

Primary Care Recovery Service






Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

We rated Primary Care Recovery Service as **good** because:

- Staff managed clients' risk safely and effectively. Staff safely carried out physical health checks on clients going through assisted withdrawal from alcohol. Clients' care plans addressed the potential risks of early exit from the treatment programme.
 - The service managed medicines well. Nursing staff followed best practice guidance when prescribing medicines for clients.
 - Staff minimised the risk to clients and children from abuse and avoidable harm. Staff worked closely with the local safeguarding lead to seek guidance and support.
 - Clients had care plans in place to support them going through alcohol detoxification. Clients' had recovery plans and staff completed relapse prevention plans with clients. Staff involved clients in planning their care and the running of the service.
 - Staff provided a range of care and treatment interventions suitable for clients' recovery. Clients had access to psychological therapies to support their substance misuse treatment. These included cognitive behaviour therapy and mindfulness.
 - Staff demonstrated a compassionate understanding of the impact clients' care and treatment could have on their emotional and social wellbeing. Clients were positive about the care they received from staff.
 - Staff actively engaged with commissioners, GPs, social care organisations and other secondary care services. This ensured staff could plan, develop and deliver the service to meet the needs of the clients.
- The service worked jointly with other services in the local borough's pathway for drug and alcohol services. This ensured that staff could appropriately place clients along the drug and alcohol pathway to meet their needs.
 - The service made sure staff were competent for their specialist roles working in substance misuse. Staff received an annual appraisal of their work performance and received regular managerial supervision to provide support and monitor the effectiveness of the service.
 - The service was well-led at team level and by the senior leadership team. Staff had access to information they needed to provide safe care and high-quality treatment to clients. The team used key performance indicators to measure the performance of the service. Nursing staff had completed a short research report into the effectiveness of a medicine that clients used for alcohol cravings.

However,

- Staff did not keep up to date with their mandatory training. Low rates of mandatory training included harm reduction, managing difficult situations, risk assessment and care planning training.
- Staff did not always actively promote the needs of all clients, including those with a protected characteristic. Staff did not always include clients' religion, ethnicity and sexual orientation into their care planning.
- The service did not have local systems to identify and manage risks within the service to ensure risks were mitigated.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	

Summary of findings

Contents

Summary of this inspection

	Page
Background to Primary Care Recovery Service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the service say	7
The five questions we ask about services and what we found	8

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards	12
Overview of ratings	12
Outstanding practice	23
Areas for improvement	23

Good 

Primary Care Recovery Service

Services we looked at

Substance misuse services;

Summary of this inspection

Background to Primary Care Recovery Service

Primary Care Recovery Service is a community based substance misuse service providing care and treatment from a main hub and eight participating GP practice hubs. The service provides a GP shared care scheme. This is an arrangement between two local healthcare professionals. This means clients substance misuse care is divided between Primary Care Recovery Service and the GP practice.

The service provides a medically monitored community alcohol detoxification programme, opiate substitution therapy, harm minimisation, group workshops and individual sessions. An aftercare service operates for those clients who are abstinent from alcohol and drugs.

The London Borough of Lewisham commissions the service.

The service treats clients over 18 years of age who drink less than 200 units of alcohol per week, and who consume alcohol daily or binge drink, and can engage in treatment at one of the eight GP practice hubs. For clients

with an opiate addiction, the service treats those people who have stable employment and/or education, do not inject opiates, and are able to engage in treatment at one of the eight GP practice hubs. Clients that do not meet the service treatment criteria are referred to a different substance misuse service in the borough.

Clients receiving opiate substitution therapy or medically monitored community alcohol detoxification attend clinics at any of the eight GP practice hubs.

The service is registered with the Care Quality Commission to provide the following regulated activity:

- treatment of disease, disorder or injury

At the time of the inspection, the registered manager had left the service and the area manager stepped in to cover this role until the new manager started in March 2019.

The Care Quality Commission had not previously inspected this service.

Our inspection team

The team that inspected the service comprised three CQC inspectors, a pharmacist inspector and a specialist advisor who had worked in drug and alcohol and community settings.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Summary of this inspection

During the inspection visit, the inspection team:

- visited the service and two GP surgery hubs, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with 10 clients who were using the service;
- spoke with the acting manager for the service;
- spoke with eight other staff members; including nurses, recovery practitioners and administrative staff;
- received feedback about the service from a commissioner and a GP;
- attended and observed a multi-disciplinary meeting;
- looked at nine care and treatment records of clients;
- carried out a specific check of the medication management at one GP practice; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with nine clients who described staff as approachable and helpful. All clients gave us positive feedback about the staff. Clients said staff supported them whenever they needed and that they appreciated this. We also spoke with clients who had completed treatment; they reported regular supportive contact from their keyworker throughout treatment.

The provider conducted an annual client satisfaction survey in May 2018. All clients who responded reported being happy with the service they received that day and all clients would recommend the service to someone else. Ninety-two percent of clients said it helped improve their overall health and well-being. Satisfaction survey results showed most clients to be happy with service.

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 rated safe as good because:

- Staff monitored clients' physical health during detoxification and knew when to escalate concerns. Staff carried out physical health checks on clients going through assisted withdrawal from alcohol in line with best practice.
- The service managed medicines well. Nursing staff followed best practice guidance when prescribing medicines for clients.
- Staff helped clients understand and manage future risks to their health and safety. Clients' care plans addressed the potential risks of early exit from the programme.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had received appropriate training and minimised the risk to clients and children from abuse and avoidable harm. Staff recognised when to report a safeguarding concern to the local safeguarding team.
- The service had suitable premises and equipment and looked after them well. The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

However,

- Staff did not keep up to date with their mandatory training. Low rates of mandatory training included harm reduction, managing difficult situations and risk assessment and care planning training.
- Patient records were not always complete. Staff had not updated two clients' risk assessments after an incident had occurred.

Good



Are services effective?

We rated effective as good because:

- Staff planned clients' care well. Clients had care plans in place to support them through alcohol detoxification. Clients had recovery plans and staff completed relapse prevention plans with clients.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Staff provided a

Good



Summary of this inspection

range of care and treatment interventions suitable for the clients' recovery. Clients had access to psychological therapies to support their substance misuse. These include cognitive behavioural therapy and mindfulness.

- Staff supported clients with their physical health needs. Clients had a physical assessment by the GP as part of their care and treatment. For example, physical observations, and baseline blood tests helped to inform appropriate treatment such as prescribing and detoxification regimes.
- The service made sure staff were competent for their roles. Staff received an annual appraisal of their work performance and received regular managerial supervision to provide support and monitor the effectiveness of the service.
- The service monitored the effectiveness of care and treatment. Staff routinely used outcome measures to see how clients were recovering from their substance and alcohol misuse. Staff measured this in collaboration with clients.

Are services caring?

We rated caring as good because:

- Staff demonstrated a compassionate understanding of the impact clients' care and treatment could have on their emotional and social wellbeing. Clients were positive about the care they received from staff. Ninety-two percent of clients responded to a recent satisfaction survey saying the service helped improve their overall health and well-being.
- Staff involved clients in planning their care. The service had a service user representative who was involved in weekly service user groups. The representative also fed back clients complaints and compliments about the service.
- Staff provided emotional support to clients to minimise their distress. Clients using the service, and their families, were provided with access to emotional support including mutual aid groups.
- Clients and families were provided with information about the service and what they could expect from staff in their care and treatment.

However,

- Staff did not always ensure that actions from the weekly service user involvement meetings were followed up as they did not record minutes for these meetings. This meant clients could not identify what actions staff had taken in response to the feedback provided.

Good



Summary of this inspection

Are services responsive?

We rated responsive as good because:

- The service planned and provided services in a way that met the needs of local people. Staff actively engaged with commissioners, social care and other secondary care services. Arrangements to admit, treat and discharge clients were in line with good practice.
- The service worked jointly with other services in the borough's pathway for drug and alcohol services. This ensured that staff could appropriately place clients along the drug and alcohol pathway to meet their needs.
- The service treated concerns and complaints seriously and investigated them. Staff told clients and carers how to complain, including how to complain to independent services. For example, the complaints procedure was visible in the clients' induction book.
- The service had enough space to support clients' treatment and care. Clients attended the premises for key work and group sessions. Clients could also attend the GP practice hubs to see their key worker and receive their physical health checks.

However,

- Staff did not always actively promote the needs of all clients, including those with a protected characteristic. Staff did not include clients' religion, ethnicity and sexual orientation into their care planning.

Good



Are services well-led?

We rated well-led as good because:

- The service was well led at team level and by the senior leadership team. Staff demonstrated the provider's vision and ethos of the service.
- Staff had access to information they needed to provide high-quality and safe care and treatment to clients. The service used key performance indicators to measure the performance of the team.
- Managers promoted a positive culture that supported and valued staff. Staff reported high morale.
- The provider was committed to improving services by learning from when things go well and when they go wrong. There was clear learning from incidents. Staff discussed incidents monthly at the team meeting.
- The service encouraged research and innovation. Nursing staff had completed a short research report into the effectiveness of a medicine that clients used for alcohol cravings.

Good



Summary of this inspection

However,

- The service did not have local systems to identify and manage risks within the service to ensure risks were mitigated. There was a lack of oversight around mandatory training.
- The service had introduced a quality improvement programme in 2017 but staff did not identify any quality improvement initiatives in 2018. The service also conducted annual staff surveys to gather feedback on the service provided but this had not been conducted in 2018.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act and staff knew how to find it. Seventy-one percent of staff had completed training on mental health awareness, which included learning on capacity and consent.






Staff ensured that clients consented to their care and treatment. Staff completed consent agreements with clients during their initial assessment. Staff assessed clients' capacity to consent by completing mini mental state examinations.

Overview of ratings

Our ratings for this location are:

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

Substance misuse services

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

Are substance misuse services safe?

Good 

Safe and clean environment

Interview rooms and group therapy rooms had alarm call systems fixed to the walls. This meant staff could summon assistance in an emergency. The alarms rang throughout the building and staff responded. Clients undergoing community alcohol detoxification or opiate substitution treatment attended the GP practice hubs for their clinical assessments and prescriptions.

The service embedded personal safety protocols for staff to follow. Staff followed lone working protocols to ensure their safety on home visits. Staff used mobile phones when they visited clients' homes and always went in pairs to reduce the risk.

The service had one dedicated clinic room, which could be used to undertake physical examinations. It contained equipment such as an examination couch, scales and height measuring equipment.

The service was clean, comfortable and well maintained. The service used external domestic staff to clean the premises. Cleaning staff recorded when they had cleaned the premises and kept these records up to date.

Staff followed infection control practices. For example, the service displayed posters for handwashing techniques. Staff disposed of sharps waste bin appropriately. Removal of clinical waste was collected by an appropriate external company. The service had a blood spillage fluid kit, due to the increased risk of clients contracting blood borne viruses.

Safe staffing

The service had enough staff to meet the needs of the client group and could manage any unforeseen shortages in staff. The establishment levels were two whole time equivalent (WTE) registered nurses and nine WTE recovery practitioners, including a team leader, working across the site and the eight GP practice hubs. The service had one vacancy for a recovery practitioner and one vacancy for a trainee recovery practitioner. At the time of the inspection, the service did not have a registered manager in post. The manager left in November 2018 and a new manager had been appointed. The service was completing pre-employment checks prior to them starting in March 2019.

The service had cover arrangements in place for sickness, leave and vacant posts. For example, the area manager and the team leader were covering the registered manager post until the new manager commenced employment. The team leader discussed staff absences and cover at the weekly team meetings.

Both nurses were non-medical prescribers (NMP). Non-medical prescribers are healthcare professionals who can prescribe certain medicines. All medical reviews and clinical decisions were completed by the GP as part of the GP Shared Care Scheme. Across each of the eight GP practice hubs, a GP had the skills and competencies with a special interest in substance misuse (GPwSI). This meant they could oversee the safe management of substance misuse within the GP practices.

The service ensured robust recruitment processes were followed. For example, we looked at five staff records. Each staff member had an up to date criminal record check to ensure they were safe to work with vulnerable adults.

Substance misuse services

Human resources also checked two references for each staff member from previous employers to ensure there were no gaps in employment and they were suitable to work with the client group.

The service's overall caseload was 446. Key workers had an average caseload of 44 clients, with the highest individual caseload being 79. The team leader allocated clients to staff based on the level of risk and the complexities of cases on each key workers' caseload. This was so the work with clients would be distributed evenly. Staff said their caseloads were manageable as clients were mainly low risk and could be referred to suitable services if their level of risk increased.

Mandatory training

The staff mandatory training completion rate was low at 65.5%. Mandatory training for staff included health and safety risk assessments, manual handling, infection control, information governance and basic life support. Low rates for training courses included managing difficult situations (43%), harm reduction (14%) and assessment, risk assessment and care planning training (7%). Three members of staff had low training completion rates. The area manager attributed this to staff finding it difficult to attend the office and complete their training. The nurses had been booked onto basic life support training for February 2019. By not completing mandatory training staff may lack the knowledge, skills and competency to safely meet the needs of clients.

The service ensured the independent NMPs had the appropriate skills and training to prescribe medicines. The two NMPs prescribed opiate substitution therapy (OST) and medicines for alcohol detoxification. They each had an 'intention to prescribe' scope of practice document. This described in detail their areas of competency regarding prescriptions. Their practice was monitored by the shared care lead GP for OST & alcohol detoxification and via online data, peer review and any prescribing errors.

Assessing and managing risk to patients and staff

We reviewed nine clients' risk assessments. When clients first attended the service, staff completed a brief risk assessment with them. Risk assessments included areas of potential risk, such as overdose or relapse. Staff screened for common risks associated with substance misuse, such

as blood borne virus status, injecting history and risks concerning family and children. The provider's policy was for staff to update risk assessments every three months, unless a change in risk had occurred.

Staff discussed high risk and complex cases at their weekly team meetings. Staff had clear discussions about clients' risks and presentation within these meetings and set out action points for the key worker to follow up. Staff referred clients along the drug and alcohol pathway to have their needs met by a different drug and alcohol organisation when their risks increased. In addition, staff attended the multi-agency risk assessment conferences to share information and work with the other professionals in the local borough to keep at risk clients safe.

Staff completed safety plans with clients. From the nine records we looked at, most were up to date. Safety plans included risks that may occur when at work and the risks associated with continued drug and alcohol use. When a client was being treated for a reduction in their alcohol and substance intake, staff discussed harm minimisation with them. This included a discussion of the risks of using illegal drugs or alcohol in addition to prescribed medicines. Staff included crisis management plans in clients' progress notes. These included how clients could access services in an emergency outside of the service hours of operation.

Overall, staff updated risk assessments after a change in risk had occurred. For example, when a clients' social or medical status changed. However, we found two incidents that had not been updated on the clients' risk assessment and management plan that should have been.

Staff followed up clients who did not attend appointments. Staff recorded when clients did not attend appointments and this information could be accessed easily to assess potential risks. For example, a client who had stopped attending the service was discussed in the weekly team meeting. Staff followed this up with a home visit, which resulted in a referral to social services being made.

Staff recognised and responded to warning signs and deterioration in clients' physical health. We looked at three records of clients who had completed a community alcohol detoxification. Staff recorded that the client had attended the GP surgery each day for the first five days. Staff completed the clinical institute withdrawal assessment for Alcohol (CIWA-Ar) each day when clients attended the GP surgery. This tool assesses and monitors the clients'

Substance misuse services

withdrawal symptoms when they are undergoing alcohol detoxification. This ensures the safety of the client and is a clinical assessment for staff to escalate any physical health concerns, such as nausea, tremors and sweating. Use of the CIWA-Ar followed best practice guidance. Staff also ensured that the client had a relative or friend with them throughout the duration of the detoxification. This meant the client could be monitored closely and any concerns could be escalated in line with best practice.

Safeguarding

Staff understood how to protect clients from abuse and the service worked effectively with other agencies to do so. Eighty-six per cent of staff had completed training in how to recognise abuse in adults. In addition, 86% of staff had attended training in how to recognise abuse in children and the processes to report abuse.

Staff gave us examples of safeguarding concerns they had reported. This included incidents of financial abuse, physical abuse and verbal abuse. The service had reported seven safeguarding concerns to the local authority between November 2017-November 2018.

The service had a safeguarding lead. This meant staff had a person they could ask for advice and guidance if they were concerned about a patient's safety. The safeguarding lead worked for the local authority and monitored the service's safeguarding alerts that had been reported. The safeguarding lead attended the weekly staff meetings to provide staff with support and updates on safeguarding incidents.

Staff followed safe procedures for clients that had children. Staff worked effectively with other agencies to promote children's safety and to share information. For example, as part of the initial assessment staff asked clients if they had any dependent children to care for. Staff then risk assessed whether a referral to the local children's safeguarding team needed to be made. Staff discussed this with the clients and informed them when a referral was made.

Staff access to essential information

Staff maintained all client care and treatment records electronically. As the service worked in partnership with the GP shared care scheme, staff recorded clients' care plans,

risk assessments and notes on two systems. This could sometimes be difficult for staff. For example, we found three incidents where records had not been updated appropriately after a clients' change in risk.

Medicines management

The provider had effective policies and procedures related to medicines management, including prescribing. The service had reliable systems for the appropriate and safe prescribing of medicines used in alcohol detoxification and opiate substitution therapy (OST). Staff prescribed medicines to clients and gave advice on medicines in line with current national guidance. The practice had detailed prescribing guidelines and protocols for clients on OST or alcohol detoxification which followed current national guidance.

The systems for managing clients prescribed OST followed best practice. Each client was supplied with a naloxone injection and information on how to administer. Naloxone is given to people who might overdose on opiates to have their overdose reversed.

Prescriptions for OST and alcohol detoxification were managed appropriately. All prescriptions for OST were individually logged and the patient signed for receipt. Staff prescribed medicines to clients from the GP practice hubs. Staff and the GP prescribed OST via instalments or requested supervised consumption at a local pharmacy, if appropriate.

Clients' health was monitored in relation to the use of medicines and followed up appropriately. Clients were involved in regular reviews of their medicines. Each patient on OST was reviewed at least once a month or more frequently if required by the GP and the non-medical prescriber (NMP). If a patient was undergoing alcohol detoxification they were reviewed each day for the first five days and on day eight after the course of medicine was completed.

Track record on safety

The service had reported two serious incidents in the last six months. These both involved the death of a client but not related to detoxification.

Reporting incidents and learning from when things go wrong

Substance misuse services

Staff reported incidents concerning safeguarding, information security and self-harm. Between October 2018 and December 2018 staff had reported 21 incidents. The service had an electronic reporting system that all staff had access to and completed reports. The manager accessed and reviewed all incidents reported to ensure appropriate action was taken. The manager encouraged staff to report incidents to ensure that improvements could be made.

Staff discussed incidents within the weekly team meeting. We saw that staff discussed several incidents that had been reported and discussed lessons from those incidents. The manager and team leader attended a borough-led meeting on recent deaths each quarter. Professionals from health and social care services in the borough came together to discuss and investigate deaths that had occurred. This was a way for professionals to update each other on what actions they have taken to investigate deaths.

Staff understood the duty of candour and the provider explained what was required of staff. The duty of candour is a regulatory duty that relates to openness and transparency. The service had a policy on the duty. Staff explained to clients when things went wrong and apologised.

When staff learnt from incidents this sometimes resulted in a change or improvement being made to the service. For example, after the death of a service user, staff changed the protocol for carrying out home visits.

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

Good 

Assessment of needs and planning of care

We reviewed nine care and treatment records during the inspection. Clients received a comprehensive assessment with their key worker shortly after referral. Assessments covered their history of drug and alcohol use, social needs, physical health and mental health care needs. In addition, staff recorded information about a client's family, including how many children they had.

Staff completed the Alcohol Use Disorders Identification Test (AUDIT) with clients to assess the degree of their alcohol dependency. In addition, the Severity of Addiction

Questionnaire (SADQ) was also used when clients were alcohol dependent. Use of these tools to assess clients' alcohol use and to guide treatment, followed best practice guidance from the National Institute for Health and Care Excellence. For clients who used opiate drugs, staff completed the Clinical Opiate Withdrawal Scale (COWS) for their assessment. GPs at the GP practice hubs carried out medical reviews at initial assessment for clients, when required.

Staff developed care plans that met clients' needs identified during the initial assessment. For example, staff referred clients to specialist services such as housing support and domestic violence charities. Staff supported clients with sleep disturbance and gave them helpful advice on sleeping patterns. In addition to substance misuse problems, clients' care plans included social needs such as relationships, legal matters, employment and housing issues.

Staff reviewed clients' care plans every three months and updated them when a change in need or risk was identified. For example, a referral to the local safeguarding team when a child was at risk or the client was in a vulnerable situation. However, of the nine records we checked, two care plans had not been updated appropriately when clients' needs had changed.

Best practice in treatment and care

The service provided care and treatment based on national guidance and evidence. Staff followed National Institute for Health and Care Excellence (NICE) guidance for substance misuse and Public Health England guidance when prescribing medicines. Staff prescribed medicines to clients and gave advice on medicines in line with current national guidance. The practice had detailed prescribing guidelines and protocols for clients on opiate substitution treatment (OST) or alcohol detoxification which followed current national guidance.

The service had urine testing kits available to detect the illicit use of non-prescribed opiates. In addition, staff carried out breath alcohol content tests on clients undergoing alcohol detoxification. This ensured clients were monitored appropriately.

Clients had access to psychological therapies to support them in their recovery. The service ran a programme of group work and one to one sessions Monday to Friday. Groups included mindfulness, alcohol support (for those

Substance misuse services

undertaking an alcohol detoxification), relapse prevention and a motivation to change group. In addition, a staff member provided acupuncture to support clients with their cravings. Staff worked closely with the local NHS trust to refer clients onto the improving access to psychological therapies (IAPT) team for support with their anxiety or depression.

Staff offered blood borne virus testing to clients. The manager said once staff had completed their training they were hoping to carry out dried spot blood testing on the premises.

Staff supported clients to live healthier lives. Staff carried out physical health reviews and smoking cessation at the clinics in the GP hubs. Staff referred clients to the local gym for exercise and to encourage motivation. Staff also promoted women's health, like contraception, by providing information about regular check-ups.

Staff used technology to support clients effectively. For example, the non-medical prescribers accessed the GPs online electronic system to obtain clients' blood results before commencing an alcohol detoxification or titrating clients.

Monitoring and comparing treatment outcomes

Staff regularly reviewed care and recovery plans with clients to monitor their progress in treatment. Staff used treatment outcome profiles (TOPs) to measure outcomes and the effectiveness of treatment. Staff completed TOPs with clients at the start, middle and end of their treatment.

For those clients who had reduced their alcohol intake or become abstinent, nurses used a tool to assess and monitor their cravings. Clients could assess their own cravings and nurses reassessed and monitored this at each follow up appointment.

Skilled staff to deliver care

The service provided all new staff with a comprehensive induction to the service. This included a separate induction to the GP surgery hubs that staff held clinics at.

The service ensured staff were competent to carry out their role supporting clients with substance misuse. Staff completed specialist training in alcohol awareness, club drugs and chemsex, opiate training, motivational interviewing and cognitive behaviour therapy approaches.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. For example, the provider put the two nurses on an independent prescribing course to qualify as non-medical prescribers.

Staff received monthly supervision and a yearly appraisal of their performance. In addition, the non-medical prescribers also met with the medical director each quarter for clinical supervision. Supervision records showed that staff discussed complex cases, well-being, training and development.

Multi-disciplinary and inter-agency team work

Staff ensured multidisciplinary input into clients' comprehensive assessment. For example, with staff from criminal justice services, the GP, housing and mental health services. Staff regularly liaised with the dual diagnosis team in the borough when they had a client who displayed anxiety or depression.

The service had regular team meetings. Staff attended weekly meetings, which had a different theme on a four-weekly rota. We looked at the minutes of these for the last six months and attended one of the meetings during the inspection. Staff shared pertinent information at these meetings including incidents, safeguarding new referrals and complex cases.

The service had effective protocols in place for the shared care of clients. The service worked jointly with the local GP practices to provide drug and alcohol treatment. Staff worked across eight GP practice hubs where clients went for their opiate substitution treatment and community alcohol detoxification. The provider produced a GP partnership agreement that staff followed when they worked in the GP hubs. In addition, staff had started meeting every quarter with the local mental health NHS trust to discuss complex cases and referrals to IAPT.

Good practice in applying the MCA

The service had a policy on the Mental Capacity Act and staff knew where it was. Seventy-one percent of staff completed training on mental health awareness which included learning on capacity and consent.

Substance misuse services

Staff understood mental capacity and were aware of how substance misuse can affect capacity. Staff worked under the principle that capacity is always assumed and where they queried a clients' capacity this was discussed in the team meetings.

Are substance misuse services caring?

Good 

Kindness, dignity, respect and support

We observed that staff responded to clients in a kind, supportive and compassionate manner. Staff were sincere and respectful when offering support to clients in one to one and group settings. Staff showed experience, confidence and compassion when dealing with challenging situations.

Staff offered specific slots for women to attend courses with the service, separately from men. We observed a group therapy session. Staff listened, were respectful, supportive, and promoted client recovery.

We spoke with nine clients who described staff as approachable and helpful. All clients gave us positive feedback about the staff. Clients said staff supported them whenever they needed and that they appreciated this. We also spoke with clients who had completed treatment; they reported regular supportive contact from their keyworker throughout treatment.

Staff said they could raise concerns about disrespectful, discriminatory behaviour to clients without fear.

Staff directed clients to other services when appropriate and, if required, supported them to access those services. For example, referrals to mental health for treatment, supporting clients with benefit issues and providing supporting letters for housing applications.

Staff supported clients to understand and manage their care, treatment or condition. Clients had regular one to one sessions with their keyworkers. The frequency of this was assessed on an individual basis. Staff understood the needs of their clients and had a genuine interest in their wellbeing.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained

the confidentiality of clients. The service kept records to confirm that confidentiality policies had been explained and understood by people who used the service. Staff provided clients with information about confidentiality, general data protection and information sharing. Staff sought clients consent to share information with other agencies, such as GPs, pharmacies, housing and social services.

Involvement in care

Staff communicated with clients so they understood their care and treatment. Clients reported that they felt very supported, informed and involved within their treatment decisions and care planning. All clients reported that they had seen their care plan and were happy with it. Clients reported that they understood what their goals were and were provided with an induction pack that set out information about their treatment going forward.

Clients facilitated weekly service user groups whereby clients could discuss any issues relating to the service and their treatment, as well as general peer support. There were no minutes or documentation for these weekly groups. Without these minutes it was difficult to demonstrate that staff followed up on client feedback.

Staff facilitated monthly service user involvement meetings. The feedback covered topics such as client experiences, planning for a client recovery café, general feedback around how to improve communication between the service and clients and ideas around social events. In addition, the service agreed to fund a social Christmas gathering in December.

Staff displayed suggestion boxes in the reception area as another way for clients or carers and family to provide feedback on the service they had received.

Staff collected feedback from the annual client satisfaction survey and displayed the feedback on notice boards and within folders throughout the premises. In May 2018, all clients who responded reported being happy with the service they received that day and all clients would recommend the service to someone else. Ninety-two percent of clients said it helped improve their overall health and well-being. Satisfaction survey results showed most clients to be happy with the service.

Involvement of families and carers

Substance misuse services

Staff informed and involved family members in the care and treatment of clients when appropriate. The service facilitated weekly groups for carers and relatives. This provided support and education about addiction, and sign-posting to other services, such as counselling and well-being.

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

Good 

Access and discharge

The service provided clear care pathways and referral systems for those whose needs could not be met. The local borough commissioned this service to work in partnership with other drug and alcohol services to meet the needs of the people in the borough. Staff worked closely with these other organisations to provide a clear pathway for clients. The organisations had created a partnership to develop a referral pathway. The service received referrals from the GP, the client, improving access to psychological therapies (IAPT) and the neighbouring drug and alcohol services in the borough. In addition, the service received referrals from clients who had never received treatment for their substance misuse before (treatment naïve). From April 2018 to November 2018, 413 referrals were treatment naïve clients.

Staff provided alternative treatment options if a client could not comply or relapsed. Staff met with the other drug and alcohol services in the borough each week to discuss complex new referrals or transfers of care. Recovery workers referred clients onto this service if they needed more support with the treatment.

The service had an agreed response time for new referrals. Clients did not wait more than three weeks from referral to initial treatment intervention. Each week the team leader and the nurse went through the referrals and allocated them to recovery workers depending on their needs.

The provider clearly documented their admission criteria. For example, the service's admission criteria included clients who were stable, able to engage in treatment and not injecting substances. The service and the other

organisations in the borough worked in partnership to set out clear criteria to meet the needs of people in the borough. Staff could see urgent referrals quickly. However, people with more complex needs, or with increased risks were referred onto the other drug and alcohol service.

Recovery and risk management plans reflected the varied needs of the client. This included referrals to other supporting services such as housing and social services. For example, clients had been referred to the local housing team and the local organisation for women at risk of violence.

Staff planned for clients' discharge including liaison with social care services. From April to November 2018, 144 clients had been discharged from the service. When clients had completed alcohol detoxification, staff sent a letter to their GP confirming the outcome and any follow up that was needed.

Staff supported clients during referrals and transfers between services. For example, staff handed over to professionals that they referred clients to with an update on their discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The service had enough rooms for clients to meet with their key worker on the premises. The rooms were adequately sound proofed to maintained privacy. The reception area welcomed clients and had comfortable furnishings whilst clients and visitors waited for appointments. Clients had access to hot drinks when they attended the premises. Staff also saw clients within the GP practice hubs where they held opiate substitute therapy clinics and the alcohol detoxification programme.

Patients' engagement with the wider community

Staff supported clients to maintain contact with their families and carers. Clients undergoing community alcohol detoxification were supported by a family member or friend throughout the duration of treatment.

Staff encouraged clients to develop and maintain relationships with people that mattered to them.

Staff encouraged clients to access the local community and social activities. Staff recognised that some clients were

Substance misuse services

vulnerable and isolated when the service was closed. The service had sub-contracted with another organisation to use the building for recovery groups at the weekend and evenings.

Staff ensured clients had access to employment and education opportunities. Most clients were in full time employment and staff worked around this when they needed to.

Meeting the needs of all people who use the service

The service made suitable adjustments for clients with disabilities to access the premises. Clients with low mobility could access the lower ground floor of the building from a ramp at the back. Clients could also access the building at street level to be able to use the ground floor.

Overall, staff demonstrated an understanding of the potential issues facing vulnerable groups such as black and minority ethnic (BME), LGBT+, older people and victims of domestic violence. Staff displayed posters of their confidential domestic violence lines including a separate line specifically for LGBT+ clients. Staff also referred clients to other local services for specialist support when needed. However, staff did not always ensure that clients' holistic needs were met. For example, clients' recovery plans did not contain information on a person's cultural, sexual identity and religious needs. This meant that staff may not consider the clients' holistic needs to support them with their recovery.

Staff used a telephone interpreting service when clients or their families could not speak English as a first language.

Clients reported that staff rarely cancelled appointments. Staff met clients on the premises, at one of the GP practice hubs or community centres. This encouraged engagement from clients who otherwise may have been hard to engage.

Listening to and learning from concerns and complaints

The service had a clear policy to treat concerns and complaints seriously and investigate them. The service received one complaint in 2018. The complaint involved staff communication and was partially upheld.

Clients knew how to complain and felt able to do so. Clients' received information about how to complain and the complaints process in their' induction pack.

The provider's policy detailed that staff should provide clients with feedback of investigations in a timely way when they complained. For example, the manager had written to the client and arranged a face-to-face meeting to discuss the outcome with them.

The policy stated that managers must handle complaints directly. The manager kept a log of all complaints, formal and informal, received about the service. The managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted.

Are substance misuse services well-led?

Good 

Leadership

Leaders could clearly explain their roles and demonstrated a high understanding of the services they managed. The managers of the provider's other services met together each quarter to share best practice about substance misuse. The medical director provided quarterly clinical supervision to the two non-medical prescribers.

Staff had a clear understanding of recovery and what this looked like. Staff spoke positively about clients' recovery and how they supported them to achieve their goals.

Managers and senior managers attended the service regularly and knew the staff and clients. The area manager attended the service every week. They had attended more frequently since they took over managing the service in the interim.

Vision and strategy

The service had a clear vision and strategy that all staff understood and put into practice. Staff emphasised the importance of supporting people to reduce their alcohol and/or drug intake and to increase their wellbeing.

Staff had opportunities to contribute to discussions about the strategy of the service.

Culture

Substance misuse services

Staff felt respected, supported and valued. Staff reported low levels of stress and felt positive about the work they did. However, staff did mention that the recent changes to the staff team had caused some anxiety, but this had improved in the last month.

Staff felt able to raise concerns and knew about the provider's whistleblowing policy and procedures. Staff could speak openly to the senior leadership team.

Managers dealt with poor performance when needed. For example, when a staff member displayed poor conduct at work, the manager followed the provider's disciplinary procedure. For the period June to December 2018, the staff sickness rate was relatively low (2.6%).

Staff worked well together as a team. Staff came together each week in the team meetings for the benefit of clients.

Governance

The provider had a clear framework of what had to be discussed at team and leadership level in team meetings to ensure essential information was shared amongst the staff. This included incidents, safeguarding, complaints and best practice. The service held monthly governance meetings at team level. These discussed pertinent information such as incidents, staffing and service performance. The managers and senior leadership team across the organisation met every quarter for business meetings. The minutes of these meetings from November, September and June 2018 showed staff discussed safeguarding, incidents (including deaths), clinical updates and ongoing projects such as the service's hepatitis C strategy. In addition, staff from the senior leadership team met quarterly to discuss clinical governance matters, including serious incidents, complaints and clinical issues like prescribing.

Staff had implemented recommendations from incident investigations, complaints and safeguarding alerts. The clinical governance meetings discussed lessons learnt from serious incidents such as deaths. This included improved communication with other agencies to ensure adequate information sharing.

Staff completed some audits to provide assurance that the service was performing well. Staff audited care plans, risk assessments and the environment. The area manager said they had just introduced peer checking of the nurse's prescribing to ensure they were safely prescribing medicines for clients' substance misuse. In addition, the

service completed a yearly quality improvement audit. However, this had not been completed for 2018. Staff last completed the audit in 2017, this was due to the reduction in area managers from five to three. The area manager stated the audit was scheduled to take place in February 2019. This meant that certain performance data may not be picked up by the manager and improved on. For example, only 65.5% of staff had completed their mandatory training which the interim manager had not monitored this performance and therefore tried to improve.

Management of risk, issues and performance

The provider maintained a strategic risk register. This included contracts and tenders and finances as the provider's main risks. However, the service did not have their own local risk register and did not contribute to the strategic risk register. The area manager identified the top risks as being able to keep the premises open as protocol states that three members of staff must be present in the building to open it. This could be difficult when staff worked remotely in the GP practice hubs. Other risks included nurses prescribing from a different system (the GP's online system) and cuts to local services. However, none of these concerns were on a service level risk register, or similar mechanism for risk oversight and management. Managers could not be assured all known risks were identified and planned for.

The service had plans in case of an emergency, such as adverse weather conditions or an IT fault. Most staff could access their online case management system from all but one of the eight GP practice hubs. The manager had now paid the one GP practice to allow staff to access their records remotely ensuring staff could update their records contemporaneously.

Where cost improvements had taken place, this did not compromise client care. The service had been through changes in staffing due to funding cuts. However, the area manager had just secured funding for a trainee post to eventually become a recovery practitioner.

Information management

The service used systems to collect data about performance. This was not over-burdensome for frontline staff. The service collected data about the performance of

Substance misuse services

the team to send to commissioners, such as accessing treatment, completed detoxifications, waiting times, referral sources and the demographics of the local population.

Staff had access to the equipment and information technology needed to do their work. The service had an administrative staff team who supported with the uploading and recording of information. The telephone system worked well and clients did not have problems contacting staff when they needed.

Staff recorded on two different systems, this could sometimes cause difficulties with keeping contemporaneous notes on clients' treatment. We found three incidents where records had not been updated appropriately after an incident or change in risk.

Team managers had access to information to support them with their management role. For example, the provider had an online human resources system. This meant managers could access supervision records, annual leave and sickness. However, this system was new so still needed embedding to work efficiently.

The service had implemented joint working and information-sharing processes with other services where appropriate to do so. For example, the service set up clear information-sharing protocols with clients and external agencies. Staff attended a deaths review meeting every quarter with professionals in the local area to share information about deaths. The service did not have a specific shared care working protocol with the GP shared

care practices. The area manager drew one up but the GPs wanted their joint working to be flexible. Staff said they had a good partnership with the GPs and agreed that a formal written protocol was not necessary.

Engagement

Staff, clients and carers had access to up-to-date information about the provider. For staff, they could access the intranet and bulletins about incidents or best practice across the organisation. Clients and carers could use the organisations website for up-to-date information about what was going on with their services.

Clients could give feedback on the service via client satisfaction surveys. Staff feedback was more informal, through meetings or supervision. The provider did provide opportunities for staff to feedback through a staff survey. However, this survey was last completed in 2017, staff did not have the opportunity to feedback about the provider in 2018. This meant the provider may not have collected staff feedback about the running of the service to make improvements.

Clients could meet with the senior leadership team to give feedback. A service user representative could feedback overall themes and comments from clients.

Learning, continuous improvement and innovation

The non-medical prescribers (NMP) had completed a short research report into the effectiveness of a medicine that clients used for alcohol cravings. The NMPs carried out this research on 15 clients using this medicine between May and November 2018.

Outstanding practice and areas for improvement

Outstanding practice

The non-medical prescribers (NMP) had completed a short research report into the effectiveness of a medicine that clients used for alcohol cravings. The NMPs carried out this research on 15 clients using this medicine between May and November 2018.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff complete the mandatory training identified to carry out their role safely and effectively.
- The provider should ensure they record the actions resulting from weekly service user meetings so that clients can see whether actions have been followed through by staff.
- The provider should ensure staff document the holistic needs of clients, including clients' protected characteristics.
- The provider should ensure local service risks are recorded so staff are aware of and can minimise these risks.
- The provider should ensure staff keep all records up to date in relation to clients' care and treatment.
- The provider should ensure they continue to complete quality audits of the service and to create a service improvement plan.
- The provider should ensure they gather feedback from staff about their experiences of working for the provider.