Humphrey House

Quality Report

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

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

Summary of findings

Overall summary

We do not currently rate independent standalone substance misuse services.

We found this service was providing recovery focused, person centred care to clients.

The service was well arranged over two floors of the building, with separate entrances for the treatment service and the needle exchange. All areas within the building were clean and tidy. The service was safely staffed, with low levels of sickness and a low turnover rate.

Staff completed assessments which included all substance use, substance use history, accommodation and employment, physical health, mental health and risks. Assessments allowed for discussions around harm minimisation and health promotion, including blood borne virus screening, alcohol use assessment and smoking cessation advice. All records contained up to date, personalised, recovery orientated treatment plans. There was effective multidisciplinary working within the service and innovative intra-agency working with statutory and voluntary organisations.

Clients described being treated with dignity and respect and staff being friendly and welcoming, with praise for volunteers too. We saw positive feedback from clients at interview, from comment cards and from reviewing service feedback. In treatment groups, we observed a client centred approach with good engagement between facilitators and clients. We saw active involvement in treatment planning evident in client records. There was excellent carer support including a designated carer champion employed by the service.

The service offered appointments for assessments by phone or on a drop in basis. We saw that staff worked flexibly in making arrangements that worked for clients and carers. Service provision was continually reviewed and adapted to meet the changing needs of the local population and the clients who used the service.

The service had a well understood vision and values. This service had a good governance structure. The manager ensured staff were aware of provider level changes and developments. Staff described a positive working culture with good team working and mutual support.

Summary of findings

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Summary of this inspection

Background to Humphrey House

Humphrey House is the registered location for the One Recovery Bury service. The service is a community based substance misuse team.

The service is funded to provide support and treatment to adults in Bury and the surrounding areas.

The service was registered with CQC in November 2016.

The service is registered for the regulated activity of treatment of disease, disorder and injury.

There is a registered manager in post.

This service has not been inspected before.

Our inspection team

The team that inspected the service comprised CQC inspector Annette Gaskell (inspection lead), a CQC inspection manager, a specialist adviser with a background in substance misuse nursing and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with two clients
- spoke with two carers
- spoke with the registered manager and the service delivery director
- spoke with four other staff members employed by the service provider, including nurses, recovery practitioners and reception staff
- spoke with a student nurse on placement
- spoke with one volunteer/peer support worker
- attended and observed two treatment groups
- collected feedback using comment cards from 24 clients and carers
- looked at eight care and treatment records for clients
- looked at 16 prescription records and
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We were given positive feedback about the service from clients and carers.

We spoke to two clients and two carers at inspection and received 24 comment cards completed by clients and carers.

There was positive feedback about staff, including staff being understanding, friendly, efficient, supportive, helpful and being treated with respect. There was one negative card which suggested the client felt staff were not empathetic. There was feedback that the premises were clean and tidy. Client feedback was that they felt listened to and that their opinion mattered. There was positive feedback for courses offered, that these were well planned and good content. Clients spoke positively of the services approach to recovery, particularly the availability of treatment groups and access to other community based resources and support.

We saw excellent carer support including a designated carer champion. Carers were positive about the support their loved ones were receiving. When carers attended appointments, they found staff to be friendly and welcoming. They described always being able to get in touch with keyworkers and that calls were returned.

Carers spoke highly of the carer support they had received. Some had had contact with the designated carer champion, including regular individual sessions. Carers had access to carer support groups run by the service with some continuing to attend these regularly. There was positive feedback about the community reinforcement and family training (CRAFT) course which aims to support carers, with carers reporting they felt this had been highly beneficial and well ran.

We attended and observed two treatment groups, a mind matters group and a pre-detoxification group. We observed a client centred approach with good engagement between facilitators and clients. There was good feedback from clients about groups they attended.

We were able to review positive feedback from four clients who had recently attended holding families groups, which were jointly run with other agencies. Feedback centred on the facilitative approach and staff being non-judgemental and positive.

We spoke to one peer support worker/volunteer who was positive about the support they had received, both initially in treatment and then when being supported into employment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service was well arranged over two floors of the building, with separate entrances for the treatment service and the needle exchange.
- All areas within the building were clean and tidy.
- The service was safely staffed, with low levels of sickness and a low turnover rate.
- Staff received appropriate mandatory training.
- Staff completed thorough risk assessments and reviewed these regularly.
- A safeguarding lead worked with the team and supervised complex cases.
- Staff were aware of the types of incidents which needed reporting and how to report them.

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

- In the urine testing room, we found one batch of out of date urine test strips. All others were in date. These were removed immediately.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff completed assessments which included all substance use, substance use history, accommodation and employment, physical health, mental health and risks.
- Assessments allowed for discussions around harm minimisation and health promotion, including blood borne virus screening, alcohol use assessment and smoking cessation advice.
- All records contained up to date, personalised, recovery orientated treatment plans.
- Staff were familiar with and used best practice guidance.
- Managers and staff completed audits of service provision.
- Staff had a range of skills and experience and were able to access training to increase their knowledge.
- Staff received regular supervision every four to six weeks.

Summary of this inspection

- There was effective multidisciplinary working within the service and innovative intra-agency working with statutory and voluntary organisations.
- Staff showed an understanding of the Mental Capacity Act and its relevance within this setting.

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

- Not all staff had had an appraisal in the last 12 months.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients described being treated with dignity and respect and staff being friendly and welcoming, with praise for volunteers too.
- We saw positive feedback from clients at interview, from comment cards and from reviewing service feedback.
- In treatment groups, we observed a client centred approach with good engagement between facilitators and clients.
- We saw active involvement in treatment planning evident in client records.
- There were monthly service user involvement meetings attended by staff from the service and clients.
- Volunteers worked at the recovery hub in group facilitation, peer support and administrative roles.
- We saw excellent carer support including a designated carer champion employed by the service.
- The service collected feedback from comments cards in the reception area, via keyworker feedback, group feedback forms and the user group meetings.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service offered appointments for assessments by phone or on a drop in basis.
- We saw that staff worked flexibly in making arrangements that worked for clients and carers.
- Staff told us that appointments were rarely cancelled or changed. Clients and carers confirmed this.
- There were adequate rooms available for client reviews and clinic appointments.

Summary of this inspection

- A large group room was used for therapeutic groups, with another room available if needed.
- Service provision was continually reviewed and adapted to meet the changing needs of the local population and the clients who used the service.
- The service had been successfully running several group programmes.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had a well understood vision and values.
- This service had a good governance structure.
- The manager ensured staff were aware of provider level changes and developments.
- Regular team meetings each month allowed all staff to meet together and discuss issues.
- Managers and staff had good administrative support in the form of an administrative team.
- The service had a local risk register which was regularly reviewed.
- Staff described a positive working culture with good team working and mutual support.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff showed an understanding of the Mental Capacity Act and its relevance within this setting. Capacity was only assessed when there were concerns raised and staff told us of situations where capacity was temporarily affected by intoxication. A policy provided guidance for staff and templates to use if needed. There had been no use of best interest decision processes within this setting.

Staff received training about the Mental Capacity Act with 83% of staff up to date.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The One Recovery Bury service at Humphrey House is located over two floors of a building shared with other local authority and mental health teams. The building has separate reception areas for the different services.

On the ground floor there were staff offices and the needle exchange. The needle exchange had its own doorway, reception and rooms.

On the first floor, there was a reception area, interview rooms and urine testing room. Staff collected personal alarms from the reception area before using interview rooms. Interview rooms had two doors to ensure staff could exit rooms safely if necessary. The needle exchange had an alarm system in case of emergencies.

Staff accessed offices and restricted areas of the building using a key fob system.

The reception area and needle exchange doorways had closed circuit cameras which had been installed by the building landlord. There were signs advising of their use. Staff in the reception area and needle exchange were able to view these.

All areas within the building were clean and tidy. Health and safety, environmental and fire safety assessments were completed and reviewed at tenant meetings with the building landlord.

Clinic rooms were clean and tidy. The ground floor clinic room was used to store naloxone kits (naloxone is a drug used to reverse the effects of opiate overdose) and adrenaline for use with vaccines, and these were stored safely. Nurses checked fridge temperatures every day.

In the urine testing room, we found one batch of out of date urine test strips. These were removed immediately. All others were in date. Staff told us they would always check the date on these before using.

Sharps bins were stored appropriately in the needle exchange.

Staff ensured equipment was calibrated regularly, for example, breathalysers. Equipment was well maintained.

Staff had access to good infection controls measures, including aprons and gloves (including thickened gloves for use in the needle exchange) in the treatment rooms. Infection control policies and procedures were in place, including needlestick policies. Staff were aware of these and knowledgeable about good infection control.

There were effective systems for the disposal of clinical waste and weekly arrangements with a contractor for removal.

Safe staffing

There were 26 substantive staff employed in the service, including three administration staff members. There had been three staff who had left in the last 12 months. The vacancy rate was 4%, which was due to vacancies for part time administrative staff.

The staff sickness for the last 12 months was 4% overall.

Average caseloads varied between staff depending on the treatment needs and level of complexity. Staff told us caseloads were manageable. There were no clients awaiting allocation of a keyworker at the time of inspection.

Managers assessed caseloads as part of regular staff supervision.

There were sufficient staff to manage annual leave and short term sickness.

Substance misuse services

Mandatory training levels showed staff received training on domestic violence, health and safety, fire safety, equality and diversity, infection control, Mental Capacity Act and safeguarding. Nursing staff were trained in basic and immediate life support, vaccination training and management of anaphylaxis. Volunteers also received mandatory training.

Prescribing clinics, led by a doctor or non-medical prescriber, took place four times per week. There was access to emergency medical advice outside of these times if needed.

Assessing and managing risk to clients and staff

Staff undertook risk assessments at initial assessment and these were updated regularly. Within these, there was always reference to blood borne virus risk screening, physical health risks, risk of violence and forensic history, risk to self, children and domestic arrangements and vulnerability. The risk of unplanned exit from treatment was also planned for.

We saw specific risk assessments compiled for supervised opiate consumption arrangements, and plans made for methadone locked storage and safety for clients with children who visited or lived at home.

Staff followed the service policies for medicines management, including issuing prescriptions. Nurses involved in community detoxification programmes followed set schedules for visits and monitoring.

Staff undertaking home visits were aware of and followed lone working arrangements. Some staff had received additional training in lone working, for example, staff working in the needle exchange who often worked alone.

Staff were able to access advice from nurses or medical staff if they were concerned about physical health conditions or deterioration. All staff had received training in blood spot testing for hepatitis and we saw health promotion advice was offered including smoking cessation support.

Staff were trained in adult and child safeguarding to level two, with all staff having attended training. Staff had a good understanding of what needed to be reported to the local authority and we saw records confirming referrals were made. The service notified CQC of incidents as required.

For all new assessments there was a standard requirement where the client had children, for staff to check with the local authority safeguarding team to assess the level of involvement, if any, with social services.

The service employed a safeguarding lead and staff could seek guidance and advice from them. The safeguarding lead had level five safeguarding training and had previously worked in children's social care.

The clinical commissioning group safeguarding lead had completed an assessment of the service, including safeguarding supervision and training arrangements, in September 2017.

Staff had good links with the local authority both for safeguarding referrals and also for domestic violence cases and child protection arrangements. There was a lead for domestic abuse, who worked closely with the local authority team, attended multi-agency risk assessment conferences and was a member of the local domestic abuse steering group.

Track record on safety

There had been 10 serious untoward incidents reported since December 2016. These related to deaths of clients.

We saw a serious incident review report prepared for the board by the safeguarding committee which analysed findings from serious incident reviews. There had been dissemination of themes from these incidents to services in the form of lessons learnt. An action plan had also been produced for each service with key areas, audit method and timescales. We saw evidence of some of these actions being implemented, for example, undertaking physical health checks to identify any underlying problems and ensuring social support is in place or offered when treatment ended. Other actions identified had longer timescales and were progressing.

Reporting incidents and learning from when things go wrong

Staff were aware of the types of incidents which needed reporting and how to report them. We saw that incidents were being reported appropriately. We reviewed six incident reports. These were followed up with actions taken and conclusions. Incidents reported included threats to staff and disclosures by clients of self-harm and/or suicidality.

Substance misuse services

Investigation findings and lessons learnt were fed back to staff at regular team meetings.

Duty of candour

The service had a duty of candour policy. Managers were aware of their responsibilities in terms of duty of candour. There had been no incidents which had met duty of candour threshold in the service.

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

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

We reviewed eight care and treatment records. Clients were assessed comprehensively when first seen at the service. Staff completed assessments which included all substance use, substance use history, accommodation and employment, physical health, mental health and risks.

Staff completed all documentation for national monitoring at appointments. They also used recognised rating and dependence scales as appropriate. Staff also used the lifestyles outcome monitoring system at assessment and points throughout treatment to measure whether there were positive changes being made across a range of domains, including substance misuse problems, being healthy, building recovery capital, happier families, service satisfaction, and, safer, stronger communities.

Assessments allowed for discussions around harm minimisation and health promotion, including blood borne virus screening, alcohol use assessment and smoking cessation advice.

All records contained up to date, personalised, recovery orientated treatment plans. These also contained social needs assessment and evidence of multi-agency working, for example, housing liaison and employment support. Staff and clients regularly reviewed these.

Keyworkers were allocated at the time of initial assessment and completed plans with clients. This meant that treatment was continuous with clients seeing the same person from the outset.

Where clients were receiving prescriptions, the prescriber had made an assessment of their needs with the rationale for treatment clearly described. A physical health assessment was undertaken as part of this consultation. Clients who were newly assessed without prescribing needs were offered a physical health assessment with one of the nurses.

Client records were stored securely on an electronic system. Paper based information could be scanned into the system. Clients discussed information sharing at initial assessment and we saw signed consent agreements in all files we examined.

The service had an information sharing protocol with the local mental health services. We saw examples where this had been effective, for example, when making inpatient detoxification or residential rehabilitation referrals where information was needed about mental health issues and treatment.

The local mental health community teams and criminal justice teams were based in the same building, which was beneficial in terms of timely access to duty workers or mental health keyworkers.

Best practice in treatment and care

Staff were familiar with and used best practice guidance, including the drug misuse and dependence: UK guidelines on clinical management guidelines. Staff working in the needle exchange ensured the service was in keeping with the national institute for health and care excellence guidance on needle exchanges (public health guideline 52, published 2014). Policies and procedures were referenced and included up to date National Institute for Health and Care Excellence guidance. The service offered hepatitis B vaccination in line with National Institute for Health and Care Excellence guidance. Over the last six months, the service had undertaken hepatitis C screening for 86% of eligible clients and undertaken hepatitis B vaccination for 89% of eligible clients.

Clients who required community alcohol detoxification had care planned in accordance with best practice, including national institute for care excellence clinical guideline 115, and the service had developed a protocol for this. Two nurses planned and completed detoxification programmes with clients.

Staff were able to provide psychologically informed interventions. Group and individual psychosocial

interventions were offered at the service from two locations. The other location, the recovery hub, offered a range of recovery focused groups, including third sector support groups.

Keyworkers referred clients to the local mental health services for psychological interventions for mental health problems. The service identified that there was often a waiting list for this and the nurses had started to run a mind matters group, which included techniques to improve anxiety and mood.

The service worked closely with statutory and voluntary organisations, for example, a worker for the homeless service was available on a drop in basis once per week.

There was close liaison with GP services and any concerns regarding physical health were followed up with GP s. Clients receiving higher doses of methadone had electrocardiogram monitoring arranged at the local hospital or their own GP practice. Blood tests could be arranged from the service and undertaken locally.

Staff completed audits of care records to ensure these contained essential data and were being regularly reviewed. Managers had recently completed an audit of treatment outcomes and data collection regarding long term clients with actions to try to improve outcomes.

Skilled staff to deliver care

The service employed a range of staff including nurses and recovery practitioners. Medical cover was provided via an agreement with a GP with special interest in substance use and a consultant who attended the service. A non-medical prescriber also covered prescribing clinics. Doctors were available for advice by phone when not at the service, and worked locally if urgent prescriptions were required.

Staff had a range of skills and experience and were able to access training to increase their knowledge. Staff had undertaken strength based training in the last year with 75% of staff attending this. This was a three day course which focused on building on clients existing strengths and skills. Staff had also been able to access psychologically informed interventions training with 62% having attended this. Three staff were trained to provide acupuncture.

Nursing staff were supported by the service delivery director to complete requirements for revalidation.

All staff, including medical staff and volunteers, had been trained in the use of naloxone kits and treatment of overdose.

Staff received regular supervision every four to six weeks. Staff also received an annual appraisal. There were 60% of staff who had been appraised in the 12 month period reviewed, with staff due to be appraised booked for these.

Staff told us they received a comprehensive induction when they started working in the service, including a period of shadowing regular staff. Volunteers also received an induction and attended mandatory training and other training available to staff. Student nurses received a comprehensive induction pack at the start of their placement and a mentor was allocated who supervised them throughout their placement.

Multidisciplinary and inter-agency team work

There was effective multidisciplinary working within the service with a meeting weekly set up to allow discussion of clients with complex or urgent needs.

The team had good working relationships with the local authority, local mental health teams, criminal justice services, pharmacies and GP practices. Shared care arrangements were in place for clients where care was agreed between the client, the service and the client's GP.

Staff attended relevant local forums to ensure the service was aware of local and national developments and fed back to the team at staff meetings. This included meetings with the local authority and local mental health service.

We saw innovative multidisciplinary working, with a regular hepatology (liver treatment) clinic held on site. A consultant and nurse from the local acute hospital saw clients to discuss treatment for hepatitis and treatment could be started and monitored within the service.

There was a collaborative approach with the local clinical commissioning group and GP practices to reduce long term prescriptions for benzodiazepines and hypnotic preparations (often started initially for insomnia). There had been good progress made in supporting clients to reduce and stop these medications, alongside health promotion advice and other support.

The service was a practice placement for student nurses and other professional students.

Substance misuse services

Good practice in applying the Mental Capacity Act (if people currently using the service have capacity, do staff know what to do if the situation changes?)

Staff showed an understanding of the Mental Capacity Act and its relevance within this setting. Capacity was only assessed when there were concerns raised and staff told us of situations where capacity was temporarily affected by intoxication. A policy provided guidance for staff and templates to use if needed. There had been no use of best interest decision processes within this setting.

Staff received training about the Mental Capacity Act with 83% of staff up to date.

Equality and human rights

Staff received training in equality and diversity. The service supported both staff and clients with protected characteristics under the Equality Act 2010. The service employed staff who had previous experience of using substance misuse services and ensured they had the same opportunities to professionally develop as other members of staff. Staff employed within the service were of different ages, races and sectors of the community to ensure that the diversity of the client group accessing the service were reflected in the staff delivering the service.

The service had a blanket restriction in place regarding bringing illicit substances or alcohol onto the premises. This was appropriate due to the nature of the service being provided, and clients were made aware of this as part of the orientation to the service on initial referral. In the recovery based section of the service, clients were able to access the service if they were receiving a maintenance prescription and/or drinking alcohol at a low level. Originally, clients could only access the service if they abstained completely from alcohol but clients had discussed this and felt this excluded some clients from the service unnecessarily. This had been acted on by the service and agreed.

Management of transition arrangements, referral and discharge

The service accepted referrals from GP surgeries, mental health services, criminal justice services, probation and client self-referral.

Staff ensured ongoing support to clients that were approaching the end of their active treatment programme. This involved ongoing support from recovery focused services in the service provided at the recovery hub.

The service had established good links with local prisons. Clients that were being released from prison were transferred in to the community service with a booked appointment to improve continuity of treatment and support on release. The service liaised with the prison and criminal justice team to ensure that clients who required substitute prescribing on release were able to continue with their prescription.

We had one report from a carer about a well planned admission and discharge from inpatient detoxification services. This had been planned well by the service, client and family were fully involved in this and the community service had fitted in around this to ensure a smooth transition.

Are substance misuse services caring?

Kindness, dignity, respect and support

Throughout this inspection, we saw brief interactions between staff and clients (for example, as clients arrived for appointments and as clients used the needle exchange or waited in the reception area) which were respectful and friendly.

We attended and observed two treatment groups, a mind matters group and a pre-detoxification group. We observed a client centred approach with good engagement between facilitators and clients. There was encouragement to participate and clients seemed relaxed and engaging with both groups. Staff presented what were often complex ideas and information in an accessible and meaningful way to promote client understanding. Clients fed back that the pre-detoxification group provided good preparation for detoxification. Materials and session planning for both groups were of a high quality.

We spoke to two clients at inspection and received 24 comment cards completed by clients and carers. Two collection boxes had been located at the needle exchange and the main reception area. Of these, 23 had positive feedback for the service.

Substance misuse services

There was positive feedback about staff, including staff being understanding, friendly, efficient, supportive, helpful and being treated with respect. There was one negative card which suggested the client felt staff were not empathetic. There was feedback that the premises were clean and tidy. Client feedback was that they felt listened to and that their opinion mattered. There was positive feedback for courses offered, that these were well planned and good content. Clients spoke positively of the services approach to recovery, particularly the availability of treatment groups and access to other community based resources and support.

Eight cards were received from the needle exchange, with positive feedback for the staff member who worked there about friendliness, efficiency, understanding and ease of use for the service. One comment was around sometimes having to wait, which likely relates to the worker already attending to another client, as only one member of staff worked in the needle exchange.

We were able to review positive feedback from four clients who had attended recently run holding families groups, which were jointly run with other agencies. Feedback centred on the facilitative approach and staff being non-judgemental and positive.

The involvement of clients in the care they receive

We saw active involvement in treatment planning evident in client records. Clients told us they were actively involved in discussions about their care and treatment.

We saw minutes of meetings where changes to service provisions had been discussed with clients and clients were asked what services they would like to see. There were monthly service user involvement meetings attended by staff from the service and clients. Some of these suggestions had been implemented, and the recovery hub for the service was largely run by peer support workers. Two peer support workers had previously been based in the reception area of the service, for clients to drop in and see in a private room. Both support workers had moved on into other employment and the service was recruiting for further peer support workers.

The provider had successfully recruited volunteers across the organisation who worked facilitating groups, as peer support workers, in administrative roles and providing brief interventions and harm minimisation. At this service, most volunteers worked at the recovery hub in group facilitation, peer support and administrative roles. The service had successfully recruited to 20 volunteer posts and in the last 12 months had facilitated access to educational courses and support for 93 clients. This included a 16 week bridging the gap programme aimed at improving employment skills.

We spoke to one peer support worker/volunteer at the service. They were positive about the support they had received, both initially in treatment and then when being supported into employment.

We saw excellent carer support including a designated carer champion. We spoke to two carers and received comment cards from carers. Carers were positive about the support their loved ones were receiving. When carers attended appointments, they found staff to be friendly and welcoming. They described always being able to get in touch with keyworkers and that calls were returned.

Carers spoke highly of the carer support they had received. Some had had contact with the designated carer champion, including regular individual sessions. Carers had access to carer support groups run by the service with some continuing to attend these regularly. There was positive feedback about the community reinforcement and family training (CRAFT) course which aims to support carers, with carers reporting they felt this had been highly beneficial and well ran.

A third sector support service for families and carers affected by alcohol use ran a weekly group in the evenings at the recovery hub.

The service collected feedback from comments cards in the reception area, via keyworker feedback, group feedback forms and the user group meetings. This was used to review the service and identify future needs.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

The service offered appointments for assessments by phone or on a drop in basis. Clients were often seen for assessment on the same day or the next day of contact. Appointments for prescribing clinics were made within two weeks of assessment, with most clients able to be seen within a week. If there were high risk issues identified,

appointments would be prioritised. The target for waiting time to treatment was three weeks and the service monitored this on a monthly basis. For the past five months, there had been no breaches of this target for prescribing clinics.

The service offered extended hours opening one day per week. Support groups at the recovery hub ran in the evenings, including carer groups and narcotics anonymous groups.

We saw that staff worked flexibly in making arrangements that worked for clients and carers, including using alternative locations than the service base and offering home visits if these were preferable.

Staff told us that appointments were rarely cancelled or changed. Clients and carers told us this didn't happen.

There was a protocol for following up missed appointments which staff followed. Staff also spoke to us about how they would ensure clients could continue in treatment and they would check their wellbeing if appointments were missed, for example, using text messages, phone calls, letters and home visits where necessary.

We had feedback that when clients required inpatient detoxification or longer term rehabilitation placements these were arranged and planned with clients. Funding applications were discussed and agreed at a weekly meeting.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a full range of rooms needed to operate effectively. Six interview rooms were available for review and clinic appointments. There was no booking system for rooms and there were never instances where there was no room available. Interview rooms were soundproofed to ensure confidentiality.

A large group room was used for therapeutic groups, with another room available if needed. This was equipped with comfortable seating, flipcharts and display boards and tea and coffee making.

Posters and leaflets in the waiting area advised clients of groups that were available and there was health promotion information displayed. A wide range of information leaflets were available in the service, including some in easier to read formats. Information about treatments was available, but the service also kept a wide range of information about mental health problems and support, physical health conditions, sexual health and community services, for example, housing support and welfare advice.

Meeting the needs of all clients

There was a hearing loop system for clients and staff if needed. A lift and a ramp were available for clients with mobility issues. The service offered home visits to clients for preference and also if medical issues meant that it was difficult to travel to the service.

Staff could access an interpretation service if needed.

Clients and carers gave examples of where keyworkers had developed individualised plans to ensure care was delivered in ways that took accounts of clients physical and mental health needs.

We also saw examples where the service had responded to feedback from clients, for example, a bereavement support group had been developed by a local healthcare organisation and ran monthly following feedback from service users and carers about their difficulty when accessing mainstream bereavement services. Other agencies could make use of the services buildings, for example, a mental health mutual aid group ran weekly and there were regular narcotics anonymous evening groups.

Service provision was continually reviewed and adapted to meet the changing needs of the local population and the clients who used the service. Staff had recognised a number of clients were presenting as homeless or in temporary accommodation and a local authority worker for homelessness was available at the service one morning a week on a drop in basis. Arrangements were being made for sexual health clinics to be offered at the service. The service had been successfully running several group programmes, which included the straight ahead programme (aimed at reducing offending), the bridging the gap programme (to assist clients into employment) and the holding families multiagency programme offering support to parents.

We saw good communication with other agencies, including community and hospital pharmacists, mental health teams and criminal justice teams as well as statutory local authority services.

Substance misuse services

As part of an ongoing programme, clients who had been discharged from treatment could continue to attend sessions and groups, for example, a weekly abstinence support group.

Listening to and learning from concerns and complaints

The service had posters and complaints/comments slips available in the reception area. Clients felt able to complain if they needed to and knew how to do this. A policy outlining the procedure for handling complaints and timescales for responding was available for staff to refer to. We reviewed one complaint that had been received in the last 12 months and this had been managed as per the policy.

We reviewed 11 compliments received in the last 12 months. These had been received via thank you cards, group feedback and emails.

Are substance misuse services well-led?

Vision and values

The service vision was:

To be recognised as a leading progressive charity excelling in quality care, safety, support, research and innovation; dedicated to improving wider health and wellbeing for our diverse population and communities.

The service values were:

Integrity, respect, dignity, pride, compassion, consideration and empathy.

These linked into strategic objectives and outcomes for the service.Staff were aware of the vision and values, and had been involved in a competition to devise a memorable acronym for these. Staff had also been involved on a whole team away day in planning how the service could specifically meet the provider's overarching objectives and devising service specific plans. Individual supervision records showed that staff were encouraged to reflect on events and discuss how they demonstrated the service values in practice.

Staff described highly person centred approaches that they had developed for individual clients and were clear about their aims to achieve outcomes for clients that they set themselves. They spoke proudly about the progress they had seen clients make. Staff described clients in a respectful and positive way.

Good governance

This service had a good governance structure. The manager and service delivery director had worked within the service for many years, and had a good understanding of the local areas and the needs of the client group. The service delivery director attended the board meetings and was a service representative at senior organisational meetings. These included organisational wide oversight, for example, meeting with the quality and performance lead and strategic development lead. Otherwise they were based at the service with the manager which meant information was shared easily. The manager ensured staff were aware of provider level changes and developments. Regular team meetings each month allowed all staff to meet together and discuss issues.

Managers ensured staff were suitably trained and that they received regular supervision. Managers and staff had good administrative support in the form of an administrative team.

The service used dashboards to monitor treatment completions, client numbers in treatment, waiting times, use of needle exchange and take up of hepatitis screening and vaccination. These were used to produce a monthly performance return to assess how the service was performing. Outcome measures were routinely reviewed to ensure the service was continuing to meet client's needs and key performance objectives. Service progress was highlighted in regular reports from the organisation and these were displayed for staff to see.

Policies and procedures were devised centrally and available for staff on an electronic system. These were reviewed and ratified at board level and staff informed of any changes.

The service had a local risk register which reflected current risks and was regularly reviewed. This fed into the organisational risk register for the provider organisation. The manager and service delivery director ensured this was reviewed regularly.

We saw that when there were issues regarding the business, for example, when the medical providers had changed earlier in the year, the managers had ensured service continuity and managed this well.

Leadership, morale and staff engagement

The sickness and absence rates in the service were low. Staff turnover rates were low, with many clinical staff having worked in the service for a number of years.

Staff morale was generally good, and staff felt well supported by their colleagues and managers. Staff described a positive working culture with good team working and mutual support. Staff were based in a large open plan office which encouraged good team working and communication. The organisation supplied tea and coffee for staff. Staff had access to an exercise session which ran regularly.

Staff knew how to raise concerns. They told us that they were able to feedback to managers and the senior leadership of the organisation, with examples of where they had done this and made changes. There was a whistleblowing policy for staff to refer to if needed.

We saw good examples of where staff and clients had been able to feed into service developments.

Commitment to quality improvement and innovation

The service used an additional measure, the lifestyles outcome monitoring system, at assessment and points throughout treatment to measure whether there were positive changes being made across a range of domains, including substance misuse problems, being healthy, building recovery capital, happier families, service satisfaction, and, safer, stronger communities. Results were analysed across all services to ensure that service provision was effective. These were reported annually as part of a comprehensive impact report.

We saw examples where service provision had been changed to reflect information gathered and improve outcomes. For example, following a number of failed detoxification placements, the service had spoken to clients and analysed these incidences to identify how they could improve the successful completion rate. This had led to the development of a pre-detox group, to prepare clients before they started an inpatient detoxification programme.

We saw that the service stayed informed of new information through links with other services and agencies and by involvement with professional forums. For example, through attendance at the local accountable officer forums the service had been able to ensure staff were aware of a national reporting service for reporting reactions to novel psychoactive substances.

Staff were part of an early warning alert network used to pass information readily between services about particular substances which may be in circulation locally and nationally to inform users. Information had also been circulated recently about a specific infection and we saw this information had been transferred to posters for the reception area and needle exchange.

The service is involved in a research study in collaboration with other services and a local university around end of life care for clients.

Outstanding practice and areas for improvement

Outstanding practice

We saw innovative multidisciplinary working, with a regular hepatology clinic held on site. A consultant and nurse from the local acute hospital saw clients to discuss treatment for hepatitis and treatment could be started and monitored within the service.

A bereavement support group had been developed by a local healthcare organisation as part of a multi-agency response and now runs monthly following feedback from service users and carers about their difficulty when accessing mainstream bereavement services.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that urine testing kits are checked regularly to ensure they are in date.
- The provider should ensure that all staff receive an appraisal of their performance annually.