Delphi Medical Consultants Limited

The Calico Group - St Johns Court

Inspection report

St. Johns Court
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated it as requires improvement because:

- The service did not provide safe care. Staff did not assess and manage risk well for all clients.
- Client records were not complete and contemporaneous.
- The service did not develop holistic, recovery-oriented care plans informed by a comprehensive assessment for all clients.
- Staff did not receive all training relevant for their role.
- The service was not well led, the governance processes did not ensure that its procedures ran smoothly.
- Staff records did not comply with the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Records did not include health screening and full work history.

However:

- The service provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and were responsive to the needs of clients that were more difficult to reach.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to The Calico Group - St Johns Court

The Calico Group - St Johns Court was based in Blackburn and provided community based support for people in Blackburn and Darwen who misuse substances. Services offered include:

• Clinical assessment

• Clinical interventions

• Psychosocial interventions

• Prescribing

• Detoxification

• Rapid access prescribing

• Drug testing

The provider was Delphi Medical Consultants Ltd. The Calico Group - St Johns Court has been registered with CQC since 12 April 2022. The service is registered to provide the regulated activity of Treatment of disease, disorder or injury. The service had a registered manager.

The service has not been inspected by CQC, this is the first inspection.

What people who use the service say

We spoke with 11 clients and one carer.

Clients told us the staff were very respectful, helpful and caring. Staff encouraged people to develop hobbies and interests as an alternative to misusing substances. People felt listened to by staff. If they missed an appointment, staff would ring them to see how they were.

Clients told us the variety of support was helpful for their recovery, including one to one sessions, group work and support with other areas of their life including housing. Within one to one sessions, goals and aims were discussed. Clients said the groups were very helpful with challenging negative thoughts and beliefs and preparing them to be members of their local community again.

Clients valued the peer support offered to them from people with previous lived experience.

However there had been a turnover of staff which meant that clients had worked with several different recovery workers, this made it difficult to have consistency.

Three clients felt groups were not appropriate for them. Staff had respected this and explored other support.

Summary of this inspection

One client was not aware of their care plan or risk assessment and did not know how to give feedback about the service.

Ideas for further development of the service that clients shared with us included a detox pod, to help people when they were reducing their substitute prescription and discuss with peers how they will cope. Another suggestion was an aftercare café where people with lived experience would volunteer to support others.

How we carried out this inspection

The inspection team comprised a CQC inspector and a specialist advisor.

Prior to and following the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information including commissioners.

During the inspection visit, the inspection team;

- visited the service, looked at the quality of the environment and observed how staff were caring for people
- reviewed the medicines management and prescribing arrangements
- observed a group session, visited the needle exchange and observed interactions between staff and clients
- spoke with 11 clients and one carer
- observed a risk pod meeting
- spoke with the deputy service manager and the nominated individual
- spoke with nine other staff members including recovery coordinators, pharmacist, nurse, support worker, counsellor and administration staff
- received feedback about the service from seven stakeholders
- reviewed six care and treatment records of clients including care plans, risk assessments and documentation
- reviewed five staff files
- looked at a range of policies, procedures and other documents relating to the running of the service.

This inspection was unannounced and covered all key questions.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that staff receive training in learning disability and autism. (Regulation 18)
- The service must ensure that staff receive all mandatory training relevant to their role including substance misuse awareness, lone worker and Mental Capacity Act training. (Regulation 18)
- The service must ensure that records are complete and contemporaneous including safeguarding referrals, capacity assessments and best interest decisions. (Regulation 17)

Summary of this inspection

- The service must ensure they offer blood borne virus screening to clients within the service and complete the screening if clients consent. (Regulation 12)
- The service must ensure they provide a consistent induction for bank and agency staff with records to support this. (Regulation 18)
- The provider must ensure that it meets the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Including health screening for staff and full work history. (Regulation 17)

Action the service SHOULD take to improve:

- The service should continue to review their electronic record system to ensure ease of access to client information.
- The service should ensure that clients care documentation is individualised, and clients are offered a copy of their care plan.
- The service should ensure that learning from feedback and complaints is shared with staff.
- The service should review the information available for clients and stakeholders about the service and the type of support and opportunities available.
- The service should review their policies and procedures to ensure they cover all requirements and are clear for staff to follow. The service should ensure there is opportunities for peer support for staff and there is clear expectations regarding supervision.
- The service should ensure they have oversight of the Mental Capacity Act implementation in the service.
- The service should ensure that gaps in audits are actioned.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based 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

Community-based substance misuse services

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

Is the service safe?

Requires Improvement

We rated it as requires improvement.

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated risk assessments of all areas and removed or reduced any risks they identified. The healthcare team completed daily checks including checking the fridge temperatures. The deputy service manager completed a risk assessment of the building which included the risks and the control measures in place.

All interview rooms had alarms and staff available to respond. We saw alarms in all interview rooms.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. The healthcare team completed thorough clinic room checks which included stock checks, calibration checks and a deep clean of the clinic room.

All areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We checked the weekly clinic room checks from November 2022 and found there were two weekly checks not completed and the cleaning section not completed for four weeks. This meant we did not know if the cleaning had been completed or the form not completed fully.

Staff followed infection control guidelines, including handwashing. There was antibacterial gel in clinic rooms and throughout the building for staff to use. We saw healthcare staff using this.

Staff made sure equipment was well maintained, clean and in working order. Annual calibration of equipment was completed, there had been an Alcolmeter missed from the last calibration and the lead for healthcare had arranged for this to be calibrated. We saw all equipment was clean and well maintained.

Requires Improvement

Community-based substance misuse services

Safe staffing

The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.

The service had enough nursing and support staff to keep clients safe. Staffing was discussed at daily flash meetings and arrangements made to cover for colleagues.

The service had low vacancy rates. There were four vacancies in the service; service manager, support worker, recovery worker and care coordinator.

The service had reducing rates of agency staff. In February 2023 agency usage was 25%, however this had reduced to 4.7% in July 2023.

Managers made arrangements to cover staff sickness and absence. There had been vacancies and absences in the assessment team. To support this, staff from the alcohol team had been conducting the assessments for their service.

Managers did not make sure all bank and agency staff had a full induction and understood the service before starting their shift. There were no formal arrangements for bank or agency inductions, no checklists in place which meant staff would not receive a consistent induction. The service had started to work on developing this.

The service had low turnover rates. With the highest turnover of 6% in June 2023 and the lowest turnover of 0% in February and April 2023. The turnover rate for July 2023 was 2%.

Managers supported staff who needed time off for ill health. Records showed sickness reviews took place.

Sickness levels were low. With an average of 4% in the last six months.

Mandatory training

Staff had not completed and kept up to date with their mandatory training. We reviewed the training matrix and found that 60% of staff had completed Basic Life Support training, 78% had completed Health and Safety Level 1, 58% had completed lone worker training, 6% had completed Naloxone (Emergency medicine for opiate overdose) training, this meant staff did not have the training and skills to respond to people in an emergency.

The mandatory training programme was not comprehensive and did not meet the needs of clients and staff. The service had a training needs plan, which included the training for the different roles. Learning disability and autism training was not listed as a mandatory course, the Health and Care Act 2022 states that from 1 July 2022 all CQC regulated service providers had to ensure that staff receive training on learning disability and autism that is appropriate to the person's role. This was an optional course at the service, with 18 out of 50 staff completing the training which was 36%. The training needs plan did not include drug and alcohol awareness training. This meant staff would not be trained to meet the needs of the clients accessing the service.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Requires Improvement

Community-based substance misuse services

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.

Assessment of client risk

Staff completed risk assessments for most clients on admission, using a recognised tool, and reviewed this regularly, including after any incident. When the service took over the contract from the previous provider, in April 2022, there were difficulties with the data transferring across. The service had had to complete assessments and risk assessments for all clients, the service was supporting 846 clients at the time of inspection. We reviewed the system which showed oversight of the records and any outstanding, we saw that 46 risk assessments were not in place or had not been reviewed in the last six months, this was 5% of records. We reviewed 30 care records to see if they had current risk assessments, we found three risk assessments had not been reviewed in the last six months and two did not have completed risk assessments. This meant 10% of records reviewed did not have a current risk assessment in place. We reviewed six care records in detail. One did not have a completed risk assessment, and another had a risk assessment, however it did not include the risks relevant to the client. This meant not all clients had a current risk assessment.

Staff used a recognised risk assessment tool. The risk assessment was part of the electronic care record.

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. There were emergency prescribing appointments available that clients could access as needed. Staff contacted clients and other services involved with them if they had missed an appointment and could not be contacted.

Staff continually monitored clients on waiting lists for changes in their level of risk and responded when risk increased. There was a spreadsheet to record new referrals, the assessment of new referrals was overseen by the team leader for the assessment team. We reviewed the spreadsheet and saw there were 20 people waiting to access the drug services and 35 people waiting to access the alcohol service. The longest person had been waiting two weeks to access the service. Due to staffing pressures the assessment team did not have capacity to complete the assessments for alcohol referrals, therefore the alcohol team had been completing these. Team leaders reviewed the referrals and allocated them to recovery workers.

Staff mostly followed clear personal safety protocols, including for lone working. Staff had access to lone worker devices when working in the community. There were alarms within all interview rooms. There was a personal safety and lone worker policy which stated there needed to be risk assessments for certain roles. We reviewed a lone worker risk assessment and found that it covered all areas of risk and included action to mitigate risks. There was lone worker training, however only 58% of staff had completed this, this meant we were not assured that staff knew how to keep themselves safe when lone working.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Training compliance was 82%.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. An example was a client with mental health needs who was vulnerable in his accommodation from others. The service had made a safeguarding referral.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Clients were discussed in the daily flash and risk pod meetings. Minutes showed actions of safeguarding referrals being made to protect people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable and records referenced contact with multi agency safeguarding hubs. However, the records did not include a copy of the referral. This meant it was difficult to track the action taken.

Staff access to essential information

Staff did not keep detailed records of clients' care and treatment. Records were mostly up to date.

Client notes were not comprehensive, and all staff could not access them easily. We reviewed six care records. Two records did not include any referral documentation. The assessment completed had 'anxiety' ticked but nothing further written, and the risk management plan did not include plans for management of anxiety. Another record had an uploaded brief summary which is a document used for initial assessment and triage, the summary did not include a name of who completed it or the date of completion. There was no care plan or risk assessment in place.

We reviewed the electronic care record system and found that you could not search it using a key word search, if staff wanted to locate an entry, they would have to search all entries, this was very time consuming and inefficient. The system also did not include at a glance the date of the completed assessment, staff would have to look in daily notes or attachments to locate this information. Staff told us it had taken a long time to familiarise themselves with the new system and was time consuming to locate information.

Records were stored securely. They were on locked computers.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Prescribers completed the prescriptions, and the administration team printed them and completed a log. Prescriptions were collected by the pharmacy.

Staff reviewed each client's medicines regularly and provided advice to clients. Reviews took place with recovery workers monthly and prescribers six monthly.

Staff completed medicines records accurately and kept them up to date. Records were all electronic.

Staff stored and managed all medicines and prescribing documents safely. Emergency medicines were stored in the service and the service had just been approved by the Home Office to hold controlled drugs. The service were planning to hold a stock of Buprenorphine prolonged-release injection (Buvidal) to be more efficient for clients and stop clients having to collect their medicines and bring it to the service to be administered.

Requires Improvement

Community-based substance misuse services

Staff learned from safety alerts and incidents to improve practice. There were peer prescriber meetings monthly, minutes showed changes in guidance were discussed and client presentation and how the service could respond consistently.

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff knew what incidents to report and how to report them. This was discussed at team meetings as refreshers for staff, examples of incidents reported were discussed at the meetings..

Staff raised concerns and reported incidents and near misses in line with the service's policy. We saw completed incident forms and actions taken following incidents.

The service had 13 serious incidents in the last 12 months, 12 of these were deaths. These had been reported to CQC with an appropriate level of detail.

The service had no never events.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. We saw an example of a prescribing error and contact had been made with the client to discuss this and apologise.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations. This was overseen by the provider as a central team and the managers in local services were allocated incidents to investigate.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were discussed at the managers meetings, these included incidents in other parts of the organisation.

Staff met to discuss the feedback and look at improvements to client care. Mortality and prevention meetings took place where deaths were reviewed, and recommendations identified.

Is the service effective?

Requires Improvement

We rated it as requires improvement.

Requires Improvement

Community-based substance misuse services

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans mostly reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive assessment of each client. We reviewed five records in detail, and they all included an assessment.

Staff did not make sure that clients had a full physical health assessment and knew about any physical health problems. The healthcare team was accessed by referral. Keyworkers made referrals to the team including for a health and wellbeing assessment. These were then allocated to a member of the healthcare team. However, there was a backlog in Blood Borne Virus screening, the contract was taken on in April 2022 and the service started screening for Blood Borne Viruses in July 2022. There were 64% of clients that had not been tested for Hepatitis B, Hepatitis C and HIV. The medical team were working though contacting clients to have screening however the team also had new referrals and other aspects of their role including ECGs, health and wellbeing assessments and hepatitis clinics to do. This meant not all clients had been offered or had their screening completed.

Staff did not always develop a comprehensive care plan for each client that met their mental and physical health needs. We reviewed six care records in detail and found that one person had anxiety but there was no detail of how this affected the person, how they managed the condition or a care plan or risk assessment in relation to this. Another record did not have a completed risk assessment or care plan in place.

Staff regularly reviewed and updated care plans when clients' needs changed. However, we reviewed 30 care records to review how regularly their care plans had been reviewed and found that four had not been reviewed in the last six months and two did not have care plans in place. This meant that 20% of records reviewed did not have a current care plan in place.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

Staff provided a range of care and treatment suitable for the clients in the service. The service worked as part of a recovery collaborative, the other providers included a service for young people and their families which was trauma informed, another focused on community engagement and health and wellbeing. Another was a self-advocacy and service user forum focus and another provided opportunities to exercise and access counselling. Key workers could refer people to the partner organisations to complement the treatment service with the aim of people's recovery being sustainable as they were receiving support and building their skills in a variety of areas. Support was also available in relation to housing. This meant people had a variety of opportunities and support to progress in their recovery.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). The service were following NICE guidance in relation to Buprenorphine prescribing and quality standard for Alcohol-use disorders: diagnosis and management. In relation to accessing community networks and support.

Staff made sure clients had support for their physical health needs, either from their GP or community services.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. The recovery collaborative included five different organisations in addition to the provider. One organisation focused on support to young people and their families. Another organisation focused on engagement and delivering services which are ethnically and culturally appropriate focusing on health and wellbeing, education and employability and community development. Another organisation coordinated and facilitated the recovery user forum focusing on empowerment and building recovery capital. Another organisation focused on volunteering opportunities. Another organisation focused on behavioural change through clients setting their own goals, support included exercise, counselling, mentoring and peer support. There were a variety of opportunities for clients in relation to accessing support to exercise, recovery focused groups and access to mutual aid.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. Audits took place of the environment, stock and care records. There was a standard agenda item to discuss these in senior managers meetings, we reviewed minutes for six months and the only update regarding audits was that they were waiting for the quality framework to be approved. This meant audits were not regularly being discussed at meetings. However, when they had been completed was discussed in the monthly reports for the senior leaders but not the findings or content of the audits. This meant we could not see that managers used results from audits to make improvements.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Audits included GDPR Audit, infection control, caseload audit and record keeping.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers did not make sure that staff had the range of skills needed to provide high quality care. They did support staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of each client. This included nurses, doctors, counsellors, recovery workers and support workers.

Managers did not make sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff. The service had a training needs plan, which included the training for the different roles. Learning Disability and Autism was not listed as a mandatory course and the Health and Care Act 2022 states that from 1 July 2022 all CQC regulated service providers had to ensure that each person working for the service receives training on learning disability and autism that is appropriate to the person's role. This was an optional course at the service, with 18 out of 50 staff completing the training which was 36%. The training needs plan did not include drug and alcohol awareness training. This meant staff would not be trained to meet the needs of the clients accessing the service. Staff and stakeholders told us that due to the turnover of staff, there were staff with limited experience in the sector, this meant they did not receive the training and support to be knowledgeable and confident in their role. This was also on the risk register for the service.

Managers gave each new member of staff a full induction to the service before they started work. The induction had been developed in April 2023 and included an introduction to the organisation and model of care. Staff were given an induction roadmap which they completed during the first six weeks of their employment. This included policies to read and tasks to complete. Staff also shadowed existing members of staff. However, the induction did not include training in drugs and alcohol and this training was not included on the training matrix.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported staff through regular, constructive clinical supervision of their work. The service did not have a supervision policy, however they had a training and development policy. This said training was discussed in supervision but did not include the expected frequency of supervision. We viewed the supervision matrix and found that staff were receiving supervision.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meetings used to be quarterly and changed to monthly in March 2023. Minutes showed that meetings took place and since they became monthly there was a standard agenda which covered incidents, operations, policies and employee of the month.

Managers did not make sure staff received any specialist training for their role. Training was based on GDPR, health and safety and basic life support not specialist skills for the service type.

Managers recognised poor performance, could identify the reasons and dealt with these. There had been five examples of disciplinary action taken by the service in the 12 months prior to the inspection, where staff had breached the code of conduct.

Managers recruited, trained and supported volunteers to work with clients in the service. There was an application and induction process in place which included clear guidance about what to do if you had a safeguarding concern. Volunteers also received a volunteers handbook with mutual expectations and relevant policies. We saw there were several volunteers at the service during the inspection, their roles included supporting the groups.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. Minutes showed that complex case meetings took place. Daily risk pod meetings took place to discuss clients that staff were concerned about and agreed action to take to safeguard individuals.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. The service liaised with community organisations, detox facilities and other services including housing. Records showed this contact took place.

Staff had effective working relationships with other teams in the organisation. We saw several teams based in one office and they seemed to be working well together. Staff also referred clients to the other teams that focused on recovery and skill development to live in the community when they had stopped using substances. One of the recovery community teams was based in the service to ensure more joined up working for the benefit of clients.

Staff had effective working relationships with external teams and organisations. We received feedback from six stakeholders who all said that the service was responsive and ensured they updated colleagues on clients progress, including if there were any concerns.

Requires Improvement

Community-based substance misuse services

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves.

Not all staff received and kept up to date with training in the Mental Capacity Act. There were 48% of staff that had completed training in the Mental Capacity Act.

There was not a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. However, this was included in the safeguarding policy which stated that "All staff undertake mandatory Mental Capacity Act training and work within the requirements of this Act. We ensure that all adults are included in decision making where able to do so."

The service did not monitor how well it followed the Mental Capacity Act and did not make changes to practice when necessary.

Staff did not audit how they applied the Mental Capacity Act and did not identify and act when they needed to make changes to improve.

Is the service caring?

Good

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.

Staff were discreet, respectful, and responsive when caring for clients. We observed staff interactions with clients in the waiting room and in the one to one appointments, staff were respectful, supportive and encouraging to clients.

Staff gave clients help, emotional support and advice when they needed it. We observed the DEAP (Dependency emotional attachment programme) group. We found the facilitators to be supportive, encouraging, nurturing and appropriately challenging within the group to enable people to reflect on their behaviours and develop skills to cope in the future, in order to live a fulfilled life in the community without the use of substances. Other groups included RAMP (Reduction and motivation programme), mental health and wellbeing, pre DEAP and routes to recovery. There was a weekly drop in session for people who had completed DEAP for that ongoing peer and reflective support, clients we spoke with who had nearly completed DEAP spoke positively about this opportunity.

Staff supported clients to understand and manage their own care treatment or condition. This was discussed in the one to one meetings with staff, clients told us they discussed their own individual goals.

Staff directed clients to other services and supported them to access those services if they needed help. The organisation worked alongside their sector organisations including ones focusing on employment, housing and meaningful activity, staff could refer clients to these services. Clients told us how they were receiving support in relation to their housing.

Requires Improvement

Community-based substance misuse services

Clients said staff treated them well and behaved kindly. Clients told us the staff were very respectful, helpful and caring.

Staff understood and respected the individual needs of each client. Several recovery workers had lived experience of substance misuse and used this for the benefit of clients by having the insight of the journey of recovery that they were working through. Clients said they found this helpful and inspirational seeing others who had recovered and were working in the field.

Staff followed policy to keep client information confidential. Discussions took place in offices and meeting rooms, not in communal areas. Client IDs were used to protect people's right to confidentiality.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Involvement of clients

Staff involved clients and mostly gave them access to their care plans. However, four out of 11 clients had not been offered a copy of their care plan.

Staff made sure clients understood their care and treatment. Clients were able to tell us what their goals and aims of the service were.

Staff involved clients in decisions about the service, when appropriate. There had been 24 completed feedback questionnaires since January 2023, they sought ideas for improvements to the service via this.

Clients could give feedback on the service and their treatment and staff supported them to do this. There was a feedback box in the waiting room for clients to give feedback. Clients also told us they would feel comfortable giving feedback to staff.

Involvement of families and carers

Staff informed and involved families and carers appropriately. The service provided family RAMP (Reduction and motivation programme) groups weekly for families to join remotely. The aim of the groupwork program was to provide support, information, and awareness to family members of people with addictions. The group comprised of 8 interactive presentations. Families of young people could access the early break service which supported young people and their families including facilitating meetings with young people and their families, specialist assessment and care planning.

The service had facilitated outreach events in local commuites, incuding communities for people from a variety of ethnic backgrounds. These events were to raise awareness to families of the service and support available, this had generated new referrals into the service.

Staff helped families to give feedback on the service. Where family members or carers attended appointments with clients, they were able to give their views and be involved in the assessment process. We spoke with a carer who was supporting a client to the appointment and the client found this helpful to help them remember what was discussed in the appointment.

Is the service responsive?

Requires Improvement

Community-based substance misuse services

Good

We rated it as good.

Access and waiting times

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

The service had clear criteria to describe which clients they would offer services to and offered clients a place on waiting lists. The service delivered an integrated substance misuse service model in Blackburn and Darwen. The Recovery Collaborative is a model of joint working and co-production with a variety of other organisations with the aim of empowering people to recover from addiction. People could self refer or be referred by a family member or a professional.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. The assessment team triaged the referrals and allocated them to staff to complete the assessment. There was a spreadsheet to record new referrals, the assessment of new referrals was overseen by the team leader for the assessment team. We reviewed the spreadsheet and saw there were 20 people waiting to access the drug services and 35 people waiting to access the alcohol service. The longest person had been waiting for two weeks. Due to staffing pressures the assessment team did not have capacity to complete the assessments for alcohol referrals, therefore the alcohol team had been completing these. Team leaders reviewed the referrals and allocated them to recovery workers.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. Urgent appointments were available for the prescribers and recovery workers. One client we spoke with had been referred the day previously and had come in for their assessment.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from services. The treatment team had a recovery worker focusing on supporting sex workers and homeless people, they worked in the community to try to engage people. There service had a midwife and recovery worker who focused on supporting pregnant women. There was a hospital in reach worker who worked into the local hospital for people with problematic alcohol use, they worked closely with the alcohol care team.

Staff tried to contact people who did not attend appointments and offer support. Records showed staff tried to contact people in a variety of ways, including contacting other agencies that were supporting the client.

Clients had some flexibility and choice in the appointment times available. Evening appointments were available for those who needed them.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible. We also saw staff covering for colleagues so that clients did not miss out on their appointments.

Appointments ran on time and staff informed clients when they did not. We saw workers arrive at planned appointment times and explaining to clients if there was a delay.

The service used systems to help them monitor waiting lists/support clients. A spreadsheet was used to record new referrals into the service, and this was overseen by team leaders and senior managers had access to this which they reviewed.

Staff supported clients when they were referred, transferred between services, or needed physical health care. Workers would introduce clients to other staff and would make the referrals to other services. We saw the physical health team being very flexible when a client attended their appointment and agreed to have a screening test, staff could facilitate it there and then.

Discharges from the service were agreed with the recovery worker and their team leader. Discharge meetings had been introduced to discuss complex clients, these discussions and agreements to discharge were included in the care records.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. These included interview rooms and clinic rooms for one to one appointments. The needle exchange was accessed via a different entrance to promote people's privacy and dignity. The group rooms were welcoming with facilities to make drinks and have snacks.

Interview rooms in the service had sound proofing to protect privacy and confidentiality. You could not near conversations that were taking place in the interview rooms.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication support needs.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. The service had a lift to access different floors. Staff could meet clients in the community if needed and at other services including probation. One of the recovery workers had been instrumental in developing an Alcoholics Anonymous meeting for people whose first language was Polish.

We heard from seven stakeholders who all said how responsive the service was at meeting individual needs and trying to support clients with other associated needs including mental health needs.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. Information was on display on the notice boards and the tables of the waiting rooms, these included other organisations and information on treatments and mutual aid groups. There was a feedback box in reception too.

The service had information leaflets available in languages spoken by the clients and local community. The information leaflet for clients had a variety of ways to contact the service and explained a little about the support available. This included a link and QR code to access the website. The website had more information on the support available and links to the phone number and email address to make contact and to the referral form. However, these did not include all elements of the service that could be accessed, and stakeholders told us it would be helpful to have information about the services and type of support that could be provided to clients, to assist when making referrals. We saw a poster in Polish promoting the Polish AA meeting. We also saw a leaflet regarding treatment in Polish.

Requires Improvement

Community-based substance misuse services

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Most clients and carers knew how to complain or raise concerns. Ten out of 11 clients said they would speak to staff or managers if they needed to complain. One person said they would use the suggestions box or feedback online.

Staff understood the policy on complaints and knew how to handle them. The service had a group complaints policy which included all organisations under the provider and had timescales for investigation of complaints. There was also a feedback policy for the organisation that the service was part of, this included all staff welcoming feedback and making reasonable adjustments for clients to provide feedback. Staff could explain how clients could give feedback and how the information was shared with colleagues, which was usually via email.

Staff knew how to acknowledge complaints. There was a central spreadsheet of complaints, and these were included in the medical monthly reports which was shared with senior staff. We reviewed the reports and found for January 2023 and February 2023, there had been one complaint each month. In March 2023 and April 2023 there had been no complaints. The medical monthly reports included the numbers of complaints but not the themes or nature of the complaints.

Managers did not routinely share feedback from complaints with staff and learning was not used to improve the service. Complaints was not on any of the team meeting or senior leadership team meeting agendas. However, they were included in the medical monthly reports which was shared with senior staff.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were stored in a central spreadsheet and were included in the medical monthly reports which was shared with senior staff. The service had received one compliment in January 2023, one in February 2023, one in March 2023 and 15 in April 2023. Themes included how caring staff were and how they enabled people to turn their lives around. Areas for improvement included more activities and clearer information of what is available.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.

Leaders provide clinical leadership. The service manager post was vacant and was being recruited to. The deputy service manager provided the day to day management and oversight of the service, however they were also a non medical prescriber and conducted prescribing clinics too. This meant that they were not always available for support and guidance. However, staff told us when they were available, they were very supportive.

Leaders had the skills, knowledge, and experience to perform their roles. The registered manager was also the area operations manager for the central region. They were covering the service until a new service manager had been appointed, they also had four other services they managed which meant their input into the service was limited.

The organisation had a clear definition of recovery, and this is shared and understood by all staff. This was embedded within all induction resources which was explained to all staff and volunteers when they started at the service.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. They were also aware of where there needed to be more focus, for example recruitment of staff, training and induction oversight.

Leaders were visible in the service and approachable for clients and staff. The deputy service manager delivered some of the prescribing clinics, they were present with the service and staff knew who they were and felt able to approach them.

Vision and strategy

Staff knew and understood the service's vision and values and how they (were) applied to the work of their team.

Staff knew and understood the vision and values of the team and organisation and what their role was in achieving that. The services vision was “With passion and excellence, Delphi makes a difference to people’s lives by providing innovative and specialist addiction services that lead the way from dependence to freedom.” Staff were very knowledgeable about the different services that they worked alongside to provide the variety of support to clients that is needed for their recovery.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Discussions took place at senior leadership meetings and managers meetings.

Staff could explain how they were working to deliver high quality care within the budgets available. Minutes showed this was discussed within the senior leadership meetings.

Culture

Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff mostly felt respected, supported and valued. However, when the service took over from the previous provider there were differences in terms and conditions which staff found difficult. Staff and clients said there had been staff turnover, meaning that new staff were less experienced and there was not consistency for clients.

The service did not have a staff group that felt positive, satisfied and had low levels of stress. Staff found the challenges with the new electronic record system difficult, client records did not migrate over from the previous provider which led to a high workload of having to re do risk assessments and care plans for clients and understand the new system. Some staff felt deskilled as their role was different with this provider compared to the last provider. However, the staff survey results showed that results were positive with 7.6 out of 10 average in the responses.

The provider recognised staff success within the service – for example, through staff awards. Employee of the month was in place, staff nominated colleagues outside of the meeting and had to explain why they were nominating the, the results were shared at the team meeting.

Staff did not feel valued and part of the organisation's future direction. Staff did not have opportunities for role specific peer meetings apart from the prescriber meetings. This meant staff did not feel supported by people in a similar role in other parts of the organisation, to share knowledge and discuss changes in practice.

Staff felt positive and proud about working for the provider and their team. Staff were very positive and passionate about their roles in the service and the difference it makes to people's lives.

There had not been any bullying and harassment cases or staff grievances in the 12 months prior to the inspection.

The service monitored morale, job satisfaction and sense of empowerment. Staff surveys took place. You said, we did information was shared with staff showing what had been implemented following feedback from staff, including changes in the induction process. Staff identified requiring support with developing skills of creating care plans and risk assessments for clients.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The service had set up a women's group where staff could discuss issues including menopause.

Teams worked well together and where there were difficulties managers dealt with them appropriately. We observed staff sharing offices to ensure team leaders were more accessible to teams.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at service level and that performance and risk were managed well.

Governance policies, procedures and protocols were regularly reviewed. However, they did not include an equality impact assessment and some policies did not guide staff to their expectations and responsibilities, including the feedback policy. The service did not have a supervision policy, however they had a training and development policy. This said training was discussed in supervision but did not include the expected frequency of supervision. There was not a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. However, this was included in the safeguarding policy which stated that "All staff undertake mandatory Mental Capacity Act training and work within the requirements of this Act. We ensure that all adults are included in decision making where able to do so." This meant there was not clear policies and procedures for staff to follow.

Staff records did not meet schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed five staff files. One had health screening in them. Four did not have health screening in. Three people's file did not include a CV or full work history. One person's file had only one job listed on the application, no CV and no full work history. One person's file did not have any references, another had one reference. One file did not include a GMC check and another file, their NMC registration date had been recorded on a spreadsheet but no current evidence of their registration in their HR file. This meant the service could not be assured that staff they recruited were fit and proper as there was no oversight of staff records and the records did not meet the requirements of the Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The agendas for team meetings were not consistent, they did not ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Mortality prevention minutes showed that clear actions and recommendations were identified from the review of deaths. An actions log was created, and these were reviewed at each meeting to monitor progress.

Staff undertook or participated in local clinical audits. However, the gaps were not always actioned, for example, clinic room audits took place, and we reviewed the weekly clinic room checks from November 2022 and found there were two weekly checks not completed and the cleaning section not completed for four weeks. This meant you did not know if the cleaning had been completed or the form not completed fully. There was no action in relation to this.

Data and notifications were submitted to external bodies and internal departments as required. CQC statutory notifications had been submitted in relation to death of clients and safeguarding concerns. These were completed to a high standard with the necessary level of detail included.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the clients. External meetings took place with the mental health team to review clients with a dual diagnosis. Minutes showed the service were members of the combating drugs partnership and recovery collaborative board with several other organisations.

Management of risk, issues and performance

Teams mostly had access to the information they needed to provide safe and effective care and used that information to good effect.

There was not a clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures. Policies were written quite differently, some were at a provider level and others at a service level. The service did not have a supervision policy, however they had a training and development policy. This said training was discussed in supervision but did not include the expected frequency of supervision. They did not all include the date of creation and date of next review.

Staff maintained and had access to the risk register at facility or directorate level. Staff at facility level could escalate concerns when required. There was a corporate risk register and a service risk register. Risks reflected the findings at inspection including training and client records. Corporate risks also included funding and compliance with legislation.

Staff have the ability to submit items to the provider risk register. This was escalated through managers and senior leaders added items to the corporate risk register. The deputy service manager added items to the service risk register.

Staff concerns matched those on the risk register. Staffing was on the corporate risk register and training compliance levels. Challenge with migration of care records and gaps in risk assessments and care plans was on the service risk register.

The service monitored sickness and absence rates. The service had low vacancy rates. There were four vacancies in the service; service manager, support worker, recovery worker and care coordinator. Sickness levels were low. With an average of 4% in the last six months.

Requires Improvement

Community-based substance misuse services

Information management

Staff collected analysed data about outcomes and performance.

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff. The majority of the data for data submissions was gathered from the electronic care record system.

Staff had access to the equipment and information technology needed to do their work. However, the electronic care record was difficult to navigate, you could not do key word searches which meant it took a considerable amount of time to locate information.

Information governance systems included confidentiality of client records. Staff had individual log ins to access the care record system.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care. Some information relied on staff adding the information to spreadsheets for example, supervision compliance and safeguarding referrals, there were also several systems used for the storage of staff records which meant it was time consuming to locate the information and there was no oversight to ensure all requirements were in place for each employee.

Staff made notifications to external bodies as needed. The CQC statutory notifications were submitted and completed with all the required information.

Not all information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. There were gaps in care records, with 10% of records reviewed not having a current risk assessment and 20% of records reviewed not having a current care plan. We also saw gaps in referral documentation.

The service had subcontracted to other providers for part of the recovery collaborative, they also worked closely with mental health services and the acute hospital, who they had developed information-sharing processes and joint-working arrangements with.

The service ensured service confidentiality agreements were clearly explained including in relation to the sharing of information and data. This was included in the volunteers induction, and they had to sign a confidentiality statement.

Engagement

Staff, clients and carers did not have access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on. There was a website which gave an overview of the service but did not cover all that the service did. There were no newsletters for staff, information was mainly shared via email or verbally.

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. This included a feedback box in reception, a feedback questionnaire and giving feedback directly to staff.

Requires Improvement

Community-based substance misuse services

Clients and staff could meet with members of the provider's senior leadership team to give feedback. The deputy service manager was one of the non medical prescribers and they had contact with clients. Senior leaders visited the service and were visible in the service. Staff could meet with senior leaders via the employee engagement group, and the CEO of Calico met with staff for 'listen and learn' events.

Staff engaged with external stakeholders – such as commissioners and other providers. There were contract reviews, panels to discuss dual diagnosis clients who also had mental health needs, planning for clients going into detox and their aftercare needs and joint work with other providers. We received feedback from seven stakeholders, all of whom said how responsive the service was and the service kept others informed of client progress. Areas for improvement include a leaflet/information that shows professional what support and services can be accessed for clients and the recruitment and retention of staff.

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. Peer prescriber meetings took place and senior leadership meetings took place to share best practice which was then disseminated to the teams.

The service assessed quality and sustainability impact of changes including financial. There was regular contact with commissioners to review the service and provide updates, the service had embraced the service model of a recovery collaborative, acknowledging that treatment was only one part of a clients recovery and sub-contracting to other services to provide support in their area of expertise including housing and meaningful activity and employment.

Records did not show that all staff had objectives focused on improvement and learning. Staff could not tell us what training they had completed and what training they needed to complete.

The service had a staff award/recognition schemes. Staff could nominate colleagues for employee of the month.

The organisation recruited volunteers and paid recovery workers with lived experience, valuing the input their experience could bring.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The mandatory training programme was not comprehensive and did not meet the needs of clients and staff. The service had a training needs plan, which included the training for the different roles. Learning disability and autism training was not listed as a mandatory course, the Health and Care Act 2022 states that from 1 July 2022 all CQC regulated service providers had to ensure that staff receive training on learning disability and autism that is appropriate to the person's role. This was an optional course at the service, with 36% staff who had completed the training. Staff had not completed and kept up to date with their mandatory training. We reviewed the training matrix and found that 60% of staff had completed Basic Life Support training, 78% had completed Health and Safety Level 1, 58% had completed lone worker training, 6% had completed Naloxone(Emergency medicine for opiate overdose) training, this meant staff did not have the training and skills to respond to people in an emergency. There was no formal arrangements for bank or agency inductions, no checklists in place which meant staff would not receive a consistent induction. For employed staff, the induction did not include training in drugs and alcohol and this training was not included on the training matrix.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

We reviewed six care records.
Two records did not include any referral documentation.
One clients risk assessment did not reflect their assessment.
Another record had an uploaded brief summary, with no name of who completed it or the date of completion.
There was no care plan or risk assessment in place.

We reviewed the safeguarding incidents for June 2023 and found two where the tracker showed safeguarding referrals had been made, however there were no copies of the referral on file.

Environmental checks took place weekly of the clinic rooms, medicines, and stock by one of the healthcare team. We checked the weekly clinic room checks from November 2022 and found there were two weekly checks not completed and the cleaning section not completed for four weeks.

We reviewed five staff files. One had health screening in them. Four did not have health screening in.
Four people's file did not include a CV or full work history.
One person's file did not have any references, another had one reference.
One file did not include a GMC check and another file, their NMC registration date had been recorded on a spreadsheet but no current evidence of their registration in their HR file.
Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a backlog in Blood Borne Virus screening, the contract was taken on in April 2022 and the service started screening for Blood Borne Viruses in July 2022. There were 64% of clients that had not been tested for Hepatitis B, Hepatitis C and HIV. There had been a problem with the electronic care record when the service took over from the previous provider, the care records did not migrate with the risk assessments and

This section is primarily information for the provider

Requirement notices

care plans, staff had been completing these for clients, however there were 46 risk assessments that were not in place or had not been reviewed in the last six months, out of 846 clients. This equated to 5%.