South Regional Office

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated South Regional Office as good because:

- At the last inspection in May 2017, we told the provider it must make improvements and notify the Care Quality Commission (CQC) of all client's deaths (as per regulatory requirements). On this inspection the service demonstrated that it had been providing notifications appropriately. The service had regional quality leads who were responsible for ensuring CQC statutory notifications were submitted.
- Lead nurses conducted monthly clinical site audits to check site cleanliness, safe medicine storage and prescription administration records that were ratified by senior managers. Action plans were then devised and followed up if issues were noted.
- The service had an appropriate number and mix of staff with relevant knowledge and qualifications to fulfil their role. All staff working at the service, including volunteers, had valid Disclosure and Barring Service checks completed before commencing work.
- Staff completed comprehensive assessments of every client at their initial appointment and had appropriate admissions criteria in place to support suitable clients. Assessments included substance misuse history, medical history, safeguarding issues, employment and social history. Staff undertook a comprehensive risk assessment of every client at their initial assessment and regularly updated them as necessary. Care and recovery plans were mostly goal orientated, holistic and included client views and wishes.
- Clients' physical health conditions were considered as part of initial assessments and regularly reviewed. Blood borne virus testing and vaccination programmes were conducted at all sites.
- The service utilised a duty system with emergency appointments available and had staff members assigned and available for open access drop-in clients daily.
- The service had a safeguarding policy in place and staff demonstrated a good awareness of the safeguarding procedure.
- Staff spoke about clients in a sensitive, caring and professional manner. Clients were very positive about the service they received and said that staff took a genuine interest in their wellbeing.
- The service had a clear confidentiality policy in place that staff adhered to and explained to clients during the assessment process.
- The service had an appropriate 'did not attend' policy in place and a missed appointment tool that team managers reviewed before any unplanned discharges were made.
- Staff demonstrated an understanding of the potential issues facing vulnerable client groups and the service employed specialist staff to support these groups.
- Service leaders had the appropriate skills, knowledge and experience to perform their roles and could explain the role and function of their teams well. All management staff received in-house leadership development training.
- There was a clear clinical governance structure in place to ensure that clinical risk was escalated and managed within the service. The service held local integrated governance team meetings that fed into an overarching national integrated governance team meeting where service quality improvement plans were also monitored.

However,

- Overall appraisal rates for all inspected sites were below 65% completion but the service had plans in place to address this.
- In Gloucester, five of the eight care records reviewed did not include client views and it was not clearly documented if clients received or were offered a copy of their recovery plan.
- The Southampton site was not accessible to disabled clients. There was no access to the 1st and 2nd floors where groups were held and the emergency cord in the disabled toilet was too short to reach.

Summary of findings

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Good

South Regional Office

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Summary of this inspection

Background to South Regional Office

South Regional Office, commonly known as Change, Grow, Live, is a substance misuse service providing community substance misuse treatment and care from 15 sites across the southern region of England. For this inspection we inspected four of the sites: Gloucester, Southampton, Hastings, Eastbourne.

South Regional Office was registered with the Care Quality Commission (CQC) in 2015 for the treatment of disease, disorder or injury. The sites we inspected offered a range of groups, one to one sessions, alcohol detoxification and substitute prescribing for opiate detoxification. The service has two registered managers: responsibility for the sites was split between them.

The four sites we inspected were commissioned by East Sussex (Eastbourne and Hastings), Gloucestershire (Gloucester) and Southampton local authorities. The service provide specialist community support for adults affected by drug and alcohol misuse. South Regional Office also offers support and information to friends and family members affected by someone's drug and alcohol use. At the time of our inspection, the four sites were providing care and treatment to 3426 clients.

CQC last inspected the service in May 2017. This was a focused inspection to see if the provider had made the improvements that we told it that it must make in October 2016. These included:

- Ensuring that all staff received mandatory training.
- Ensuring that all staff received regular supervision.
- Ensure that all staff renewed their disclosure and barring service checks in line with the provider's policy.
- Ensuring that all clients had an up to date risk assessment.
- Ensure there was a sink in the doctor's clinic room in the Chichester service.

At the inspection in May 2017 we found that the provider had made improvement in all of these areas. However, we told the provider it must:

- Notify Care Quality Commission (CQC) of all clients' deaths (as per regulatory requirements).

At this inspection (September 2018) we found the provider had made the required improvements and were now notifying CQC appropriately

Our inspection team

The team that inspected the service comprised of five CQC inspectors and two specialist advisors with experience of substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

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

During the inspection visit, the inspection team:

- visited four sites, looked at the quality of the environment and observed how staff were caring for clients;
- looked at the clinical environment for each site and the maintenance of medical equipment;
- spoke with one director, two service managers, four team leaders and four other senior leaders;
- spoke with 22 other staff members including doctors, nurses, non-medical prescribers, social workers, students and admin staff;
- spoke with three clients and attended three client appointments (with their permission);
- attended three morning meetings and two clinical meetings;
- observed two group therapy sessions;
- looked at 23 client care records;
- carried out a specific check of the medicine management at all sites;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients we spoke with were extremely positive about their experience and the impact the service had on their lives. Some clients commented that the service was invaluable to them. All clients stated that staff were respectful and polite and that they did not feel judged when using the service.

Clients felt that staff were always available when needed and that they could access the service at short notice. Clients told us that staff helped them understand their drug and alcohol use and always felt welcome in the service.

Clients stated that they had access to appropriate group and individual therapy sessions that felt well run and were well facilitated.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- At the last inspection in May 2017, we told the provider it must make improvements and notify the Care Quality Commission (CQC) of all clients' deaths (as per regulatory requirements). On this inspection the service demonstrated that it had been providing notifications appropriately. The service had regional quality leads who were responsible for ensuring CQC statutory notifications were submitted.
- The service had dedicated clinic rooms to undertake physical examinations. All rooms contained the necessary equipment required to carry out basic examinations and were appropriately maintained and calibrated.
- Senior management conducted monthly clinical site audits to check site cleanliness, safe medicine storage and prescription administration records. Action plans were then devised and followed up if issues were noted.
- The service had an appropriate number and mix of staff with relevant knowledge and qualifications to fulfil their role. All sites had at least one qualified nurse and all staff had valid Disclosure and Barring Service checks completed before commencing work
- Staff undertook a comprehensive risk assessment of every client at their initial assessment and regularly updated them as necessary. The service monitored risk assessments for quality and regularity.
- The service utilised a duty system with emergency appointments available and had staff members assigned and available for open access drop-in clients daily.
- The service gave practical and efficient harm minimisation advice to clients and utilised drug screening urinalysis and alcohol breathalysers to aid treatment decisions.
- Clients' physical health conditions were considered as part of initial assessments and regularly reviewed.

Summary of this inspection

- The service had a safeguarding policy in place and staff demonstrated a good awareness of the safeguarding procedure. Safeguarding adults and children mandatory training module had an overall completion rate of 89% across the sites inspected.
- The service had good medicines management procedures in place and all sites had non-medical prescribers in post, in addition to consultants.
- The service used an electronic incident reporting system in which all staff members could access and submit incidents.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments of every client at their initial appointment. Assessments included substance misuse history, medical history, safeguarding issues, employment and home life.
- Medical assessments conducted by the service doctors was very thorough and detailed.
- National institute for health and care excellence guidance (CG51) on detoxification and psychosocial interventions was followed when assessing treatment need and prescribing medicine at the service.
- The service had pregnancy liaison workers in post at each site and an appropriate policy to ensure safe prescribing for pregnant clients.
- Care and recovery plans were mostly goal orientated, holistic and included client views and wishes.
- Blood borne virus testing and vaccination programmes were conducted at all sites.
- The service offered psychosocial interventions with peer support counsellors at every site and developed good links with a wide range of external partners to offer a greater number or support networks and groups.
- All staff were fully inducted to the service and given a staff induction handbook and specialist training was available to staff at the service.
- The service had effective joint working protocols in place for the shared care of people who used their service.

However,

Summary of this inspection

- Overall appraisal rates for all inspected sites were below 65% completion but the service had plans in place to address this.

Are services caring?

Good

We rated caring as good because:

- Staff spoke about clients in a sensitive, caring and professional manner. Clients were very positive about the service they received and said that staff took a genuine interest in their wellbeing.
- Clients felt involved in developing their care plans and felt ownership over their recovery.
- Staff supported clients to access other services when appropriate.
- The service had a clear confidentiality policy in place that staff adhered to.
- Clients had access to independent advocacy services at all sites.
- There was suitable carer and family member support available with carer groups and one to one sessions if required. Feedback on sites were sought from clients, carers and family members in an array of forums.

Are services responsive?

Good

We rated responsive as good because:

- All referrals were processed and clients contacted within three working days. Clients were offered assessments within a week of contact and higher risk clients were prioritised.
- The service had an appropriate 'did not attend' policy in place and a missed appointment tool that team managers reviewed before any unplanned discharges were made.
- All sites had a range of appropriate rooms to support the delivery of care and treatment in groups and individual therapies.
- Staff demonstrated an understanding of the potential issues facing vulnerable client groups and the service employed specialist staff to support these groups.
- The service developed an equality dashboard to provide local sites with a demographic breakdown of their workforce and clients for the protected groups of gender, disability, ethnicity and sexual orientation.

However,

Summary of this inspection

- The Southampton site was not accessible to disabled clients. There was no access to the 1st and 2nd floors where groups were held and the emergency cord in the disabled toilet was too short to for disabled clients to reach.

Are services well-led?

Good

We rated well-led as good because:

- Service leaders had the appropriate skills, knowledge and experience to perform their roles and could explain the role and function of their teams well. All management staff received in-house leadership development training.
- Staff were aware of and could explain the visions and values set by the provider. Staff reported that morale was good amongst teams and that they felt respected and well supported. Staff were encouraged to participate in a weekly 'wellbeing hour' to support any work-related stress.
- The provider encouraged staff to participate in a weekly 'wellbeing hour' to support staff with any work-related stress.
- The service had a clear definition of client recovery that was shared and understood by all staff. The service empowered clients to take ownership of their recovery.
- There was a clear clinical governance structure in place to ensure that clinical risk was escalated and managed within the service. The service held local integrated governance team meetings that fed into an overarching national integrated governance team meeting where service quality improvement plans were also monitored.
- Team managers had an online dashboard that displayed relevant team information to support them in managing their teams.
- Staff opinion and support for change was gathered through consultations and group input when change was discussed within the service.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service implemented a Mental Capacity Act (MCA) policy that was readily available to staff for guidance and advice.

The service had an appointed MCA lead who staff were aware of. Mental Capacity Act training formed part of staff mandatory training. The service offered two modules of MCA training and all locations inspected had above 83% overall compliance rate.

Staff demonstrated an understanding of the MCA. If clients attended appointment intoxicated or under the influence of drugs, the appointment was re-arranged. This was to ensure clients had the capacity to make an informed choice regarding their treatment.

The service had a brief guide on the MCA that was displayed in teams that staff could refer to for information at a glance.

Good

Substance misuse services

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

Are substance misuse services safe?

Good

Safe and clean environment

- All staff carried personal alarms and response teams were assigned during the morning meetings at each site.
- The service had dedicated clinic rooms which were used to undertake physical examinations. All rooms contained the necessary equipment required to carry out basic examinations such as drug and alcohol screening, vaccinations and blood borne virus testing. Staff completed daily fridge monitoring checks.
- Some sites had electrocardiogram (ECG) machines. An ECG is a test which measures the electrical activity of the heart to show whether it is working normally. The ECG machines were appropriately maintained and ready for use.
- Medical equipment requiring calibration was all up to date and calibrated as required at all sites.
- Senior management conducted monthly clinical site audits to check site cleanliness, safe medicine storage and prescription administration records. Following each audit, action plans were drawn up locally and followed up regularly by the deputy director of nursing for each region.
- All areas that clients accessed were clean, comfortable and well maintained. External companies provided cleaning services at each site and we saw evidence that this was thorough and regular. Where service managers were not satisfied with the standard of cleaning, meetings were arranged to ensure standards improved.
- The service demonstrated evidence of safe storage, handling and removal of clinical waste with a weekly collection by an appropriate external company.
- Fire risk assessments and health and safety assessments were up to date at all sites.

Safe staffing

- The service had an appropriate number and mix of staff. These included consultant psychiatrists, speciality doctors, non-medical prescribers, nurses, care coordinators, programme workers, hospital liaison workers and peer support volunteers/counsellors. We also saw evidence of secondments into the service from social services at the Southampton and Gloucester sites. There were sufficient numbers of staff on duty with appropriate senior support throughout the service's opening times.
- Where sites carried vacancies, we saw appropriate cover in place to ensure ongoing client safety and care. Additionally, the service was actively recruiting to posts. In Southampton, the team were without a team manager due to sickness. This role was being fulfilled by a director who was also a registered manager and the Gloucester team manager.
- The overall staff turnover rate for South Regional Office was 22%. The east Sussex service were below this rate with 16% turnover, Gloucester with 22% and Southampton had higher rates of 45%.

- Caseload numbers varied across the service. Some staff had capped caseloads of 30-50 with higher risk clients, whilst other staff members held caseloads of 100.
- The service had previously re-modelled to a care coordination model with the differing sites now all operating within this model. This meant that teams were split into care coordinator teams, programmes teams and clinical teams. The programmes teams undertook most group and induction sessions alongside initial assessments and clients were assigned to care coordinators during the following morning meeting. Care coordinators helped navigate clients through their treatment journeys with appropriate referrals for medical reviews, psychosocial groups and/or external programmes amongst other functions. This meant that care coordinators undertook fewer one to one sessions and shared responsibility for their clients care amongst other roles and professionals. Staff reported that whilst there was some anxiety about the greater caseload numbers, there was appropriate training and support put in place to ensure they were manageable.
- We saw recruitment plans across the service for soon after our inspection. This was intended to reduce caseloads, whilst additionally bringing in additional peer support workers for the Southampton site.
- All staff working at the service, including volunteers, were required to have Disclosure and Barring Service checks completed before commencing work. We saw evidence that these were all up to date and renewed every three years, in line with service policy.
- The service implemented a business continuity plan to ensure client continuity and safety in the event of emergencies to staffing or premises for example.
- There were arrangements in place to cover staff leave with assigned duty and open access staff each day to account and cover for staff sickness.
- Mandatory training levels amongst the sites we visited ranged from 89% to 93% overall compliance rate. This included all members of staff, volunteer and student mandatory training.
- In East Sussex (Eastbourne and Hastings), the overall mandatory training compliance rate was 93%, In Southampton this was 89% and Gloucester was 92% No mandatory training modules at any inspected service was below 75% completion.
- The service had a lone working policy in place and all staff were aware of the policy guidance and adhered to it. Where home visits were scheduled, two members of staff mostly conducted the visits
- Mandatory training included Mental Capacity Act 2005 training and the service had a 83% overall compliance rate.

Assessing and managing risk to clients and staff

- Staff undertook a risk assessment of every client at their initial assessment. The risk assessment policy stated that a review of each client's risk must be made at least every three months, unless circumstances changed or incidents occurred when it should be reviewed earlier. We reviewed 23 care records and found all to have a current and up to date risk assessment in place. Risk assessments considered a range of risks including substance use, mental health, physical health and safeguarding. Risk management plans included risk indicators, triggers and protective factors.
- A risk and care plan tracker was in place in the service and maintained by the data analyst team. The tracker captured the date of client's current risk assessment, previous review date and included a formula that flagged in red to identify any overdue reviews. The service undertook regular care and risk plan audits based on the data and the data lead provided weekly updates to service managers.
- The service used a risk profiling tool as part of the initial assessment process to ensure that clients at a greater risk of harm were identified quickly and managed appropriately. Using this tool, staff identified those clients who needed to be discussed in clinical safeguarding meetings and required more urgent medical reviews.
- At all sites there were morning briefing meetings in teams to discuss immediate risk and planning for the day. These were appropriately recorded and shared with staff to ensure all staff were aware of the days plan and duty arrangements.

Good

Substance misuse services

- The service utilised a duty system with emergency appointments available and had staff members assigned daily and available for open access drop-in clients.
- We saw evidence of practical and efficient harm minimisation advice given to clients who were made aware of the risks of continued substance misuse and reduced tolerance when treatment commenced. In the Gloucester and Southampton sites we saw that this was delivered by a non-caseload holding health care assistant, following consultation with staff on how best to deliver the advice.
- The service utilised drug screening urinalysis prior to prescribing medicines. Drug screens were used during treatment to ensure clients were not using any other drugs on top of prescriptions. Once clients proved they were stable and not using any illicit drugs, staff undertook risk assessments to determine if clients were ready to have regular prescriptions to take home and self-dose. Additional home visits were conducted for clients identified with children in the home.
- Prior to prescribing alcohol detoxification medicine, the service also undertook alcohol breathalyser tests and completed alcohol screening tools to ensure suitability and client safety when prescribing.
- All sites had strong links to local domestic abuse multi agency teams to assess and monitor clients at risk of violence and abuse in their relationships. Staff attended Multi-Agency Risk Assessment Conference (MARAC) meetings where appropriate.
- Clients' physical health conditions were considered as part of initial assessments and regular review appointments to monitor physical health. The service undertook basic physical health monitoring such as weight and blood pressure and also offered blood borne virus vaccinations and a needle exchange clinic. All sites employed a full-time health and wellbeing nurse to undertake and support monitoring of physical health assessments.
- All sites had emergency adrenaline and naloxone available for use. Naloxone is an antidote to an opioid overdose. Staff completed regular checks to make sure that medicines were in date. Emergency medicines were kept in staff offices and in locked clinic rooms. Staff trained and dispensed it to family members, carers and clients who were at risk of opiate overdose in the community. They were also able to administer it to clients in active overdose on site. Staff requested that clients brought their naloxone with them to every appointment to ensure that it was still in date and safe to use.

Safeguarding

- The service had a safeguarding policy and staff demonstrated a good awareness of the safeguarding procedure. All sites had a dedicated safeguarding lead for advice and support and in Southampton this was a social worker, seconded from the local authority.
- In Hastings, the team was co-located with the local authority adult social care team who also attended morning meetings at the service to facilitate effective liaison.
- Staff knew what to do if a safeguarding concern arose and gave examples of possible signs of abuse of a client such as changes in behaviour, bruising, wounds and self-neglect. We saw examples of staff acting appropriately and demonstrating good communication with external agencies where there were safeguarding concerns,
- Regional safeguarding meetings were held monthly and attended by the safeguarding leads for each site. Local specialist midwives also attended these meetings when appropriate in addition to pregnancy leads in the service. Safeguarding leads disseminated any learning from these meetings to their local teams.

Staff access to essential information

- The service utilised an electronic care records system. All client records were kept electronically and any correspondence was uploaded onto the system.
- All staff, including agency staff, had secure access passwords to the electronic care records system.
- Tablets were utilised within the service to ensure live updates and minutes were recorded during multi-disciplinary meetings, team meetings and safeguarding meetings.

Medicines management

Good

Substance misuse services

- The service had a medicines management policy that staff adhered to with appropriate reconciliation and stock taking of emergency medicines.
- The service held emergency adrenaline and naloxone for trained staff to use in the event of an opioid overdose and these were appropriately stored and accessible in an emergency.
- There was appropriate recording for medicines with medicines management audits undertaken monthly. Audits fed into quarterly organisational medicine management meetings. The service also had a holiday script checklist for staff to follow to ensure safe prescribing for clients who were going on holiday.
- All fridges and clinic rooms containing medicines and vaccines were locked. The service did not handle or store any controlled drugs. Staff carried out daily fridge and ambient clinic room temperature checks and records we reviewed showed that they were all within correct ranges.
- All sites had non-medical prescribers in post, in addition to consultants. This meant that there was increased access to prescribing interventions for clients of the service. Non-medical prescribers are healthcare professionals who have undertaken additional training and qualifications in order to be able to independently prescribe from a limited formulary of medicines.
- If clients missed prescribed opiate substitute medicine for three to five days, there was an appropriate procedure in place for staff to follow up with service users and discuss re-titration of therapeutic doses with the prescriber. After five days, a client's prescription was terminated, the pharmacy was informed of the service's action and the client was invited to re-engage with the service for a medical review. This ensured all sites continued to engage their clients and managed their risks.
- Staff at the service sought consent from clients to receive medical summaries from the clients GP's, in order to appropriately reconcile medicine on commencement of treatment.
- The physical health of clients was monitored regularly when undertaking an opioid or alcohol detoxification. Clients additionally underwent an initial period of supervised prescription consumption for newly prescribed medicines and we saw good liaison with partner agencies to reduce the risks of 'double scripting' or diversion of medicines. This is when clients are involved in the transfer of any legally prescribed controlled medicines from the individual for whom it was prescribed for, to another person for illicit use.
- We reviewed documentation where considerations were given to those clients with children at home and the use of lockable storage boxes given to clients to safety store medicines.

Track record on safety

- The service reported 457 incidents at the four sites inspected for the previous 12 months. The Hastings service reported the most incidents with 161 and Eastbourne reported the least with 89 incidents. Incidents varied in degree of severity from 'no harm' to 'moderate' or 'severe' harm. The data received from the service did not specify incident level details.
- No serious incidents were reported from the sites for the past 12 months.

Reporting incidents and learning from when things go wrong

- At the inspection in May 2017 we found that the provider was not notifying the Care Quality Commission CQC of client deaths. On this inspection, the service evidenced notifications of client deaths that were passed onto the CQC. There was an appropriate monitoring and recording system in place to ensure that all parties were notified and actions taken following any client deaths. The service had regional quality leads who were responsible for ensuring CQC statutory notifications being submitted.
- The service implemented an incident reporting policy that staff were aware of and followed. Staff gave good examples of what to report and could explain the process clearly.
- The service used an electronic incident reporting system in which all staff members could access and submit incidents. Staff were aware of what required reporting and we saw evidence that incidents were appropriately investigated and followed up. All managers at the service had received root cause analysis training to ensure better understanding and learning from incidents within teams.

Good

Substance misuse services

- The services quality and governance team supported the collation and analysis of incident data to determine trends, learning outcomes and areas of risk at national, regional and local service level. Quarterly reports were submitted to the service board, integrated governance and reducing mortality committees. At a local level, the analysis and learning was shared and discussed via local integrated governance team meetings. Service managers could access an online dashboard that displayed real time incident data to identify emerging themes and patterns.
- The service evidenced discussions and learning from incidents as an agenda item when required in weekly team meetings and monthly integrated governance team meetings in addition to supervision records and monthly service bulletins. We saw learning from different regional sites being discussed across the service.
- Incidents discussed within integrated governance team meetings were considered from each perspective of the client, the staff and the stakeholder perspectives to generate appropriate actions and learning from each incident.
- In Gloucester the teams recently role-played a previous serious incident that occurred on the premises to re-live the situation and reflect on how they reacted and managed the incident, to learn and better inform future practice.
- Staff understood the duty of candour responsibility and explained they were open and transparent to clients and families if things went wrong. The service had a thorough duty of candour policy and procedure and was considered as part of the incident reporting form.

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

Good

Assessment of needs and planning of care

- Staff completed comprehensive assessments of clients at their initial appointment. Assessments included substance misuse history, medical history, safeguarding issues, employment and home life. All records we reviewed contained thorough initial assessments and these were appropriately updated when necessary. Medical assessments undertaken at all sites were very thorough and comprehensive.
- Clients requiring alcohol detoxification and with alcohol related support needs, completed a severity of alcohol dependence questionnaire. This was a clinical screening tool designed to measure the presence and level of alcohol dependence.
- Care plans were developed based on the needs identified at initial assessment. All records we reviewed contained a client care plan that staff updated regularly.
- Care and recovery plans were mostly goal orientated, holistic and included client views and wishes across the service in line with national institute for care and health excellence guidance (QS14). However, in Gloucester we found that five of the eight care records reviewed did not include client views. Additionally, within Gloucester, it was not recorded if clients received or were offered a copy of their recovery plan.
- The service had recently moved towards a coordinator model of practice and principles. This meant there was a collective team responsibility for the care and treatment of clients with a designated case holding care coordinator. Treatment plans were developed with clients and shared with partners involved under information sharing agreements. In Eastbourne and Hastings, we saw agreements in place following client consent of information sharing between the service and local ambulance services for greater joint working.
- In Gloucester, the new model of care was supported by staff pod groups. each pod consisted of a range of staff with differing roles and skills including a clinical staff member, all of whom were seated within a workspace pod setup. This supported a team-shared approach to managing caseloads to alleviate staff anxieties around higher caseloads than the previous key working model by enabling staff to share risk, knowledge and strengths and reducing the likelihood of co-dependency on individual workers.
- Clients were discharged from treatment in a planned for way, however unexpected exit or crisis plans were not included as part of risk management or recovery plans. Of the care records reviewed, 18 (78%) did not include individual action plans for if clients unexpectedly exited

treatment. However, client risk and engagement was regularly visited in clinical team meetings and there was an appropriate re-engagement policy and missed appointment checklist in place. This policy and guidance was followed before any unplanned client discharge. Any unplanned discharges were reviewed by team managers against the discharge criteria to ensure that every effort had been made to re-engage clients.

- In Eastbourne, the service was piloting a 12-month scheme of 'remote consult'. This scheme was available for existing clients and those in crisis only. This was an outreach service whereby a member of staff phoned clients for a review or crisis intervention with a quicker response time than waiting for an appointment on site. Consultants also linked into calls where appropriate to offer support. Client feedback so far was largely positive, commenting that it was less intrusive and more responsive.

Best practice in treatment and care

- National Institute for Health and Care Excellence guidance (CG51) on detoxification and psychosocial interventions was followed when assessing treatment need and prescribing medicine at the service.
- We saw evidence that electrocardiogram scans were undertaken at least every six months for clients who were deemed to be on high doses of methadone (100mls or more) because of the increased risks associated with this.
- The service had pregnancy liaison workers in post at each site and an appropriate pregnancy policy to ensure safe prescribing for pregnant clients. These staff members worked closely with local hospitals and attended monthly meetings chaired by the family substance misuse team in areas this was functioning.
- The service offered ambulatory and home detoxification programmes to clients. Ambulatory detoxification was a group based community detoxification programme based on an outpatient model for clients requiring detoxification from drugs and alcohol. The service had a policy and procedure in place with relevant indications and cautions for staff to consider when considering ambulatory or home detoxification to clients with appropriate contraindications for their use.
- Where it was identified that clients required more intensive in-patient detoxification, there was a policy and referral procedure for care coordinators to follow.
- All sites offered an efficient needle exchange clinic for clients which was covered on a duty rota system in line with national institute for health and care excellence (QS23). A healthcare assistant was employed at the Gloucester site and two at the Southampton site to offer practical harm minimisation advice to clients. The needle exchange clinic aimed to offer information and advice on safer injecting, advice on preventing the transmission of blood borne viruses and a route for access to treatment.
- Blood borne virus testing and vaccination programmes were conducted at all sites. The service demonstrated evidence that this was considered and offered to clients from their initial assessment.
- The service offered psychosocial interventions with peer support counsellors at every site. There was a recovery programme in place offering one to one support and group sessions for clients based upon a programme with the foundations of 'Change, Grow, Live'. Each site worked with local external partners to offer additional psychosocial support groups.
- Client treatment and recovery outcomes were measured using Treatment Outcome Profile Screen (TOPS). Staff used the TOPS tool to measure change and progress in key areas of clients' lives such as substance use, mood, crime, social life, physical and mental health and quality of life. This tool was collated every 12 weeks and fed into monthly service performance meetings.

Skilled staff to deliver care

- All staff were fully inducted to the service and given a staff induction handbook. Staff had a period of shadowing before holding a gradually increasing caseload.
- All staff were suitably qualified and experienced at all sites. At Eastbourne, Southampton and Gloucester the teams had specialist staff working with sex workers and homeless clients, with an ongoing rough sleepers project in East Sussex. In Gloucester, they sub-contracted a street drinker outreach worker to engage this client group with the service.

- Mandatory training levels across the service were all above 75% for each module. Staff had access to an electronic dashboard that displayed their compliance with mandatory training. Where training was due to be renewed, an email was sent to the staff member and manager to prompt them to book onto the next course. Mandatory training was additionally discussed in all supervision sessions.
- Specialist training was available to staff at the service, for example pregnancy in substance misuse, safer injecting and suicide awareness. Professional development was discussed within supervision and where the need was identified, a range of training was provided both internally and externally. Additionally, the service offered an application for funding options for staff if an appropriate course was identified and justified based on the service needs.
- The service had a robust recruitment process and we saw evidence of appropriate qualification checks and Disclosure and Barring checks for all members of staff and volunteers.
- Supervision was provided to staff on a monthly basis. There was an appropriate supervision tree in place at all sites to ensure that all staff had a supervisor. Non-medical prescribers received clinical supervision from the consultants within their teams.
- Overall compliance for supervision at the sites was 70%. However, this figure also included staff on long term sick leave and maternity leave. The Hastings and Eastbourne sites had the highest supervision levels with 80% completion.
- The service had recently introduced observed practice as part of the staff supervision process. This was being rolled out across all sites and intended to be an on-going practice to inform staff personal development plans and service delivery.
- As part of supervision, caseloads and casework were reviewed alongside the programme of observed practice. Where the service had concerns around performance of staff, individual support plans were developed and followed.
- In addition to formal one-to-one supervision, staff accessed clinical team meetings weekly in which they could discuss clients with the multi-disciplinary team. This acted as an additional reflective practice discussion and ensured appropriate management and input from the whole team with client care.
- Overall appraisal rates for all inspected sites was below 65% completion. However, the service was in the process of reviewing their appraisal process and had recently halted any appraisals taking place.
- The appraisal process within the service included a competency framework checklist to monitor staff competencies.

Multi-disciplinary and inter-agency team work

- Each sites held weekly clinical meetings that the whole multi-disciplinary team were expected to attend. We witnessed appropriate sharing of information within these meetings and discussions around best practice and risk. The service developed a clinical meeting form to ensure that all clinical discussions were captured contemporaneously and added to client care records immediately.
- The service had effective joint working protocols in place for the shared care of people who used their service. This multi-agency working encouraged joint assessments, intervention and support for cases where more than one agency was involved.
- All sites held clinics each month within local GP surgeries to ensure shared care and encourage clients to access services without fear of stigmatisation.
- The services new model of care coordination meant there was more liaison and working with partner agencies such as mental health colleagues, local authorities and housing providers to holistically care for clients. We witnessed evidence that across the service teams held partnership meetings with agencies such as probation, social services and midwifery.
- Using this model of care, 'programme' workers carried out initial assessments of all new clients, following on from an induction group. Managers then reviewed assessments to decide who to place clients with. High risk clients were discussed in daily multi-disciplinary morning meetings to jointly decide who best to care

coordinate the client. Care co-ordinators were then responsible for accessing a range of services for the client by other teams within the service or separately commissioned partner agencies.

- Each site demonstrated strong working relationships with local dispensing pharmacies, health and justice colleagues and maternity colleagues. There was a referral system in place for local mental healthcare providers and we saw evidence within care records of input from community mental health teams.
- The Southampton, Hastings and Gloucester sites had a mental health link worker or dual diagnosis lead who attended mental health service meetings to ensure a collaborative working partnership was maintained with the community mental health team. Mental health leads additionally provided ad-hoc mental health training to other staff members.
- The Eastbourne, Southampton and Gloucester teams additionally had sex worker leads and alcohol link workers who visited the local general hospital wards and emergency department daily. The staff acted to support hospital staff with substance misuse clients care and treatment and ensure that those clients could be referred and picked up by the service.
- The service had good links with regional agencies such as alcoholics anonymous, narcotics anonymous and SMART group who provided 12 step psychosocial recovery groups for clients to attend.
- In Gloucester we saw evidence of dual diagnosis multi-agency meetings held monthly where individual cases were raised. These included a monthly rough sleepers/homeless panel, monthly sexual exploitation meetings, weekly probation meetings and attendance at child protection meetings.
- In Gloucester, there was close working with the 'emerging futures' agency which offered transition from treatment to community based support and activities. The emerging futures team contained lead network coaches who held small caseloads of alcohol service users who scored low on alcohol audit scores and had no other reported risk factors and provided a 6-8 week brief intervention programme. In addition, they supported the delivery of psychosocial programmes.
- Additionally, within Hastings and Eastbourne, they worked with the local St John Ambulance service to deliver first aid for overdose sessions to clients, carers and family members at events held throughout the year.
- In Southampton, there was close working with local partner 'The Society of St James'. They were co located and offered client support for mental health, homelessness and substance misuse issues. They offered a range of psychosocial peer support groups and one to one therapy as well as opportunities for volunteering, qualifications and accreditations through their drug and alcohol recovery service.

Good practice in applying the Mental Capacity Act

- The service implemented a Mental Capacity Act policy that was readily available to staff for guidance and advice.
- The service had an appointed Mental Capacity Act lead who staff were aware of. Mental capacity Act training formed part of staff mandatory training. The service offered two modules of MCA training and had an overall compliance rate of 83%.
- Staff demonstrated a basic understanding of the Mental Capacity Act. If clients attended appointment intoxicated or under the influence of drugs, the appointment was re-arranged. This was to ensure clients had the capacity to make an informed choice regarding their treatment.
- The service had a brief guide on the Mental Capacity Act that was displayed in teams that staff could refer to for information at a glance.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff spoke about clients in a sensitive, caring and professional manner. We saw staff interacting positively with clients and appeared responsive and respectful. Staff understood the needs of their clients and appeared to have a genuine interest in their wellbeing.

Good

Substance misuse services

- Clients were very positive about the service they received and stated that staff took a genuine interest in their wellbeing in a non-judgemental way.
- Staff gave clients suitable information regarding their treatment to support clients to better understand and manage their care.
- Staff supported clients to access other services when appropriate. This included healthcare, work and educational services and partner support agencies.
- The service had a clear confidentiality policy in place that staff adhered to. Staff maintained the confidentiality of information about clients and ensured clients were aware of and understood when confidentiality may be broken.
- The service clearly recorded client consent in care records that specified if clients wished to receive letters to their address and if they wanted to opt into service text message reminders, in order to maintain a sensitive and personalised approach.

Involvement in care

- All sites had leaflets available to clients explaining about their care and treatment. Clients also received detailed information about any medicine they were taking.
- Clients could access independent advocacy services at all sites. Clients were aware of this and there were leaflets available to clients in waiting rooms.
- All clients were invited to induction group meetings following referrals. All clients identified as requiring opioid substitute therapy during this group were offered and trained on naloxone for use in the community. The service also trained close family members on overdose and naloxone use in the community.
- All clients had a care plan in place that they felt involved with and suitably informed about. Care and recovery plans demonstrated client views and preferences and evidenced the involvement of clients. Staff encouraged clients to develop their own recovery plans and risk management plans to enable them to take ownership of their recovery and ensure their treatment needs were being met.
- The service had recently implemented a new assessment and recovery planning tool. This tool encouraged staff to take a strength based and collaborative approach to exploring and managing risk, whilst working towards clients own aspirations and goals.
- Clients could request changes to their medicines via their care coordinator. The care coordinator filled in a standard script changes form and took this to the weekly clinical meetings to discuss any actions with the multidisciplinary team. The script change forms were split into urgent and non-urgent requests and staff were appropriately guided to the most suitable one.
- In Southampton, there was a sub contracted parent support link service and they also had a building recovery in the community team lead. These staff members supported personal growth and development of clients into voluntary and paid work roles. Gloucester contracted Barnardo's to deliver parenting groups to clients and young Gloucestershire to aid young peoples transition into adult services.
- Additionally, within the Southampton site, they used part of their budget to provide a food scheme whereby food was available in their open access area to all those attending the service. Feedback from clients on this service was extremely positive.
- Feedback was sought from clients and carers via comment boxes in waiting areas, client surveys and regional client forums. Family members and carers were supported by the service with carer groups and one to one sessions if required. The service also encouraged clients, carers and family members to complete their annual client survey.

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

Good

Access and discharge

- All referrals were processed and clients were contacted within three working days. Teams ensured that clients

were offered an assessment within a week of contact and higher risk clients were prioritised. Referrals arrived from a variety of sources including GPs, hospitals, social services and self-referrals.

- We saw evidence that all sites undertook home or alternative venue visits when required to ensure clients were seen. Staff followed the lone working policy at all times and actively engaged clients to the service.
- The service had a daily rota of duty workers and open access appointment system in place which meant clients presenting without an appointment or referral had quick access to support and an initial assessment. This meant that their risks could be quickly assessed and managed.
- The service ran late night and Saturday clinics to ensure that clients who could not attend during normal working hours could still access the service.
- The service had an appropriate 'did not attend' policy in place that stipulated the process for staff to follow to re-engage clients to the service. All staff were aware of their responsibilities and followed the guidance. We saw staff liaising with external partners, family members and the local police to ensure welfare checks could be made, before re-engaging the client with the service.
- Additionally, the service had a re-engagement missed appointment tool for staff to follow that was reviewed by team managers before any unplanned discharge could be made. This tool aided staff to risk assess clients to ensure the appropriate follow up was achieved with immediate actions, three working day actions and future actions.
- The missed appointment tool also guided staff as to the actions to take regarding any children of clients at home or safeguarding issues. This was also risk assessed as high, medium or low risk with the appropriate actions thereafter. Quality leads regularly audited the missed appointment checklist to ensure consistent use across the service.
- The Gloucester and Southampton teams introduced postcards which clients wrote to themselves for if they stopped engaging with sites in the future. If that client then disengaged with services the postcard was sent to their address alongside following the re-engagement policy.
- The service had clear pathways to other supporting services such as specialist midwives, social services, housing associations and community mental health teams. We saw evidence of consideration of a range of services within risk and recovery plans and we saw appropriate referrals in care records.

The facilities promote recovery, comfort, dignity and confidentiality

- A range of rooms were available to support the delivery of care and treatment in groups and individual therapies to clients at every site. These included many individual rooms, group rooms and clinic rooms.
- The service had adequate room and seating for clients in all waiting areas. Waiting areas were appropriately supervised by a member of staff and access throughout all buildings was by secure keys or key codes.
- Interview rooms were suitably soundproofed and conversations could not be heard between adjoining rooms.

Meeting the needs of all people who use the service

- The Southampton site was not accessible to disabled clients. There was no access to the 1st and 2nd floors where groups were held and the emergency cord in the disabled toilet was too short to reach. However, we did see home visits conducted for clients with mobility difficulties. Additionally, the service told us of plans to move premises at the earliest opportunity, however no date was currently set for any move.
- Staff demonstrated an understanding of the potential issues facing vulnerable client groups. Within the Eastbourne, Southampton and Gloucester teams, there were dedicated sex worker staff to offer appropriate advice and support and accompanied police on patrols. The service employed domestic violence teams to help protect and support clients identified at risk or with a history of domestic violence.
- Where language differences were identified, all teams had access to translation services to enable clients to access treatment. Additionally, for clients who had visual or hearing impairment, teams could access appropriately adapted communication and a sign interpreter support.

Good

Substance misuse services

- The provision of daily open access slots across all teams and the food scheme at the Southampton site encouraged engagement from clients who otherwise may have been hard to engage. This alongside the homeless teams, Southampton food scheme, sex worker teams, clinics held in GP settings and 'remote consult' ensured that hard to reach clients were aware of and assessing services.
- The service recently worked with external partners and a community engagement organisation in Birmingham to pilot an app to support Muslim service users, using a 12 steps approach and motivational quotes from the Quran.
- A new equality dashboard was developed to provide local sites with a demographic breakdown of their workforce and clients (compared to local census data) for the protected groups of gender, disability, ethnicity and sexual orientation.

Listening to and learning from concerns and complaints

- The service had a complaints policy in place and clients we spoke with said they knew how to make a complaint and would feel confident to do so. Clients were given information on making a complaint on their first visit to the sites with complaint posters and forms displayed in waiting areas.
- The service had an official complaints feedback module that acted to collate and manage all formal complaints. This was managed by the Information governance team with investigations and outcomes undertaken by service managers.
- Complaints could be raised formally and informally and effort was made by the service to ensure local resolution was sought wherever possible. Clients received feedback on their complaint and the stage of the process.
- Staff were aware of the complaints policy and understood how to handle both formal and informal complaints appropriately and received feedback from investigations in team meetings. However, in Eastbourne we found that staff were not appropriately following the complaints process. The team had two complaints logged with no evidence of any investigations undertaken, acknowledgements or outcomes sent to the complainants.
- Client representatives were appointed within the service whose main focus was to encourage client feedback to support improvements with service delivery. They additionally acted as client support in raising concerns and complaints.
- A quarterly complaints report was produced and discussed at executive management meetings, board meeting and the information governance committee. The report included numbers of complaints, trends, severity rating, and learning from complaints.

Are substance misuse services well-led?

Good

Leadership

- Service leaders had the appropriate skills, knowledge and experience to perform their roles. They had a clear understanding of the sites they managed and could explain the role and function of their teams.
- All management staff attended the service wide in-house leadership development programme which provided the opportunity to develop further management and leadership skills amongst current service leaders.
- The service had a clear definition of client recovery that was shared and understood by all staff. The service empowered clients to take ownership of their recovery.
- Immediate service leaders were visible within all the sites. Staff told us they were happy to approach them with any concerns or queries.
- Senior management visited the sites to monitor clinical practice, conduct walk arounds and converse with staff. We additionally saw evidence of senior staff members attending partnership meetings and clinical management meetings. Staff reported that they felt comfortable to approach senior management with any concerns.

Vision and strategy

- Staff were aware of and could explain the visions and values set by the provider. All staff could explain their role and function within teams and could voice their opinion and contribute to discussion regarding the service when the service was changing.
- Service values were displayed in all sites and visible to clients to ensure a mutual understanding of the values underpinning staff attitudes and practice
- All staff were aware of budget constraints placed upon the teams and were conscious when working within these confines. Staff were consulted on any change processes proposed as a result of any reductions in funding.

Culture

- Staff reported that morale was good amongst teams and that they felt respected and well supported.
- Staff felt that their workloads were high with large caseload numbers but felt that the teams all worked well together to ensure client safety and recovery.
- Staff explained that they felt proud to work for the organisation and were happy with the career development opportunities offered.
- The provider encouraged staff to participate in a weekly 'wellbeing hour' to support staff with any work-related stress. This meant that staff could take one hour each week to do something which helped reduced their stress, for example walking or mindfulness practice. We were also told of recent team building days within the Gloucester and Southampton teams.
- The service had a culture of inclusion for all members of society and had appropriate equality policies in place. Additionally, the service also embedded a transgender equality policy. The policy set out how the service planned to meet the needs of transgender staff, volunteers and service users. The service aimed to exceed the requirements of the Equality Act and provide a welcoming environment in all sites.

Governance

- Service policies and procedures were regularly reviewed and updated. There were systems in place to ensure that policy review dates were met.
- Team meetings followed a set agenda to ensure that essential information was discussed. Learning from incidents was shared across the service to ensure teams could learn from one another.
- Teams had local safeguarding logs to keep track of safeguarding and we saw discussions of incidents, complaints and deaths that were disseminated to staff in various way to ensure learning was passed onto staff across the whole service.
- The service undertook audits to monitor and improve care. Senior leaders undertook monthly clinical site visits and data analysts undertook monthly caseload audits and passed information onto team leaders to action. There was a clinical audit group that met bi-monthly to discuss clinical audit activity and review progress on action plans.
- The service regularly met with and submitted reports to their local commissioning partners. This included monitoring of key performance indicators such as client successful treatment completion, unplanned discharges, re-presentations and incidents.
- Each site held local integrated governance team meetings that fed into an overarching national integrated governance team meeting. These meetings discussed recent audit findings, service quality improvement plans, incidents, lessons learnt, training and supervision and key performance indicators

Management of risk, issues and performance

- There was a clear clinical governance structure in place to ensure that clinical risk was escalated and managed within the service. Minutes from these meetings demonstrated clear actions to be taken to protect clients and ensure managerial oversight of issues both locally and service wide.
- We saw evidence of local risk registers in place with appropriate action plans or controls for each point. We saw discussions in team meetings around local risk and local risk registers fed into the corporate risk register. A range of risks were considered on the risk registers including clinical risk, information governance risk, health and safety, business disruption, safeguarding and human resources issues.

- Staff could not submit items onto the risk register directly, however they could have discussions with their team managers to decide if a new risk had arisen and needed to be added.
- There was an appropriate contingency plan in place for the service. This ensured business continuity in emergency situations

Information management

- The service had systems in place to collect and analyse data from local teams. Most of the data was pulled automatically and analysed from existing systems by the central data analyst team so was not burdensome to staff.
- The care records system clearly recorded client confidentiality on each client front page. Where consent to share information was or was not given, this was explicitly clear to staff reading the clients care records.
- Each site had a local security document which outlined the procedures for data security and responsibilities.
- Team managers had an online dashboard that displayed relevant team information pertinent to their role. This included information on performance, incidents, clinical care and a human resources portal to manage staff performance, sickness and absence. The service implemented a performance development framework to guide managers with staff performance.
- The service made appropriate notifications to external bodies as required, for example to the Care Quality Commission.
- Client information and care records were appropriately stored using an electronic care records system. All staff including agency staff had secure access to the system and this was accessible to staff at all times.

Engagement

- Staff received monthly central bulletins to keep up to date with information regarding the service in addition to information sharing at team meetings.
- Clients and family members had opportunities to offer feedback on the service they received. We saw feedback being discussed and changes being considered within the service. The service held regular forums and feedback sessions for clients and their family members.
- Staff opinion and support for change was gathered through consultations and group input when change was discussed within the service.
- We saw future capacity remodelling exercises in which staff and commissioners were invited to attend a two-day workshop to give their views. Additionally, there was a service wide strategic view day upcoming that all staff were invited to attend and contribute to.
- There were workers forums in place with staff representatives who fed back issues to local monthly manager meetings and attended quarterly regional staff worker forums, chaired by a service director.
- Service leaders regularly met with external stakeholders such as commissioners and produced reports pertaining to the services key performance indicators. ‘Live’ key performance indicators were displayed in in all sites for staff to view at a glance.

Learning, continuous improvement and innovation

- The service embedded a service quality improvement plan that indicated their top five priorities. Each locality developed targets and action plans to best meet the service priorities. Monthly local integrated governance team meetings discussed and tracked progress towards these objectives.
- The Gloucester team were piloting a secondment opportunity for a digital engagement officer. This role aimed to raise awareness of the service and provide opportunities for clients to access the service. This involved planning how telephone and skype could be integrated into service delivery to clients, heightened social media presence, co-produced events in schools and colleges and development of an online app.
- The service implemented both external and internal training opportunities for staff to ensure an up to date evidence based practice was implemented. The service utilised the skillset of the staff within the teams to run learning sessions based on identified areas of need.

Outstanding practice and areas for improvement

Outstanding practice

The service was trialling some innovative schemes including 'remote consult', the 12 steps approach and motivational quotes from the Quran app for Muslim service users.

Additionally, the digital engagement officer secondment opportunity provided an innovative opportunity for the service to grow their presence within communities and ensure information technology was efficiently utilised to manage their client caseloads.

These practices all aimed to support client care and for the services to become more accessible for hard to engage client groups.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff receive annual appraisals to support their performance and development.
- The provider should ensure that all care plans include client's views and record when copies of care plans are offered to clients.
- The provider should consider the inclusion of unexpected exit from treatment plans in all client records.
- The provider should consider the accessibility of the Southampton location for all client groups.