Good

North Staffordshire Combined Healthcare NHS Trust

Substance misuse services

Quality Report

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Date of inspection visit: 12-15 September 2016
Date of publication: 21/02/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RLY88	Harpland's Hospital	Edward Myers Unit	ST4 6TH
RLY00	Trust Headquarters	One Recovery South East, Tamworth	B79 7HL
RLY00	Trust Headquarters	One Recovery South West, Cannock	WS11 1JN

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	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 / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

We have changed the overall rating for substance misuse services from requires improvement to good because:

- Services had made important improvements since their last inspection in 2015. These improvements included consistent approaches to risk formulation and management across all services. There was a strong focus on ensuring the safety of staff and those who used services and the introduction of new systems and processes maintained a robust focus on managing the risk of harm.
- There was a commitment from leadership to standardise a consistent supervision system across all of substance misuse services. There were career development opportunities, role specific training and organised reflection and learning and development sessions for staff at all levels.
- There was good partnership working between the trust community teams and their partner agency Addiction Dependency Solutions. They were fully integrated clinical and medical services with recovery at the forefront.
- Services were patient, family, carer and community focused and led. Recovery and building recovery capital were the objectives of stakeholders. There was a strong focus on providing support to families and carers, involving them and supporting them in managing some of the difficulties that they might experience.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All the services we visited were committed to providing safe and clean environments for patients and staff. For example, all environmental risk assessments were carried out and any risks identified were mitigated against to reduce or remove risks. Equipment was maintained to ensure safety and efficacy.
- Staffing levels were changeable because of the service redesign. However, there were robust plans and monitoring in place to ensure staffing levels were suitable for the number of patients on the ward and caseloads in the community. Managers were being proactive and using a number of methods to keep patients safe in the circumstances.
- Each service had access to medical staff during office hours and an effective and accessible out of hours' service.
- Staff were suitably skilled and trained to make sure they could provide the best possible care and treatment to patients during their recovery.
- The trust worked with commissioners and the coroner to look at drug related deaths. They focused on the themes and changed practice to ensure the patient group was protected from drug related harm where possible. Staff learned from incidents by reporting and having follow-up systems, which were fit for purpose. Staff were trained in root cause analysis and there were good processes in place to investigate and learn from incidents.

Are services effective?

Good

We rated effective as good because:

- All patients received a comprehensive, holistic, and timely assessment. Other agencies contributed to the process, as did family and involved others when appropriate. Treatment plans that we looked at were patient led.
- Staff used a number of evidence-based interventions in order to have positive and measurable effects in supporting patients in their recovery.

Summary of findings

- Staff participated in audits which were designed to ensure that the services reached a pre-determined standard. Staff were also involved in research to generate new knowledge to ensure good outcomes.
- Skilled and multi-disciplinary staff were engaged across the directorate to support patients in their recovery.
- There were effective working relationships with teams outside of the organisation, for example, local authority social services and GPs.
- Staff had received mandatory training and role specific training programmes. There were opportunities for development and career progression, for example, training for nurses to progress to non-medical prescribers who were then qualified to supplement prescribing with supervision for doctors.

Are services caring? Good

We rated caring as good because:

- Staff were kind, caring and compassionate. Patients and involved others told us that they felt cared for, involved in the process of receiving treatment and that they received good quality, professional care. There were specific support services for families, former and current patients.
- Patients were invited to involve their carers, family, and other professionals in their treatment when appropriate. They were also encouraged to comment and make suggestions about how to improve care.
- Staff treated everyone involved in services with dignity and respect.

Are services responsive to people's needs? Good

We rated responsive as good because:

- Staff effectively managed admissions, assessments, discharges, and unexpected exit from treatment with the patient and involved others where appropriate.
- Services were multi-disciplinary in approach and they met regularly to discuss patient needs and to plan care and treatment.
- All services had facilities to promote recovery, comfort, dignity, and confidentiality.

Summary of findings

- Patients across all services had access to and were encouraged to use mutual aid. There were community groups made up of those who had used substance misuse services in the past who helped support each other in their recovery. .
- Patients who had a disability or were unable to access local services were accommodated by staff providing appointments/ meetings, either at home or another location, to suit the patient.
- Patients could make complaints or give compliments. Staff encouraged this by providing comments cards and information relating to thePatient Advice and Liaison Service(PALS), a service which offered confidential advice, support and information on health-related matters.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew and understood the organisation's vision and values. This was reflected in the work with patients in the service, those who volunteered to work in the service, and friends, families and carers of those who used services.
- Managers shared the service's key performance indicators with teams and staff used them to help meet their objectives.
- There was a strong focus on clinical governance and there was a lead to facilitate governance processes.
- Managers were managing the service redesign in a proactive way. They were working with staff, patients and commissioners to ensure the safety of those who work and use services.
- Staff morale was high despite the imminent service redesign. Managers supported staff by keeping them informed and involving them in the redesign process by seeking their views.

Summary of findings

Information about the service

North Staffordshire Combined Healthcare NHS Trust (NSCHT) substance misuse services, provides integrated drug and alcohol support services covering the whole of the county with the exception of Stoke-on-Trent. The service is part of a wider partnership (led by Addiction Dependency Solutions (ADS) of providers who deliver services to this patient cohort who are at least 18 years old (there is no upper age limit).

NSCHT delivers the clinical function of the service with opiate substitution prescribing clinics as well as a home based detoxification service for alcohol and drug dependent patients. They also provide inpatient detoxification and stabilisation for drug and alcohol users at the Edward Myers Inpatient Unit. Located at NSCHT's Edward Myers Unit, is an Intoxication Observation unit (IOU). The unit comprises two beds which are used to allow intoxicated patients to become sober and return home. The patients are observed by staff and, once recovered, are offered specialist help to tackle any underlying issues and referred to other agencies for ongoing support.

The services we inspected comprise of an inpatient service; the Edward Myers Unit and community drug teams and their partnership agency Addiction Dependency Solutions (ADS) across four different locations. At this inspection we visited:

- The Edward Myers inpatient unit, which offers inpatient detox and stabilisation for drug and alcohol users.
- The Intoxication Observation Unit situated within the Edward Myers inpatient unit, which comprised two beds on one of the wards.
- One Recovery teams at Cannock and Tamworth, both of which are recovery focussed drug services offering a combination of psychosocial interventions and substitute prescribing.

North Staffordshire Combined Healthcare NHS Trust substance misuse services were at the early stages of working with commissioners in a service redesign. The impact of this announcement has meant some staff have either left or were deciding to leave the service before changes were implemented.

Our inspection team

Our inspection team was led by:

Chair: Beatrice Fraenkel, Chair of Mersey Care NHS Trust.

Head of Inspection: James Mullins, Head of Hospital Inspection (Mental Health), Care Quality Commission.

The team was comprised of: two CQC Inspectors and two specialist advisors, both were registered nurses with experience of working in the substance misuse field.

Why we carried out this inspection

We undertook this inspection to find out whether North Staffordshire Combined Healthcare NHS Trust had made improvements to its substance misuse services since our last comprehensive inspection of the trust on 13 – 16 September 2015.

When we last inspected, we rated substance misuse services as requires improvement overall. We rated requires improvement for Safe, requires improvement for Effective, good for Caring, good for Responsive and requires improvement for Well-led.

Following this inspection in September 2016, we rated the core service for substance misuse as good in every area and made no formal recommendations for improvement.

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from patients at trust wide focus groups.

During the inspection visit, the inspection team:

- visited one inpatient unit and two community services across three different sites and looked at the quality of the environments and observed how staff were caring for patients
- spoke with ten patients who were using the service
- spoke with two domestic staff
- spoke with one ward manager, two clinical managers and two operational managers for each of the services
- spoke with the clinical and operational directors for the directorate
- spoke with one volunteer, two student nurses, one recovery practitioner, eight registered nurses, and one junior doctor
- attended and observed a hand-over meeting, patient group, one to one sessions and an inpatient group work session.

We also:

- collected feedback from 24 patients using comment cards
- looked at 20 treatment records of patients
- carried out a specific check of the medication management at the inpatient unit and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

In the twelve months prior to the inspection, services had received a number of compliments from patients who had received treatment; the majority of these had been for the Edward Myers Unit.

Overwhelmingly, patients thanked staff for their kindness and support during their treatment, which had contributed to discharge from treatment.

One contribution indicated a concern about staffing levels and interventions being cancelled as a result.

North Staffordshire Combined Healthcare NHS Trust

Substance misuse services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Edward Myers Unit	Harplands Hospital
One Recovery South East, Tamworth	Trust HQ
One Recovery South West, Cannock	Trust HQ

Mental Health Act responsibilities

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

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received mandatory Mental Capacity Act training. We saw evidence of this in training records.Staff told us that they understood the principles and that they supported patients if they had impaired capacity and patients were given assistance where needed.
- In the community, deprivation of liberty safeguards (DoLS) did not apply.At the Edward Myers Unit, when impaired capacity was identified, patients were generally cared for by staff on a more appropriate ward. For example, if a patient had a neurological condition alongside a substance misuse condition then they would be looked after on a neuro ward supported by Edward Myers staff to manage their substance misuse issues. We were given examples of when this had happened and told that it worked well.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

Edward Myers Unit, Harplands Hospital

- At the Edward Myers inpatient unit, the ward layout allowed staff to observe all parts of ward.
- Staff had identified ligature points via environmental risk assessments and adequately mitigated any risk by regularly reviewing any change in circumstances which might raise the risk.
- Environmental risk assessments were undertaken regularly. The inspection team identified that there was an issue with a tap with a ligature point, this was identified in the risk assessment and we were assured this was due to be changed to remove the risk as a matter of urgency. In the interim staff used individual observations and risk assessments to mitigate against the risks.
- There were separate bedroom corridors for male and female patients which ensured that the ward complied with same sex accommodation guidance. The ward also provided a separate female only lounge. There were also separate bathrooms within each separated corridor, including disabled washroom facilities.
- The ward had fully equipped clinic rooms, with accessible resuscitation equipment and emergency drugs that were checked weekly. There was a technical team to carry out calibration on equipment and this was monitored, which meant that equipment gave accurate measurements.
- Seclusion rooms were not required and restraint was not used.
- In relation to cleanliness, PLACE assessments, which were patient led assessments undertaken by teams of NHS and private/independent health care providers, were carried out on an annual basis. Place assessment data for North Staffordshire Combined Healthcare NHS Trust was at 99.6%. The national average was 97.8%.
- We did not receive specific data related to cleanliness for the Edward Myers Unit. Full time domestic staff were employed on the unit and kept cleaning schedules, which indicated rooms were cleaned every day and then deep cleaned every week. Domestic staff kept cleaning cupboards secure and there was correct storage of cleaning products. Control of substances hazardous to health (COSHH) standards for storage were met, which meant potentially toxic cleaning products were kept in a locked cupboard away from patients.
- Staff followed infection control practices, including hand washing. There was an infection control lead within the team. The lead oversaw a cleanliness programme, making sure that fridge temperatures were within safe limits. They also led on environmental action plans and ensured that the team was adhering to trust policy.
- Equipment was cleaned and recording systems were in place to monitor good infection control practice. Staff checked equipment to ensure it was well maintained and safe to use. All electrical equipment had been PAT tested at appropriate intervals. This meant that all electrical equipment had been checked for safety.
- Staff and patients who were assessed as suitable, for example patients who had mobility problems, had access to appropriate alarms and nurse call systems. This meant that staff and patients were in a position to assist help and support if needed in an emergency.

Safe staffing

- The directorate staffed the services in line with safer staffing requirements. They used a safer staffing tool to estimate the number and grade of nurses required. There were two nurses per shift – early and late and one qualified nurse on a night shift. The Edward Myers Unit factored in additional qualified nursing staff on Mondays and Fridays to ensure that there was sufficient staffing for ward reviews. These additional staff were on a rota and the duties were shared between qualified substantive staff.
- Overall, the teams had sufficient staffing to respond appropriately to their patients' needs and provide one to one time with patients on the ward. Staffing establishments for each team at the time of inspection

Good

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were ten whole time equivalent (WTE) qualified nurses and six health care assistants with one vacancy for a qualified nurse. The intoxication observation unit (IOU) employed five whole time equivalent (WTE) staff.

- Staff could refer to Furlong Court, a step down provision for patients with less complicated needs. Patients started their detox on the Edward Myers Unit and after three to four days, depending on their progress were transferred and continued their treatment in the 24/7 supported detoxification accommodation. It provided short episodes of medically managed inpatient detoxification or stabilisation for drug and/or alcohol use involving 24-hour medical cover from a multidisciplinary clinical team with specialist training in managing addictive behaviours.
- There were no patients at Furlong Court at the time of inspection, however there had been three patients assessed as suitable to start the process the week following our inspection.
- The intoxication observation unit (IOU) employed one nursing assistant for each shift and the ward had one nursing assistant each shift. The IOU nurses were regularly used to cover other wards in the hospital, which meant there were sometimes less staff available on the Edward Myers Unit. This was highlighted on the trust risk register and was being monitored by the clinical director and the newly appointed nurse lead through the incident reporting system.
- The ward had one qualified nurse vacancy that had been advertised. In the meanwhile, bank and agency staff were used when services were short staffed.
- The Edward Myers Unit had the highest sickness rate in the directorate in the 12 months prior to the inspection date with 5.7%. The ward manager told us they had two staff on long-term sick at the beginning of the year and they had now returned to work. The sickness was not work related and support was given to staff when indicated.
- There had been no reported staff leavers in the 12 months prior to the inspection. However, there were a number of people who were due to leave their posts. Staff who were leaving and managers told us that this was a result of potential job insecurity due to reduced funding and service redesign. Across the substance misuse services, the overall turnover rate was 0.11%.
- Agency staff were inducted locally to the services and were given the opportunity to shadow a member of staff to familiarise themselves with the environment before commencing work there.
- Staffing levels were adjusted to take in to account staff shortages. There was regular use of agency and bank staff to support the team and patients when the unit were short staffed.
- A qualified nurse was available and present in the communal areas at the Edward Myers Unit.
- There was adequate medical cover day and night. There was on-call cover at all times. In the event of a medical emergency, staff rang 222 and a crash team would attend.
- The trust had set a target of 90% compliance for mandatory training courses. At the time of inspection, overall compliance was over the 90% target. Three of the four teams in this core service achieved a higher compliance than the trust average of 87.21%. The inpatient service had the lowest training compliance rate with 82.7%
- All qualified staff were level 3 safeguarding adults trained. All staff received mandatory training which consisted of Mental Capacity Act, safeguarding, medicines management and clinical risk training. Staff also received training in cardiopulmonary resuscitation, commonly known as CPR, falls, fire, and information governance.
- Domestic staff at the Edward Myers Unit had mandatory training in health and safety, COSHH and managing violence and aggression. They had monthly meetings with their supervisor and ongoing training sessions.
- All staff who worked with patients were trained to use the defibrillation machine and emergency resuscitation equipment.

Assessing and managing risk to patients and staff

- Staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident. This was evidenced in care records and in discussions with staff and patients. Staff also discussed risk in weekly team meetings using a complex case template. Admission to the Edward Myers Unit covered a range of vulnerability factors, for example, falls, violence

Good

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and harm to others and self-neglect. The unit had a risk assessment co-ordinator and there was a handover file, which shared risks. The manager expressed the importance of this due to variation in shift patterns and to ensure staff were up to date with current risks. All high level risks were consistently and regularly monitored and reviewed.

- Staff used two electronic recording systems for risk and care planning. All staff had been trained to use the systems. The trust were in the process of migrating all patient records to electronic and were working hard to have this in place for October 2016.
- There were rules and policies that restricted some items, for example, alcohol was not allowed on to the unit. Any restrictions were in agreement with the patient upon admission and were in place to protect everyone using the service.
- All patients were informal and could leave at will and we saw this in practice at the unit.
- There were good policies and procedures for the use of observation (to minimise risk from ligature points) and searching patients.
- There had been no use of restraint, rapid tranquilisation or seclusion in the 12 months prior to the inspection.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and did this when appropriate. There was evidence of this in care records, in discussions with staff and with patients. There was a safeguarding lead and link nurse at the unit. The link nurse on the Edward Myers Unit had good associations with local authority safeguarding teams and an accessible lead nurse for the trust. Safeguarding referrals went through an electronic process. They were discussed with the nurse in charge and the rest of the team.
- A pharmacist or technician visited the Edward Myers Unit weekly to audit medicines records. They looked at safe storage, dispensing practices, and medicines reconciliation. This meant the unit was mindful of good medicines management to help to reduce the likelihood of medication errors and patient harm.
- The family room at the Edward Myers Unit was based on the ward. The ward manager told us that they had considered moving the family room off the ward as a measure to protect children who visited. However, staff discussed the matter with patients and agreed the room would remain on the ward. There were risk assessment and management procedures in place for children who visited the ward.

Track record on safety

- There had been no serious incidents at the Edward Myers Unit in the 12 months prior to the inspection.

Reporting incidents and learning from when things go wrong

- Staff understood the importance of being open and transparent and explaining to patients if things went wrong.
- Staff knew what incidents to report and how to report them.
- There was shared learning from incidents among all staff groups. We saw evidence of learning from incidents through email briefings, team meetings and incident reports. There had been changes in practice as a result of incidents; for example, we saw that there had been a tool developed to identify changes in a service user's mood and prompt risk reviews.
- There was a directorate governance lead and also a training lead. There was a robust policy and governance system in place for managing incidents. Staff were trained as investigating officers and investigated incidents from other teams to ensure objectivity. The clinical director used one incident a week for learning purposes and shared the learning with staff.
- Staff discussed incidents as a team and individually, through supervision and within team meetings; each discussion had a learning lessons aspect. The ward manager sat on a weekly incident review group where all trust incidents were discussed and lessons learned. Incidents were monitored for themes and if there was an identified theme, this was reviewed.
- Staff were given the opportunity to debrief following a serious incident. They were also given the option to access the trust's counselling service and get support in dealing with the difficulties associated with serious incidents.

Safe and clean environment

One Recovery, South East, Tamworth and One Recovery, South West, Cannock

Good

Are services safe?

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- The community buildings for each service had waiting rooms and reception desks that were staffed by either substantive staff or trained volunteers. Reception staff had full view of patients in the waiting rooms and there was a signing in and out system for people entering the buildings.
- There were fully equipped clinic rooms, with accessible resuscitation equipment and emergency drugs that were checked weekly. A technical team carried out calibration on equipment and this was monitored.
- Staff followed infection control practices, including hand washing. There were infection control leads based at each site. Equipment was cleaned and recording systems were in place to monitor good infection control practice. The leads oversaw a cleanliness programme and led on environmental action plans to make sure everyone was adhering to trust policy.
- Staff checked equipment to ensure it was well maintained and safe to use. All electrical equipment had been PAT tested at appropriate intervals. This meant that all electrical equipment had been checked for safety.
- Cleaners were employed at each location and there were cleaning schedules, which indicated that rooms were cleaned regularly. Cleaning cupboards were secure and there was correct storage of cleaning products. Control of substances hazardous to health (COSHH) standards were met, which meant potentially toxic cleaning products were stored appropriately and away from patients.
- The community teams had alarm systems in rooms where they saw patients. Staff at One Recovery, South East Tamworth, used portable alarms. These were battery-powered, made a high-pitched sound when triggered and could be heard from a limited distance. A manager told us, that because of the limitations of this system, staff would not be left in the area without another member of staff present. This would remove the risk of the alarm going off and not being heard.

Safe staffing

- The directorate were undergoing a service redesign and as such, there was change and movement of staff. All services were experiencing a high level of staff leaving. Managers told us that they were in the process of losing four nurses across services. There were regular change management meetings and good contingency management plans in place to adapt to meet the needs of the service and patients. This included the use of agency and bank staff when needed.
- Managers used a safer staffing tool to estimate the number and grades of staff required. One Recovery Service was headed by a consultant psychiatrist who was supported by a medical team and head of directorate. Both community services had a clinical services manager employed by the trust and an operational manager, employed by Addiction Dependency Solutions (ADS).
- Staffing establishments at the time of inspection, at one recovery Cannock, were four whole time equivalent (WTE) medically assisted recoverynurses (MARS), with one WTE nurse vacancy and two WTE recovery co-ordinators, with one WTE vacancy. The service used a robust process for employing agency staff. For example, applications were filtered for suitability and based on skills and experience followed by an interview process. The manager ensured that agency staff were given the opportunity to shadow a member of staff and that they had regular performance reviews.
- Staffing establishments at the time of inspection, at One Recovery Tamworth, were four WTE medically assisted recovery (MARS) nurses, with one WTE nurse vacancy, and three WTE vacant recovery co-ordinators posts, which were being covered by agency staff. These vacant posts had been vacant for over twelve months. At the time of inspection there were staffing issues and we saw that there was considerable reliance on one substantive, experienced member of staff who was unavailable. Despite these staffing issues, managers and staff told us they were coping with the day-to-day running of the service.
- There were no reported sickness absences from One Recovery Cannock. One Recovery Tamworth sickness levels were at 2.5% in the 12 months prior to the inspection.
- No teams reported any staff leavers in the 12 months prior to the inspection. However, there were a number of people who were due to leave their posts. This was a result of potential job insecurity due to reduced funding and service redesign.

Good

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- There was regular use of agency staff at One Recovery Tamworth. One Recovery Cannock did not use agency staff, however they had contingency planning in place to use agency staff if substantive members of the team were to move on to new roles.
- Doctors told us that doctor sickness was covered and that there was on-call cover across the directorate at all times and that the on-call doctor had to be 15 minutes away from the service.
- One Recovery Tamworth held an overall caseload of 253 patients who had problematic alcohol needs, 76 patients who had non-opiate needs and 489 patients who were experiencing problematic opiate use. One Recovery Cannock held an overall caseload of 194 patients who required support with their problematic alcohol use, 52 patients who had non-opiate needs and 407 patients who were engaged with services who required support for their opiate use.
- Caseloads were distributed based on complexity of the patient and risk. Staff and managers told us that the caseloads were manageable at the time of inspection averaging anything from 30 to 70 cases per member of staff based on individual need and the responsibilities of the staff member. Managers were reviewing caseloads regularly to ensure safety and quality of care.
- Community services did not operate a waiting list. Patients who dropped in to community services had an immediate initial assessment with harm reduction brief interventions delivered. For professional referrals, or self/family referrals via telephone/email, a recovery coordinator actively contacted the patient to undertake an assessment and give brief interventions within 48 hours. Other assessments took place within three working days of referral.
- The trust had set a target of 90% compliance for mandatory training courses. At the time of inspection, overall compliance was over the 90% target. One Recovery Tamworth achieved 92% compliance and One Recovery Cannock, achieved 89% compliance, falling just short of 1% target compliance rates for mandatory training courses.
- All qualified staff were level 3 safeguarding adults trained. All staff received core training which consisted of Mental Capacity Act, safeguarding, medicines management and clinical risk training. Staff also received training in cardiopulmonary resuscitation, commonly known as CPR, falls, fire, and information governance.

Assessing and managing risk to patients and staff

- All new referrals to the community teams received a fully comprehensive assessment. This was used to identify substance misuse related issues and vulnerability factors. For example, staff looked at a patient's history of drug use, safeguarding issues, violence, and harm to others and risk of overdose.
- Staff worked with other agencies, for example, probation services to ensure they were joint working to manage the known risks. Staff undertook a risk assessment of every patient during initial assessment and updated this regularly. These included identifying what to do if the patient did not attend future appointments. This was evidenced in care records and in discussions with staff and patients. Staff also discussed risk in weekly team meetings using a complex case template, which was populated identifying risk and complexities.
- Staff used two electronic recording systems for risk and care planning. All staff had been trained to use the systems and updates around risk and care planning were planned annually. The trust was migrating patients' notes to an electronic format and were working hard to get this in place for October 2016.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and did this when appropriate. There was evidence of this is care records, in discussions with staff and with patients. There were safeguarding leads across all sites. Staff worked with local authority safeguarding teams to support them in managing risks, for example, attending case conferences and core group meetings.
- Staff managed each contact with patients in the community based on individual risks. The trust had a lone working policy and there were local policies in place to keep staff safe. For example, there was a signing in and out system in place. Staff had mobile phones to contact colleagues while they were out in the community. Staff would carry out home visits with

Good

Are services safe?

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another member of staff or agreed partner agency staff member. We were given examples of joint home visits by staff during inspection. For example, recovery workers and probation staff.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. There was shared learning from incidents among all staff groups. There were a range of methods used to share information. For example emails briefings, team meetings and incident reports.
- There was a robust policy and governance system in place for managing incidents. Staff were trained as investigating officers and investigated incidents from other teams to ensure objectivity. There was a directorate governance lead and a training lead who shared learning lessons information with staff across the community services.
- Staff discussed incidents as a team and individually, through supervision and also within team meetings as an opportunity to learn lessons. Incidents were monitored for themes and if there was an identified theme, this was reviewed.
- Staff gave an example of a new tool that was developed and used because of a serious incident with the aim of preventing harm. The tool was used to monitor a change in a patient's mood, which may result in them being at greater risk of harm while in treatment. This would alert staff to review risk, engage with the patient to a greater extent and involve other people in the patients care to reduce risk.
- Staff were given the opportunity to debrief following serious incidents. They were also given the option to access the trust's counselling service and support in dealing with the difficulties associated with serious incidents.

Track record on safety

- The clinical director told us that the directorate worked very closely with the coroner and commissioners to look at themes and learning from drug related deaths in the community. There had been 29 drug related deaths in the area over a 12-month period.
- Commissioners, the coroner and the directorate worked together to identify themes from serious incidents. They looked at where there were gaps in provision, which service improvements were needed, and recommendations for changes to practice. For example, they identified that naloxone, a drug that helped reduce overdose, should be prescribed to those with an identified need. They also recognised that closer links with partners, such as ambulance services could help reduce harm to those who misused substances.

Are services effective?

Good

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

Our findings

Edward Myers Unit, Harplands Hospital

Assessment of needs and planning of care

- All patients received a comprehensive and timely assessment. We looked at 20 care records, all of which were of good quality and included care and recovery plans. The doctors at the Edward Myers Unit were holistic in their approach. They carried out a joint assessment on admission with the service user and nursing staff, focussing on patients physical health, mental capacity and mental health.
- Care records showed that physical examinations were undertaken and that there was ongoing monitoring of physical health problems. Services had good links with other local medical services. For example, referrals to cardiology at the Royal Stoke hospital for those with irregular electrocardiogram (ECG); a simple test that can be used to check the heart's rhythm and electrical activity. All physical health issues were highlighted to patients GPs in the form of letters.
- Care planning was patient led and all patients set their own goals using the recovery star, which was a tool to support individuals to understand their recovery and plot their progress. Professionals could also use the tool to measure and assess the effectiveness of the services theydeliver.
- All information needed to deliver care was stored securely and available to staff when they needed it and in an accessible form; however there were limitations due to the paper system that had not yet been transferred to the electronic record system in its entirety.

Best practice in treatment and care

- Clinicians across all services used NICE guidance and the Drug Misuse and Dependence: UK Guidelines on Clinical Management, which was used for those providing pharmacological interventions for drug misusers as a component of drug misuse treatment.
- Staff who carried out alcohol detoxification used the clinical institute withdrawal assessment for alcohol, commonly abbreviated as CIWA orCIWA-Ar; a ten-item scale used in the assessment and management of alcohol withdrawal. We saw evidence of this in the care records we looked at.
- Patients received group work programmes at the Edward Myers Unit and we observed a session at inspection. The session was attended by eight patients and two members of staff. It was educational and the theme was about the liver. Patients were involved, contributed to the sessions, and were invited to provide feedback. Patients also had access to a support group called New Beginnings, established for over three years, and facilitated by people who had used services in the past. The aim of the group was support, signposting, training and one member of the group had won an award for volunteer of the year in 2015.
- Staff used an audit cycle and a clinical audit department to support local audits. There were audits of the ward environment, care notes, care plans, risks assessments and prescription charts. One junior doctor told us they were involved in liver guidelines and diabetes audits, which would be used throughout the trust. Outcomes from audits were discussed in team meetings and supervision.
- Patients' physical healthcare needs specific to their detox and stabilisation were met. For example, patients had access to blood borne virus services which operated within the NICE guidance on reducing drug related harm and infectious disease prevention and control. Staff were trained to do dry spot blood testing, which was an easy way of collecting, shipping and storing blood samples and the service was accessible across all community teams. Staff could also access specialist services to support the assessed physical healthcare needs.
- There was an established and effective volunteer programme for ex-patients across the services and we saw this in practice during the inspection. Some ex-patients had gone on to find substantive employment with the trust.
- Patients were encouraged to use mutual aid. Alcoholics Anonymous were engaged with the directorate and attended the Edward Myers Unit every Saturday morning. There was also an initiative called Voices, who were support workers who targeted hard to reach

Are services effective?

Good

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

patients with dual diagnosis and social issues and support to access services. Voices attended the Edward Myers Unit twice a week. Recovery service, an aftercare team who built on recovery capital in the community, also attended the Edward Myers Unit once a week.

Skilled staff to deliver care

- A full range of skilled staff were available to support patients in their recovery. For example, at each service, there were qualified nurses, trained recovery practitioners, pharmacists, access to medical staff.
- The service was led by a consultant psychiatrist. There were a range of skilled professional staff to support the patient group. For example, physiotherapy was involved where indicated and mental health professionals supported staff when needed. At Edward Myers Unit, community key workers were invited on to the ward to carry out joint work with nurses and health care workers for the benefit of the patient.
- All staff received an induction to the trust and local services and were suitably experienced, skilled and qualified.
- Staff were supervised, appraised and there were regular team meetings. We saw good quality supervision and appraisal records and team meeting minutes. At the time of inspection, there were six appraisals outstanding across all services. We did not have individual area breakdowns. Managers kept dashboards of due dates for supervision and appraisal and these were monitored by clinical managers. Managers told us they were sent reminder emails and we saw this documented in the substance misuse directorate minutes.
- All staff had received specialist substance misuse training, for example, training in novel psychoactive substances, sometimes known as 'illegal highs'. Staff had access to substance misuse specific conferences.
- Staff with management responsibility were supported in their development with specific leadership and management training. Staff with group work responsibilities had completed group work training.
- Doctors received role specific training, mandatory training and supervision suitable to their grading. Doctors received weekly supervision from a senior clinician and attended Balint groups. These give doctors the opportunity to present specific cases and gain support from their peers.
- Staff at the Edward Myers Unit had achieved 89% of their 90% target for mandatory training. Managers told us they had to rearrange mandatory training for a new starter. This was booked but not complete at the time of inspection.

Multi-disciplinary and inter-agency team work

- There were regular, recorded and effective multi-disciplinary meetings and handovers and multi-disciplinary communication every morning. At the end of every night, the on call doctor was informed of any issues.
- The multi-disciplinary team at the Edward Myers Unit had extended meetings every Monday and Friday. They recorded in detail the patient discussions and a copy was put in each patient's file. To ensure continuity of care and safe staffing levels on the ward, they employed two extra nurses to cover the extended meetings.
- There were effective working relationships with teams outside of the organisation, for example, local authority, social services, housing and educational services. The ward manager at the Edward Myers Unit attended a trust meeting with local police once a month, looking at hospital issues, for example, missing persons or drug use on the hospital grounds.
- A nurse was allocated to care for patients in two intoxication observation beds in the 'Intoxication Observation Unit' (IOU) on the ward. These beds were for intoxicated patients who might otherwise be cared for at the accident and emergency department. This meant that the accident and emergency department could use their resources for other patients.

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

- All patients at the Edward Myers Unit were informal. Mental Health Act (MHA) training at the trust was non-mandatory and had a 90% target compliance level (which it had met trust wide since August 2015). The

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trust provided the compliance rates for the period June 2015 to June 2016 and substance misuse services were one of the lowest scoring services for the trust, achieving 76% overall compliance during these dates.

- There was a Mental Health Act administrator within the trust and staff reported knowing how to access additional information on the intranet.
- Detained patients would go to other wards and medicine titration would be supported by substance misuse staff. We were given one example of when this had worked well.

Good practice in applying the Mental Capacity Act

- 87% of staff were trained in the Mental Capacity Act 2005 (MCA). Staff we spoke with had a reasonable understanding of the Act and the five statutory principles. Staff could tell us that they supported patients to make decisions where appropriate and when they might lack capacity. They understood that decisions had to be made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.
- There was a policy on Mental Capacity Act, including Deprivation of Liberty Safeguards (DoLS). Staff were aware of the policies and could refer to them. Staff knew where to get advice regarding Mental Capacity Act, including DoLS, within the Trust.
- For people who might have impaired capacity, capacity to consent was assessed and recorded appropriately. This was done on a decision-specific basis about significant decisions, and people were given every possible assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.
- Consent to treatment and capacity requirements were documented and copies of consent to treatment forms were attached to medication charts where applicable.

One Recovery, South East, Tamworth and One Recovery, South West, Cannock

Assessment of needs and planning of care

- All patients received a comprehensive and timely assessment carried out by an experienced member of staff. At this point patients would help outline an initial recovery or care plan to help them on their road to recovery. Where initial assessments took place would be dependent on circumstance. It could take place in a range of locations, for example, there were options to be seen at their GP's surgery, at home or a probation office.
- All information needed to deliver care was stored securely and available to staff when they needed it and in an accessible form. However, there were limitations due to the paper system that had not migrated to the electronic record system in its entirety.

Best practice in treatment and care

- Skilled staff at the community teams carried out drug and alcohol recovery programmes, which were supported by medical staff. Clinicians across all services used the Drug Misuse and Dependence: UK Guidelines on Clinical Management, which was used for those providing pharmacological interventions for drug misusers and is linked to NICE guidance..
- Community teams used evidence based psychosocial interventions, for example, the Birmingham treatment effectiveness initiative (BTEI), which was known to have positive and measurable effects in supporting patients in their recovery. Staff used social behaviour and network therapy (SBNT), which was an evidence based psychosocial intervention.The core principle of SBNT was that positive change was more effective with support from a close network of family members and/or friends. Patients also received group work programmes in community settings. At One Recovery Cannock, patients were provided with the option to attend groups, however, they required travel. Patients were provided with bus fare to attend venues that were further afield.
- Staff used an audit cycle and a clinical audit department to support local audits. Outcomes from audits were shared with staff in team meetings and supervision.
- There was a volunteer peer support programme led by a volunteer co-ordinator. Each volunteer had the opportunity to be involved with different aspects of the service. For example, the outreach worker had a volunteer who attended outreach visits. The family worker had four volunteers supporting them in engaging involved others. Each volunteer hoped to go on to full time employment.

Are services effective?

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

- Patients across all services were encouraged to use mutual aid such as narcotics and alcoholics anonymous. People with experience of substance misuse problems were employed as volunteers to provide hope to those in recovery, help them stay in recovery and to reduce the likelihood of relapse.
- Care records showed that physical examinations were undertaken and that there was ongoing monitoring of physical health problems. Services had good links with other involved medical services. For example, one consultant psychiatrist worked closely with a patient in managing their physical health needs in the home. They kept the patient's GP involved by joint working and providing feedback by letter or telephone.
- Patients were screened for liver function where appropriate and were offered the option of being tested for blood borne viruses at assessment. At One Recovery Tamworth, they had not yet set up a blood borne virus clinic, however, the lead nurse, who was new in post, was in the process of setting this up. There was liaison with the patients' GP and community pharmacist ensuring safe and clear practices. Discharge letters and summaries were sent to every GP relating to physical health issues.
- Patients developed their own care plans and set goals using the recovery star. This was a tool, which supported individuals to understand their recovery and plot their progress. Professionals could also use the tool to measure and assess the effectiveness of the services theydeliver.

Skilled staff to deliver care

- Teams across community sites comprised NHS qualified staff and staff employed by Addiction Dependency Solutions. At each service, there were qualified nurses, trained recovery practitioners, and access to medical staff. There were non-medical prescribers to supplement prescribing.
- All staff received an induction to the trust and local services and were suitably experienced, skilled and qualified.
- Staff were supervised, appraised and there were regular team meetings to reflect and explore issues. We saw good quality supervision and appraisal records and team meeting minutes. At the time of inspection all services had achieved 100% compliance achieved in supervision and appraisal.

Multi-disciplinary and inter-agency team work

- Staff attended regular and effective multi-disciplinary meetings across community sites. There were effective working relationships with teams outside of the organisation and opportunities to skills share, for example, working alongside probation and social services.
- There was good joint working at One Recovery Cannock with the dual diagnosis service, which was based in the same building. We witnessed professionalism, functional and organised joint work between the services dealing with a patient emergency. In contrast to this, One Recovery Tamworth were finding joint working with mental health partners more difficult based on the locality of the provider and the inability to access the right information at the right time.
- Each team worked closely with partner agencies and patients to help build on recovery capital, for example, where appropriate, probation staff, local authorities and other third sector organisations to support with social needs, for example, housing support.
- The services were led by a consultant psychiatrist. Community teams referred and care co-ordinated patients who were ready for stabilisation and detox to the Edward Myers Unit. Community care co-ordinators were invited on to the ward to carry out joint work for the benefit of the patient.

Good

Are services caring?

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

Our findings

Edward Myers Unit, Harplands Hospital

Kindness, dignity, respect and support

- Staff attitudes towards patients were positive and kind. All staff we spoke with told us that they enjoyed working with the patient group. Three patients agreed to speak with us at the Edward Myers Unit and they told us that staff were caring and compassionate.
- Staff knew and understood their patients and we could see evidence of this demonstrated in care records, interactions with patients and discussions with staff.
- PLACE assessments were self-assessments undertaken by NHS and private/ independent health care providers, and included at least 50 members of the public (known as patient assessors). They focussed on different aspects of the environment in which care is provided, as well as supporting non-clinical services. We did not receive PLACE information specific to the Edward Myers Unit, however, Harplands Hospital scored higher than the England average and Trust average with 98%.

The involvement of people in the care they receive

- We looked at four care records. The care plans indicated that patients were involved in their recovery planning. Staff had a strong focus on care and recovery planning. Patients were given copies of their recovery and care plans and staff were sent email reminders to always give patients copies of their care plans.
- Two of the three patients at the Edward Myers Unit told us that they knew how to access advocacy and we saw posters were displayed on the walls.
- Patients on the ward received a local induction. They were invited to involve their carers and families in their care and treatment. We saw in care plans that other professionals, including the community team care co-ordinators were involved in patients' treatment when appropriate. The ward staff were committed to encouraging relatives and friends in supporting their loved ones while in treatment.
- At the Edward Myers Unit, patients attended weekly community meetings and we saw that they were listened to. For example, they had requested access to Wi-Fi, which was implemented and meant that everyone using any of the services could access the internet.

One Recovery, South East, Tamworth and One Recovery, South West, Cannock

Kindness, dignity, respect and support

- Community staff interactions with patients were responsive, respectful and provided appropriate practical and emotional support. We observed this in one to one sessions with staff and patients and we were provided with positive feedback from all patients and carers that we spoke with.
- Staff knew and understood their patients and we could see this in care records, interactions with patients and in our discussions with staff.
- We carried out observations of one to one sessions with patients which were very empowering. There was a strong focus on motivation to change, harm reduction, social and mental health issues.

The involvement of people in the care they receive

- All care records we looked at indicated that patients were involved in their recovery planning. Patients also told us they were involved in planning for their recovery and we saw this in practice when we observed one to one sessions. Staff had a strong focus on care and recovery planning. Patients were given copies of their recovery and care plans and staff were sent email reminders to always give patients copies of their care plans.
- Patients in the community were invited to bring their carers and family with them to appointments and we saw in care plans that other professionals were involved in their treatment when appropriate. We also spent time with one patient and their carer at inspection. They told us that they were encouraged to be involved in all aspects of their treatment and care.
- All services were committed to providing support to help relatives and friends to talk about their experiences of supporting people with a dependence on drugs and/ or alcohol. There was evidence of mutual support across community services. The community teams had

Good

Are services caring?

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

a dedicated family worker. Managers, patients, and staff at the community teams were very proud of the success of this programme. Engagement was high and we were told that the meetings with involved others were regularly full. There were leaflets and posters in the waiting room and patients were involved in recruitment.

- Patients were encouraged to feedback about services, for example at One Recovery Cannock, we saw that patients were given a comments and complaints card at the end of a one to one session. There was a comments box in the waiting room at one recovery Cannock. However, we did not see this replicated at one recovery Tamworth.

Are services responsive to people's needs?

Good

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

Our findings

Edward Myers Unit, Harplands Hospital

Access and discharge

- All admissions to the Edward Myers Unit were informal, planned and were short stay, averaging seven days. Patients in the Intoxication Observation Unit were on the warder for shorter times based on their individual circumstances.
- **The trust provided us with bed occupancy figures for the Edward Myers Unit for the period of October 2015 to September 2016, which was 83%. At the time of inspection, there were two vacant beds.**
- Staff monitored patients physical healthcare needs and provided a healthy, balanced diet to support the patients detox and stabilisation during their stay on the unit.
- Discharges were managed to cause the least disruption, for example, not on a Friday afternoon when there was less support available to manage difficulties. Patients sometimes unexpectedly discharged themselves from the Edward Myers Unit and, when this happened, the unit continued to offer the treatment to detox in the community.
- The ward manager told us they were flexible and liked to observe, monitor and give support to those who found the inpatient detox too difficult and wanted to leave the service. There was a protocol to follow and a copy of the plans for unexpected exit from treatment could be found attached to recovery plans.
- Staff managed an unexpected discharge during the inspection. The patient had no accommodation to return to. The patient consented to stay at the unit until staff could help organise temporary accommodation. Staff immediately worked with the community team to put plans in place to ensure that accommodation was organised for discharge.
- Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and was in the interests of the patient.
- **A patient's average length of stay as at May 2016 for the** Edward Myers Unit **was 7 days.** Discharge was never delayed for any reason other than clinical reasons. There were no delayed discharges in the 12-month period prior to inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- There were rooms and equipment to support treatment and care such as activities rooms for patients, lounges and a dining room. There were also rooms where staff could sit with patients to carry out one to one sessions.
- Patients had access to quiet areas on the ward and a room where patients could meet visitors. Visitors could access a family room which was clean but it was sparse and not very warm or child friendly. The ward manager told us that they were in the process of buying resources to improve the family room.
- Patients could make a phone call in private. There was a payphone on wheels, situated in the lounge that could be wheeled to a private area. All patients had access to their mobile phones.
- Patients had free access to a secluded and private outside space with seating, a smoking area and outdoor activities such as football.
- Patients told us that the food was of a good quality and that they could make hot drinks and snacks at any time.
- Patients at the Edward Myers Unit had somewhere secure to store their possessions. All bedrooms had safes in the wardrobes and bedroom doors were lockable.
- Patients had access to activities throughout the week at the Edward Myers Unit, including at weekends. Patients could access the gym. There was a mutual aid group every afternoon; physiotherapy took people for walks, garden activities, evening activities, bingo, quizzes, Saturday groups, community meetings and discharge planning.
- Staff checked food temperatures before dispensing to patients. The fridge in the patient kitchen had a temperature checklist. The patient fridge, which stored milk, did not have a thermometer. We highlighted this at inspection, and the ward manager put one in place immediately.

Are services responsive to people's needs?

Good

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

Meeting the needs of all people who use the service

- The Edward Myers Unit included adjustments for people who required disabled access and facilities.
- Patients had access to information leaflets in languages spoken by people who used the service if needed, and also had access to interpreters and/or signers. Patients could access spiritual support if needed.
- There was provision of accessible information on treatments, local services, patients' rights, how to complain etc. One patient at the Edward Myers Unit said they did not know how to complain, however there was a weekly community meeting for all to attend and contribute their views to the service.
- There were choices of food to meet dietary requirements of religious and ethnic groups. All patients reported that the food was of a high quality.

Listening to and learning from concerns and complaints

- Staff told us if patients had a complaint, they would try to deal with this locally and they knew the process for supporting formal complaints. There were accessible complaints forms for patients at Edward Myers Unit and there were PALS posters in waiting areas.
- The Edward Myers Unit had received three complaints in the 12 months before the inspection. One complaint was upheld and staff were investigating two other complaints, the outcome of which had not been concluded at the time of the inspection.
- There were good investigation protocols in place and we saw evidence of various investigations into complaints and incidents.
- The unit received 20 compliments during the 12 month period from 1 April 2015 – 31 March 2016.

One Recovery, South East, Tamworth and One Recovery, South West, Cannock

Access and discharge

- Referrals to community services came from a number of routes. Patients could self-refer; they could be referred via their GP or following contact with criminal justice services. The community teams managed patients who were on a range of treatment orders, for example, some of those accessing services were on a drug rehabilitation requirement, which a court could order a service user to attend treatment for a period time and in conjunction with the probation requirements.
- Patients who dropped in to community services had an immediate initial assessment with harm reduction brief interventions delivered. For professional referrals, or self/family referrals via telephone/email, a recovery coordinator actively contacted the patient to undertake an assessment and give brief interventions within 48 hours. Other assessments took place within three working days of referral. Patients were given appointments to suit their individual needs and circumstances, for example, if someone worked they could access late night appointments.
- Staff effectively managed unexpected exit from treatment with patients. There was a protocol to follow and a copy of the plans for unexpected exit from treatment could be found attached to recovery plans. Patients who were discharged back in to the community had the option to re-engage with services if they needed to. Patients were encouraged to seek support from mutual aid and ongoing aftercare.
- Patients accessing community drug services often disengaged from treatment. Outreach workers were employed to reengage with these patients and encourage them to re-engage in treatment. The outreach workers were supported by volunteers who were proactive in re-engagement. They attended police and partnership vulnerability meetings to discuss a number of patient related issues such as accommodation and safe disposal of needles.

The facilities promote recovery, comfort, dignity and confidentiality

- Each service had rooms and equipment to support treatment and care. For example, there was a fully equipped clinic room to examine patients and carry out prescribing and rooms with privacy to have key work sessions. Patients were encouraged to engage in a range of activities and programmes. There were mutual aid groups, coffee, and craft mornings and group work programmes dedicated to recovery.

Are services responsive to people's needs?

Good

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

- There was provision of accessible information on treatments, local services, patients' rights, how to complain etc. One Recovery Tamworth did not have a complaints box but we did see a supply of complaints leaflets in the reception office.
- Community sites had well-resourced waiting rooms for patients which included a good range of leaflets and posters. At One Recovery Tamworth, patients were provided with bottles of water in the waiting room because there were no water cooler facilities.

Meeting the needs of all people who use the service

- The facilities at One Recovery Tamworth were not accessible to those who required wheelchair access. Those with a disability would have to been seen in the community or at home. The manager told us that they had experience of being flexible for those who might find it difficult to attend the service.
- Patients had access to information leaflets in languages spoken by people who use the service if needed and also had access to interpreters and/or signers. Managers talked to patients about the service redesign and its impact. There was information in waiting rooms to share with patients without causing anxiety. Managers gave assurances around safe care and monitoring as part of the redesign.
- One Recovery services offered a range of services to meet the needs of patients. For example, a needle exchange and home detoxes were offered and seen to be working effectively. One doctor gave us an example of where they helped a patient with their physical health needs as well as their substance misuse needs at home.

Listening to and learning from concerns and complaints

- A clinical service manager took the lead to facilitate governance processes. The role encompassed management and facilitation of responding to serious incidents, incidents, complaints and compliments. This meant that concerns and complaints were managed, and learned from to improve services for patients.
- Staff told us if patients had a complaint, they would try to deal with this locally, and they knew the process for supporting formal complaints. There were PALS posters in all waiting areas and staff knew how to access complaints forms. The manager of the team directly managed the complaint where the issues were informal. They provided updates and feedback to the person who made the complaint. For formal complaints, an investigating officer met with the complainant and investigated the complaint. They would also provide regular and final feedback on the conclusion of the process.
- There were three complaints across services in the 12-month period before the inspection. One was not upheld and two were still ongoing complaints. None of the complaints were required to be referred to the Ombudsman.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff knew and understood the organisation's values. We saw the vision and values of the service in the form of posters, in staff records and through discussions with staff. The team objectives reflected the organisation's values and objectives.
- Managers shared the service key performance indicators with teams. They were displayed in staff areas and were shared in team meetings to help staff work to objectives and meet targets.
- We saw senior members of staff at the teams during inspection and staff told us that they knew who senior managers were and that they could approach them if needed.

Good governance

- The clinical director was the clinical governance lead for the directorate and one manager took the lead to facilitate governance processes. The role encompassed management and facilitation of responding to serious incidents, incidents, complaints and compliments.
- Incidents were reported and there was a robust process in place for learning lessons. There was a dedicated governance lead and staff were trained in investigations. Staff learned from incidents, complaints and patient feedback and we saw there had been changes to practice as a result of learning lessons from incidents. Investigation officers had full comprehensive training in investigating incidents and root cause analysis. The governance lead supported the investigating officers to carry out investigations, write reports and to build their skills. The systems and processes were robust and we saw examples of investigations that were carried out.
- The service had a three monthly learning group looking at themes and current issues, for example, the service identified that there had been an increase in drug related deaths. They used the learning group to explore this and learn lessons. In addition, there was a drug related death group lead by commissioners with the coroner in attendance.
- Staff had received mandatory training and a range of suitable role specific training programmes. The trust has set a target of 90% compliance for mandatory training courses. Three of the four teams in this core service achieved a higher compliance the trust average of 87.21%. The Edward Myers Unit had the lowest training compliance rate of 82.7%.
- Staff with leadership and management responsibilities were supported with role specific training and there were routes to career development. Volunteers were also encouraged to develop and gain meaningful employment both internally and externally of the trust.
- The trust were committed to ensuring that all staff were appraised and supervised. There were quality records kept of supervision; there were additional clinical supervision opportunities as well as local management supervision.
- Managers ensured shifts were covered by a sufficient number of staff of the right grades and experience, and used agency or bank workers with specialist skills. Managers were managing vacancies as a result of the service redesign by advertising internally. They were also managing caseloads and staff roles and responsibilities to ensure staff were fully supported in the interim.
- All levels of staff participated actively in clinical audit. Clinical staff also engaged in role specific audits, for example, care plan audits, checking quality and standards to help improve interventions for patients.
- Staff were committed to safeguarding and there were robust systems and processes in place. Mental Capacity Act procedures were understood and followed.
- The provider used key performance indicators and other indicators to gauge the performance of the team. The measures were in an accessible format and used by the staff team who develop active plans where there are issues. All trust managers told us that they shared the key performance indicators with staff. We saw evidence of this being shared with staff at staff meetings, electronically and there were posters on the walls for staff to view if needed.
- Ward managers and managers from community services had sufficient authority and admin support.
- Staff had the ability to submit items to the trust risk register such as staffing levels in the intensive observation unit.

Are services well-led?

Good

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

- Staff with management responsibility were supported in their development with specific leadership and management training. For example, one manager had managing difficult people training and Aston leadership training. Staff with group work responsibilities had completed group work training.

Leadership, morale and staff engagement

- A project redesign group was reviewing the model of practice as a result of potential reduced funding to the services. Managers were meeting weekly to compile views of staff and patients. Managers sent out information to all staff to relay updates regarding the redesign. They had an engagement day planned to look at what the future was for the service; seeking views and opinions across the directorate. Managers were working closely with commissioners and stakeholders to manage the change.
- Sickness and absence rates across all services were relatively low and managed well locally with managers and staff telling us that there was a culture of support.
- There were no known bullying and harassment cases. All staff spoke highly of their managers and felt that they were approachable and that they were supported when needed. Staff felt able to raise concerns without fear of victimisation.
- Staff told us that they were aware of the organisation's whistleblowing policy.
- Staff told us that morale was high and that they worked very well together as teams despite the imminent service redesign which could potentially impact upon their service and jobs.
- Staff told us they were committed to being open and transparent and explained to patients when something went wrong.
- Staff were offered the opportunity to give feedback on services and input into service development.

Commitment to quality improvement and innovation

- Clinicians were involved in specific research into an alcohol medication as a treatment and its effectiveness. There were no research outcomes at the time of inspection.
- Staff participated in audits which were designed to ensure that the services reached a pre-determined standard. Staff were also involved in research to generate new knowledge to ensure good outcomes.
- All levels of staff participated actively in clinical audit. Staff used an audit cycle and a clinical audit department to support local audits. There were audits of the ward environment, care notes, care plans, risks assessments, and prescription charts. Outcomes from audits were discussed in team meetings and supervision.