We are With You

We are With You - Darlington

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated it as good because:

- The service provided safe care. The premises where clients were seen were safe and clean. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-orientated care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The team included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

However:

- Clients who spoke with us said they wanted to have access to more therapeutic activities.
- Three of the seven clients we spoke with told us they were unaware of what their care plan was, which indicated they had not been offered a copy of it.
- Staff told us they were stressed due to the levels of their caseloads.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection — Page

Background to We are With You - Darlington — 5

Information about We are With You - Darlington — 5

Our findings from this inspection

Overview of ratings — 7

Our findings by main service — 8

Summary of this inspection

Background to We are With You - Darlington

We Are With You (formerly Addaction) deliver 81 services across England and Scotland. We Are With You work with adults and young people, in community settings, in prisons, in residential rehab and through outreach.

We Are With You Darlington provides specialist community substance misuse services for adults which include substitute prescribing, a needle and syringe exchange service and recovery coordination.

People can access the service via drop-in, self-referral or referral from a healthcare service such as GPs or by criminal justice services such as the police, probation or prisons.

The service is registered with the Care Quality Commission to carry out one regulated activity; treatment of disease, disorder or injury. The service has a registered manager who is also the contracts manager.

The service has not been previously inspected.

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 service.

This was a short-notice (24 hours) announced inspection to ensure the service could provide us with information about staff availability and arrange for us to speak with clients by phone.

Our inspection team comprised a Care Quality Commission inspector, a nurse working as a specialist advisor to the Care Quality Commission and an expert by experience with lived experience of substance misuse.

During the inspection visit, the inspection team:

- spoke with the registered manager
- spoke with the interim service manager

Summary of this inspection

- spoke with nine staff members including recovery navigators, administrators, the clinical lead, a pharmacy technician, team leader and ambassadors.
- spoke with seven clients and one carer
- looked at 10 clients' care and treatment records
- looked at the quality and safety of the service building
- observed a daily flash meeting and a group session ran by ambassadors within the service
- observed how staff were interacting with clients and,
- looked at documents relating to the running of the service.

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

Areas for improvement

Action the provider SHOULD take to improve:

- The provider should ensure that clients have regular access to therapeutic activities.
- The provider should ensure that all clients are offered a copy of their care plan and that the client's decision as to whether or not to accept it is always recorded within the client's care record.
- The provider should continue with its recruitment to ensure there are adequate numbers of staff to meet the needs of the people who use the service and make staff caseloads more manageable.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community-based substance misuse services

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

Are Community-based substance misuse services safe?

Good

We rated it as good.

Safe and clean environment

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

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. We looked at health and safety information during our inspection. Staff undertook environmental risk assessments, health and safety audits and ensured gas, fire, electrical, personal appliance and legionella testing was undertaken.

Staff carried alarms and there were staff available to respond if they were sounded.

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

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control guidelines, including handwashing.

Staff took measures to reduce the risk of COVID-19 transmissions within the service. Staff were required to wear masks during appointments with clients and cleaning regimes had been increased to ensure touch points within the building were regularly cleaned. Any visitors to the building were questioned about COVID-19 symptoms, contact with people who had symptoms and were asked to wear a face covering.

The service had enough fire wardens and first aiders. They were identifiable and staff were reminded who they were in daily flash meetings.

The service had a system in place for checking, identifying and rectifying issues within the building.

Staff made sure equipment was well maintained, clean and in working order.

Clinic room and equipment

The clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The clinic room had the necessary equipment for clients to have thorough physical examinations and carry out urine and blood tests.

The service had equipment and medicines for dealing with emergency situations. This included Naloxone, a medicine used to reverse the effects of an opioid overdose and adrenaline for people experiencing anaphylaxis.

An emergency grab bag was held in the reception area. This contained gloves, a venti-mask and aprons.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep clients safe. These included:

- 0.5 whole time equivalent contracts manager
- One whole time equivalent interim service manager
- Three whole time equivalent team leaders
- 2.8 whole time equivalent administrators
- 6.8 whole time equivalent recovery navigators
- One whole time equivalent pharmacy technician
- One clinical lead/non-medical prescriber
- Two whole time equivalent non-medical prescribers

The service had low vacancy rates. There was only one recovery navigator vacancy within the service for which the provider had advertised on its website. It was anticipated candidates would be shortlisted and interviewed within the next three weeks.

The service rarely used agency staff. Over the last 12 months, agency staff had been used to cover the administrator role for eight days over a one and a half week period.

Managers made arrangements to cover staff sickness and absence. Cover was arranged within the team, or staff could be brought in from the Redcar and Cleveland service.

The service's turnover rate in the last 12 months was 43.75%. Feedback from staff who had left was that caseloads were high, management at service level was poor and others cited personal reasons. However, staff who spoke with us said the management of the service had improved since the interim service manager had been appointed.

Managers monitored caseloads. The average caseload per team member was 75. Staff told us that the caseload levels were causing some stress in the team. However, two new members of staff had commenced work at the service and another recovery navigator post was being recruited to, so it was anticipated individual caseloads would reduce.

Managers supported staff who needed time off for ill health. Staff told us managers did not put pressure on them to return to work and wanted to ensure they returned only if they were well enough to do so.

The average sickness absence level over the last 12 months was 10.54%.

Most staff within the service carrying out regulated activities had up to date Disclosure and Barring Service checks in place to ensure they were suitable to work with vulnerable adults and children. Ambassadors were awaiting their Disclosure and Barring Checks to come through, but risk assessments had been put in place to allow them to work with clients using the service.

Medical staff

The service had access to enough medical staff. The service employed a clinical lead who was a registered nurse and two non-medical prescribers. These staff were trained in basic life support. The service was also based a few minutes' drive away from the acute hospital so paramedics and other medical staff could attend the service quickly if needed.

The service could get support from a psychiatrist quickly when they needed to. The service had forged links with a local mental health hospital who could arrange for clients to receive support when necessary.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Staff were 100% compliant in all areas of their mandatory training.

The mandatory training programme was comprehensive and met the needs of clients and staff. The service manager had access to a dashboard system which allowed them to monitor staff compliance with mandatory training and alert staff when they were due to complete it.

Assessing and managing risk to clients and staff

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

Assessment of client risk

Staff completed risk assessments for each client on admission, using an in-house tool built into the provider's care records system. The tool was in line with recognised tools within the substance misuse sector and included risk to self and others, addiction history, criminal history, mental health and other pertinent issues. We looked at 10 care records and saw evidence that risk was regularly discussed and recorded, and staff updated risk assessments following an incident. Examples of risks identified included concerns about the welfare of children at the client's home, suicidal ideation and physical health conditions.

The service manager used a case tracking tool which allowed them to monitor when risk assessments were due to be reviewed in line with the provider's risk assessment policy. The tracker was sent to staff on a weekly basis. This system was effective as we found no issues in relation to risk assessments.

Good

Community-based substance misuse services

Management of client risk

Staff created risk management plans to mitigate the effects of risks that had been identified. For example, staff had liaised with mental health services when there were concerns about clients' mental health including thoughts of suicide or self-harm. We saw evidence in care records that staff had referred clients to psychosis and early intervention teams and provided clients with contact details for the crisis team.

Staff responded promptly to any sudden deterioration in a client's health. Staff gave examples of the signs of health deterioration which included changes in skin tone, changes in mood and sudden communication difficulties.

Staff made clients aware of the risks of continued substance misuse and safety planning was an integral part of recovery plans.

The service had effective lone working processes in place.

Staff created individualised plans for clients to be followed when clients unexpectedly exited from treatment. These included steps to take and contact details for the client, their next of kin or other interested parties and checking with pharmacies of prescriptions had been picked up by the client.

The service had a process in place for what to do when there were suspicions or there was evidence that clients had passed their substitute medicine to a third-party for illicit purposes (an act commonly known as diversion). Staff recorded issues in relation to diversion as incidents and these were reviewed by a manager who determined what action needed to be taken. This could include the client being requested to attend an appointment with a non-medical prescriber and changing the client's prescription from collection to supervised consumption.

Staff offered all clients naloxone to minimise the risk of death following an overdose. Clients who spoke with us said their recovery navigator had given them naloxone and they had it stored at their home.

Recovery navigators recorded any conflicts between clients within their records which flagged as alerts when opened. This meant administrators could ensure appointments for these clients could be arranged at different times/dates, so they did not come into contact with each other in the service.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. All staff were up to date with their safeguarding training at the time of our inspection.

The service manager was the safeguarding lead for the service.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. In the last 12 months, staff had sent 25 safeguarding referrals in relation to children and 12 in relation to adults to the local authority.

There had been no serious case reviews in relation to the service in the last 12 months.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Client notes were comprehensive, and all staff could access them easily.

Staff within the service used an electronic care records system and made sure they were up to date and complete.

Records were stored securely. Staff were required to use a login name and password to access the care records system.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely.

The service followed the National Institute for Health and Care Excellence guidance, and The Drug Misuse and Dependence: UK guidelines on clinical management (also known as The Orange Book).

We saw evidence in care records that staff reviewed each client's medicines regularly; provided advice to clients about their medicines and reviewed the effects of medicines on clients' physical health according to national guidance and best practice.

Staff completed medicines records accurately and kept them up to date.

Medicines management audits were carried out by staff each month. Prescribing rationale was discussed in supervision and during peer non-medical prescriber forums. Staff were able to seek support and advice from the provider's pharmacy director who was the medicines safety officer for the service.

Staff stored and managed all medicines and prescribing documents safely. Records kept by staff demonstrated medicines were stored within their recommended temperature ranges.

Staff followed national practice to check clients had the correct medicines when they commenced treatment at the service or moved between services.

Staff learned from safety alerts and incidents to improve practice. Alerts were sent to staff by email from the regional pharmaceutical officer, local pharmacies and from the Department of Health. Learning from medical incidents were shared in daily flash meetings, team meetings and during supervision.

Good

Community-based substance misuse services

The main incidents were in relation to local pharmacies losing clients' prescriptions and not reporting this until the client had raised it as an issue with their recovery navigator or non-medical prescriber. The service had instigated a process in response which required the pharmacy to sign for the receipt of the prescription.

Track record on safety

The service had a good track record on safety.

There had been no serious incidents in the last 12 months.

Safety improvements included issuing all staff with personal alarms and ensuring local pharmacies signed for the receipt of prescriptions following issues with pharmacies losing them and failing to notify the service promptly.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Examples included incidents of violence and aggression, problems with the service building and clients with suicidal ideation or who are self-harming.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service had no never events.

Staff understood the duty of candour. They knew they were required to be open and transparent and offer clients and families an apology and full explanation if and when things went wrong.

Staff had made no number of duty of candour reports in the last 12 months.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. They were discussed in daily flash meetings, team meetings or in supervision.

Staff met to discuss the feedback and look at improvements to client care.

Are Community-based substance misuse services effective?

Good

We rated it as good.

Good

Community-based substance misuse services

Assessment of needs and planning of care

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

We saw evidence in care records that staff completed comprehensive mental health assessments and care plans for each client that met their mental and physical health needs. Staff regularly reviewed and updated care and recovery plans when clients' needs changed.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. The service had access to clients' GP summaries which allowed for the sharing of information in relation to physical health conditions and concerns.

We looked at 10 care records and found care and recovery plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

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

The percentage of adult clients who had successfully completed their care and treatment in the last 12 months had improved on the previous year. The previous year's figures (2021) are in brackets.

- 4.67% for opiate clients (2.63%)
- 33.70% for non-opiate clients (18.67%)
- 25% non-opiate and alcohol clients (8.3%)
- 29.72% for alcohol clients (12.63%).

Staff provided a range of care and treatment suitable for the clients in the service in line with best practice and national guidance. These included substitute prescribing, needle and syringe exchange service and recovery group sessions. However, clients who spoke with us told us they wanted to have access to more therapeutic activities.

The number of group sessions had reduced during the COVID-19 pandemic but once the Disclosure and Barring Service checks were received for the service ambassadors, it was anticipated group sessions would increase to normal levels.

Clients could also participate in the Wisconsin recovery project (known more commonly as WISC), a rolling 12-week programme, delivered by a trained facilitator with support from an ambassador. Clients could engage at any stage of the programme. Week 12 included graduations for those completing the programme.

The provider was also rolling out 12-week alcohol treatment requirement and drug rehabilitation requirement programmes nationally (including the Darlington service). At the time of the inspection there were interim programmes looking at substance and alcohol misuse, offending and anti-social behaviour, consequential thinking, problem solving, harm reduction, relapse prevention and goal setting and planning. Referrals for these programmes came from the probation service.

We saw evidence in clients' care records that staff routinely offered clients blood borne virus testing and treated viruses accordingly. Staff offered dry blood spot testing to clients throughout their treatment journey.

Staff made sure clients had support for their physical health needs, either from their GP or community services. Staff reminded clients to attend their GP appointments and physical health checks. Staff also signposted or made referrals to primary healthcare services in order to address any physical health issues that had arisen.

Staff supported clients to live healthier lives by supporting them by giving advice or promoting support services in the community. This included smoking cessation advice, the mental health benefits of accessing green spaces, healthy food choices, cooking on a budget, promotion of local food banks and regular exercise. The service also received donations of toiletries from local pharmacies which were given to clients suffering financial hardship.

Staff used rating scales to assess and record severity and outcomes. This included the use of treatment outcome profiles and sub-intervention reviews which assessed the outcomes of psychosocial interventions and pharmacological treatments.

Staff used technology to support clients. This included online meeting platforms for virtual appointments with clients in addition to onsite face to face appointments.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. These included audits of the quality of documentation of harm minimisation advice given by staff, the use of the service's 'did not attend' process and plans, discharges and clients' care records, referrals, assessments and allocations. Findings of the audits were discussed as part of team meetings.

Improvements were made to the service as a result of clinical audit findings. An example included 86% of clients being able to access treatment within five days as a result of a new and clear referral process being implemented following an audit of referral processes (only 15% accessed treatment within five days in the previous year).

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the clients. These included a clinical lead, non-medical prescribers, recovery navigators, mental health services, GPs and other primary medical services.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals and constructive support of their work. At the time of our inspection, all staff were compliant with their appraisal and supervision.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Examples of specialist training included social care, blood borne virus testing, Hepatitis B and veterans' support.

Good

Community-based substance misuse services

Managers recognised poor performance, could identify the reasons and dealt with these. The provider had a performance management system in place which included a process for addressing staff performance issues.

Managers recruited, trained and supported volunteers to work with clients in the service.

Multidisciplinary and interagency teamwork

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

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

The multidisciplinary team held meetings to discuss clients and improve their care as and when required.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care.

We saw evidence in clients' care records that recovery plans included clear care pathways to other supporting services such as mental health services and mutual aid groups.

Staff had effective working relationships with other internal teams in the organisation and external services.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of our inspection, all staff had completed their Mental Capacity Act training.

There was a clear policy on the Mental Capacity Act, which staff could access via a shared drive.

Staff knew where to get accurate advice on the Mental Capacity Act. This included advice from the clinical lead, director of nursing, medical director or from a local mental health hospital.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. This was done via supervision and the review of care records and incidents.

Staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so.

We saw evidence in clients' care records that staff assessed capacity at each client's appointment and ensured that clients signed consent to treatment forms.

Are Community-based substance misuse services caring?

Good

Community-based substance misuse services

Good

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

During our inspection, we saw that staff interacted with clients in a kind, caring, respectful, discrete and compassionate manner. We spoke with seven clients during our inspection who told us staff treated them well and behaved kindly.

Staff gave clients help, emotional support and advice when they needed it. Clients told us staff had helped them complete benefit applications, get a fit note from their GP and felt staff listened and empathised with them.

Staff supported clients to understand and manage their own care treatment or condition. Staff understood and respected the individual needs of each client.

Staff directed clients to other services and supported them to access those services if they needed help. These included referrals to mental health services and GP appointments.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff.

Staff followed policy to keep client information confidential.

Involvement in care

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

Involvement of clients

Staff made sure clients understood their care and treatment and found ways to communicate with clients who had communication difficulties.

Clients who spoke with us said staff involved them in decisions about their care and treatment. However, three of the seven clients we spoke with told us they were unaware of what their care plan was.

Clients could give feedback on the service and their treatment and staff supported them to do this. Clients could complete comments cards, completed satisfaction surveys or use the provider's complaints process to give their feedback.

Staff made sure clients could access advocacy services.

Staff informed and involved families and carers appropriately if the client had consented for them to do so.

Good

Community-based substance misuse services

Involvement of families and carers

We saw evidence in care records that staff informed and involved families and carers appropriately. We also looked at feedback received about the service via comments cards and surveys and saw evidence that carers had provided positive feedback. A carer had thanked the service for keeping their loved one alive. We attempted to speak with four carers who had given their consent for us to contact them by phone. However, only one accepted our call. This carer told us they felt involved in decisions and discussions about their loved one's care and treatment; their loved one was treated well by staff and their nurse was caring and empathetic.

Staff helped families to give feedback on the service. Families and carers could complete comments cards, completed satisfaction surveys or use the provider's complaints process to give their feedback.

Staff gave carers information on how to access a carer's assessment. A carer's assessment is used to determine whether a person qualifies for support from their local authority in their role as an unpaid carer.

Are Community-based substance misuse services responsive?

Good

We rated it as good.

Access and waiting times

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

The service had clear access criteria that had been agreed with key stakeholders and other relevant services.

People could access services and appointments in a way and at a time that suited them. For example, appointments could be made at times which took into account a client's working pattern.

The service had robust alternative care pathways and referral systems in place for a range of other support services. These included referrals to primary medical services and mental health services. Staff also helped clients access housing support and services who helped victims of domestic abuse.

Staff offered clients alternative treatment options when they were unable to comply with specific treatment requirements. For example, clients could be offered buprenorphine as an alternative to methadone and clients with diabetes could be given sugar-free medicines.

The service had processes in place for when clients arrived late or failed to attend their appointments which were fair and reasonable and did not place the client at risk. Staff tried to contact people who did not attend appointments and offered support. The service had its own did not attend process and there were individualised plans in clients' care records advising staff of the steps to take if they failed to attend their appointment.

There were no waiting lists within the service.

The service met target times for seeing clients from referral to assessment and assessment to treatment.

Good

Community-based substance misuse services

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time.

The service rarely cancelled clients' appointments. Over the last 12 months, the service had cancelled 12 health appointments out of 4022 and 18 recovery navigator appointments out of 7898.

Clients who spoke with us said their appointments ran on time.

The facilities promote comfort, dignity and privacy

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

The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service were situated in quiet areas of the building to maintain clients' privacy and confidentiality.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Clients were seen on the ground floor as there were no lifts due to the service premises being situated in a listed building.

Staff made sure clients could access information on treatment, local services, their rights and how to complain.

The service provided information in a variety of accessible formats so the clients could understand more easily. Information could be produced in easy-read for people with a learning disability or in braille for people with a visual impairment.

The service had the facility to produce information leaflets available in languages spoken by the clients and local community via online translation services.

Managers made sure staff and clients could access interpreters or signers when needed.

Listening to and learning from concerns and complaints

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

Clients, relatives and carers knew how to complain or raise concerns. Clients were told how to make a complaint during their appointments and there were posters in the reception area advising people how to make a complaint.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint.

Good

Community-based substance misuse services

There had been no complaints within the last 12 months.

Staff protected clients who raised concerns or complaints from discrimination and harassment.

Clients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff during flash and team meetings or during one to one supervision sessions and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. For example, a client had thanked their recovery navigator for all their support, and this was shared with all staff in a daily flash meeting.

Are Community-based substance misuse services well-led?

Good

We rated it as good.

Leadership

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

Leaders provided clinical leadership through appraisals, supervision, observations and shadowing.

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They attended flash and team meetings regularly, so they were up to date with issues about the service and used systems and data to monitor team performance.

Leaders were visible in the service and approachable for clients and staff. The service manager regularly attended daily flash and monthly team meetings and the contracts manager spent fifty percent of their time based at the service.

Vision and strategy

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

The provider's vision and values were to be a caring, passionate and inclusive organisation where people can thrive, progress and connect with others. Its mission was to radically improve people's chances of getting better; help ten times more people, transform the organisation to get the best from each other and change the conversation.

Staff knew and understood the vision and values of the team and organisation and what their role was in achieving them.

All staff had a job description.

Staff had the opportunity to contribute to discussions about the strategy for their service during daily flash and monthly team meetings, appraisals and supervision and during reflective practice sessions.

Culture

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

Staff felt respected, supported and valued. They felt proud, positive, satisfied and part of the organisation's future direction. The leadership within the service had recently changed and staff told us this had changed the culture of the service to a more open, inclusive and respectful environment.

Managers monitored staff morale, job satisfaction and sense of empowerment.

The provider had staff award and recognition schemes.

Staff appraisals included conversations about career development and how it could be supported.

Staff members felt able to raise concerns without fear of reprisals since the recent appointment of the interim service manager. Organisational policies and procedures positively supported staff being able to speak up about any concerns.

The provider had a whistle blowing policy in place that was accessible to all staff via a shared drive.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The service also had wellness action plans, virtual health-based activities such as yoga and meditation and staff could access counselling sessions.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. There were gender-specific groups, all staff were trained in equality and diversity and the service's admission criteria meant the service was open to any adults who wished to seek help in battling their addictions. There were equality and diversity leads within the service.

All policies and procedures had been subject to equality impact assessments to ensure they did not place vulnerable groups or people with protected characteristics under the Equality Act at a disadvantage.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

The service's governance systems were effective. There were systems and procedures to ensure that all areas of the service building were safe and clean. There were sufficient numbers of trained, experienced and skilled staff. Staff complied with their mandatory training; received regular supervision and were appraised. Clients were assessed and told us they were treated well by staff. Staff adhered to the Mental Capacity Act. Access and discharge were managed well. Incidents, complaints and safeguarding concerns were reported, investigated and managers shared any lessons learned so the service could improve.

Governance systems, policies, procedures and protocols were reviewed and reflected best practice.

There was a clear framework of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. For example, a hospital discharge pathway had been introduced to ensure all clients were seen within two weeks upon discharge from hospital following previous issues in which clients had been discharged without support in place to manage their addictions.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the clients.

Management of risk, issues and performance

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

There was a clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures.

Staff had access to the risk register and were able to submit items for inclusion on it. Staff concerns matched those on the risk register.

The service had plans for emergencies such as adverse weather or a flu outbreak. The service had a business continuity plan which included the processes to be followed and who to contact if an emergency arose.

Managers monitored staff sickness and absence rates

The service had not been asked to make any efficiency savings.

Information management

Staff collected and analysed data about outcomes and performance.

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of client records. Staff ensured the service confidentiality agreements were clearly explained to clients in relation to the sharing of their information and data.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Good

Community-based substance misuse services

Staff submitted data and notifications to external bodies as needed such as the local authority and Care Quality Commission.

All information needed to deliver care was stored securely.

The service had developed information-sharing processes and joint-working arrangements with other services where appropriate to do so.

Staff participated in research to improve the quality of the service. Research programmes included:

- A system designed for women: understanding the barriers women face in accessing drug treatment support services.
- Evidence-based and theoretically informed recommendations for scaling up Hepatitis C virus testing and treatment for people who inject drugs.
- Exploring the Characteristic Profile and Parental Experiences of Child Criminal Exploitation.
- Addressing ageism and age discrimination in alcohol policy, practice and research report.