Good

Humankindcharity

Barnsley Recovery Steps

Quality Report

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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)
1-5029002071		Barnsley Recovery Steps	S70 1XY

This report describes our judgement of the quality of care provided within this core service by Humankind charity. 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 Humankind charity and these are brought together to inform our overall judgement of Barnsley Recovery Steps.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated Barnsley Recovery Steps as good because:

- The service had a strong and positive culture. Staff were committed to delivering a service that was inclusive, non-judgemental and caring. The feedback from clients was universally positive about the service and the staff that worked there. The service sought feedback from clients and acted upon this to improve the service. Clients had been involved in co-producing the provider's vision, mission and values.
- It was very clean and well-maintained and had a warm and welcoming atmosphere.
- Governance systems and processes assessed, monitored and improved the quality and safety of the service. Systems and processes were not over burdensome for staff to generate information required on performance. The incident reporting and management system was robust and reports were developed to identify trends and learning from incidents. Most of the issues that we identified had been identified by the provider and leaders had a plan in place to address these.
- The service had strong links with external organisations. They provided a hospital liaison service, specialist midwifery, had increased the uptake of hepatitis C treatment significantly and had set up a training skills exchange.
- Overall, mandatory training rates were high at 95%.
- Staff understood their roles and responsibilities in safeguarding adults and children at risk and carried these out.

However:

- Clients care plans and risk assessments did not fully reflect the personalised and holistic care and treatment that was delivered in practice and was documented in other parts of clients' care and treatment records.
- The service's environmental risk assessments did not consider the risk of potential ligature anchor points.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The service had robust incident reporting and management systems. Systems had clear audit trails and processes. Staff received feedback from incidents. That included a quarterly report on incidents that contained information on trends, themes and learning identified. Incidents involving aggression were assessed using a behavioural assessment and response tool to ensure that consistent and appropriate action was taken by staff.
- Staff demonstrated detailed knowledge on safeguarding adults and children and acted appropriately to safeguarding adults and children at risk of significant harm.
- The service was very clean and well-maintained. Clinic rooms had the equipment needed that had been checked regularly.
- Managers were working on ways to improve the service and staff caseloads through the implementation of a segmentation model, which was in line with the UK Clinical Guidelines on Drug Misuse and Dependency 2017.
- Overall, mandatory training rates were high at 95%.

However:

- Environmental risk assessments did not identify or assess the risk of potential ligature anchor points.
- Client risk assessments contained brief and generic information. They did not reflect staff knowledge on client risk and the information recorded in the other areas of clients' records.

Are services effective?

Good

We rated effective as good because:

- Following changes made by the service, the provider had seen an increase in the uptake of hepatitis C treatment from 40% up to above 90%.
- The service provided a multi-disciplinary team of staff who could deliver a range of care and treatment interventions appropriate to the needs of clients. The team included specialist midwives and two designated hospital liaison hope workers that had led to 103 referrals from the local acute hospital in quarters one and two of 2018 to 2019.
- The service had access to external training through a training skills and knowledge exchange they had set up with the local authority.

Summary of findings

- The service had strong links with external organisations including, GPs, community pharmacies, social services and the local acute hospital.
- Staff used outcome measures and performance returns appropriately. Where performance had been lower than expected for successful opiate treatment completions, the service had been open in discussions with commissioners about the challenges in working with complex client groups. Commissioners had been supportive of the service.

However:

- Clients' care plans were brief and basic and did not fully reflect the personalised, holistic and recovery oriented care and treatment that clients and staff told us about and that we could see evidence of in other areas of clients' care and treatment records.

Are services caring?

Good

We rated caring as good because:

- The service had a strong and positive culture. Staff demonstrated they were inclusive, respectful and non-judgemental. Staff were highly motivated to their roles in supporting clients to improve their lives through treatment and recovery.
- Clients provided universally positive feedback about staff and the service. They described that staff had excellent attitudes and worked flexibly to support them. Many clients told us that staff had changed their lives and some thought that staff had saved their lives because they had believed in them.
- Staff provided education and information to help clients understand and manage their substance misuse.
- Clients told us that they had a named worker who they saw consistently and knew them well.
- The service sought feedback from clients and acted upon this feedback to make improvements to the service.

However:

- Clients' recovery plans contained limited information to show how clients had been involved in their care and treatment. They were not personalised to individual clients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- The service had clear referral criteria and an effective single point of contact that screened referrals promptly and could see urgent referrals quickly.
- Staff informed referrers where clients had not responded to contact made or had declined involvement.
- Hospital liaison staff worked closely with the acute hospital to respond to referrals and provide support.
- The service operated at two sites, which meant that clients living on the outskirts of the area could access services close to where they lived.
- The service had a warm and welcoming atmosphere. It was well decorated and contained a wide range of relevant and well-presented information for clients aimed at recovery and well-being.
- Staff supported clients to maintain and develop positive and meaningful relationships and opportunities in the community to maximise recovery in the longer term.

Are services well-led?

Good

We rated well-led as good because:

- Leaders were visible, approachable and supportive.
- The provider had undertaken a project to co-produce their vision, mission and values with staff and clients. Staff identified and demonstrated the provider's vision and values in practice.
- Systems and processes were mostly effective in assessing, monitoring and improving the safety and quality of the service. The provider had plans in place to address issues that we identified including a new system to manage supervision and training to improve the quality of care plans and risk assessments.
- The service had a clear structure of meetings with processes to escalate and cascade information to and from the provider's board.
- Most systems enabled leaders to prepare information for reports and submissions automatically and this meant that it was not over burdensome on frontline staff.

Summary of findings

Information about the service

Barnsley Recovery Steps is an independent substance misuse service provided by Humankind charity in Barnsley. The service is an integrated drug and alcohol recovery service that aims to support clients to recover from drug and alcohol dependency and reduce harm to people and those around them.

The service is commissioned by and provided on behalf of a local authority. It provides a range of services and support including: substitute medication for drugs, detoxification from alcohol or drugs, harm reduction and overdose prevention, blood testing and vaccinations for blood borne viruses, structured interventions, group work therapies, early intervention and prevention support including brief interventions, outreach and training. The service also facilitates access to treatment for Hepatitis C and specialist midwifery services.

The service operates across two sites. One is based close to the town centre of Barnsley and the other in East Barnsley in the Goldthorpe area. Clients can access the service between 9am and 5pm Monday to Friday. On Thursdays, the central service opens until 7pm.

Humankind charity became the provider of this service in April 2017. In April 2018, Barnsley Recovery Steps was registered with the CQC as its own location. The provider is registered to provide treatment for disease, disorder or injury regulated activity. The service has a registered manager.

The location has not been inspected by CQC previously.

Our inspection team

The team that inspected the service comprised three CQC inspectors and one Specialist Advisor who was a registered mental health nurse with relevant experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked the service's commissioners for feedback.

During the inspection visit, the inspection team:

- visited both sites, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with eight clients who were using the service;
- spoke with the registered manager who was the area manager and the director of service;
- spoke with 19 other staff members; including a doctor, nurses, a quality and performance manager, hope workers, a building recovery in communities' worker, specialist midwives, a clinical services manager, recovery navigators, an administrator and a volunteer;

Summary of findings

- received feedback about the service's commissioners;
- attended and observed five sessions with clients;
- collected feedback from 14 clients using comment cards;
- looked at 10 care and treatment records of clients:
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Clients provided universally positive feedback about staff and the service they received. They told us that staff were amazing, polite, had excellent attitudes, were wonderful and very friendly. Clients told us that they felt welcome at the service and not judged by anyone.

Many clients told us that staff had changed their lives and some clients told us that staff have saved their lives because they had believed they could be successful in treatment and in their recovery.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that environmental risk assessments consider ligature risks.
- The provider should ensure that client care plans, risk assessments and risk management plans are an accurate, complete and contemporaneous to reflect the care and treatment that clients are being provided fully.

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Barnsley Recovery Steps

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Barnsley Recovery Steps	Barnsley Recovery Steps

Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety eight percent of staff had training in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act 2005 including the five statutory principles. Staff that we spoke with explained that due to the nature of the clients that they worked with, the most common capacity issue was around fluctuating capacity, due to intoxication from alcohol and/or other drugs. They explained that they would try to postpone any decisions until the client regained capacity, which was in line with the statutory principles of the Mental Capacity Act and its code of practice.

Staff had access to the provider's policy on the Mental Capacity Act via the intranet. They reported that they could seek advice from their managers and clinicians if required.

Deprivation of liberty safeguards does not apply to type of service and therefore was not assessed as part of this inspection.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

Staff carried out regular detailed risk assessments of the environment. These did not consider potential ligature risks through fixed ligature anchor points. A fixed ligature anchor point is something that can be used for the purpose of hanging or strangulation. When we asked the registered manager about this, they confirmed that they had not considered this when assessing the environment. However, when clients visited the service, they were always with a member of staff who could observe them. The toilets in the service were accessible in staff only areas. This meant that staff were aware of clients' whereabouts in the service. There had been no incidents where anyone had attempted to ligature in the service.

All one to one rooms, clinic rooms and the needle exchange room were fitted with static alarms, which would sound throughout the building if they were activated. This system was tested twice every week. All staff responded to the alarm being activated. The panel indicator for where the alarm was sounding was located on the ground floor.

Clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. These contained equipment including electrocardiograms, equipment to measure blood pressure, weighing scales, blood testing equipment including for blood borne viruses. All equipment was clean, tested and calibrated if this was required.

Staff had access to the appropriate emergency equipment including a defibrillator, emergency drugs, oxygen and first aid equipment that was checked regularly to ensure it was ready to use.

The service was very clean, well decorated and furniture was in good condition throughout. The buildings were safe and well maintained and regular checks were carried out to ensure standards were kept up to date. Cleaning staff came in each night and worked to a specific schedule. Clients that we spoke with told us that the buildings were always clean and tidy. It was clear that the service had recently been decorated and the rooms contained comfortable furniture. The reception area contained many wipeable seats that meant it could be easily cleaned.

There were hand gel dispensers fitted to the walls throughout the building including in areas used by clients, which gave everybody the opportunity to keep their hands clean. Handwashing posters were displayed in all toilets and toilets had adequate facilities to wash and dry hands. In the busier parts of the building, such as the reception, clinic rooms and needle exchange, there were hard floorings that meant they could be cleaned more easily.

The service had good housekeeping to reduce fire risk. This included exits clear of obstructions and debris. Desk tops and under desks were clutter free. Staff ensured that bins had been emptied regularly and walkways were always clear. Fire doors were kept closed and there was an adequate amount of fire safety apparatus throughout the buildings.

Safe staffing

The service had enough staff. The clinical team comprised 4.8 whole time equivalent registered nurses who were non-medical prescribers and a consultant psychiatrist, 0.8 whole time equivalent, who was the clinical director. The service also had one whole time equivalent specialist midwife.

There were three project managers (2.6 whole time equivalent) and four senior practitioners (3.8 whole time equivalent) and a quality and performance manager that supported a team of 31 staff. Staff worked in a range of roles including: hope workers, building recovery in community workers, housing workers, night concierge, recovery navigators, shared care navigators, criminal justice navigators and a duty worker.

The service had one vacancy for a hope worker and one agency staff member was filling a recovery navigator post for a fixed term for maternity leave cover. The service did not have any bank staff.

In the 12 months leading up to 31 July 2018, the provider reported that there had been an average sickness rate of 10%. In the same period, there had been 12 staff leavers

Good

Are services safe?

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

which equated to an average turnover of 21%. The service had an average 17% vacancy rate. However, the provider reported that the vacancy and turnover rates had increased due to the provider taking over the service. This was because the service had gone through some redundancy processes and had created new posts when the provider took over the service.

The average caseload per worker ratio ranged between 40 to 80 clients. During the inspection we found that some staff carried lower caseloads depending on their role, recovery navigators carried a full time equivalent of 75 clients. Staff and managers acknowledged that caseloads were high. However, these were not more than what had been agreed with the service's commissioners during the tender process. In the first year of operation, the service had an increase of clients accessing the service of 9%. The provider reported that caseloads were managed in line with best practice guidance and this was an agreement with the commissioners. The provider told us that if caseload numbers went above 80 then they would raise this with the commissioners to highlight the need for additional resources.

The registered manager was working on a project on segmentation of treatment stages in line with The UK Clinical Guidelines on Drug Misuse and Dependency 2017. They hoped this would provide more structure and consistency in recovery management through a planned recovery pathway for clients. This would enable the service to job plan and weigh caseloads better for staff.

Staff received and were mostly up to date with mandatory training. Overall staff had undertaken 95% of the various elements of training that the provider had set as mandatory.

Assessing and managing risk to patients and staff

We reviewed ten care and treatment records. The service used the provider's own risk assessment tools.

Staff working at the service provided a single point of contact. This involved triage assessments of all referrals. This process involved establishing the presenting issues, needs and risks. Staff offered immediate advice to reduce risk for example, where clients were alcohol dependent not to stop drinking alcohol. Records showed detailed initial assessments including all relevant information needed to understand clients' needs.

All records reviewed contained a risk assessment and risk management plan. Risk assessments contained information gathered from all contacts with clients including triage and initial assessments. Risk assessments were brief and basic. They contained generic statements. However, other parts of documentation from assessments and contacts showed much more detailed and personalised risk information. Staff demonstrated detailed knowledge of clients that they worked with including information on key risks. Staff updated risk assessments in response to notable incidents such as safeguarding issues.

Staff and managers told us that they were delivering training to staff on record keeping to try to improve the quality of documentation. Record keeping training was taking place at the time of our inspection. We were also told that care plan training was being planned for early 2019.

Management of risk

Staff encouraged patients to access the appropriate health services including registering as patients with their local GP. The service had two hope workers who were designated hospital liaison workers. Where clients who were using the service had been admitted to an acute hospital or accident and emergency, the hospital liaison workers worked with hospital staff to ensure that the right information was shared to ensure the continuity of clients' care.

Hospital liaison workers also visited the acute hospital each day between Monday and Friday to introduce the service to people who were unwell and may have wanted to access this for support with drug or alcohol treatment and recovery.

The service's single point of contact managed the service's waiting list. They completed a telephone triage assessment the same day or first working day after referral. This included a risk assessment. Whilst clients were waiting for assessment staff contacted them each day where they reviewed information from the triage assessment including risks.

Staff generally did not work alone. On some occasions, staff saw clients away from the service. Staff completed risk assessments and visits could be completed with two staff if this was required. Arrangements for staff personal safety were agreed prior to visits taking place.

Good

Are services safe?

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The service had previously had access to secure premises to see clients. However, this agreement had ended and the registered manager had raised this with commissioners so that there was a secure place to see clients where there was an identified increased risk which meant it would not be appropriate for the client to attend the service.

Safeguarding

Staff were trained in safeguarding, knew how to make an alert and did so when it was appropriate. The training provided included safeguarding adults and children. Staff demonstrated a good awareness of the types of abuse and neglect including those at risk of significant harm including children and young people and the local safeguarding processes. The service had a designated safeguarding lead.

Staff were assertive and escalated their safeguarding concerns where it was necessary. They challenged decisions made by other organisations where they felt that their concerns had not been addressed. Staff maintained records on safeguarding and worked in partnership with other agencies, teams and services.

Staff access to essential information

The service used an electronic client recording system, it has used this system since April 2017 when Humankind took over the service. Where clients had been involved in services before this date a summary record was available as an attachment on the new system. When staff had completed all of the relevant training then they were granted access to the systems. Access to the electronic records is limited to those staff with permission which is granted via several security checks carried out by the provider. Staff were given a card that gives them access to the system. This was a secure way of storing confidential client records.

Staff were positive about the electronic systems. However, they reported challenges because in the interview rooms there was no access to a computer. This meant that staff often recorded notes on paper and inputted these into the system later.

A separate system was used by the service and community pharmacies for records in relation to the needle exchange. This meant that accessing the needle exchange was more confidential and separate from the treatment and recovery record system.

Medicines management

The service did not hold any controlled drugs. They did however have a stock of Naloxone, which was all in date. Naloxone is an opioid antagonist used for the complete or partial reversal of opioid overdose. Staff told us that it is kept on site in case anyone were to present displaying symptoms of an overdose, staff could administer the necessary dose. All staff had received basic Naloxone training. The service provided naloxone kits to some clients at high risk of overdose. Staff told us that these clients receive basic training in how to use the kits.

There were some vaccinations stored on site and these were kept in fridges that had a well-documented cold chain policy in place and all vaccinations were in date.

The service had robust arrangements in place for the management of prescriptions including prescriptions for controlled drugs.

The service provided locked boxes to clients to ensure that medicines were kept securely and reduce the risk of these being misused.

Track record on safety

The service categorised 18 incidents as serious incidents in the last 12 months. However, 14 of these were notifications of safeguarding reporting. There was one violent incident on the premises and the remaining three related to errors in the way that information had been processed. The service responded quickly and effectively to incidents.

The service notified CQC promptly of eight deaths of people in the community in the last 12 months. The service had a robust system in place for reviewing incidents and deaths. The service had responded to an increase in drug related deaths by developing a plan which involved alerting the public, local and regional partners of risks involving varying strengths of heroin that had contributed towards clusters of deaths.

Reporting incidents and learning from when things go wrong

The provider used an electronic incident reporting system to monitor and report all incidents including deaths, safeguarding, near misses, alleged abuse, complaints and behavioural issues. The system was easy to use, incident notifications were sent to managers to review and feedback was provided to staff through the system. Each incident had a timeline that showed the work completed at each stage in the process. The system was used to store

Good

Are services safe?

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documentation relating to specific incidents including a copy of the notification to CQC. It also had sections to record updates on incidents, what lessons had been learnt and how they would be disseminated.

Staff received information on trends, themes and lessons learnt from incidents. Team meeting minutes showed that these were discussed with staff. Each quarter, the quality and performance manager created a report that analysed the types of incidents reported to identify trends, themes and lessons learnt. This report was shared with staff. We saw that this report identified a breakdown of incidents, findings including good practice, learning identified and actions to be taken.

For incidents that involved aggressive or violent behaviour, the service had developed a behavioural assessment and response tool. The tool asked standardised questions about the client and the behaviour and was used to establish an incident score. The score was used to enable staff to consistently measure the impact of these types of incidents on the service. This meant that everyone involved could respond appropriately and fairly where action needed to be taken because of an incident. We saw this tool being used in consultation with clients that used the service and the positive impact it had on managing these types of behaviour.

Staff understood the duty of candour and explained that when something went wrong they would be open and honest about this. The service would provide an explanation and an apology.

The service had a reflective practice group where they discussed issues presented by staff.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

Clients' care and treatment records contained a comprehensive assessment of their needs. The parent provider started to provide the service in April 2017. This meant that any clients receiving care and treatment had a review and transfer of care from a previous provider. In four of the records reviewed, clients' cases had been transferred from the previous provider. The other care and treatment records contained a triage assessment and a comprehensive assessment. The assessment requested information on physical and mental health, substance misuse and potential safeguarding issues. These clients had started to access the service under the current provider.

At assessment, staff discussed physical health with clients. This included whether they were registered with a GP. They asked clients whether they had been screened and vaccinated for blood borne viruses. Clinical staff carried out blood borne virus testing and vaccinations for clients that consented to this. The service had a visiting clinician who provided hepatitis C treatment at the service. Staff organised health clinics to run at the service and the same time as other clinics so that clients only needed to attend the service once for their treatment and other interventions. The service had reported an increase in the uptake of hepatitis C treatment from around 40% to above 90%.

Staff developed recovery plans based on information provided by clients. All records that we reviewed contained a recovery plan. The recovery plans contained brief and basic information. For example, to reduce substance use, methadone prescription or alcohol consumption. However, the recovery plans were all focussed on the clients' own treatment and recovery goals. Our review of other areas of client records including, the assessment, documentation from client appointments and feedback from staff and clients demonstrated that recovery plans were not fully reflective of the personalised, holistic and recovery oriented care and treatment being delivered by staff.

Best practice in care and treatment

Staff provided a range of care and treatment interventions and aftercare services suitable for the client group. The service provided the full substance misuse treatment services for Barnsley. At the front end of the service a team of hope workers provided a single point of contact to the service including duty workers to screen and triage referrals. Staff working in the hope team provided education, harm reduction advice and brief interventions based on psychosocial approaches. Anyone requiring treatment was allocated to the care navigation pathway. The service allocated clients with a recovery navigator and where appropriate a named clinician. Clients had access to the appropriate interventions including support, detoxification, substitute prescribing and psychosocial interventions.

Where clients required a residential rehabilitation placement, the service held the budget to source and organise this provision.

Staff working in the building recovery in communities team provided sessions to prepare clients for detoxification or residential rehabilitation. The team also worked with clients on successful completion of treatment. They supported clients to build the skills, networks and routines that would support them in the future.

Staff ensured that clients' physical healthcare needs were met. Staff encouraged clients to register with a GP and visit the GP for any physical health issues. Staff carried out the necessary physical health monitoring and precautions including titration, physical observations and baseline bloods to help inform appropriate treatment, including when prescribing and detoxification regimes.

The service had one whole time equivalent specialist midwife that worked alongside recovery navigators to provide care, treatment and support to pregnant clients.

Staff provided clients with information about leading healthier lives. They signposted clients to the appropriate external organisations.

Staff used the following recognised clinical tools to assess clients' severity of side effects and outcomes: alcohol audit, Leeds dependency questionnaire, clinical opiate withdrawal scale, six-item cognitive impairment test and the clinical institute withdrawal assessment of alcohol scale.

The service used outcome measures and performance returns to report on performance appropriately. They used the treatment outcomes profile to assess progress through care and treatment. This was completed every 12 weeks.

Are services effective?

Good

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

The service also completed returns to the National Drug Treatment Monitoring System. The provider received a quarterly Diagnostic Outcomes Monitoring Executive Summary exception report of any performance outlier areas. The service was performing well on treatment outcomes for clients receiving and completing treatment for the use of non-opiate substances, alcohol and non-opiate substances and alcohol. The service was underperforming on successful opiate treatment completions. However, it was recognised by both the service's leaders and the commissioners that the service was working with a complex client group and a high caseload of clients. They were working together to try and support the service to maintain safe and effective care and treatment to give clients the best chance of recovery.

Skilled staff to deliver care

The team included a full range of disciplines required to meet the needs of clients. The team comprised a doctor, nurse non-medical prescribers, a prescribing facilitator, recovery navigators, criminal justice recovery navigators, hope workers, building recovery in communities workers. In addition, the service had one whole time equivalent specialist midwife.

Staff working in the service were experienced and had the appropriate skills and knowledge to meet the needs of clients. Most staff had worked in the local substance misuse services for many years and demonstrated a good understanding of the issues relevant to clients that use the service and issues in the local community.

Staff received the appropriate inductions and training. In the 12 months leading up to 31 July 2018, 82% of staff had received an appraisal of their performance. The provider reported that the remaining staff had been employed for less than 12 months by the organisation. All staff had an allocated supervisor. They told us that they received regular supervision and support. They told us that they could seek support and advice from their colleagues and managers at any time. The provider was in the process of implementing a new system for staff training and supervision. At the time of our inspection, this was not operating and managers were not able to provide a supervision rate.

The provider had a range of training opportunities and e-learning packages available for staff. In addition, the service had an agreement with the local authority for a training exchange programme. Staff from the service provided training to local authority staff and in return they could attend any courses provided by the local authority without cost. Staff reported that this had been successful for both organisations providing opportunities for interagency working and exchanging skills and knowledge.

The service had volunteers. They ensured that they had the appropriate disclosure and barring service checks, training and support. Managers told us that the service was trying to recruit more peer mentors for the service to support with building recovery in communities projects and group work.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multi-disciplinary meetings. The hope team, recovery team and the clinical team had a bi-monthly team meeting and every three months there was a service wide meeting attended by all staff including the director of services. All meetings had standard agendas and minutes were detailed and comprehensive to reflect discussions held with staff. Meeting minutes showed that managers discussed performance, safeguarding, organisational updates, guest speakers and any key issues including remedial actions required.

Multiple staff that worked with one client had systems to share information. They had access to the clients care and treatment records where they could look at notes made from sessions led by other staff and they could see any prescriptions issued on the electronic record system.

The service had good working links with other external organisations including, GPs, community pharmacies, social services and the local acute hospital. Staff ensured that GPs were aware of the courses of treatment being delivered where this was necessary. The electronic record system showed regular correspondence to clients' GP surgeries. A number of clients were under shared care with their GP and a recovery navigator from the service. The service worked with community pharmacies under a service level agreement where they provided needle exchange locations and services for supervised consumption of medication. Community pharmacies informed the service of any issues around attendance and compliance with supervised consumption so that the appropriate safeguards were put in place around prescribed treatments.

Two staff in the hope team performed a hospital liaison role and carried a pager during the service's opening hours

Are services effective?

Good

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

to provide support. The provider reported that in the first two quarters of 2018 to 2019 that 103 referrals were made from the local acute hospital to the service. As a result, 77 clients received one or more brief interventions, one client received semi-structured interventions and 25 clients started structured treatment. They attended multi-disciplinary meetings to discuss frequent users of emergency and accident and emergency services meetings to provide substance misuse service input.

Good practice in applying the Mental Capacity Act

Ninety eight percent of staff had training in the Mental Capacity Act. Staff had a good understanding of the Mental Capacity Act 2005 including the five statutory principles.

Staff that we spoke with explained that due to the nature of the clients that they worked with, the most common capacity issue was around fluctuating capacity. They explained that they would try to postpone any decisions until the client regained capacity which was line with the statutory principles of the Mental Capacity Act and its code of practice.

Staff had access to the provider's policy on the Mental Capacity Act via the intranet. They reported that they could seek advice from their managers and clinicians if required.

Deprivation of liberty safeguards does not apply to type of service and therefore was not assessed as part of this inspection.

Good

Are services caring?

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

Our findings

Kindness, privacy, dignity, respect, compassion and support

The service had a strong and positive culture. All staff were very inclusive, respectful, non-judgemental and were highly motivated to work with clients to help them to improve their lives through care, treatment and aftercare services. Observations between staff and clients showed that staff understood the totality of clients' needs and treated them with dignity and respect, worked flexibly and consistently to provide care and treatment.

Clients provided universally positive feedback about staff and the service they received. Many of the clients that we received feedback from told us that the staff that worked with them had changed their lives and some felt that staff had saved their lives because they had never given up hoping that clients could be successful in treatment and recovery. Clients described staff as amazing, polite, having excellent attitudes, being wonderful and very friendly. Clients also told us that staff worked flexibly with their appointment schedules, worked tirelessly to support them and they always felt welcome when they visited the service. Some clients told us that staff challenged them to adhere to what they had agreed as part of their care plan to meet their goals. They told us that they needed this to make sure they committed to do the things that they said they would for their own recovery.

Staff provided education and support to enable clients to understand and manage their substance misuse through education and discussions. For example, how many units were contained in alcoholic drinks.

Staff maintained client confidentiality and clients had trust in staff protecting their confidentiality. They did not share information with others unless they had clients' consent or this was necessary to safeguard an adult or child at risk of significant harm. That included when clients accessed the needle exchange. The needle exchange service was confidential and access was recorded on a separate client care record system. Staff told us that they would not share this information with other staff involved in the clients' care.

Involvement in care

All clients had named workers they told us that they always saw their allocated worker that knew them and their needs well. Staff involved clients in their assessments and used these as a tool to gather information from clients to establish what their recovery goals were and any risks. Although, we identified that care plans and risk assessments contained brief and generic information, other parts of care and treatment records and feedback from staff and clients demonstrated that staff placed clients at the centre of their care, treatment and recovery. The interventions delivered were tailored around the goals of the client and what they wanted to achieve. For example, in some cases we saw that this was to reduce alcohol intake and in others to stop drinking alcohol. Care and treatment records showed that staff discussed with clients their goals for example, the long-term challenges of reducing but not stopping drinking alcohol.

Staff had access to a range of resources to support them to communicate with clients about care, treatment and recovery. They used different mediums and props to help clients to understand the information and interventions they were providing.

The service had posters displayed to encourage clients to take part in a mystery shopping review of the needle exchange provision across the community pharmacies the service worked with. They were also trying to recruit more volunteers to support some of the aftercare building recovery in communities services.

Clients could provide feedback on the service through a suggestion box. The service also had a service user forum meeting regularly. The reception area of the service displayed information to show summaries of the previous meeting minutes and show what action had been taken in response to feedback. This was part of a 'you said, we did' display. The feedback from service users had led to changes including the needle exchange provision, purchasing a bike rack for outside of the service, having somewhere that dogs could get a drink and provision of mobile phone chargers that clients could use in the service for free. The last service user forum meeting had taken place at another venue and it had been poorly attended. Staff had reflected on this and the next meeting was at the service and a budget had been set aside for refreshments to encourage clients to attend.

Good

Are services caring?

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

Staff involved clients' families and carers appropriately. With clients' consent they were involved and staff could refer families and carers to the local carers support services.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The service had clear referral criteria. It accepted self-referrals from clients and referrals from external organisations for any individual with a substance misuse issue. For any inappropriate referrals, staff discussed this with the referrer signposting to the most appropriate local services.

During opening hours, the service had a single point of contact team for all incoming communication which was staffed by at least two and sometimes three hope workers. Staff on the single point of contact screened and triaged all referrals and booked assessment appointments. If an urgent referral was received, staff acted promptly to complete assessments.

Staff reviewed referrals promptly and contacted clients to complete triage assessments. This was typically on the day of referral unless it had not been possible to contact the client. If staff had not been able to contact the client, they attempted daily contact with the client. After seven days, if they have not been able to contact the client then staff write a letter to the client and inform the referrer that they have not been able to engage with the client. They also informed the referral if the client had declined involvement.

Each day between Monday and Friday, hospital liaison staff attended the local acute hospital. When they were not on site, they carried a pager so that the wards could inform the service that they needed to speak to them. Wards identified had a box where referrals out of hours could be completed and left for hospital liaison staff to pick up during the service's operating hours.

The service operated at two sites. One in central Barnsley and one in the East of Barnsley. The Factory, based in the East of Barnsley, provided the same services available at the central service. This meant that people who lived on the outskirts of the area could access a service near to where they lived.

Staff tried to engage with clients who were reluctant to engage. They focussed on the client's recovery goals and made adjustments to try to ensure that engagement was maximised wherever possible. For example, reassurance and support provided to clients nervous about accessing the service and adjusting appointment times.

Clients told us that their appointments usually took place at the time that they should and staff on the reception kept them informed if there were any changes to their expected appointment times. Staff had a fair and reasonable response to clients who did not attend their appointments or who were late to ensure that clients were not at risk from not receiving treatment and support.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a warm and welcoming atmosphere. It was decorated brightly and had enough space. The reception area contained a range of useful and relevant posters and information that was well displayed. Clients could see what educational, recreational opportunities were available in the local community, health and well-being information and access to support groups. There was also information displayed on the service user forum meeting minutes and changes made as a result of feedback. The service had a range of rooms and clinical space to support care and treatment provided. The rooms had adequate sound proofing to promote privacy and confidentiality.

Patients' engagement with the wider community

Staff encouraged clients to access positive and meaningful opportunities in the community. Staff worked on this throughout their involvement with clients so that they could have the networks and meaningful activity to support their recovery in the longer term. The service had a building recovery in communities team that worked with clients after they had completed their treatment. The aim was to support clients in their personal development, self-esteem and to help with managing behaviours. They supported clients with social, recreational and educational activities. Activities provided by the team included support with accessing the local and recovery colleges, gym sessions, walking and sports. The team also ran twice weekly group sessions called SMART aimed at developing skills.

Staff encouraged clients to develop and maintain positive relationships with people that mattered to them and that would support their recovery.

Meeting the needs of all people who use the service

The service could meet the needs of all clients. Although the service was based on multiple floors, there were

Are services responsive to people's needs?

Good

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

enough facilities and space on the ground floor levels to see disabled people or those with reduced mobility. Staff had access to materials and interpreters to meet any communication needs.

Staff demonstrated an understanding of the potential issues faces by vulnerable groups of people including those with protected characteristics. They were committed to providing an inclusive and non-judgemental service to all.

Listening to and learning from concerns and complaints

The provider managed complaints well. In a 12-month period, the service received 21 compliments and eight complaints. At the time of our inspection, one complaint was under investigation and none of the closed complaints had been upheld or referred to the ombudsman. None of the clients interviewed told us that they had ever been dissatisfied with the service or staff and had not needed to make a complaint. They told us that if they were unhappy about something they would know how to make a complaint and would be confident that their concerns would be investigated and action taken.

Are services well-led?

Good

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

Our findings

Leadership

The service had an established leadership team with the skills, knowledge and experience of the service, needs of clients and the local community. Leaders had comprehensive knowledge of their services and how the teams functioned to provide safe and effective care and treatment.

The area manager who was the registered manager was based at the service and the director of service worked at the service regularly. Staff reported that leaders were visible, approachable and supportive towards staff and clients.

Vision and strategy

The provider had changed their name to Humankind charity recently. As part of this process, they had undertaken a project to co-produce their vision, mission and values with clients and staff. Leaders reported that the project had been successful as clients had engaged and this was important to the organisation. Staff understood and demonstrated the provider's vision and values in their work.

The provider had a vision statement that was for people of all ages to be safe, building ambitions for the future and reaching towards their full potential. The provider also had a mission statement which was: "humankind creates services and support to meet people's complex health and social needs, helping them to build healthier lives that have meaning and value for themselves and their families. We support local people to create stronger, better-connected communities".

The provider had three values which were:

Honest: We are open and realistic, building trusted relationships in which we challenge, collaborate and change

Committed: we are passionate about being the best that we can be, and we do this by keeping people at the heart of everything that we do

Inventive: we are ambitious, drawing together skills and resources to innovate and adapt in determined pursuit of our mission.

Leaders explained how they managed budgets including holding their own budgets for services like residential rehabilitation and cost of medicines. One of the risks on the provider's risk register was the cost of buprenorphine which had increased significantly higher than forecasted within the budgets. They told us that they had communicated some of these challenges with their commissioners and the organisation had written letters to Public Health England and the media raising that issue. Leaders had held discussions with clinicians to ensure that prescribing was within the provider's policy but confirmed that they did not allow budget constraints to impact upon clinical and treatment decisions. They told us that they would try to save unnecessary costs elsewhere wherever possible.

Culture

Overall, staff felt respected and valued. Staff reported that going through transfer from a previous provider had been stressful however, this had not been any more stressful than they had experienced previously. Staff felt positive about working for the provider and identified with the provider's mission and vision for the organisation.

Staff told us that they could raise their concerns without fear of retribution. They reported positive relationships with the leaders of the service. Staff knew where they could access the provider's policies including whistleblowing if they needed this.

Teams worked together to support each other and provide a service to clients when this was required. All staff reported that they provided mutual support to their colleagues when this was required. For example, when the recovery navigators were limited for assessment appointments, the hope team supported them and when the single point of contact was busy with incoming calls, reception staff supported them to answer calls.

Staff had access to emotional and well-being support as part of the provider's occupational health scheme.

Governance

The service had mostly effective systems and processes that ensured that leaders could assess, monitor and improve the safety and quality of the service. Example of this included: the cleanliness and maintenance of the service, staff received training and an appraisal of their performance and although the service was stretched they ensured that clients were assessed and treated promptly.

Are services well-led?

Good

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

There was a clear structure of meetings from individual team meetings to service wide and integrated governance meetings. Each meeting had a standard agenda and there was a clear process to escalate and cascade information upwards to the provider's board and down towards the frontline staff in the service. Feedback from staff and minutes evidenced that staff were fully informed of important information.

Leaders acted promptly to support clients, the service and the local population in response to an increase in drug related deaths. They provided information for awareness and implemented the naloxone kit provision quickly in the area. All incidents were reviewed by the service's performance and governance lead who produced quarterly reports to share learning and implement actions to improve the service.

The service submitted the appropriate returns and performance monitoring as part of their contract with their commissioners.

Management of risk, issues and performance

The service had a risk register and this fed into the provider's risk register. We saw that appropriate incidents that had been reported had been escalated to the risk register. Each risk had clear remedial actions to lower the risk. Risks on the service's risk register matched the risks that we had identified and those identified by leaders and included, the performance of the service for successful opiate treatment completions and the cost of buprenorphine.

The provider had plans to address issues around record keeping through staff training. During our inspection, we identified that clients' risk assessments and care plans were not fully reflective of the detail of staff and client interactions and documentation that was available in other parts of clients' records. The provider had identified that there was a training need for staff and had organised training to support staff in this area.

The provider was due to launch a new system to manage staff training and supervision that would enable them to record supervision rates more effectively.

The service had business continuity plans in place to ensure that they were prepared for events that may stop the service from operating as usual.

Information management

The provider's systems and processes were not over burdensome on frontline staff. Leaders reported that many of the provider's systems enabled them to prepare information for reports and submissions automatically which was more efficient than previous systems and processes.

Staff had sufficient access to equipment, however, they reported that they thought they could work more efficiently if they had access to computers in the interview rooms at the service. They relied on typing up their notes after sessions with clients.

The service had the appropriate safeguards in place for information governance. The service had a clear desk policy and staff had lockers to store papers until these were scanned onto the electronic client record system. Staff had to undertake mandatory training requirements on information governance and could only access the systems with valid training.

The registered manager ensured that the relevant notifications were made when these were required. Our review of the provider's incident recording system showed evidence of notifications made to CQC for each notifiable incident.

Staff ensured that the appropriate confidentiality agreements were in place with clients around information sharing. They ensured that they adhered to what had been agreed with clients for example, information sharing with the National Drug Treatment Monitoring System.

Engagement

Clients had opportunities to engage with the work of the provider through projects available and routinely at the service through the service user forum. They could also provide suggestions at any time through a suggestion box at the service. The provider's website showed a range of information that service users could access to learn more about the provider's work and services.

Staff had access to information to be up to date with developments. Staff reported positively about their experience of transitioning from the previous provider to Humankind charity. They felt that the systems and processes were much simpler, effective and less cumbersome on staff. Staff received information from

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incidents including deaths and information on the services performance through regular and effective team meetings and documentation provided by the service's performance and governance lead.

The service's leaders engaged well with external organisations, networks and stakeholders in the local areas. They attended and contributed to meetings and information sharing forums. The service had also developed memorandums of understanding with the local authority for a training exchange.

Learning, continuous improvement and innovation

The provider was working with national pharmaceutical companies to explore new and innovative treatment options available. This included longer acting medicines. Leaders told us that they were looking forward to developments in this area because there had not been opportunities like this for some years.