care records in relation to client information, including equality and diversity considerations.
- Staff were not always categorising scanned information correctly which meant information was scanned in the wrong place. We were unable to see evidence within some care records that consent to treatment forms and confidentiality agreements were in place because staff had made this sort of error.

However, we found the following areas of good practice:

- The service buildings were clean and tidy, staff adhered to infection control procedures, carried out environmental risk assessments and rooms used to see the people who used the service were accessible.
- There were sufficient numbers of staff to deliver safe care and treatment. Agency staff were rarely used and appointments were not often cancelled due to staff absences.
- Staff knew how to report incidents, made safeguarding referrals when appropriate, responded appropriately when clients' health suddenly deteriorated and were open and honest when things went wrong.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of this inspection

- Staff did not record sufficient information about clients who used the service. Omissions included recovery plans, risk assessment and management plans, clients' strengths, goals and motivation to change, alcohol dependency and discharge planning and equality and diversity information.
- We found some care records were neither person-centred nor holistic and were written using generic language.

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

- The service offered a range of care and intervention treatments which followed national guidance on best practice. They included substitute prescribing, psychosocial interventions, needle and syringe programmes and substance reduction and detoxification.
- Staff monitored and addressed the physical healthcare of clients. Blood born virus testing was offered routinely to clients, staff offered advice on leading healthier lifestyles and referred clients to primary healthcare services when appropriate.
- Staff were skilled, experienced and competent to carry out their roles. Staff were regularly supervised, had access to specialist training for their roles, received an induction when they began working at the service and managers identified and addressed their learning and development needs. Staff participated in clinical audits. These included infection control audits and full inspections at each of the three services. Findings were used to improve practice within the service.
- One of the service's third-party organisations employed mental health nurses who advised staff when there were concerns about clients' mental health and mental capacity. The service also had a service level agreement with the local mental health trust and referred clients to its services when appropriate. Clients had access to an independent mental health advocate or mental capacity advocate when required.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients in a kind, caring and compassionate manner. We saw positive interaction between staff and clients during our inspection and the people who use the service that we spoke with felt supported and treated with dignity and respect.
- Clients told us that staff helped them to understand and manage their care, treatment and condition. Staff used a variety

Summary of this inspection

of communication methods such as hearing loops for people with hearing impairments, arranged for signers and translators to support people and produced written information in braille, easy read, other languages and large font when required.
- Staff directed clients to other services and supported them to access these services. Staff had helped clients to access mental health services, counselling groups, social services, mutual aid groups and housing support. Clients told us that staff had picked them up at home and taken them to see their GPs.
- Clients were offered alternative treatment options if they were unable to comply with a particular treatment regime.
- Staff enabled the people who used the service to give feedback on the service they received. There were comments cards and boxes in each of the services' reception area, you said, we did noticeboards and people provided feedback through one of the services charitable partner organisations.

However, we found the following areas the service needs to improve:

- Clients were not always involved in decisions about their care and treatment. This was evidenced by the fact that four clients did not have a recovery plan in place, three did not have risk management plans in place and seven clients' records did not include their strengths, goals or motivation to change.

Are services responsive?

Good

We rated responsive as good because:

- The service had no waiting lists, referrals were monitored by administrators who prioritised urgent referrals so they were seen quickly. The service operated an open access system so clients were able to attend one of the services and commence their treatment the same day.
- The service did not routinely refuse to see clients who arrived late for their appointments and made efforts to see them on the same day. The service had a policy in place for dealing with clients who were late or missed their appointments which was fair and reasonable.
- The service had robust alternative care pathways and referral systems in place for when it was unable to meet the needs of clients. These included veterans' services for people suffering from post-traumatic stress disorders and counselling services.
- The service offered alternative treatment options to clients who were unable to comply with specific treatment requirements. Examples included offering buprenorphine for clients intolerant of methadone and inpatient detoxification for clients who were unable to comply with community detoxification.

Summary of this inspection

- Staff supported clients during referrals and transfers between services. Staff had taken clients to see their GPs and signposted clients to services that could potentially enhance their care and treatment needs.
- Staff knew how to handle complaints and lessons learned from investigating complaints were used to improve the service.

However, we found the following areas the service needs to improve:

- Staff did not always plan for clients' discharge from the service. Out of the 15 care records we looked at, 11 did not contain evidence of discussions or plans around the clients' discharge from the service.
- Staff did not always record equality and diversity data in relation to clients. Out of the 15 care records we looked at, six contained no evidence of equality and diversity issues being considered as part of the clients' care and treatment needs.

Are services well-led?

Requires improvement

We rated effective as requires improvement because:

- There were ineffective governance systems in relation to the completion of clients' care records. Care records contained significant gaps in relation to discharge planning, equality and diversity information, dependency on alcohol and clients' strengths and goals.
- Mandatory training systems were not always effective. Only 65 per cent of staff within the service had completed mandatory e-learning training which covered information governance, equality and diversity and records management.

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

- Leaders had sufficient skills, knowledge and experience to perform their roles, provided clinical leadership and had a good understanding of the services they managed.
- Staff had opportunities to contribute about the strategy for the service and had job descriptions in place. Staff raised their ideas in relation to the strategy of the service during team meetings and daily flash meetings. Staff felt respected, supported, valued and proud to work within the service.
- The provider recognised staff success within the service. Staff had received or been nominated for awards, there was an employee of the month initiative in place and managers sent thank you cards to individuals for good standards of work. The service had been awarded an Investors in People accreditation. It was also working towards being accredited with a Better Health at Work award.

Summary of this inspection

- The provider promoted equality and diversity in its day to day work and provided opportunities for career development. Humankind had held the Equality North East 'Equality Standard Gold Award' since 2012. The service had adapted its delivery model in response to the 2016 NHS Accessible Information standards to make information accessible to people with dyslexia, literacy issues, visual impairments and for whom English was not a first language. The service had its own equality and diversity champion.
- The provider had a whistleblowing policy in place. This was accessible to all staff via the provider's intranet. Staff maintained and had access to the provider's risk register and agreed the items currently included on it matched their own concerns.
- The people who used the service had opportunities to give feedback on the service they received. People were able to provide feedback using comments cards and boxes in the reception area or people were able to provide feedback through one of the services third party organisations.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider had a policy on the Mental Capacity Act which was accessible to staff through the organisation's intranet. Staff received mandatory training in the Act and at the time of our inspection, 84% of staff were up to date with this.

The service's sub-contracted partner agency included mental health registered nurses which were used as resource for advice, discussion and involved in multi-disciplinary team meetings around clients with mental health complex needs. The service had links with the specialist dual diagnosis lead within the local mental health trust and the service's health, outreach, prevention and engagement team provided in-reach to County Durham's specialist mental health inpatient facilities.

Staff had a basic understanding of the Act. They were aware of the need to always presume a client has capacity, to help the client to make their own decisions and knew that social workers and advocacy were available to support clients if required.

However, 10 of the 15 care records we looked at made no reference to mental capacity being considered. We also found eight records which did not contain any records that the clients had consented to their treatment or signed confidentiality agreements. This appeared to be due to staff using an incorrect categorising system when they had scanned these documents onto the system which meant they had saved to the wrong folder. However, the service had a failsafe system in place as once the duty staff had created a patient record, a check was made by an allocated care worker to ensure these forms were present and the next stage of the client's care and treatment could not progress without them. No paper copies were destroyed until the care worker was assured the scanned information was held on the electronic system. In light of this failsafe system, we were assured that clients signed confidentiality agreements and consented to their treatment and that the issue was more in relation to flaws in relation to the uploading of paper-based information.

Clients had access to an independent mental capacity advocate. Staff arranged for an advocate to attend the service if required and often within a day.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Substance misuse services

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

Are substance misuse services safe?

Requires improvement

Safe and clean environment

Safety of the facility layout

Each of the three sites we inspected were accessible for people with mobility issues and floor surfaces allowed for wheelchair access. All three sites had lifts. However, the lift at the Durham site was out of order at the time of our visit but we saw evidence that staff had submitted a request to the manufacturer for repairs to be made.

Rooms used to see clients contained alarms so staff and clients were able to call for help in the event of an emergency.

Maintenance, cleanliness and infection control

The sites were clean and tidy and we saw evidence that cleaning duties were carried out daily. Domestic staff had checklists which meant that all areas of the service were cleaned.

All three services we inspected had clinic rooms which were fit for purpose. There were handwashing facilities and chairs and furnishings used for venepuncture complied with infection control prevention measures as they were wipeable.

There were handwashing facilities available throughout the building including liquid soap and hand sanitising gel. We saw evidence that the services had carried out infection control audits in September 2018. We also saw evidence that there were arrangements in place for the disposal and collection of clinical waste. For example, all staff were required to arrange for any sharps bins to be disposed of within three months, even if they were not full.

Health and safety related tests, including the control of substances hazardous to health, fire, gas and electrical wiring, personal appliance testing, legionella and water temperatures were up to date. Evacuation plans were held within health and safety files so staff were aware of how to safely evacuate people from the buildings in an emergency. Regular checks of the environment took place and any potential hazards or repair work was identified, logged, actioned and mitigated accordingly.

There were fire wardens and first aiders within each of the service and their names and contact details were included on noticeboards so people knew who they were. The first aiders held current certificates in first aid at work. The topic this training covered included helping someone who was unresponsive and breathing, the use of an automated external defibrillator, choking, bleeding, suffering from shock or burns, had a head injury and other medical emergencies.

Safe staffing

Staffing levels and mix

There were sufficient staff in place to provide safe and effective care and treatment and provide one to one care to clients when required. The whole time equivalent staffing levels at the time of our inspection were:

Durham

- One team leader/advanced nurse practitioner
- Two nurse medical prescribers
- 0.6 registered general health nurse

- One project manager
- One lead practitioner
- 18.5 recovery co-ordinators
- Two administrators

Bishop Auckland

- One team leader/advance nurse prescriber
- 1.6 nurse medical prescribers
- 0.6 registered general health nurse
- One project manager
- One lead practitioner
- 14 recovery co-ordinators
- Two administrators

Peterlee

- One team leader/advance nurse prescriber
- Two nurse medical prescribers
- 0.6 registered general health nurse
- One project manager
- One lead practitioner
- 18.1 recovery co-ordinators
- 2.6 administrators

Other roles at the service included:

- One area manager
- One quality, performance and data analysis manager
- One senior administrator
- One criminal justice lead practitioner
- One health, outreach, prevention and engagement lead practitioner
- One sustained recovery project manager
- One recovery academy lead practitioner
- One aftercare lead practitioner

The service had developed protocols from previous providers to establish the numbers and grades of staff it needed to deliver safe care and treatment. These included managing critical functions, looking at service delivery such as manning the reception areas and recovery co-ordination. The services had also drawn up comprehensive lists of tasks carried out by each jobholder so that anybody picking up their work while they were absent knew what the expectations of the role were.

In September 2018, the provider reported four members of staff had left the service, the total average sickness absence was 7% and there were 7.5% vacancies since February 2018 when its contract began. The provider did not report any nurse vacancies within the service. Staff and senior managers told us that part of the reason for sickness absence was due to work-related stress because staff had been adversely affected by the constant change of provider caused by awarding substance misuse services short-term contracts.

No bank staff had been used to cover any vacancies at the time of our inspection. The service has, however, recently began to use agency staff to cover sickness absences for administrator duties. An additional recovery co-ordinator had been put in place at the Durham service as managers had identified the service was under-resourced.

The provider's human resources and strategic planning teams were responsible for monitoring potential future changes in the services staffing profile such as upcoming retirements or requests to change working hours. These teams alerted managers within the service about possible upcoming changes so that they could hold discussions with staff to determine if they wished to stay on after retirement and if any requests to increase or reduce working hours could be accommodated.

Mandatory training

Overall, staff were compliant with their mandatory training requirements. The provider's compliance target for each training module was 85% and the only areas that fell below this target were the Mental Capacity Act (84% compliance) and e-learning (65% compliance). The e-learning comprised data protection, freedom of information, information security, records management, introduction to equality and diversity and the use of display screen equipment. In all other areas, the service had exceeded the provider's target. 94% of staff within the service had completed their mandatory health and safety awareness training at the time of our inspection.

Staff attended classroom based training sessions in equality and diversity and were required to complete a mandatory e-learning module relating to equality and diversity as part of their induction to the organisation. The mandatory training included:

- The protected characteristics under the Equality Act 2010 and the stereotyping and prejudice faced by the people it covered
- The need to promote a proactive inclusive approach to equality and diversity
- The benefits of an effective approach to equality, diversity and human rights

- The importance of valuing people as individuals and treating everyone with dignity, courtesy and respect
- External and internal influences on behaviour
- Language, strategies and behaviour that fosters equality
- What to do if there are concerns about equality and diversity practices

Assessing and managing risk to clients and staff

Assessment of patient/service user risk

We looked at 15 clients' care records across the three services we inspected. Staff did not always record information about risks associated with clients. Three care records contained no evidence of any risk assessments and a fourth had a risk assessment that was not up to date.

The service used its own in-house risk assessment tool. However, this followed the principles of recognised risk assessment tools and captured information about the client's history, risk to themselves and others, mental health, blood born viruses, housing, employment, offending history and other pertinent data.

Staff recognised and responded to warning signs and deterioration in clients' health. Each site had a lead practitioner from whom health advice was sought and staff were trained in first aid which included life saving techniques. Staff encouraged any clients for whom there were concerns about to visit their GP or their local walk-in centre.

The service had a process in place for when a client was suspected of passing on their prescribed medication to others for illicit purposes; a process known as 'diversion'. This included testing clients to ensure they were complying with their medication, discussing rumours or evidence of possible diversion with the client and placing the client back on supervised consumption. Supervised consumption means the client consumes their medication in the presence of a pharmacist as opposed to taking it in the confines of their home.

Management of patient/service user risk

Out of the 15 care records we looked at, four contained no evidence that the clients had been offered harm reduction advice, three contained no evidence that staff had created risk management plans for the clients and three contained no evidence that clients had been offered advice about their treatment and the risks associated with it.

Staff identified and responded to changing risks to or posed by clients. Staff encouraged clients to attend health checks with their GP. If there were immediate concerns about a client's health condition, staff rang the emergency services. Administrators had access to information about conflicts between different clients and booked their appointments at separate times.

There were sufficient numbers of staff at each of the services trained in emergency first aid at work. There were also sufficient fire wardens who were easily identifiable as their details were posted on noticeboards throughout the service buildings.

The service had effective lone working processes in place. These included the use of a signing in and out books in the reception areas, visual boards in the reception office to inform staff of their colleagues' whereabouts, the use of electronic calendars and a buddying system by which a colleague contacted the person working alone in the community to check they were safe if they had not returned to the service when expected.

Use of restrictive interventions

The service did not use physical interventions but did have a zero-tolerance policy on abusive and aggressive behaviour. All staff who came into close contact with clients were trained in managing violent and aggressive behaviour. When people had behaved in an aggressive manner, they were asked to leave the building and a manager within the service discussed the standards of behaviour expected. The client was informed that repeated instances of aggressive behaviour could lead to them being discharged from the service and the police being notified.

Safeguarding

At the time of our inspection, 93% of staff were up to date with their safeguarding training.

Staff gave examples of how the service helped to protect clients from harassment and discrimination. These included staff being made aware of any conflicts between different clients so appointments could be made to avoid them seeing each other. The organisation's policies on equality and diversity and numbers for associated helplines being posted on noticeboards in the reception areas. The service also had an equality and diversity lead.

Staff worked within teams and with other services and agencies to promote safety information. Safety information

was discussed in daily flash team meetings which were short, focussed meetings to discuss any progress and developments. The service liaised with the police, probation services and social workers and raised concerns about the safety of individual clients or their carers and families.

Staff knew how to make safeguarding referrals when appropriate. The service had its own safeguarding lead who tracked the progress of any referrals made. Staff were required to copy the safeguarding lead into any emails to the local safeguarding teams in relation to referrals. Safeguarding issues were discussed during staff supervision, at daily flash meetings which were short, focussed meetings to discuss any progress and developments, team meetings and staff received mandatory training in the safeguarding of children and vulnerable adults.

At the time of our inspection, there had been no allegations of abuse made against staff since the service had begun its contract in February 2018.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. There has been no prevention of death reports sent to the provider in relation to the service since it began its contract in February 2018.

Staff knew how to identify adults and children at risk of, or suffering significant harm. Staff gave examples of the possible signs of abuse which included sudden weight loss or gain, changes in financial status, changes in presentation, self-neglect and missing appointments. Staff also gave examples of working with other bodies to address any safeguarding concerns such as the police, social care, refuge centres and GPs.

Staff access to essential information

Patient information was held on the service's electronic care records system which they had been mandated to use by the commissioning authority. Any paper based information such as signed consent to treatment and confidentiality agreement forms were scanned onto the system by a duty member of staff and the paper copy was subsequently destroyed. Each time a paper record was scanned onto the system, it needed to be given a specific event categorisation accordingly so it could be saved in the correct folder. However, staff were not always categorising information correctly which meant information was held in the wrong place. We were unable to see evidence within some care records that consent to treatment forms and confidentiality agreements were in place because staff had made this sort of error. We were told that the information could ultimately be found but it would potentially mean spending time searching through numerous events to find it.

However, the service had a failsafe system in place as once the duty staff had created a patient record, a check was made by an allocated care worker to ensure these forms were present and the next stage of the client's care and treatment could not progress without them. No paper copies were destroyed until the care worker was assured the scanned information was held on the electronic system. In light of this failsafe system, we were assured that clients signed confidentiality agreements and consented to their treatment and that the issue was more in relation to flaws in relation to the uploading of paper-based information.

Staff reported that the structure of the care records system was sometimes made navigating around it frustrating.

Staff at the service highlighted problems with access to information on the transfer of clients from other organisations. This was due to the multitude of different computer systems used by various organisations and meant that there were delays as staff were required to contact these organisations individually to source information. This issue had been raised during flash meetings which were short, focussed meetings to discuss any progress and developments and team meetings and the service was looking at ways to improve information sharing with other organisations.

Medicines Management

The service had effective medicines management arrangements in place to govern the storage of medication, substitute prescribing, detoxification, review of the effects of medication on clients' physical health and other associated factors. These arrangements followed guidance from the National Institute for Health and Care Excellence and the Drug Misuse and Dependence: UK Guidelines on Clinical Management.

Requires improvement

Substance misuse services

The service only stored emergency drugs at the three sites which was ordered by a central team within the organisation from an external provider. This included naloxone which is used for managing overdoses and medication for the treatment of anaphylaxis. Emergency medication was in date and all prescriptions were securely stored in safes.

Patient group directions at the service were in date and the associated documentation governing these was safely stored in the main office.

During our inspection, we identified a fridge used for storing emergency medication at the Peterlee service had been out of order since 14 September 2018. The service had shared provision of medication with the Durham service in the interim period. Staff and managers within the service were aware of the fault and had ordered a replacement which arrived later on the day we raised the issue with staff at the service.

Track record on safety

The provider reported as at September 2018 that there had been six serious untoward incidents in relation to the service. Staff within the service had identified four incidents in relation to the neglect, emotional abuse and sexual exploitation of children and had taken appropriate action such as making safeguarding referrals and notifying the police. Another incident related to the inappropriate storage of prescriptions and another related to two clients that had self-harmed.

The service manager at the Peterlee site said that there had been an adverse event at the Seaham site. There had been a power cut which meant that the shutters on the doors could not be opened and the building could not be accessed. However, the service had good relationships with other services so alternative premises, including the Peterlee site were used until the problem was rectified.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and what types of incidents to report. The service used an electronic reporting system known as 'the hub' which allowed the person reporting the incident to notify any relevant staff. The service had an incident reporting policy which was accessible to all staff via the intranet and which outlined the definitions of incidents, what staff's responsibilities were and how to respond to incidents accordingly. Staff gave examples of incidents which included near misses, safeguarding concerns, violence and aggression and potential health and safety hazards.

We saw evidence that discussions around lessons learned from incidents were shared with staff during team and flash meetings which were short, focussed meetings to discuss any progress and developments.

The provider had a duty of candour policy. However, staff did not recognise the term 'duty of candour' but after further questioning, were able to demonstrate that they were open, honest and transparent when things went wrong, offered an apology to the people concerned and kept them informed of any investigations or outcomes accordingly.

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

Requires improvement

Assessment of needs and planning of care

We looked at 15 care records during our inspection which were held in an electronic system the service had been mandated to use by the commissioning authority. We saw evidence that staff carried out comprehensive assessments on clients in a timely manner. However, staff did not always develop recovery plans that were person-centred, holistic or contain other information relating to the client's care and treatment. For example, eight records were written in a generic way which did not reflect the client as an individual, seven records did not make any reference to the client's strengths and goals, six contained no evidence of equality and diversity issues being considered as part of the clients' care and treatment, seven contained no evidence of discharge planning and six records made no information about the clients' alcohol dependency. Four care records contained no recovery plans at all. Other missing information included mental health and mental capacity, consent to treatment, confidentiality agreements and harm reduction advice being given. However, recovery plans in place did identify the client's recovery

co-ordinator. An internal audit carried out by the service had identified issues with the completion of care records and limitations within the care records system which the service was planning to address.

Although none of the 15 records contained plans for if clients unexpectedly dropped out of treatment, the service had a process in place for dealing with clients who did not attend their appointments which gave advice to staff about how to re-engage clients with the service. This included speaking with probation services and alerting the police and local pharmacy services.

Best practice in treatment and care

The service offered a range of care and treatment interventions which were appropriate to the client group. These included substitute prescribing, drug misuse prevention, needle and syringe programmes, psychosocial interventions, hepatitis B and C testing, alcohol reduction and opiate detoxification. These interventions followed guidance from the National Institute for Health and Care Excellence and the Drug Misuse and Dependence: UK Guidelines on Clinical Management.

The service ran educational activity groups for its clients during weekdays which included women's and men's groups, group centred on abstinence, self-reflection, recovery, pre-detox, wellbeing and family and parenting groups. Staff helped clients to access opportunities for education and employment and provided advice on day-to-day living skills. We saw evidence in clients' care records that staff offered clients blood born virus testing routinely.

Staff monitored and addressed clients' physical healthcare needs. We saw examples in clients' care records that the non-medical prescribers monitored and addressed physical healthcare issues associated with the use of prescribed substitute drugs and staff signposted clients to primary healthcare services for other conditions when required.

Staff provided examples of when they had provided clients with advice to help them lead healthier lifestyles. These included referring clients to their GP for issues around diabetes, healthy food choices, financial advice and smoking cessation. However, staff did not always record evidence of this sort of advice in clients' care records. Out of the 15 care records we looked at, seven contained no evidence of advice around leading healthier lifestyles being offered.

The service used the health of the nation outcome scales and Public Health England treatment outcome profile to assess and record clients' severity and outcomes. These tools are both widely recognised tools in the substance misuse and mental health sectors.

Staff at the service engaged in clinical audits and used findings from them to improve practice. Six clinical audits had been completed since the service's contract had begun in February 2018; three full internal inspections and three infection control audits. Infection control audits identified a need to remind staff that all sharps bins needed to be disposed of within three months, even if they were not empty to comply with the provider's health and safety standards.

Monitoring and comparing treatment outcomes

The service had been awarded an Investors in People accreditation. It was also working towards being accredited with a Better Health at Work award.

Staff reviewed care and recovery during appointments with their clients. However, care records did not always reflect this as there was no evidence that four clients had recovery plans in place and there were gaps in other clients' care records such as clients' strengths and goals and motivation to change.

Skilled staff to deliver care

There was a range of disciplines and staff within the service to deliver care and treatment. These included nurses, non-medical prescribers, recovery workers, administrators and senior managers.

All staff, including bank and agency, received a comprehensive induction into the service. This included an Introduction to their team, health and safety, incident reporting, handling complaints, information governance and equality and diversity.

Staff were provided with mandatory training which included health and safety, equality and diversity, the Mental Capacity Act, safeguarding awareness and e-learning. Completion of this training was monitored by managers within the service.

Managers used supervision and appraisal sessions to identify the learning and development needs of their staff. Specialist training identified included managing sex offenders and Stockholm training. Managers sent training requests to the provider's training team who then sourced the most appropriate training for the staff member.

Staff received regular supervision from appropriate professionals. The provider's target was for staff to receive supervision once every 12 weeks which the service was meeting and in most cases exceeding. Appraisals took place annually and because the service had only been in operation since February 2018, no staff member had been appraised at the time of our inspection. However, the service was planning to introduce a mid-year review for all its staff to enable managers and staff to review progress towards meeting objectives and expectations before the end of the reporting year.

The service used prescribing staff from a sub-contracted partner agency. The provider ensured these staff were qualified and competent to carry out their prescribing role via monitoring systems used by its human resources team and reviews of competency matrixes undertaken by heads of service.

The provider had a performance management system procedure which enabled managers to address any staff performance issues in a prompt and appropriate manner.

Multidisciplinary and inter-agency team work

The service held daily flash meetings which were short, focussed meetings to discuss any progress and developments and bi-weekly team meetings during which clients' needs and current progress were discussed and planned for. Multidisciplinary team meetings were attended by the client, their recovery co-ordinator, nursing staff and GP. The service's safeguarding lead and professionals from the probation service, social care and criminal justice services were invited to attend when appropriate. However, out of the 15 care records we looked at, six made no reference to any input from members of the multidisciplinary team though this appeared to be a recording issue. All care records clearly stated who each client's recovery co-ordinator was.

Within the County Durham contract there were no formal protocols for the shared care of clients who used the services. However, the service had pathways in place with acute and mental health hospitals, as well as GP practices within the area. The service was also working towards agreeing protocols with the police for clients engaged with the local constabulary's initiatives such as Checkpoint. Checkpoint is a scheme which identifies individuals at risk of further offending and harm according to a range of risk factors, with the aim of working with multiple partners to address these risks and prevent escalation.

Good practice in applying the MCA

The provider had a policy on the Mental Capacity Act which was accessible to staff through the organisation's intranet. Staff received mandatory training in the Act.

There was not a central mental health focused team within the service, however the service's partner agency included mental health registered nurses which were used as resource for advice, discussion and involved in multi-disciplinary team meetings around clients with mental health complex needs. The service also had links with the specialist dual diagnosis lead within the local mental health trust and the service's health, outreach, prevention and engagement team provided in-reach to County Durham's specialist mental health inpatient facilities, where referrals were discussed and assessments of clients undertaken.

The service monitored staff awareness and compliance with the Mental Capacity Act during internal inspections. Staff were asked to complete questionnaires about their understanding and discussions followed to address any gaps in knowledge or need for clarification. The service was planning on introducing an additional screen within its care records system to capture any concerns around clients' mental capacity and allow managers to improved monitoring of the use of the Act.

The staff we spoke with had a basic understanding of the Act. They were aware of the need to always presume a client has capacity, to help the client to make their own decisions and knew that social workers and advocacy were available to support clients if required.

However, 10 of the 15 care records we looked at made no reference to mental capacity being considered as there was no specific field within the care records system to prompt staff to record such information.

We also found eight records which did not contain any records that the clients had consented to their treatment or signed confidentiality agreements due to staff using an

incorrect categorising system when they had scanned these documents onto the system which meant they had saved to the wrong folder. However, the service had a failsafe system in place as checks was made by allocated care workers to ensure these forms were present and the next stage of the client's care and treatment could not progress without them. No paper copies were destroyed until the care worker was assured the scanned information was held on the electronic system. In light of this failsafe system, we were assured that clients signed confidentiality agreements and consented to their treatment and that the issue was more in relation to flaws in relation to the uploading of paper-based information.

Clients had access to an independent mental capacity advocate. Staff were able to arrange for an advocate to attend the service if required and often within a day.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

During our inspection visit, we saw that staff interacted with clients in a kind, caring and compassionate manner. People who used the service said staff were always kind, treated them with dignity and respect, were compassionate and supportive.

Staff who spoke with us said they felt they would be able to raise concerns about disrespectful, discriminatory or abusive behaviour without fear of reprisals. They said managers encouraged a culture of openness and transparency as it ultimately led to the service improving its care towards the people who used the service.

The people who used the service who we spoke with said that staff helped them to understand and manage their care treatment and condition.

Clients we spoke with said that staff went the extra mile and their care support exceeded their expectations. Clients said that staff had collected them from their home, taken them to see their GPs and agreed to support them during their consultation and had saved them from suicide by actively working to help find them accommodation. We saw evidence in clients' care records that staff had either signposted or helped clients to access local mental health services, social services, counselling groups, mutual aid groups and housing support.

The service had clear confidentiality policies in place which were understood and adhered to by staff. Staff had received information governance training which included the need to maintain clients' confidentiality and other issues associated with data protection. However, we were unable to see evidence within some care records that confidentiality agreements were in place because staff had selected the wrong code when uploading the paper copy to the electronic system. We were told that the information could ultimately be found but it would potentially mean trawling through numerous events to find it.

Involvement in care

Involvement of patients/service users

Staff communicated with clients in ways that helped them to understand their care and treatment. The service had hearing loops for people with hearing impairment, people had access to signers and interpreters, written information could be produced in different format such as easy read, braille, other languages and large font and clients who spoke with us said staff explained things clearly, in a way they understood.

All three of the services were able to arrange for independent mental health advocates and mental capacity advocates to support people who used the service, often within a day.

Not all clients within the service had recovery plans or risk management plans in place. We looked at 15 clients' care records and four had no evidence that staff had created recovery plans and three contained no evidence staff had created risk management plans for the respective clients. Seven records contained no evidence of the clients' strengths and goals and motivation to change.

Staff engaged with the people who used the service to develop responses that met their needs and gave them information to make informed decisions about their care. Clients were given treatment choices and when a treatment regime was found to be incompatible with the client, alternatives were offered. The people who used the service who spoke with us said that they were given clear

and sufficient information to enable them to make informed decisions about their care and treatment. They also said they felt involved in decisions about planning their care and treatment.

Involvement of families and carers

Staff enabled carers and families to give feedback on the service they received. Each of the three services had comments cards and boxes in the reception area and received feedback via 'you said, we did' boards. Complaints were responded to on an individual face to face basis. The lead practitioner at the service was developing service user focus groups to give the people who used the service further opportunities to provide feedback and ideas for improving the service. People who used the service also provided feedback through one of the service's third-party organisations that was run by people affected by substance misuse themselves.

The service helped carers access a carer's assessment. Staff issued leaflets to carers with information about how to apply for an assessment from the local authority. Information about support available for carers was also available on noticeboards in the reception areas.

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

Good

Access, waiting times and discharge

The service had robust alternative care pathways and referral systems in place for when it was unable to meet the needs of clients. Clients with physical health needs or concerns regarding mental capacity that the service was unable to sufficiently or safely support were referred to the local authority's social care and health team who completed a care assessment with the client to develop an appropriate care package.

The service had strong links with veterans' services in Durham and Catterick, where staff could refer clients requiring specialist support for post-traumatic stress disorder to.

The service had referral systems in place with a range of other support services, such as bereavement support, domestic abuse, sexual abuse and rape and links with a suicide prevention service. The service worked in partnership with criminal justice teams in supporting clients with behaviours that challenge and were difficult to engage with, by offering joint appointments at partner premises.

The service offered alternative treatment options to clients who were unable to comply with specific treatment requirements. Clients who were receiving pharmacological intervention and who were unable to tolerate methadone were offered buprenorphine as an alternative medication. Clients who are unable to attend the recovery centre in person, due to physical or mental health issues were offered home visits or visits at alternative locations. Clients who were unable to comply with the requirements for community detoxification were offered the alternative of inpatient detoxification or a community alcohol reduction programme.

The service operated an open access system, whereby a client was able to attend the service for assessment and commence psychosocial intervention on the same day. The service had a target of 21 days from assessment for clients to commence pharmacological interventions if these were required.

At the time of our inspection, the service did not have any waiting lists. When referrals were made by a third party, such as the client's GP, they were monitored by the duty worker who made every attempt to contact and engage the individual to attend for assessment, taking into consideration any risks that have been identified on the referral. The duty worker also ensured urgent referrals were prioritised and the clients were seen quickly.

The service did not routinely refuse to see clients who arrived late for their appointments and made efforts to see them on the same day. The service has a policy in place which advised staff how to deal with clients who were late for appointments or had missed an appointment. We looked at this policy and found it took a fair and reasonable approach to clients whilst also being clear of the need to remind clients that every effort should be made to attend their appointments on time.

Requires improvement

Substance misuse services

Humankind provided the figures and reasons for the number of appointments that were cancelled by the service at each of its three sites between February and September 2018:

- 44 were cancelled due to environmental issues such as adverse weather, power cut or equipment failure
- 44 were cancelled due to there being staff absences
- 7 were cancelled due to the necessary clinical information such as blood test results being unavailable

None of the people who use the service that spoke with us said that their appointments had been cancelled or were delayed.

Discharge and transfers of care

Recovery and risk management plan templates included fields for capturing details about the diverse and complex needs of clients. However, staff were not routinely recording this data. Out of the 15 care records we looked at, six contained no information in relation to the diverse or complex needs of the client.

The service operated an open access system so clients were able to attend one of the services and commence their treatment the same day. The service's criteria had been agreed by other services and key stakeholders.

Staff did not always plan for clients' discharge from the service. Out of the 15 care records we looked at, 11 did not contain evidence of discussions or plans around the clients' discharge from the service. We raised this with staff and in some instances, the clients' presentation, reluctance to engage and current level of dependence on alcohol or drugs meant that plans for discharge were not appropriate. However, staff did not always record this in the clients' care records.

Staff supported clients during referrals and transfers between services. For example, clients who spoke with us said that staff had picked them up at their homes and had driven them to see their GPs. We also saw evidence in care records that staff had either taken clients to other services directly or had signposted them to services that could potentially enhance their care and treatment needs.

The service complied with the transfer of care standards by ensuring referral forms and letter templates contained standard clinical information to facilitate the smooth transfer or discharge to other care services.

Facilities that promote comfort, dignity and privacy

Rooms used for one to ones between staff and clients were adequately soundproofed to ensure clients' dignity and confidentiality were maintained. The people who used the service were able to make phone calls in private when rooms were available.

Patients'/Service user's engagement with the wider community

Staff supported clients to maintain contact with their families and carers. Patients and carers who spoke with us is said staff encouraged them to maintain contact and we also saw evidence in clients' care records that staff encouraged them to stay in touch with their loved ones and people that mattered to them within the wider community.

We saw evidence that staff encouraged clients to partake in community groups and client activities. These included mutual aid groups such as alcoholics and narcotics anonymous and the services had their own breakfast clubs which were intended to enhance clients' ability to interact socially with each other and with the wider community.

Staff ensured clients had access to education and work opportunities. One client was close to completing a construction course that staff had encouraged them to undertake and another confirmed that staff had supported them to complete training courses to improve their communication skills and build their confidence.

Meeting the needs of all people who use the service

The service buildings were accessible for people with mobility issues. However, at the time of our inspection, the lift at the Durham service was out of order but we saw evidence that this had been reported to the manufacturer and was due to be addressed.

Staff confirmed their equality and diversity training covered the issues faced by vulnerable groups. For example, staff were aware that due to issues associated with coming out and homophobia and transphobia, lesbian, gay, bisexual and transgender people sometimes had mental health issues and suicidal thoughts in addition to their addiction problems.

Requires improvement

Substance misuse services

Noticeboards in the reception areas at each of the services contained details of helplines for vulnerable people including gay advice lines, people living in abusive relationships, disabled people and black, minority ethnic people.

The service provided information in a variety of forms to meet the needs of people who used the service. Written information was available in different languages, braille, easy-read and large font on request. Staff arranged for an interpreter or signer to attend the service if required, often within a day. The provider's website also used assistive technology software that added text-to-speech functionality for people with a visual impairment or issues with literacy.

Listening to and learning from concerns and complaints

Each of the three sites had complaints and comments cards and boxes in their reception areas. There were also posters on noticeboards informing the people who used the service how to make a complaint or raise a concern.

Staff protected patients that had raised complaints or concerns from discrimination or harassment. Where possible, complaints and concerns about staff were dealt with through discussion and mediation between the associated parties. If the complaint related to a dispute between clients, notes were made on each clients' care records and appointments were scheduled so that the clients attended the service at different times.

The provider had a complaints procedure which was accessible to all staff via the provider's intranet. Staff we spoke with knew how to handle complaints effectively.

We reviewed two complaints and found they had been appropriately investigated in accordance with the provider's policy. There had been several complaints from clients about the supply of a type of needle which they had found difficult to use. The complaints were investigated and upheld and because of lessons learned, the issue had been raised with the supplier and clients received advice about the safe use of the needles. The results of the investigation were posted on 'you said, we did' noticeboards in each of the service's reception areas.

Are substance misuse services well-led?

Requires improvement

Leadership

Leaders within the service provided clinical leadership. The Head of Service and Clinical Lead employed by the service's partner agency, together with nursing colleagues based within the recovery centres provide day to day clinical expert resource to recovery staff, in relation to prescribing, physical and mental health concerns/issues. There are four non-medical prescribers in team leadership roles within the service, who provided leadership and resource to the service, staff and client group.

Leaders had sufficient skills, knowledge and experience to perform their roles. Senior managers within the service had worked in substance misuse between 18 and 30 years respectively, the Office for Standards in Education, Children's Services and Skills corporate services, probation, the NHS, charitable organisations and criminal justice. They were experienced in setting up new systems, governance, information technology, people management and communications.

The service had a clear definition of recovery. This was to support people affected by substance misuse, helping them to understand that recovery is for life, that recovery starts as soon as the client steps through door, identifying what success looks like for the client as an individual, agreeing client realistic and achievable goals and milestones for the client, devising appropriate relapse prevention work and strategies and ensuring there were suitable accessibility standards in place for clients and their carers and families.

Leaders had a good understanding of the services they managed. As standard, leaders received reports of referral receipts, structured treatment, National Drug Treatment Monitoring System data, training needs for staff, performance reports, minutes of team meetings, integrated governance information, performance management data, quarterly targets around successful treatment outcomes and caseload monitoring.

Staff who spoke with us said that leaders were visible within the service and were approachable to patients and

staff. During our inspection visits, we noticed that senior managers knew clients by name and spoke to them in a friendly and down to earth manner which the clients clearly appreciated.

Vision and strategy

Humankind's vision was to envisage a compassionate society where the inherent value of every person is recognised, where families are healthy, and communities where everyone can prosper. Its values were service, integrity, teamwork, excellence, developing potential and diversity. These were understood by staff and formed part of discussions during supervision and appraisal sessions.

Staff who spoke with us had the opportunity to contribute about the strategy for the service and had job descriptions. Staff raised their ideas in relation to the strategy of the service during team meetings and flash meetings which were short, focussed meetings to discuss any progress and developments. Leaders confirmed staff had been vocal about the level of change they had faced since Humankind took over as the provider and this level of change had, as a result, been included on the provider's risk register.

Culture

Staff felt respected, supported, valued and part of the organisation's future direction. They felt proud to work within the service and in making a difference to the lives of people affected by substance misuse. Staff felt teams worked well together and managers were proactive in dealing with any issues. However, staff were stressed, unsettled and expressed anxiety over the constant changes of provider and were worried about having to potentially go through the process again in 2020.

Managers within the service monitored staff morale, stress, sense of empowerment and job satisfaction via attending team meetings and flash meetings which were short, focussed meetings to discuss any progress and developments, supervision and appraisals. The service had recently run a survey around the staff transfer arrangements from the previous provider to Humankind and were due to review the responses at the time of our inspection visit.

The provider recognised staff success within the service. Staff had received or been nominated for awards, there was an employee of the month initiative in place and managers sent thank you cards to individuals for good standards of work.

There had been no cases of bullying, harassment and discrimination lodged since the service's contract had begun in February 2018.

The provider promoted equality and diversity in its day to day work and provided opportunities for career development. Humankind had held the Equality North East 'Equality Standard Gold Award' since 2012. The application and accreditation process of this award required Humankind to provide and evidence examples of its practical approach to promoting equality and diversity. An example included promoting the Show Racism the Red Card campaign across services and teams. The service had adapted its delivery model in response to the 2016 NHS Accessible Information standards, included text-to-speech software within its website and its marketing literature was accessible to people with dyslexia, literacy issues, visual impairments and people for whom English was not a first language.The service had its own equality and diversity champion.

Humankind's staff performance, supervision and training policies referred to the provider's commitment to actively supporting team members to develop skills both within their current role and equip staff to progress to other roles within the organisation. This included progression within its organisational management structure and progression in specialist skills and knowledge areas. Annual appraisals forms included notes of discussions for each staff member's future career plans which were used in the development and delivery of personal development plans. The provider had a directory of training courses to help develop and enhance the staff member's personal effectiveness within their role and support career progression.

Staff had access to support for their own health and wellbeing. There was a staff wellbeing and support team within the organisation which provided staff who were encountering feelings of low mood, stress, anxiety, isolation, difficulty coping or reduced self-esteem with initial support, self-help strategies and signposted staff to appropriate services for professional help.

Requires improvement

Substance misuse services

Governance

Overall, governance structures within the service were effective. For example, staff supervision took place regularly, internal audits were carried out by staff, patients and carers were happy with the service they received and arrangements were in place for when there were concerns about clients' mental capacity.

However, we identified significant gaps relating to the care and treatment of patients in the service's care records such as evidence of discharge planning, equality and diversity information, dependency on alcohol and clients' strengths and goals. The care records system had been inherited from the previous provider and the service had been mandated to use it by the commissioning authority. The service had completed an internal audit had identified the need to address the issues. Following the audit, the service had built in trackers into the system to identify gaps and quality issues, had developed a rapid action plan and wider service development plan two months prior to our inspection and were planning to implement plans within the next month. Managers had also undertaken quality reviews of caseloads. As a result, best practice guidance and further support had been given to staff on the completion of care records. The service was developing a working party from all three services to focus on improving the system and further supporting staff in its use.

The provider had developed a performance management procedure for both its own staff and those in its sub-contracted partner agencies. This included routine performance review and expectations and governance information to support effective oversight. The provider's quality team completed inspections of the service. These included a review of the partner agencies clinical provision, including processes for clinical waste procedures, prescription handling and infection control. The service had tracking information in place, the results of which were fed back in team meeting and used to motivate staff and highlight performance achievements.

The provider had reviewed its policies, procedures and protocols and we saw evidence that these had been subjected to equality impact assessments to ensure they did not discriminate or place vulnerable groups or people with protected characteristics under the Equality Act 2010 at a disadvantage.

We saw standard agendas for team and management meetings. These included communication, caseload management, safeguarding, deaths, incidents, complaints and concerns, the Mental Capacity Act and general advice regarding best practice and service consistency. This ensured that there was a clear expectation of what needed be discussed in meetings at team and directorate levels within both Humankind and its partner agencies.

Staff implemented recommendations and learning from the reviews of deaths, incidents, complaints and safeguarding alerts. For example, lessons learned from death in service reviews included the need to ensure that staff recorded information about the involvement of other services in clients' care and treatment in their care records and engaged with clients when they were inpatients in acute hospitals.

Staff undertook and engaged in local clinical audits. These included an internal inspection and infection control audit at each of the three sites. The infection control audits identified the need to remind staff to dispose of sharps bins every three months.

Staff submitted data and notifications to external bodies and internal departments when required. We saw evidence that information regarding incidents was shared routinely with interested parties and safeguarding alerts were made to local safeguarding teams.

The service had clear pathways, protocols and referral systems in place so staff could easily identify the arrangements for working with both internal teams and external services. For example, the service had a service level agreement in place with the local mental health trust so staff in both organisations knew each other's ways of working, responsibilities and expectations.

The provider had a whistleblowing policy in place. This was accessible to all staff via the provider's intranet.

Management of risk, issues and performance

There was a clear quality assurance management and performance frameworks in place integrated across all organisational policies and procedures. Policies had been recently reviewed to ensure they met with the provider's quality and performance expectations.

Staff maintained and had access to the provider's risk register. Items on the risk register included the transition of premises following the closure of the Newton Aycliffe site,

the level of change staff had faced within the service and its impact on morale and new ways of working towards CQC fundamental standards. Staff confirmed these concerns matched those that they had and had raised with managers within the service.

The service had its own business continuity plan. This included the arrangements and procedures for emergency situations such as adverse weather conditions and loss of systems and premises.

All but two staff within the service had a current Disclosure and Barring Service check in place. However, applications for these two staff to be checked were underway and risk assessments and supervision structures were in place to monitor their conduct and practice within the interim period. The service had systems in place which enabled managers to monitor sickness absence rates. They were aware that some staff sickness absence was due to work related stress following the change of provider and resultant high level of change it brought for staff.

The service had not been asked to make any efficiency savings and there was no issue with client care being compromised by budget levels.

Information management

The service's systems used to collect data from facilities and directorates were not over-burdensome for staff. Staff felt the information systems and equipment they used were sufficient in allowing them to carry out their roles. However, staff commented that they found the structure of the provider's care records system, which the service had been mandated to use by the commissioning authority, was sometimes difficult to navigate around and was frustrating and there were issues with receiving information from external organisations following referrals and transfers.

Staff had received information governance training. This included the need to maintain clients' confidentiality and other issues associated with data protection.

As standard, team managers received information to enable them to carry out their role. This included staff training and development needs, complaints and concerns, performance data, minutes of team meetings and information about clients' progress and treatment outcomes. Managers confirmed the information was in an accessible form, was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies and internal departments when required. We saw evidence that information regarding incident was shared routinely with interested parties and safeguarding alerts were made to local safeguarding teams. Notifications were also sent to the Care Quality Commission such as unexpected deaths of clients.

The service was in the process of becoming a paperless office. The only information relating to clients that was paper format was consent to treatment forms and confidentiality agreements which needed to be hand signed by clients but these were scanned onto the care records system and the paper form was subsequently destroyed. The electronic care records system was secure and required staff to enter a username and password to access it.

The service had service level agreements with external organisations. It was looking to improve information sharing with other organisations as staff had reported issues with the quality of information they received following the referral or transfer of clients from their previous care provider.

Engagement

Staff, and the people who used the service had access to up to date information about the service and wider provider. Staff received messages about the latest developments in team meetings, flash meetings which were short, focussed meetings to discuss any progress and developments and via email and the provider's intranet. The people who used the service received information on noticeboards and during discussions with their recovery co-ordinators.

The people who used the service had opportunities to give feedback on the service they received. Each of the three services had comments cards and boxes in the reception area and received feedback via 'you said, we did' boards or, if they had lodged a complaint, on an individual face to face basis. The lead practitioner at the service was developing service user focus groups to give the people who used the service further opportunities to provide feedback and ideas for improving the service. The provider

had also enabled people who used the service to give feedback via a sub-contracted self-help charitable organisation that was run by people affected by substance misuse themselves.

The Durham service was running bi-monthly meetings with residents in the area which was attended by commissioners in response to initial opposition of the site. These meetings had helped to alleviate the residents' concerns. Staff were providing on-campus interventions and advice to students at the local university and went into all colleges within Durham University to raise awareness of issues associated with alcohol misuse. The service also worked in other colleges within County Durham to raise awareness of drug and alcohol issues. The service was involved in area action partnerships. These partnerships allow people to have a say on services, and give organisations the chance to speak directly with local communities. Three staff members from the service attended related events and provided training and advice about substance misuse. Staff also attended the police crime and victims commissioner's office to provide advice to attendees about substance misuse.

Learning, continuous improvement and innovation

The service had identified the need for clients who had taken an overdose to have access to naloxone and at the time of our inspection, there were ongoing discussions with the police about the possibility of supplying local police stations with the medication so that custody staff could administer it to people who had suffered an overdose.

The service's health, outreach, prevention and engagement team had been proactive by engaging with external organisations such as primary healthcare services, criminal justice services and the police to ensure people with alcohol or drug addictions were made aware of the service and were referred for care and treatment. The service also provided gloves and scarves to homeless people.

The service had been awarded an Investors in People accreditation. It was also working towards being accredited with a Better Health at Work award.

The service monitored the impact of changes upon its staff and service delivery. The level of change faced by the service was included on the provider's risk register and was regularly discussed in team and senior management meetings.

Staff who spoke with us confirmed their objectives focussed on improvement and learning. Staff were given opportunities to undertake tasks that would enhance their skills, experience and help with their career progression.

The service had staff award and recognition schemes. There was an employee of the month initiative in place and managers sent thank you cards to individuals for good standards of work.

Outstanding practice and areas for improvement

Outstanding practice

Clients told us that staff at the service went the extra mile. Staff drove clients to see their GPs which meant they did not need to rely on public transport and supported them during their consultations and actively helped to find homeless clients accommodation.

The provider held the Equality North East 'Equality Standard Gold Award' since 2012. One of the initiatives that led to this award being given was the provider's promotion of the Show Racism the Red Card campaign across services and teams.

The service had adapted its delivery model in response to the 2016 NHS Accessible Information standards to make information accessible to people with dyslexia, literacy issues, visual impairments and for whom English was not a first language.

The Durham service ran bi-monthly meetings with residents in the area which were attended by commissioners in response to initial opposition of the site. These meetings had helped to alleviate the residents' concerns. Staff were providing on-campus interventions and advice to students at the local university and went into all colleges within Durham University to raise awareness of issues associated with alcohol misuse. The service also worked in other colleges within County Durham to raise awareness of drug and alcohol issues.

The service was involved in area action partnerships which allow people to have a say on services, and give organisations opportunities to speak directly with local communities. Three staff members from the service attended related events and provided training and advice about substance misuse. Staff also attended police crime and commissioner events to provide advice to attendees about substance misuse.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clients have person-centred and holistic recovery plans which are recorded and contain up to date information necessary to deliver safe and effective care and treatment. This must include information about the level of the client's alcohol or drug dependency, multidisciplinary team's input into reviews of care and treatment, the client's motivation to change, strengths and goals, harm reduction advice, discharge planning and any equality and diversity considerations as part of the client's care and treatment.
- The provider must ensure all clients have regular risk assessments, risk management plans are created to mitigate risks identified which are regularly reviewed, updated and recorded.
- The provider must ensure all staff are up to date with all elements of their mandatory training.

Action the provider SHOULD take to improve

- The provider should ensure that all clients are routinely involved in decisions about their care and treatment such as reviews of their recovery plans.
- The provider should ensure that consent to treatment and confidentiality forms are saved correctly within care records to make them easily accessible for staff when they need them.

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 Three care records did not include risk assessments or risk management plans for clients and one risk assessment was not up to date. Four care records did not contain evidence that staff had provided the clients with harm reduction advice. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Staff did not record sufficient information about clients who used the service. Omissions included recovery plans, equality and diversity information, clients' strengths, goals and motivation to change, alcohol dependency and discharge planning. We also found care records were neither person-centred nor holistic and were written using generic language. Regulation 17 (2) (a) (b) (c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The mandatory training compliance figures for e-learning (65%) and the Mental Capacity Act (84%) were below the provider's target of 85%. The e-learning training included modules on information governance,

This section is primarily information for the provider

Requirement notices

equality and diversity and records management and we found issues in relation to these areas within clients' care records so the fact training compliance was low was impacting on the quality of care records.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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