Requires improvement

Humber NHS Foundation Trust

Substance misuse services

Quality Report

Willerby Hill
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV936	Willerby Hill	Baker Street Specialist Drug Service	HU2 8HP
RV936	Willerby Hill	Goole Community Drug and Alcohol Team	DN14 6AE
RV936	Willerby Hill	Bridlington Community Drug and Alcohol Team	YO16 4ND
RV936	Willerby Hill	Open Access and Primary Care. Lairgate, Beverley	HU17 8EU

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated substance misuse services as requires improvement because:

- Staff were not up to date mandatory training.
- Staff did not update risk assessments and management plans following changes in a person's circumstances or following a multi-disciplinary team review.
- Patients did not have care plans that were up to date, holistic, personalised or recovery orientated.
- Patients had limited involvement in the care plan.
- There was limited evidence that staff used psychosocial interventions in treatment.
- Staff did not fully assess patients' physical health needs.
- Treatment pathways were problematic for patients resulting in longer waiting times and higher unplanned exits from treatment.
- The service was clinically focussed with a lack of encouragement for recovery.
- Staff were unsure of the indicators the trust used to monitor their performance.

However:

- Both staff and patients felt safe.
- Staff promoted harm minimisation throughout a person's treatment.
- The service had recruited peer mentors to support new patients.
- The multi-disciplinary team meetings discussed all patients in detail at least every 12 weeks.
- The service supported people who used image and performance enhancing substances.
- Morale was high in teams and there was a good partnership relationship between trust staff and ADS staff.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were not up to date with mandatory training.
- The service had not carried out recommendations from a fire risk assessment and health and safety report at the community drug and alcohol team in Bridlington.
- The service had an insufficient number of staff able to prescribe medication promptly.
- Staff did not use the risk assessment tools or risk management plans to periodically review risk.
- Staff did not make plans with patients detailing the agreed actions that staff would take, if a patient missed an appointment or dropped out of treatment.

However:

- Staff and patients felt safe.
- Caseloads were manageable and staff rarely cancelled appointments.
- Staff were knowledgeable about safeguarding and how to raise concerns.
- Services provided harm minimisation advice to patients throughout their treatment.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care plans were not up to date, holistic, person centred or recovery orientated.
- Staff did not record detailed assessments of peoples' needs or strengths.
- The service focussed on clinical interventions and maintenance in a patient's treatments and did not promote or embed recovery as an achievable option.
- There was limited evidence that staff used psychosocial interventions at all times in a patient's treatment.
- Staff did not fully assess patients' physical health needs.
- Prescribing staff did not always evidence the rationale for prescribing decisions.
- Staff working in the primary care team did not have easy access to patient records.

However:

- Staff offered patients immunisations and screening for blood borne viruses.

Summary of findings

- The service used treatment outcome profiles to measures changes and outcomes for patients.
- The service recruited and trained peer mentors to support newer patients.
- Staff received specialist training for their role.
- All the teams held effective multi-disciplinary team meetings.

Are services caring?

Good

We rated caring as good because:

- Patients felt supported by staff and that their concerns were listened to.
- Patients were able to telephone their keyworker and would always get a response.
- Patients had the opportunity to make suggestions about their service.
- Staff talked about patients in a respectful manner.

However:

- Staff did not reflect patient involvement in care planning.
- Letters sent to patients were not worded in an empathic way.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Patients were required to travel to different locations as their needs changed
- There were high waiting times and high unplanned exits resulting from the pathway.
- Appointment times at the specialist drug service did not consider patients' personal circumstances.

However:

- Staff took active steps to re-engage people who missed appointments.
- The facilities were welcoming with a good range of information available on treatments, local services and how to complain.
- The service provided specific support to people who used image and performance enhancing drugs.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The steps a patient was required to take to achieve recovery were often unmanageable or problematic.

Summary of findings

- The service was not recovery orientated as recommended in best practice guidance.
- Staff were unaware of indicators that could gauge their performance.

However,

- There was high morale among staff teams and partnership working between trust staff and ADS staff was good.
- Staff felt supported by the service's manager.

Summary of findings

Information about the service

he East Riding Partnership deliver community substance misuse services throughout East Riding. Humber NHS Foundation Trust are the lead trust in this partnership with the Alcohol and Drug Service (ADS). The partnership, commissioned through the East Riding of Yorkshire Council, was formed over 10 years ago.

As from 1 April 2016, a new contract was awarded to the partnership under the terms of Public Health England. This resulted in a restructured model.

This inspection focused on elements of the provision that were also included in the previous model. However, the structures of the teams have changed under the new contract. Therefore, information we have reviewed as part of this inspection process, which cover periods before 1 April 2016, relate to the previous complete service and not specific areas.

We inspected the following teams:

Open Access
This is the first point of contact for all people who are misusing any substance and entering into treatment. Drop in services are located at a variety of locations across East Riding with the central base in Beverley.

Specialist Drug Service
This is provided in the centre of Hull for those referred from open access, the community drug and alcohol teams or from primary care. It provides support for patients requiring intensive clinical support. At the time of our inspection, the specialist drug service had 30 patients being treated at this location.

Community Drug and Alcohol Teams
This service provides support for patient with drug or alcohol issues. There are two teams; one based in Goole and one based in Bridlington. The teams also hold 'drop-in' sessions at host locations in the East Riding. At the time of our inspection, Goole community drug and alcohol team had 168 patients being treated and Bridlington community drug and alcohol team had 236.

Primary Care Team
This team work within a number of GP surgeries across the East Riding. They provide joint support alongside the GP to patients experiencing difficulties with any substance and who have a low level of complexity. At the time of our inspection, the Primary Care Team had 140 patients who were treated in 15 GP locations.

CQC had previously inspected substance misuse services delivered by Humber NHS Foundation Trust under the previous contract in 2014. The trust met all the requirements at that time.

Our inspection team

This team was led by:

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission.

Team Leaders: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission and Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team that inspected substance misuse services consisted of one CQC inspector and three specialist advisors in substance misuse.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

use services, we always ask the following five questions of every service and trust:

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the premises and observed how staff were caring for patients
- spoke with 20 patients who were using the service
- spoke with 23 members of staff (including the service manager, consultant, nurses, team leaders, practitioners and administrative staff
- looked at 28 patient records and 10 medical cards
- spoke with one relative
- attended and observed one multi-disciplinary meeting, one primary care clinic, one focus group and one team meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 20 patients who used the service and one relative.

Mostly patients were positive about the services they were receiving. They told us that staff mostly had lots of empathy and that they found it easy to be honest. Patients felt safe while at the services and that they could ask for help if they needed it.

Some patients told us they found it difficult when they were required to be seen at different locations and that they often had changes in their keyworker. One patient felt that staff did not listen to them and one patient told us they had to be very assertive to get staff to discuss their wish to reduce treatment as opposed to maintain their treatment.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff are compliant with mandatory training.
- The trust must ensure that staff carry out a comprehensive assessment of a patient's needs that explores all areas in detail and includes assessment of recovery capital and consideration of physical healthcare.
- The trust must provide up to date, person-centred care plans that are personalised, holistic and focus on recovery from substance misuse and treatment.
- The trust must provide psychosocial interventions at all stages in a patient's treatment.
- The trust must ensure the pathway through treatment is responsive to people's needs and reduces waiting times and unplanned exits.

Action the provider SHOULD take to improve

- The trust should ensure that requirements from a Health and Safety Assessment in May 2014 and from a Fire Assessment in May 2015 be actioned as recommended.
- The trust should ensure that there are sufficient staff able to prescribe medications promptly.
- The trust should ensure that staff use the risk assessment and risk management plans to regularly review and record updated information.

Summary of findings

- Risk management plans should include actions staff should take if a patient misses appointments.
- The trust should ensure that staff working in the primary care team have easy access to patient's records including risk assessments and care plans.
- Staff should ensure care plans reflect involvement from the patient.
- The trust should ensure appointment times for the specialist drug service accommodate patients' circumstances wherever possible.

Humber NHS Foundation Trust

Substance misuse services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Specialist Drug Service	Willerby Hill
Goole Community Drug and Alcohol Team	Willerby Hill
Bridlington Community Drug and Alcohol Team	Willerby Hill
Open Access	Willerby Hill
Primary Care	Willerby Hill

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. All the teams we inspected had a compliance rate of above 75% in the Mental Capacity Act training. They were aware of the trust policy and of leads within the trust they could use for advice. If staff had concerns regarding a patient's capacity, they would refer to the patient's GP or the service consultant. If a patient appeared to be lacking capacity due to intoxication, staff would postpone any decisions or requirements to consent to treatment.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

All locations visited were clean with up to date cleaning schedules. The trust provided domestic staff to clean all base locations each day of opening. Where staff delivered sessions from GP surgeries, pharmacies and other venues, the host organisation was responsible for ensuring a clean environment.

Premises displayed infection control guidance and anti-bacterial hand gel throughout. The service had an infection control lead that carried out an audit on handwashing techniques. Staff had access to protective personal equipment, for example, gloves and aprons as required.

Staff carried personal alarms when seeing patients. In the specialist drug service, there were alarm points in patient toilets. Staff working from GP surgeries were easily able to raise an alarm if required from the computer terminal. This alarm was heard throughout the surgery. GP surgeries also ensured that staff were located in an area of the building that was not isolated.

Staff told us they felt safe working at all locations. Most patients also felt safe. One patient from the specialist drug service told us that there were sometimes disputes between patients in the waiting area but staff managed these well. The specialist drug service had CCTV in this area and observing the outside entrance. Reception staff monitored the CCTV and operated entrance doors through an intercom and there was a glass partition between the staff reception and patient area.

Nurses checked and calibrated equipment in clinic rooms as necessary. Fridge temperatures were correct and monitored through an electronic system. Staff correctly managed clinical waste and clinic rooms had bins for the safe disposal of needles. The first aid boxes were well maintained. However, at Goole community drug and alcohol team, there was out of date sterile eyewash. The defibrillation pads for the ECG machine were also out of date; staff rectified this at the time. The clinic room at the specialist drug service was untidy with old patient files being stored in a drugs cupboard and an unlabelled inhaler loose on a shelf. Medicines management code states that all medicines used in a clinic environment by patients (e.g. inhalers, eye drops) should be labelled with patients name, this could otherwise lead to misuse and/or cross infections.

Teams had fire wardens and first aiders on duty. All required fire checks for the specialist drug service, community drug and alcohol team at Goole and open access were up to date and premises had fire evacuation procedures displayed. Staff and visitors signed in and out. However, at the community drug and alcohol team in Bridlington, a fire risk assessment from May 2015 showed that recommendations had still not been actioned. This involved displaying an assembly point notice, a notice to keep a fire door shut closed and to ensure fire drills occurred.

Safe staffing

There was one service manager, one lead nurse, one consultant psychiatrist and one speciality doctor who provided cover across all the substance misuse locations in the partnership. With the exception of the speciality doctor (0.6 WTE); these staff were full time posts. The lead nurse was the only non-medical prescriber in the partnership, however two other nurses had begun training for this.

Each team comprised of a team leader, nurses, practitioners and administrative staff. The community drug and alcohol team at Bridlington also had a social worker employed as part of the team. The trust provided the clinical staff and ADS provided practitioners, with a focus on social care, who were not clinically trained. However, both job roles provided the same support to patients. This was apart from vaccinations that the nurses carried out.

Open access had eight peer mentors at the time of our inspection. Peer mentors are people who are recovering from drug or alcohol misuse themselves; the partnership expects them to be free of illicit substances or alcohol use for at least a minimum of six months. Their position is to support newer patients and act as positive role models. The partnership provided certified training in level two peer mentoring.

There was minimal use of bank or agency staff. The service had used one bank administrator and one nurse

previously. There had been a locum consultant however, this trust had now employed into this role. There were no current vacancies across the service and one member of staff on long term sick.

Staff from the specialist drug service and open access did not hold a caseload. Open access staff saw patients on entry into the service that they would then transfer onwards to either the specialist drug service, the community drug and alcohol teams or the primary care team. The specialist drug service had approximately 20 patients in the service at any one time; these did not receive keywork sessions and were only at this location for a short time. The community drug and alcohol teams held caseloads averaging around 30 each. Staff working from primary medical services held caseloads of around 25.

All staff we spoke to felt that caseloads were manageable. Staff worked flexibly across the teams which meant that sickness and leave could be covered. Patients told us that the service rarely cancelled appointments and if they did, staff would give them plenty of notice and a newly agreed date. However, this did mean that patients often saw different workers.

All teams had doctors cover at least one day per week with the specialist drug service having a prescriber on site all five days the service was open. This meant that patients were able to access a prescriber daily but may have to travel to a different location to do this if the need was urgent. This may mean that the service delayed changes in a patient's medication due to limited access to a consultant, doctor or non-medical prescriber.

Staff were not up to date with mandatory training. The trust had a target of 75% compliance. However, overall compliance across the substance misuse teams was 67% at the time of our inspection with managing conflict at 36%, equality and diversity at 36% and adult safeguarding at 65%. All staff had been booked onto an adult safeguarding course.

Assessing and managing risk to patients and staff

Staff completed a risk assessment for patients entering into treatment. They did this at the initial comprehensive assessment mostly at open access. The risk assessment covered self-neglect, personal safety, domestic violence, harm to others, children and childcare, injecting, poly drug use, sexual behaviour and blood borne viruses. The initial risk assessments contained a plan detailing how staff and patients would manage risks. Staff had dated risk assessment as reviewed and up to date. However, we did not see any updated risk assessments or changes made to the original risk assessment. Staff used the multi-disciplinary team meetings to review risks and any changes were then recorded in these notes rather than updating the risk assessment itself. Staff also detailed risks in the contemporaneous notes. This meant that staff could not use the risk assessment or management plans as a reference point as updated information had been recorded elsewhere. It could also result in staff not identifying new risks if not regularly reviewing the assessment tool.

The risk management plan did not include agreed actions that staff would take if a client missed an appointment or dropped out of treatment.

The service provided substitute prescribing for patients with opiate addictions. Substitute prescribing is a clinical intervention with a primary focus to reduce and replace illicit opiate use and in doing so, reduce harm and improve the health and psychological wellbeing of the person. For patients that required substitute prescribing, staff referred them onto the specialist drug service. While patients were waiting for this intervention to start, staff at open access continued to provide support as required.

Staff knew what constituted a safeguarding alert and the process they would follow if needed. They were able to give us examples of when they had raised an alert and informed us that the local safeguarding authority always gave them feedback. The service had a safeguarding lead who they could contact for advice. Mandatory training in safeguarding was 65., below the trust target of 75%. However, the manager told us that this was because of limited availability on courses and records showed us, that all staff had now been booked onto future sessions. Staff co-delivered training around parental substance misuse with the local safeguarding board for the East Riding area.

Harm minimisation was evident throughout the service. Staff used checklists that covered advice relating to injecting, poly-drug use, tolerance, overdose, sexually transmitted infections, blood borne viruses, social, legal and health implications. All locations we visited had harm minimisation posters displayed and accessible leaflets. This included literature around domestic violence.

Information was displayed informing patient which pharmacies provided needle exchange services. This

Requires improvement

Are services safe?

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

enabled patients who injected their drugs to obtain clean equipment and dispose of used needles. This reduced the risks of injecting behaviours and protected the wider community. Staff from the partnership delivered training to the pharmacy staff in this area.

Medications for substitute prescribing are class A drugs. They have a value on the black market and therefore at risk of being diverted. They are also extremely dangerous if taken without being safely prescribed especially if taken by children. Clinicians can direct substitute prescribing under a regime where the dispenser supervises the consumption; otherwise, the patient takes it away with them. All new patients starting substitute prescribing attended the specialist drug service where they consumed their medication on the premises. Following this, staff used the multi-disciplinary team meetings to consider the risks regarding whether a patient was required to take their medication at the pharmacy in a supervised way or not. For those taking their medications away with them, we saw staff had clearly discussed the need for it to be stored safely.

In the community drug and alcohol team at Bridlington, staff had displayed posters warning patients about a particular batch of strong heroin on the streets and a related death.

Staff informed the patient's GP of any prescribing. This reduced the possibility of a person obtaining substitute prescribing from more than one trust, which would be harmful to the patient and community if this were diverted elsewhere.

There were good practices in place for the management of medications. The service only dispensed medications directly from the specialist drug service. They had regular pharmacy checks, clear and accurate records and correct storage and dispensing practices. Prescriptions at all locations were securely stored with an effective audit trail.

Track record on safety

There had been no serious incidents for substance misuse services in the 12 months leading up to our inspection.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and what was considered an incident. During the previous 12 months, the service had reported 50 incidents. The service manager and nursing lead signed off all incidents following investigation and disseminated learning through multi-disciplinary team meeting and staff team meetings. Teams had made changes as a result of feedback. For example, staff from the community drug and alcohol team at Goole informed us of an incident where prescription records went missing. The manager conducted an investigation and found that this was due to reception staff needing to remove them swiftly from the reception area due to confidentiality. This resulted in a change of procedure and location relating to generating prescriptions. Staff were aware of the duty of candour.

The trust cascaded learning from incidents elsewhere in the trust through emails.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

The service carried out comprehensive assessments to new patients entering treatment. Staff from open access completed the assessments in a timely manner. The assessment, which followed a patient through their treatment with the partnership, included current drug use, historic use, alcohol, evidence of dependency, previous treatment, physical health, mental health, social situation, forensic, risks, client wishes, attitude and children. However, the assessment tool that staff used had an open box for each of these titles. This meant that the detail gathered was very dependent on the skills of the worker and how thoroughly they explored this area with the patient. From the records we looked at, we found that staff did not provide details in these sections. For example, records showed that patients had previously injected, however, there was no detail how historic this was and if the patient had shared any equipment. We also found sections that staff had completed as 'none', however when reading into the patients' detailed notes it showed information not contained in the assessment record. The assessment tool did not include any strength-based questions such as employment, education, supportive people or groups. These are the resources an individual requires to achieve and maintain recovery from substance misuse, often referred to as recovery capital. The service manager did inform us that the comprehensive assessment tool had very recently been reviewed, updated and was now being used. At the time of our inspection, records we looked at still used the previous assessment.

Following assessment, patients agreed care plans with staff. There was a generic care plan for those patients the service transferred to the specialist drug service for prescribing interventions. This care plan only included goals directly relating to maintaining their substitute prescribing treatment. There was no inclusion of personalised, holistic or recovery orientated plans.

In the community drug and alcohol teams and the primary care team, staff used a recovery star to identify areas where plans were required. The recovery star rated a patient's needs around drug use, alcohol use, physical health, meaningful activity, community involvement, emotional health, accommodation, money, offending and family and relationships. However, the recovery star itself did not form a plan of care, it only identified a patients rating without associated goals to improve these aspects in a patient's life. Staff then used a care plan template to record goals for the patient. There was a care plan in 20 of the 28 records we looked at, 11 of these were more than three months out of date. Care plans were limited in details. Staff focused goals around clinical interventions and maintenance on substitute prescribing rather than being recovery orientated. In the majority of plans we saw, staff had not included the wider needs of the patient or personalised goals.

Staff stored patient records securely in locked cabinets at open access, the community drug and alcohol teams or the specialist drug service. This enabled all staff working in these locations to have easy access to records. Staff securely transported patient files for outreach appointments.

Primary care workers stored their patient's records at the open access base and did not take them out to GP surgeries. This included risk assessments and comprehensive assessments. Staff also recorded the contemporaneous notes following an appointment on the GP's electronic system. They were required to transport copied appointment notes back to patient files from the primary care location following clinics. This meant that staff who were unfamiliar with patients, were not able to easily and quickly view patient risks prior to appointments. Staff would have to firstly travel to the open access base prior to appointments or read through the historic notes on the GP system. However, all primary care workers had access to the GP system and patients seen at primary care all had low risks.

Best practice in treatment and care

The service prescribed medications as recommended by the Department of Health's UK Guidelines on Clinical Management for Drug Misuse and Dependence. Clinicians conducted face-to-face appointments for patients starting a prescribing regime, staff screened for drug use routinely throughout treatment and nurses carried out recommended tests for those patients on high doses of methadone.

However, doctors did not evidence the rationale around some prescribing decisions. For example, reasons for increases or decreases in medication or reasons for changes from methadone to buprenorphine. It was therefore unclear how prescribing took into account

Are services effective?

Requires improvement

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

personal circumstances alongside guidance. Although staff carried out drug screens routinely, they did not take necessary steps to limit the opportunities for patients to tamper with specimens and to check their integrity, such as temperature testing.

The Strang Report 2012 (commissioned by the National Treatment Agency) detailed the need for treatment trusts to focus on recovery rather than maintenance on medication. The report detailed that recovery is best defined by factors other than medication status and hinges on broader achievements in health and social functioning. From the 28 records we looked at, only three included detailed goals and interventions relating to recovery beyond medication. The remainder did not include interventions to build recovery capital or detail aspirations for a patient's discharge from treatment with improved health and wellbeing. They mainly contained goals relating to becoming stable on medication and attending appointments. With the exception of one, patients we spoke to talked about their maintenance in treatment. They told us that they had been in treatment for many years and visited the service every two weeks for a new prescription. They did not talk about their ambitions to reduce their medication with a view to successfully exiting services. One patient focussed on their recovery, told us that they had to be assertive with staff for this to happen. Staff we spoke to were aware of the Strang report and recovery agenda; however, this was not evident in practice. Staff had not reflected the consideration of wider health and social needs in care plans. However, patients did tell us that staff referred them appropriately if needed. Reception areas and interview rooms also had a wide range of information leaflets for support groups and organisations.

As recommended by the Strang Report, the service used peer mentors to make recovery visible to patients. Peer mentors communicate to people in treatment that recovery is possible. They effectively improve understanding, heighten people's treatment ambitions and motivate them to work towards recovery. At the time of the inspection, peer mentors were only being utilised in open access services. However, the manager told us that due to the new contract, peer mentors would be utilised in all areas.

The department of health's guidance states that treatment for drug misuse should always involve a psychosocial component. The trust and ADS had trained staff in evidence based psychosocial interventions including cognitive behaviour approaches and motivational interviewing. The specialist drug service used psychosocial interventions to deliver harm minimisation in brief interventions. They did not have key working sessions with patients. All other teams did have key working appointments with patients. However, we only saw six records where staff had clearly evidenced psychosocial interventions. These were in the form of node link maps. Node link mapping is a technique recommended in Public Health England's "Routes to Recovery" guide. It is a simple way for presenting verbal information in the form of a diagram that has positive benefits for key working. Some records contained mapping tools in files, for example, 'My strengths', however, these had not been completed.

Staff did not fully assess a patient's physical health. The comprehensive assessment had a section where staff could record any physical health concerns. However, this did not contain any question or prompts for staff to conduct a full assessment. The manager had however identified this and had developed a new physical health assessment form for staff to use. The new form considered all health concerns with relevant questions. At the time of our inspection, we did not see this new assessment form in patient records. Physical health examinations did not take place routinely but staff informed us that they would carry these out if they identified a concern.

Nurses carried out screening and immunisations for blood borne viruses if a patient agreed to this. Patient records confirmed that staff offered this to all patients.

Changes and progress of patients using the service were measured using treatment outcome profiles. Treatment outcome profiles is a monitoring instrument developed by the National Treatment Agency for staff to use throughout treatment and reported through the National Drug Treatment Monitoring System. Public Health England holds the responsibility for gathering these statistics providing data locally and nationally. For the period April 2014 to March 2015, the service had 7.5% of opiate using patients discharging successfully from treatment (national average 7.2%) and had achieved 41.2% successful discharges for non-opiate using patients (national average 38.5%).

Staff also used the objective opiate withdrawal scale for some patients. This tool measures the signs and symptoms of opiate withdrawal.

Are services effective?

Requires improvement

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

Staff from band 6 and above carried out audits on patient case files at every supervision. There was also a programme for staff to routinely audit 10 sets of notes every month.

Skilled staff to deliver care

The teams included appropriate roles to care for the patient group. Staff had the required skills and experience to provide effective treatment. Staff told us that they were supported in relevant requests for specific training needs, these included new psychoactive substance, harm minimisation, hepatitis C, image and performance enhancing drugs, dual diagnosis and mindfulness and relapse prevention.

The trust supported the consultant psychiatrist to keep up to date with developments by attending relevant conferences. Team leaders employed by the trust had completed management development courses. Peer mentor had received accredited courses in peer mentoring and tackling substance misuse.

Staff felt they received effective supervision both formally and informally including clinical supervision where required. There was an overall compliance rate of 70% across the service; the manager had recognised that this was lower than expected due to the re-structuring of the teams following the new contract. 96% of staff had received an annual appraisal.

All teams had weekly or fortnightly team meetings which including discussions around training needs, global issues, leave, building issues, service developments and service user involvement.

Multi-disciplinary and inter-agency team work

The service used multi-disciplinary team meetings as the focus for all patient activity. Staff reviewed all patients at least every 12 weeks. Patients with updated information or need were included when required. Each team had a regular weekly multi-disciplinary team meeting apart from the specialist drug service who held daily meetings. The nurse lead or consultant attended all meetings along with the nurses and practitioners for the team. The patient did not attend the meeting. During the meetings, staff discussed all new referrals and patient movement. We observed a meeting with full contribution from all disciplines, good evidence of best practice discussions and safeguarding consideration. Staff talked about psychosocial interventions and transfers between the teams. Staff considered and reviewed risks although they did not record any updates on risk assessments or management plans. There was good evidence of effective relationships and input from social services. Staff did not talk about discharge plans from the treatment system. Staff completed a multi-disciplinary team summary sheet for each patient discussed. We looked at 28 patient records, all included multi-disciplinary team summary sheets within timescales. However, the summary sheets were very brief and did not reflect the detailed discussions we observed. For example, several summaries stated 'care plan review' only without any further details and no associated changes on the car plan itself.

Staff communicated treatment information with the patients' GPs. This included the summaries from the multi-disciplinary team meetings.

Good practice in applying the Mental Capacity Act

Staff had mostly completed training in the Mental Capacity Act. Staff in the specialist drug service were 85% compliant, in the community drug and alcohol team in Goole they were 100% compliant and teams in the community drug and alcohol team in Bridlington, open access and the primary care team were all 75% compliant.

Staff we spoke to generally had an understanding of the principles of the Mental Capacity Act and were aware of the trust policy. If a patient attended the service either intoxicated or under the influence of substances, staff would postpone any decisions until they regained capacity. If they had concerns, they would refer to the GP, consultants or speak to the trust lead.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Staff mostly showed a caring and empathic attitude to patients. They talked about patients in a respectful manner. We observed reception staff treating patients with dignity, respect and with consideration to their confidentiality. There was sufficient interview rooms which protected the confidentiality of the patients in key work sessions.

We spoke with 20 patients and one relative, they were mostly positive about the service they were receiving and the care they received from staff. We were told that staff listened to their concerns. One patient told us that staff did not always ask about all their needs but felt able to be honest and was confident that staff would support them in all aspects of their life if they needed help. From the 20 we spoke to, one patient said that they sometimes felt that staff judged them. Patients told us they were able to phone their keyworker in between appointments and that their worker would always return their call.

We observed a multi-disciplinary team meeting where staff showed their commitment to meeting the needs of the patient. All staff spoke about patients with dignity and respect.

However, of the 28 records we looked at, we saw two letters to patients who had been illicitly using substances. The letter warned that if illicit use did not stop within two weeks, the service would withdraw substitute prescribing in a rapid detoxification and the patient must take a three-month motivational treatment break. The service had worded the letters in a punitive manner which lacked empathy.

The involvement of people in the care that they receive

Care plans showed and patients told us that they were not fully involved in their care plans. Most patients were unaware of what was on their care plan but felt involved in their treatment. This was because care plans were not regularly reviewed with the patients during their appointments. Reviews mostly took place during the multi-disciplinary team meetings in the patient's absence. The care plan itself was not updated with new goals and interventions. Records showed us that staff recorded whether a patient had received a copy. All care plans we looked at indicated that copies offered to patients had been declined. Although staff evidenced patient's involvement in their care in contemporaneous notes, this was not reflected in care plans.

Patients were able to get involved with decisions about their service using suggestion boxes that were located at all team base locations. The teams also offered comment cards to patients which were regularly reviewed and displayed on 'You said…We did' boards. These were updated monthly by the teams.

There was little support for family members or for service user involvement at the time of our inspection. However, the partnership had acquired an additional component in their new contract from 01 April 2016. This was specifically for service user involvement and family and carer support. The manager recognised the previous shortfalls prior to the new contract and had plans for the newly acquired provision to address these.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

The open access team was the first point of contact for a person who was experiencing difficulties with drug or alcohol misuse. The central hub was located in Beverley with drop in venues located across the East Riding area. People were not required to make an appointment and referrals were from GPs or other professionals and from people attending as a self-referral.

Staff assessed patients at open access. If the patients treatment needs did not require clinical interventions, staff would deliver brief keywork sessions and discharge. This would likely to be relevant to those people attending who were not misusing opiates or alcohol, for example, cannabis, cocaine or new psychoactive substances.

For those patients who required clinical interventions, i.e. opiate or alcohol users, staff from open access would refer them mainly to the specialist drug service where prescribing was initiated. Occasionally, the multi-disciplinary team would transfer patients directly to primary care if there use had been short term with no risks and agreement by the GP concerned.

The patient would remain at the specialist drug service until stable. This was for approximately two weeks where a clinician saw them daily apart from weekends. Staff would then transfer the patients either to the community drug and alcohol teams or to the primary care teams working alongside their own GP.

If a patient's needs or risks changed, they may be transferred back from the community drug and alcohol teams or primary care to the specialist drug service.

Staff agreed transfers within the pathway using the multi-disciplinary team meetings.

The pathway meant that often patients had to use a variety of locations during their treatment. This mostly included the specialist drug service at the start of a patient's treatment; the specialist drug service is located in Hull, which is outside the East Riding area the partnership serves. Records showed us that staff also often referred back to the specialist drug service from community drug and alcohol teams if they relapsed with their illicit drug use, required medication changes or had increased risks. For example, we spoke to one patient and saw from their records, they had a positive drug screen for illicit opiate use. In response to this, staff and the patient recognised a need to increase their substitute prescribing. However, their worker informed them this would be referred to the specialist drug service. As the patient had children to consider, and lived too far away from the specialist drug service and would need to use public transport to travel daily, they were not able to receive the appropriate treatment needed. Patients told us that the pathway compromised their treatment particularly if they were required to go to the specialist drug service as the travelling was not only time consuming on a daily basis but they needed to fund the travel in the first instance. The partnership did re-imburse patients if they were able to produce evidence that they were receiving certain benefits. Patients also told us that changes in location, travel and seeing different staff, caused them anxiety that often prevented them attending appointments. National Drug Treatment Monitoring System data showed us that the proportion of patients dropping out within 12 weeks of referral or transfer was at 24.6% for opiate users (national average 14.8%). The proportion of patients the trust retained in treatment for over 12 weeks was lower than the national average.

As all staff agreed new referrals and transfers in the teams' weekly multi-disciplinary team meetings. This meant that patients had to wait for an appointment at the specialist drug service after the meetings and for a space to become available. The partnership had a target of three weeks from referral at open access to the specialist drug service. Data from the National Drug Treatment Monitoring System showed that 5.2% of opiate patients waited over the three-week target. The national average of people waiting over three weeks was 1.9% for opiate interventions.

We were unable to confirm waiting times for patients being transferred between teams. However, patients told us that this could be up to six weeks. Staff offered new patients brief interventions through the open access team while waiting for an appointment at the community drug and alcohol teams or specialist drug service; this involved motivational support. Staff fast tracked pregnant patients directly through to services. Records showed us the patients did not have gaps in their prescribing due to transfer.

This meant that the pathway across the treatment system provided by the partnership resulted in long waits and high

Are services responsive to people's needs?

Requires improvement

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

percentage of patients dropping out. For people with addictions, it is important to act when they are motivated to change; long waits or additional barriers to treatment can often mean they revert to their previous state of pre-contemplation.

When a patient was ready to be successfully discharged from the service, staff gradually reduced their contact and integrated wrap around services. They gave patients information on how they could return to treatment if needed. The latest data showed us that the proportion of people returning to treatment within six months of their discharge was 14.3% compared to the national average of 10.73%. The previous contract included an aftercare provision only for alcohol users. However, the new contract includes aftercare for all substances. The means that all patients discharge will have the opportunity to attend day groups and support to help prevent relapse.

Staff took measures to re-engage patients who unexpectedly dropped out of their treatment. They did this through liaising with pharmacies, GPs and other involved professionals and attempting contact with the patient via phone and letter. If unsuccessful, the multi-disciplinary team meetings would discuss the patient before being discharged from the service. Staff sent out letters to patients advising them that they could return to open access they still required support. The service would arrange for police welfare checks if there were a concern for a patients safety following a period of disengagement.

The facilities promote recovery, comfort, dignity and confidentiality

Waiting areas in all the locations we visited were reasonably well maintained, clean and comfortable. There was comfortable seating and a good range of information relating to treatments, risks, harm minimisation and external services and support. This included information on where a patient would go visit for mutual aid support and to access activities such as dance classes and computer courses.

Patients were able to help themselves to water while waiting for their appointment. We saw books and magazines available.

All teams had sufficient rooms they could use for key working appointments with adequate soundproofing.

Meeting the needs of all people who use the service

The open access drop in locations were well placed around the East Riding area with varying opening times to ensure a person would be able to access support at a time and venue appropriate to them. Both community drug and alcohol teams offered their services weekdays and included one late night each per week. This enabled those patients who were working or who had childcare responsibilities to attend convenient appointments. For patients seen at primary care settings, appointment times varied but were generally limited to one day a week as the primary care staff were not located at the GP surgeries as their base. However, if this were not appropriate to the patient, staff would discuss community drug and alcohol teams as a more appropriate option. The specialist drug service opened five days per week with appointments in the mornings. All patients would require significant travelling time; this may therefore be difficult for patients with employment or childcare responsibilities.

All services were accessible for patients using wheelchairs. Waiting areas, clinics and interview rooms were located on ground floor level. Offices for staff use were mainly on upper levels meaning that the service would need to make arrangements if staff had accessibility requirements. The community drug and alcohol teams had facilities for patients with hearing difficulties. Services displayed information in a variety of languages and used interpreters when this was required. The community drug and alcohol team in Goole had a polish speaking practitioner who would case manage this group of patients.

The service provided advice and support to people who used image and performance enhancing drugs such as steroids and tanning agents. Staff delivered these clinics from Goole and Bridlington community drug and alcohol teams. They offered a needle exchange service, safer injecting advice, dry spot blood testing, weight monitoring and free condoms. Staff had also delivered training to local gym staff relating to steroid use.

Listening to and learning from concerns and complaints

There had been three complaints in the 12 months leading up to our inspection for the substance misuse services provided. Managers had investigated the complaints which had not been upheld.

Are services responsive to people's needs?

Requires improvement

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

Services displayed posters informing patients what steps they needed to take if they had a complaint. Patients told us they were aware of the complaints process or they felt confident they could speak to their keyworker for guidance if needed.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust vision was to be caring, compassionate and committed. The trust values were putting the needs of others first, acting with compassion and care at all times, continuously seeking improvement, aspiring to excellence, and valuing each other and teamwork. The values were on display throughout the locations. Staff were vague about the values of the trust. However, staff acted with compassion and evidenced strong teamwork.

Most staff knew the managers in the directorate and who the chief executive was. They were vague in their knowledge of other members of the senior leadership team. The managers for the specialist services had visited locations in the past six months. Staff were familiar with the service manager for substance misuse and told us that she visited locations regularly.

Good governance

Systems were in place for managers to monitor training, supervision and appraisals. The mandatory training figures were lower than the trust target in some areas; this may be due to the changes in provision and re-structuring. Management had recognised this and were taking actions to improve compliance.

Staff knew processes for reporting incidents and safeguarding concerns. The managers monitored these with learning shared across the trust and in local teams.

The manager and staff were unclear how their performance was managed. They were unable to describe what indicators were used to gauge their performance and how this was reflected in the supervision or appraisal process. This meant that staff would be unclear what targets they needed to achieve and how they, or their manager, could monitor this.

The service appeared to be clinically driven with a lack of recovery orientation. Guidance and best practice around recovery had not been embedded into all aspects of their delivery. However, staff had received training in the ethos of the recovery model. The trust also informed us that they were in the process of embedding recovery better into their delivery. The pathway used by the service for a patient to progress effectively through their treatment, was often un-manageable or problematic for the patient.

The service manager had sufficient authority and administrative support to carry out the responsibilities. They were aware of the trust risk register and how to submit items. At the time of our inspection, the service had no concerns on the register.

Leadership, morale and staff engagement

Staff morale within the whole service was high. We observed committed staff and an excellent partnership between trust staff and practitioners from ADS. Staff respected the service manager and felt supported by managers, team leaders and clinicians. They were aware of the whistleblowing process and felt able to raise concerns without the fear of victimisation. There were opportunities for staff to give feedback through multi-disciplinary team meetings and local team meetings.

Team leaders had undertaken trust delivered management development course and the trust had offered the service manager external mentoring if required.

Commitment to quality improvement and innovation

The substance misuse service was involved in the development of the image and performance enhancing drug service and the regional network in this area.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • Staff across all teams were not compliant with mandatory training. This was in breach of regulation 18 (2) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: • Staff from all teams did not fully assess or monitor a person's physical health. • Care plans were not up to date, personalised, holistic or recovery focused. • Staff did not deliver recovery focussed psychosocial interventions. This was a breach of regulation 9 (3) (a) and regulation 9 (3) (b)