Swanswell Kidderminster

Quality Report

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Date of inspection visit: 14 to 15 September 2016
Date of publication: 19/12/2016

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The service had a good mix of suitable staff at a local level. This, alongside the support from staff in the county-wide service, enabled them to meet local need. Staff turnover had become low and the staff team was very positive and supportive of each other.
- The premises minimised risk to clients and staff, as facilities and equipment were properly maintained and checked. Staff were properly checked to ensure they had no criminal convictions that might bar them from working with vulnerable people.
- Initial risk assessments were prompt and thorough which helped maximise safety for clients, staff and other vulnerable adults. Safeguarding procedures were in place, staff reported and learned from incidents. The service was open and transparent with clients.
- Medicines and prescriptions were managed safely. Vaccines and emergency medicines were stored safely and were accessible.
- Staff showed a good understanding of the needs of clients and responded to them in a positive manner. Staff followed national guidelines in the treatment

Summary of findings

and support of clients, with appropriate clinical support and signposting to other agencies. Recovery workers supported clients to access essential services such as housing, benefits and employment.

- The service had developed positive links with police, probation and local authority safeguarding. Although there was no dual diagnosis protocol, the service worked positively with community mental health services to help meet the needs of clients who had mental health as well as substance misuse issues. The service worked well with GPs under shared care protocols, to ensure they addressed physical health needs as well as recovery and relapse prevention.
- The service used treatment outcome measures and worked with commissioners to improve its effectiveness in supporting clients. It had produced a thorough audit after it had been awarded the contract and had used the results of this to identify and improve areas of shortfall.
- Clients were fully involved in their treatment and care. Staff supported them to make informed choices. Clients were appreciative of the time and approach of staff. The service was able to meet the diverse needs of clients.
- The service responded to referrals in a timely and proportionate way, and saw clients within agreed timescales. Clients who did not attend appointments were followed up by the service to minimise risk and support their well-being.
- Clients were able to make complaints and were confident the service would respond appropriately.
- The service supported clients in recovery to become mentors and volunteers.

However, we also found the following issues that the service provider could improve:

- Staff take-up of mandatory training in risk assessment, care planning and case note recording was low. Although case note recording was good, risk assessments and care plans were not routinely and regularly updated. Recovery tools, such as audits of alcohol use, were not always present in care plans.
- The service did not provide consistent training to enable staff to deliver psychosocial interventions where appropriate. As a result, there was little evidence of such interventions taking place, except on the initiative of individual staff who were already trained and confident in these areas.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		inspected but not rated

Summary of findings

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Background to Swanswell Kidderminster

Swanswell is a national charity and has been supporting people who misuse substances since 1970. It became the provider of services in Kidderminster in April 2015, as part of the county-wide service in Worcestershire. Swanswell Kidderminster is located in the centre of Kidderminster and offers a service to people in Kidderminster and the surrounding area.

The service offers:

• Health promotion• Needle exchange• Testing for blood borne viruses• Vaccinations for Hepatitis B

• Medical interventions including prescribing subsitite medication for opiate dependence • Community home detoxification• GP shared care

• Action planning, care co-ordination and key working• Group work, including relapse prevention • Referral and assessment for residential rehabilitation and detoxification• Supporting alcohol and substance users involved in the criminal justice system• Harm reduction and abstinence-based treatment• Debt advice, housing advice and health engagement• Life skills•

The service is funded by local commissioners and provides a free service to those who use it. There is a registered manager for the county service who had oversight over the four area locations; Worcester, Evesham, Redditch and Kidderminster. Each location, including Kidderminster, is led by a team leader. Some county-wide specialist roles are delivered in a range of settings by family workers, a blood borne virus nurse, young people's workers, a peer mentor and volunteer co-ordinator, non-medical prescribers, criminal justice workers and an assertive outreach team. This report looks at the running of services in Kidderminster.

The service provides diagnostic and screening procedures and treatment of disease, disorder or injury as regulated activities. It has not previously been inspected by the CQC.

Our inspection team

The team that inspected the service comprised a lead CQC inspector, Martin Brown, two other CQC inspectors, a CQC inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of this inspection

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

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

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment, and observed how staff interacted with clients
- spoke with five clients
- spoke with the team leader who managed the service at Kidderminster
- spoke with eight members of staff primarily or solely employed at Kidderminster
- spoke with six members of staff who worked at Kidderminster, but who were employed to work in the Swanswell service county-wide or, in two instances, regionally
- spoke with, as part of the inspection of all the county-wide service, eight other staff members employed by the service provider, including nurses and support workers
- spoke with one staff member who worked in the service but was employed by a different service provider
- received feedback about the service from seven care co-ordinators or commissioners
- spoke with a peer support volunteer
- attended and observed a detoxification panel meeting with a client
- collected feedback using comment cards from nine clients
- looked at ten care and treatment records for clients, including medicines records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

People we spoke with on the day of the visit were extremely positive about the service and about individual staff. These were echoed by comments written on the comment cards, which mentioned respect, approachability and compassion shown by staff. Clients felt staff understood their situation, helped them and offered choices. They felt equally that staff were honest in explaining actions and choices, and that as clients; they felt fully involved in all courses of action taken. People were complimentary about the groups and the work done in them.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had suitable levels of staff to safely support people using the service. Staff at Kidderminster were supported by staff operating a county-wide service, enabling the service to call on the necessary range of expertise to minimise harm and risk to clients, while maximising their recovery.
- Staff turnover, although initially high, was now low as the service was stabilising after its first year and staff showed keenness in working for the service.
- The premises used by the service minimised risk, with equipment and facilities being properly maintained and kept securely. Alarms were in place, regular safety checks were carried out and necessary equipment to help keep people safe was in place
- Staff were properly vetted and clinicians had their suitability to practice professionally maintained (revalidation).
- Initial risk assessments took place promptly, ensuring the service highlighted and managed any risks appropriately, including risks to children and vulnerable people.
- The service responded effectively to changing health needs of clients.
- Staff were trained in safeguarding and were confident in making appropriate referrals.
- Staff had good safe working practices, including a lone worker policy.
- Prescriptions and medicines were managed appropriately.
- The service had had no serious incidents in the 12 months prior to the inspection. It had mechanisms in place to support staff if incidents occurred and had suitable mechanisms in place to ensure incidents were reported and that relevant learning took place.
- An agreement was now in place whereby the service would inform the care quality commission of the deaths of any clients. We had not previously been notified of deaths by the service.
- When things went wrong, the service was open and honest with clients.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Staff carried out initial assessments promptly and thoroughly, with follow up appointments offered promptly.
- Staff demonstrated a good understanding of client needs.
- The service followed appropriate guidelines in the treatment and prescribing for clients.
- The service supported community detoxification for clients and had a budget for residential detoxification for clients who met access criteria.
- Recovery workers supported clients in areas such as housing, employment and welfare benefits.
- The service addressed clients' physical healthcare needs, either directly, or by appropriate referrals.
- The service used treatment outcome measures to show it was achieving parity with national averages.
- A thorough audit by the service had helped them identify areas for improvement, enabling the service to improve, for example, with screening for blood borne viruses.
- The service effectively used peer mentors and mutual aid groups to promote harm reduction and relapse prevention.
- The service had a good mix of skilled staff and was well supported by clinicians and other professionals in the county-wide service.
- The service ensured staff received regular supervision and performance reviews plus able to contribute to regular team meetings.
- Staff received mandatory training in areas such as safeguarding and mental capacity.
- The service worked effectively with other statutory agencies. It had shared care protocols in place to support effective working with GPs and pharmacies. The service also worked well with other agencies to tackle related issues such as homelessness.
- The service showed it was able to address and meet the diverse needs of potential and existing clients.
- The service had processes and support mechanisms in place to help clients move across services and towards recovery.

However, we also found the following issues that the service provider could improve:

- The provider had not always clearly evidenced where screening tools such as alcohol audits, had been used..
- The service did not consistently provide training to enable staff to provide psychosocial interventions where appropriate.

Summary of this inspection

- Staff take-up of training in risk assessment, care planning and case note recording was low. Care plans we reviewed reflected this, as information from good, thorough case note recording was not always updating risk assessments and care plans in a timely manner.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff took time and care to ensure clients understood the reasons for treatments and how they would work.
- Client feedback about staff was very positive, indicating staff were respectful, approachable, and honest and open with clients.
- The service maintained client confidentiality, privacy and dignity.
- Clients were fully involved in their treatment and recovery. Staff supported them to make informed choices.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service responded promptly and proportionately to referrals, based on the level of urgency. There were no waiting lists and clients were seen within agreed timescales.
- The service operated a telephone service to respond to clients at potential crisis times such as at Christmas. It opened one evening a week to see clients who found it difficult to attend during normal working hours.
- The service had a policy to follow up when clients did not attend appointments to ensure they were safe.
- Facilities were accessible and supported privacy, dignity and confidentiality. Information and services were available to clients whose first language was not English.
- Clients were able to make complaints and were confident the service would respond appropriately.
- The service supported clients in recovery to become mentors and volunteers.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Staff worked in a way that reflected and promoted the organisation's values. The team worked well together, staff were positive and client feedback about staff was equally positive.
- Staff received regular supervision and support. They felt well supported by management. The service reported, recorded and ensured it learned from incidents
- Audits took place, which had identified shortfalls and helped improve the service.
- The service worked with commissioners to achieve set targets that demonstrated its effectiveness.

However, we also found the following issues that the service provider could improve:

- The provider was not yet fully ensuring staff were completing mandatory training regarding risk assessments, care planning and recording.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff at Kidderminster had completed e-learning training on mental capacity. They demonstrated a good understanding of the Mental Capacity Act through their working practices. They understood that clients might not always have the capacity to make decisions if intoxicated and would discuss this with senior practitioners before providing interventions.
- Staff would ask a client to rebook an appointment if the client was heavily under the influence of a substance and unable to understand and retain information. This was part of the client's agreement to access treatment through the service.
- Staff stated they filled in the form for consent to treatment and consent to share information but did not routinely record this in the electronic records. Of the ten client records we looked at, only four showed clear evidence of a confidentiality agreement and consent to treatment and to sharing of information.

  We observed a duty worker complete a telephone assessment following a referral from another professional. The worker checked confidentiality and consent promptly as part of the assessment.
- The Mental Capacity Act 2005 is not applicable to children under the age of 16. Gillick competence and Fraser guidelines, which balance children's rights and wishes with the responsibility to keep children safe from harm, should be used for those under 16. Staff in the young person's team showed an understanding of Gillick competence and Fraser guidelines. They stated they would talk to the child and adolescents mental health team if they were concerned about a child's capacity to make a decision about support. Staff were clear that support was for the young person but would share information with, and support families, if the young person had given consent.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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Are substance misuse services safe?

Safe and clean environment

- The service was accessible directly from the street, with appropriate security and accessibility for people with restricted mobility. The client area was on the ground floor, with staff only offices on the second floor. There was a suitable waiting area with chairs overseen by the reception counter. The offices were secure. All areas were uncluttered, tidy and clean.
- The premises had up-to-date health and safety assessments. There were named fire wardens and named first aiders. There were regular fire alarm tests.
- All areas were visibly clean and tidy. There was a cleaning rota in place.The manager had previously raised cleaning issues with the cleaning company and was now satisfied with the level and quality of cleaning.
- There was a clinic room that had a couch and weighing scales. There were suitable handwashing facilities, appropriately signed. Weight was measured on request, or on the basis of assessed risks.
- There was a first aid box, which was regularly checked. Medicines were stored safely, with a fridge to keep vaccines at required temperatures. Fridge temperatures were monitored daily during opening days, and records showed temperatures were within safe levels. However, there was no way for the service to know if the temperature had stayed at an appropriate level during

weekends. Supplies of Naloxone (used in cases of opiate overdose) and adrenaline (used if a client had a serious allergic reaction) were readily available and in date. Staff were trained to administer these.

- There was a urine testing room with an adjacent toilet giving clients privacy. Suitable disposal facilities were in place. There were adjacent rooms where staff and clients could discuss any issues relating to the testing in confidence.
- There was a suitable needle exchange room where clients could dispose of used needles, collect fresh ones and discuss any issues with a staff member in safety and privacy. Needle supplies were in date and stored appropriately.
- The reception area had an emergency alarm. We witnessed the effectiveness of this when two staff, who had not been aware it was to be pressed as a test, rushed to respond and were in the reception area within seconds. Staff also carried personal alarms they could use in an emergency.
- Rooms were sufficiently sound-proofed so that conversation in those rooms could not be overheard. If voices were raised, they could be heard, but not distinctly.
- Records detailed the effective destruction of clinical/ hazardous waste, which took place monthly, or more frequently if required.

Safe staffing

- The team at Kidderminster consisted of a team leader, five substance misuse workers, a recovery worker, two criminal justice workers, a support worker and an administration and prescribing clerk. At the time of our inspection, there was also one peer mentor. The service also had support from staff who worked as part of the county-wide Swanswell service, at Kidderminster and the three other Worcestershire locations – Worcester, Evesham and Redditch. This gave support under the umbrella of a recovery and engagement team and a cross county clinical team. Staffing was sufficient to allow workers at Kidderminster to have caseloads of between 30 and 80. These varied according to the intensity and complexity of cases. Staff felt they had manageable caseloads, although they expressed concern that any proposed redundancies could negatively affect this.
- The county-wide clinical team included a team leader and three nurses who were lead nurses for detoxification, blood borne viruses and non-medical prescribing. If not on site, they were available for staff consultation via telephone if required. Two sessional doctors provided a weekly clinic at Kidderminster. The non-medical prescriber also provided a weekly clinic.
- The provider reported an average permanent staff sickness of 8.5% and a substantive staff turnover of 36% at Swanswell Kidderminster, as at 31 March 2016. The high figures for staff turnover related to the fact that the service had recently been awarded the contract, in April 2015, and many staff had been transferred over from the previous service provider. All staff we spoke with were keen to continue working with the service. Neither staff nor people we spoke with (or received comments from) who were using the service mentioned sickness or staff turnover as an issue.
- The service currently had a peer mentor who led groups, and received support from the team leader and recovery worker. Volunteers received full induction and training. Volunteers could be ex-clients who had first become peer mentors, helping support and motivate other clients leading by example. The peer mentor told us of training they had undertaken, and of training they intended to do, in order to become a volunteer. Beyond that, they hoped to be a paid worker in substance misuse.
- The service used two regular locum doctors to run a weekly clinic each Friday. This was the only use of agency or bank staff documented by the service for the three months up to 22 June 2016. Doctors offered assessment and substitute prescribing. The non-medical prescribing nurse held a clinic on Tuesdays.
- All staff had checks to ensure they were suitable to work with vulnerable adults. These were recorded electronically and would flag up when they were due for renewal.

Assessing and managing risk to clients and staff

Substance misuse services

- Staff undertook an initial risk assessment of each patient at the initial assessment. Client appointments took place at Kidderminster or at the GPs under shared care arrangements. Where home visits took place, these were made by two staff for initial visits, or where risk assessments had identified potential risks to staff. Staff assessed any initial referrals involving home visits. The service had a lone worker policy that helped minimise risk to staff and clients. Staff were aware of the lone worker policy and showed they were able to use it effectively.
- Care records showed good examples of staff highlighting risks to children, ensuring appropriate agencies were alerted, where necessary.
- Physical health checks were completed by doctors, usually the client's GP, where shared care arrangements were in place. We discussed an example which showed how staff responded effectively to deterioration in a client's physical health and ensured they received prompt and appropriate medical attention.
- We reviewed ten client records. All showed that they had an initial risk assessment.Assessments included an exploration of the client's history of substance abuse, risk and any safeguarding children and adults concerns.
- Staff we spoke with were knowledgeable and thorough when they explained how they holistically assessed clients' needs at the point of admission and throughout treatment. This was supported by observations of an initial contact received by a duty worker. Assessments were stored on an electronic recording system. Older assessments, made prior to the current provider taking over the service in April 2015, were recorded on securely kept paper files in the office.
- Staff could regularly discuss safeguarding cases in supervision, through team meetings or as needed with team leaders. All staff had received safeguarding training. Staff gave clear examples of when and how they had made safeguarding referrals and how they worked with other agencies to promote safeguarding. These examples showed staff were confident in making safeguarding referrals and worked well with other agencies to minimise the risk of harm to children and vulnerable people.
- The service did not provide specific facilities for clients with children within the building. This was because the environment and content of discussion was not appropriate for children. The service offered appointments to clients within school hours or staff could undertake home visits if required or arrange appointments at other venues.
- There was a clear policy on assessing risks where clients had children or frequent contact with children and vulnerable people. This included the client attending the pharmacist daily to take substitute medication, under the supervision of the pharmacist or the issue of free safe storage boxes to store medicines at home. The client and worker co-signed agreements on the acceptance and proper use of such storage.
- The service had a dedicated and trained prescription administrator. This person was new in post. Their role was to co-ordinate and produce batches of prescriptions for clients using a computer-generated programme in readiness for doctors to sign and issue to clients. They also coordinated prescription files for clients who hand collected them.
- Staff stored prescriptions securely in a locked safe and ensured a limited number of staff had access to them. No medicines were stored on site except for emergency use Naloxone and adrenaline. All staff were trained in how to administer Naloxone.

Track record on safety

- The service reported no serious incidents requiring investigation in the twelve months prior to our inspection.
- The organisation's recording system showed there had been 45 incidents recorded concerning this service between January and September 2016. Of these, 25 were recorded as 'no harm', 10 as 'low harm', 9 as deaths of clients, and one as moderate harm (short term). This also concerned the formal complaint made by a user of the service during this period.
- No direct notifications have been received by the CQC from this service in the last 12 months up until June 2016. The service did not routinely notify CQC of deaths of clients within the service. Swanswell's clinical governance implementation team had decided in July 2016 they would henceforth notify CQC of all deaths of clients regardless of the circumstances.

Substance misuse services

Reporting incidents and learning from when things go wrong

- Staff we spoke with were aware of how to report incidents and what incidents to report. Staff logged incidents, including deaths, on the service's electronic recording system. We saw evidence of appropriate incident reporting. A recent incident, where a client was verbally abusive, had resulted in staff setting up a behaviour agreement with the client, in order for the client to continue using the service.
- Staff received feedback through the lessons learnt bulletin, supervision, and team meetings. Incidents, including deaths of clients, were discussed in team meetings. Staff had been de-briefed following these, and any resulting learning had been applied. Managers could refer staff to the employee assistance programme provided by Swanswell for additional support and counselling.

Duty of candour

- Staff gave examples of being open and honest with clients when incidents or mistakes happened. They were aware of the need to keep clients fully informed and provided information throughout any investigations or complaints made. Comments from people using the service showed they felt staff were honest and forthcoming with them. One client noted staff "were always straight with answers they give me".

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- Staff offered clients an initial welcome appointment to discuss their needs and to explain what the service could offer. The assessment process started at this point. This was an initial triage assessment and the service offered follow up assessment appointments promptly.
- All clients had a comprehensive assessment completed at the beginning of treatment. This included assessment of their psychological, physical and social needs, including offending history and safeguarding concerns. Clients who reported alcohol use also completed an alcohol audit and, if required, a severity of alcohol dependence questionnaire. We observed a telephone assessment. The worker spent time ensuring they gained the clients' perspective and allowed the client to discuss issues that concerned them. The assessment included physical, social, mental health, offending, drug and alcohol concerns, as well as disability and access to services. Staff also provided harm reduction advice to clients.
- The service kept both paper and electronic records. Records for the past year were recorded electronically. Staff recorded new information about clients from visits or other contacts in individual client case notes. These were used to update assessments and recovery plans. Our observations showed that staff had a good understanding of clients, and shared knowledge and recovery plans with them. Less than half of the recovery plans showed clear evidence that clients had received a copy of their plan. However, all clients we spoke with told us they had discussed their care and recovery and indicated they were a full partner in their recovery. Comment cards also indicated that clients were aware of and involved in their recovery plans. One client recorded on a comment card, "all my goals have been reached" and another spoke of the holistic approach of staff to their treatment. The manager identified that client records may not all be consistently detailed but identified ways they were addressing this within the service. They detailed how workers should record client notes and treatment options.
- Electronic client records were stored securely on a password protected web-based case note recording system. Paper records were stored in alphabetical order in the office, which accessible only to staff. Managers and staff were responsible for maintaining these files.
- We looked at a sample of ten client care records. These contained risk assessments and risk management plans. Risk assessments were not up to date in three of the files. All had detailed on-going case notes that gave a good picture of the client's situation, recovery and support needs. There were assessments of drug and alcohol use. However, the recognised tools for alcohol audits were only clearly in evidence for half of the clients who were misusing alcohol. There was evidence of harm reduction advice being offered and of assessment of

motivation for change. This was reflected in positive comments by clients and by our observations of interactions. All but one record had an up-to-date recovery plan. Only one client was recorded as having received a copy of their recovery plan, but feedback and observations showed that clients were joint partners in their recovery plans, had a good knowledge of them and were involved in changes.

Best practice in treatment and care

- Doctors followed National Institute for Health and Care Excellence guidelines in treating and prescribing for clients (Methadone and buprenorphine for the management of opioid dependence, NICE, 2007; DH, 2007; NICE, 2011). They also used the Drug Misuse and Dependence: UK guidelines on Clinical Management. When carrying out community detox with clients, nurses ensured clients had proper levels of assessment, support and monitoring, in line with national guidance.
- Staff we spoke with gave us examples of the psychosocial interventions they used with clients. However, these interventions appeared to be based on the skills, knowledge and training of individual staff. We saw no evidence of training to equip all relevant workers with the skills and confidence to undertake psychosocial interventions on a consistent basis.
- Recovery workers supported clients with housing, employment and benefit issues. Clients spoke positively of the help the service gave them, either directly, or in helping them to access partner agencies.
- Staff considered physical health needs. Nurses were trained to provide electrocardiograms to monitor for potential heart abnormalities in clients taking over 100ml of methadone. This was in accordance with national guidance (DH, 2007). Staff also referred clients to their own GP for physical health checks such as liver function tests to be completed.
- Staff offered clients blood borne virus testing for hepatitis and HIV. This was in accordance with best practice (DH 2007). The county-wide service had increased the number of clients tested from zero to 400 since the start of the contract in 2015. The blood borne virus nurse had been responsible for raising awareness of the need for testing and supporting training of other workers. The service also offered clients hepatitis vaccinations.
- The service had a nurse available to them from the county-wide clinical team who supervised and supported clients with community detoxification programmes. The client received an assessment, which included considering avenues of support available to them whilst at home. The service reported seven community detoxifications completed in the 12 months up until August 2016.
- The service held a budget to provide inpatient detoxification and residential rehabilitation places. In the period up to August 2016 the service completedthree in-patient detoxes.We observed a detox panel where the client and staff agreed upon a residential detox. The client was fully involved in the evaluation of risks and decision to undergo a residential, rather than a community detoxification.
- Staff completed the treatment outcome profile (TOP) which measured change and progress in key areas of the lives of clients being treated in drug and alcohol services. Staff measured outcomes when clients entered treatment and every three months during support in accordance with national guidelines. When clients were discharged from the service, a final outcome measurement was undertaken. The most recent NHSDiagnosticshowed that the county service was achieving parity with national targets.
- Staff were not involved in clinical audits. However, Swanswell had produced a report of their shared care arrangements in December 2015 and completed a thorough audit of case files in January 2016. The service used action points from both of these to develop and improve the service.
- We received positive feedback from clients concerning the women's group, as an important intervention that helped prevent relapse. This group had discussed concerns about Christmas being a time of high risk to substance misusers, then ran sessions on making non–alcoholic cocktails.
- The team used peer mentors and was currently supported by one peer mentor. A peer mentor is someone who has completed their own recovery and is supporting the recovery of others, by taking part and helping run mutual aid groups.

Skilled staff to deliver care

Substance misuse services

- There was a range of experience within the staff team, further complemented by the county-wide service. This included nurses experienced in blood borne viruses, detox, and prescribing. Although psychosocial therapy was not routinely offered, individual staff in Kidderminster were able to demonstrate their knowledge, ability and enthusiasm in this area.
- Substance misuse workers and recovery workers had mixed caseloads of drug and alcohol clients. Staff had the opportunity to shadow colleagues who worked in other areas to build skills and understanding of the clients they supported. Recovery workers provided additional support to clients and helped them to maintain accommodation and employment through giving advice on areas such as benefits, training and independent living skills. Across the service in Worcestershire, staff were working towards national vocational qualifications or equivalent.
- We spoke with one worker who had been at the service for six months. They told us they had been well integrated into the service, had been able to shadow, and received training and support as part of their induction into the team.
- There was access to sessional doctors who ran two clinics a week. Doctors had undergone the Royal College of General Practitioners Certificate in the Management of Drug Misuse Part 1. Both doctors were employed by the service on a locum basis and had undertaken revalidation within the last 12 months. Revalidation is the process by which alllicensed doctors are required to demonstrate, on a regular basis, that they are up-to-date and fit to practice in their chosen field and are able to provide a good level of care.
- Staff received regular management and clinical supervision. This included caseload management, safeguarding cases and treatment outcome profile completions. Supervisions were up to date and records contained detail and action points for review at the next session. Staff attended peer support with colleagues and could access reflective practice sessions. Nurses were able to access specialist training. Clinicians told us they were able to pursue training as part of their professional development and to benefit the organisation. As part of supervision, staff received regular performance reviews.
- Staff attended fortnightly team meetings. Minutes from these showed staff were informed of, and involved in, updates and improvements in practice.
- Mandatory training tables supplied by the service showed good take up in such as safeguarding and mental capacity, but poor take up in risk assessment, care planning and case note recording. This was reflected in care records where information from case notes was not always informing and updating risk assessments.
- Managers addressed poor staff performance through supervision and the use of Swanswell's formal policy if necessary. We discussed with management examples of performance, monitoring, support and improvement that illustrated how the service supported staff to improve where required.

Multidisciplinary and inter-agency team work

- There was a shared care protocol in place with GPs across the county, so that clients were seen by their local GP at surgeries, supported by a Swanswell worker as required. Seven practices joined the scheme and two practices provided rooms where workers saw clients. In total, the service had 102 clients in shared care. Shared care supports clients to normalise treatment in their local community, as they are not required to attend specialist treatment services. The GPs who were part of the shared care scheme had completed the Royal College of General Practitioners part 1 in the management of drugs and the Royal College of General Practitioners part 1 in the management of alcohol. The GPs received supervision and support from the clinical lead at Swanswell.
- Swanswell criminal justice workers were working effectively with police and probation staff. Good communication enabled workers to support people immediately from the police station as required. The local police service commented favourably on the improved relationship and working with Swanswell.
- A worker from the young person's team was seconded to the youth offending service. They worked closely with probation, children's services, child and adolescent mental health services, local schools and the pupil referral units.

Substance misuse services

- The service did not have a dual diagnosis protocol in place with the local mental health trust, but we saw examples of good information sharing and individual working with local mental health teams where clients had both addictions and mental health needs.
- Staff contributed to local groups concerned with homelessness and begging. Within case files, we saw evidence of positive multi-agency working across a range of services including criminal justice and local authority safeguarding. We also saw regular correspondence with clients' GP and pharmacy services.

Good practice in applying the MCA

- Staff at Kidderminster had completed e-learning training on mental capacity. They demonstrated a good understanding of the Mental Capacity Act 2005 through their working practices. They understood that clients might not always have the capacity to make decisions if intoxicated and would discuss this with senior practitioners before providing interventions.
- Staff would ask a client to rebook an appointment if the client was heavily under the influence of a substance and unable to understand and retain information. This was part of the client's agreement to access treatment through the service.
- Staff stated they filled in the form for consent to treatment and consent to share information but did not routinely record this in the electronic records. Of the ten client records we looked at, only four showed clear evidence of a confidentiality agreement and consent to treatment and to sharing of information. We observed a duty worker complete a telephone assessment following a referral from another professional. The worker checked confidentiality and consent promptly as part of the assessment.
- The Mental Capacity Act 2005 is not applicable to children under the age of 16. Gillick competence and Fraser guidelines, which balance children's rights and wishes with the responsibility to keep children safe from harm, should be used for those under 16. Staff in the young person's team showed an understanding of Gillick competence and Fraser guidelines. They stated they would talk to the child and adolescents mental health team if they were concerned about a child's capacity to make a decision about support. Staff were clear that support was for the young person but would share information and support families if the young person had given consent.

Equality and human rights

- The service offered easy access to all. We noted an example of a potential client who was homeless and found it hard to engage with other services. Swanswell were flexible and adaptable and enabled them to use the toilet at Swanswell Kidderminster. The service saw this as part of the process of gaining trust with this person.
- The service was mindful of the number of Eastern European people living in the area. There were leaflets available in Eastern European languages, and a worker who spoke a number of Eastern European languages.
- The service was accredited as
- The service was flexible in providing support to meet particular needs. For example, if someone with learning disabilities was better suited to the young person's services then they could access that service.
- The service was also positive in ensuring good support for staff with disabilities. One staff member praised the service for its prompt and effective adaptions enabling them to work more effectively.

Management of transition arrangements, referral and discharge

- Staff we spoke with were able to describe how they planned for discharge with the client and that they explained to clients how they could re-access the service, if needed. We saw no evidence in care plans we looked at of plans for the unexpected treatment exit of a client. However, staff were able to detail in discussion the policy and procedure for the unexpected exit of clients from treatment. This was proportional according to assessed risks.
- The county wide youth service ensured a smooth transition to adult services. The transition process could be flexible to suit individual client needs. For example, the transition bar could be between 19 and 24 to meet with people's support needs, risks and level of vulnerability. The service provided both a young person's and the adult's service

Substance misuse services

- Clients were encouraged to access mutual aid such as self-management and recovery training (SMART) groups. The service used peer mentors, who were people who had previously used substance misuse services, to help facilitate these groups.
- Swanswell employed assertive outreach workers who actively worked to engage hard to reach groups such as clients who were homeless.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff took care and time to ensure clients understood processes and reasons for treatments and shared in the understanding and desirability of outcomes. This was evident in discussion with staff, in observing interactions with clients, in client feedback, direct to us and via comment cards.We spoke with five clients. Eight clients did not wish to talk with us, and one client scheduled to discuss the service with us did not attend.
- Clients in the service were very positive in their comments about staff. All nine comment cards we received were positive, with only one including a concern about whether telephone messages had been passed on in a timely manner. Comments praised individual staff as well as the team and groups that had been set up, such as the women's group. Respect, compassion, accessible and approachability were all terms clients used to describe the team, as well as positive comments about staff being 'strong and straight' with answers.
- The service maintained records safely and confidentially. Discussions with clients were confidential and appointments were held in private. When clients came for needle exchanges or wished to speak to the duty worker, these interactions took place with suitable privacy and confidentiality.

The involvement of clients in the care they receive

- All the clients we spoke with told us they were fully involved in discussions and plans regarding their treatment and care. Care records contained signatures from clients showing they had agreed their recovery plans. There was less evidence of clients having a copy of their care plans. Clients we spoke with did not regard having a copy of their recovery plan as a priority. They felt the important thing was to be aware and involved in the discussions that helped their recovery. Clients told us of being involved in their recovery. One client told us:"My worker helps me stay focussed and on track… works with me so I understand about choices…lets me identify and make the choices." Observations of interactions and other comments from clients showed this to be typical of the level of client involvement.
- There was information available about advocacy services and clients were able to access these. None of the clients we spoke with saw advocacy as a need for them. Posters for the local advocacy service were displayed in public areas.
- The service had not yet completed a survey to obtain clients' views. A survey 'get involved, have your say' had been commenced, with survey forms being given to clients for them to fill in and return. These were in the process of being distributed, returned and collated at the time of our inspection.

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

Access and discharge

- There was a range of referral routes. The service received referrals from GPs, social services, the criminal justice system or from clients themselves. The service did not have waiting lists; clients were seen as soon as possible. After an initial assessment, the service saw clients at the next available appointment, which would be within the week. Client risks were rated as red, amber or green and were seen within the allocated times prescribed by these ratings.
- The service was open Monday to Friday, nine to five, but had a county-wide call service that was open bank holidays, including Christmas, recognising that these were often crisis times for clients. The service had a duty worker available during opening hours, who was able to ensure client requests for needle exchanges and assessments were managed promptly and effectively. The service opened until 7pm one day a week, allowing access for those who found it difficult to use the service during normal working hours.

- When clients did not attend appointments, the service would follow up with phone calls and further contacts, including possible home visits, as required. There was a policy on managing those who did not attend appointments. Staff we spoke with explained how they followed this procedure and maintained a balance between ensuring clients were safe and respecting their right to choose to disengage from the service. The service also worked to reduce the likelihood of clients not attending appointments and the number of missed appointments by using texts, calls and other reminders to clients.
- Appointments ran on time. We had no negative feedback from clients about having to wait for scheduled appointments, or of appointments being cancelled.

The facilities promote recovery, comfort, dignity and confidentiality

- Rooms, waiting areas and toilet facilities used by clients were visibly clean and well-maintained.
- There were a range of rooms in which practitioners could see clients. The clinic room and needle exchange room were both of an appropriate size and had suitable facilities to support treatment and care.
- Rooms enabled conversations to be private. Standing outside the rooms, we could hear nothing of conversation in two rooms, and only indistinct words from a louder discussion in a meeting room.
- A range of information was available for clients. Information leaflets were available regarding opiate treatment, alcohol advice and complaints.
- Clients who had stopped using drugs and alcohol could become volunteers or peer mentors in the service. There was one peer mentor at the service at the time of our inspection. They were very positive about their role and the support given to them by the team and the team leader.

Meeting the needs of all clients

- The building and rooms were accessible to people with disabilities. Wheelchair users and people with mobility scooters were able to access the building and did so during our visit.
- Information leaflets were available. Basic information was available in languages other than English for the clients who were identified in the area demographics.
- Interpreters were available when required. One member of staff of staff spoke several Eastern European languages

Listening to and learning from concerns and complaints

- Clients we spoke with knew how to make a complaint about the service if they were unhappy about any aspect of it. One told us staff had informed them of the complaints procedure at their first introduction to the service. Two clients told us they had complained to the service informally and felt staff had responded to them appropriately. All clients we spoke with said they knew how to complain and were confident the service would respond appropriately if they had concerns.
- Staff were aware of how to deal with complaints. In line with Swanswell policy, they initially sought to resolve complaints informally.
- The service had received one formal complaint in the twelve months up until June 2016. This had had been partially upheld.

Are substance misuse services well-led?

Vision and values

- Staff worked in a way that reflected and promoted the organisation's values of being positive, collaborative, innovative, clear, trustworthy and holistic. They shared Swanswell's vision of achieving a society free from problem alcohol and drug use. Staff felt part of a strong and close team and enjoyed working within the team. Staff had high praise for their manager and team leader. Staff were familiar with the registered manager who visited regularly. Staff we spoke with were passionate about their roles and showed knowledge and enthusiasm around supporting service users to achieve recovery.

Good governance

Substance misuse services

- Swanswell provided mandatory training but not all staff had completed this. Managers were aware of this and said getting the service running well after taking over the contract had been a priority.
- Staff received regular supervision, including performance reviews. Positive comments by staff about supervision supported records of regular supervision and review.
- Incidents were reported, staff de-briefed as appropriate and incidents learned from to help improve services.
- The organisation had conducted two major audits of the county-wide service in December 2015 and January 2016. These were audits of case files and of shared care. These showed shortfalls, which the service was addressing. Offers to screening of blood borne viruses, for example, had now improved to 100% from the low level of 24%. A further audit was scheduled to take place to measure progress in all areas.Shortfalls observed in case files resulted in staff who had not already done so being prompted to take up training on care planning and recording training.
- The service had key performance indicators that linked to outcomes for payment by results. These included successful outcomes for clients and the number of referrals. Commissioners reviewed these regularly in monthly meetings. The service also met with commissioners quarterly, to look at performance, review incidents, deaths, and sub-contracting arrangements.
- All staff had undergone a disclosure and barring service check. Fit and proper person checks were carried out at the service.

Leadership, morale and staff engagement

- The service reported that there were no bullying and harassment cases. Staff told us they could raise concerns with their line managers or senior staff and were confident they would be listened to. Staff knew about the whistle blowing policy and how to use it.
- The team worked together in a co-operative and supportive manner. The team spirit was extremely positive. Comments by staff and by clients, who praised individuals and the team, reflected this.

Commitment to quality improvement and innovation

- Swanswell had undertaken a case file audit in January 2016 and a shared care report in December 2015. The action points identified in these audits were helping to improve and develop the service.
- Swanswell has a bronze award for Investors in People, which is an internationally recognised standard for the management of people.

Outstanding practice and areas for improvement

Outstanding practice

The service was innovative and reached out into the community with effective preventative and interagency work. On a small, local scale, it identified issues with substance misuse in local public toilets and worked with the cleaning agency there on measures to minimise harm and occurrences. The service worked with local police in having 'clean sweeps' to remove hazardous materials from local areas where substance misuse posed an issue, helping provide facilities and minimise harm.

Areas for improvement

Action the provider SHOULD take to improve

- The service should clearly evidence where screening and recovery tools, such as alcohol audits, are used.
- The service should provide training to enable staff to deliver psychosocial interventions where appropriate.
- The service should ensure that staff undertake mandatory training in risk assessment, care planning and case note recording in line with its policy.

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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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