EDP Drug & Alcohol Services - Exeter hub

Quality Report

Uplands
81 Heavitree Road
Exeter
EX1 2LX
Tel: 0800 2335444
Website: https://www.edp.org.uk/together-drug-alcohol-service/

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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.

Summary of findings

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.

Overall summary

We rated EDP – Exeter as **requires improvement** overall because:

- Staff were not always managing risk to clients. Clients who had been using the service prior to April 2018 did not have a disengagement plan in place. A disengagement plan details what the client expects from staff when they disengage from the service or do not attend appointments, for example by contacting their next of kin. This meant that if a client disengaged with the service staff might not know who to contact including relatives, carers or health professionals and others involved in the clients care to make them aware this had happened. Three out of six records reviewed did not contain a risk management plan. Risk management plans did not reference to crisis planning.
- Staff were not always developing detailed recovery plans which included client's goals and what treatment they were receiving. The recent care plan audit did not identify these issues.
- Staff did not ensure that clients received a comprehensive assessment of physical health needs from the client's GP or other relevant health professional. The provider did not have a physical health monitoring policy and staff were concerned that physical health monitoring was not comprehensive. Only clients who were prescribed medication by their service or undergoing home detoxification had their physical health checked.
- The provider did not have a robust recruitment process to ensure staff had an up-to-date DBS in place. The human resources (HR) department was responsible for ensuring staff had a valid DBS and had not realised when a number of staff DBS had expired.
- Staff were not recording informal complaints. This meant that managers could not be assured that complaints were actioned fully, and complaints could not be analysed to determine themes of trends.

However:

- The clinical assessment service staff assessed risk at the point of assessment. When clients were allocated a recovery navigator, they would then complete a comprehensive assessment. The comprehensive assessment included completing a risk assessment and incorporated information received from the client's GP at the point of referral. Clients requiring a prescription received a face to face assessment with the service's doctors or non-medical prescribing nurses.
- The assessment team were completing initial assessments with clients within two weeks of receiving a referral. Urgent client referrals were seen promptly. High risk clients were prioritised for example pregnant women and opiate-users. Staff monitored clients on the waiting list to detect increase in level of risk or need.
- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care, treatment or condition.
- Staff felt respected, supported and valued by management. Staff and clients described a change in culture in the last six months and felt optimistic and positive about the future direction of the organisation. Managers had introduced initiatives to improve morale such as arranging team away days.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Requires improvement 	EDP - Exeter hub is a substance misuse service providing support to clients in the community.

Summary of findings

Contents

Requires improvement

EDP Drug & Alcohol Services - Exeter hub

Services we looked at
Community-based substance misuse services

Summary of this inspection

Background to EDP Drug & Alcohol Services - Exeter hub

EDP Drug & Alcohol Services are a charity that provide a range of substance misuse services to adults over 18 in Devon and Dorset.

In April 2018, EDP Drug & Alcohol Services took over the contract to provide community substance misuse services in Devon. EDP and other organisations such as Devon Doctors and Devon Partnership NHS trust formed a partnership to provide these services. This partnership is known as the Together Drug & Alcohol Service.

Devon County Council commission the Together Drug & Alcohol Service to provide services across Devon. There are three registered locations across the county:

- Bideford Hub
- Newton Abbott Hub
- Exeter Hub

In addition to the three registered locations, there are a number of satellite locations clients can access.

Exeter Hub is a community substance misuse service providing support to clients aged 18 and above across Exeter and some of West Devon. At the time of the inspection the service had a registered manager in place. The service had a dedicated team to respond to referrals and complete initial assessments. The clinical assessment team (CAS) covered all areas of the county and had a team leader managing the team.

Exeter Hub is registered as a location under EDP Drug & Alcohol Services to provide the regulated activity for treatment of disease, injury or disorder. This was the first comprehensive inspection since registering with the Care Quality Commission in October 2018.

Prior to the inspection of Exeter Hub on 4 April 2019, inspections took place at Newton Abbott Hub and Bideford Hub. These reports are published separately.

Our inspection team

The team that inspected the service comprised three inspectors and a specialist advisor who has professional experience of 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 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.

Summary of this inspection

During the inspection visit, the inspection team:

- visited the service in Exeter, looked at the quality of the environment and observed how staff were caring for clients
- reviewed the clinic room
- spoke with the registered manager
- spoke with two clients who were using the service
- spoke with eight other staff members; including one nurse, one non-medical prescriber, two healthcare practitioners, two recovery navigators one team leader, and the clinical assessment service (CAS) team leader
- Spoke with two volunteers at the service
- attended and observed one medication review meeting
- attended and observed one treatment group and spoke to nine clients attending the group
- looked at five care and treatment records of clients and
- looked at three staff personnel files and
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to two clients currently using the service and received feedback from nine clients attending a group therapy session. Clients said that they valued group sessions as they felt they learned useful skills from the content of the sessions and handouts they received. They described staff as approachable and said that they were well supported by staff and could be honest with them.

Clients described good working relationships with their recovery navigators and felt they could get help when they needed it and staff were responsive to their needs.

Clients stated there had been an improvement in the service they received following the new contract and felt that they could recommend the service to others.

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?

Requires improvement 

We rated safe as **requires improvement** because:

- Staff were not always managing risk to clients. The clinical assessment service (CAS) were completing initial disengagement plans for all newly referred clients. However, staff were not routinely updating or developing plans with current clients. This meant that if a client disengaged with the service staff might not know who to contact including relatives, carers or health professionals and others involved in the clients care to make them aware this had happened. The provider did not have a policy in place for clients who disengage from the service.
- Clients did not always have a detailed risk management plan in place and did not include reference to crisis planning. Client's risks were identified but ways to mitigate the risk were not always included. Three of the five care records did not include risk management plans and where these had been completed they were not detailed.
- Staff were not ensuring that all clients were having their physical health checked regularly. The provider did not have a physical health monitoring policy and staff were concerned that physical health monitoring was not comprehensive. Only clients who were prescribed medication by their service or undergoing home detoxification had their physical health checked. Although physical health equipment had been recently calibrated, equipment such as the pulse oximeter and blood pressure machines were not working on the day of inspection.
- Out of 27 staff, four did not have an active Disclosure and Barring Service (DBS) certificate. These staff had completed applications for new DBS certificates.

However:

- The clinical assessment service staff assessed risk at the point of assessment. When clients were allocated a recovery navigator, they would then complete a comprehensive assessment. The comprehensive assessment included completing a risk assessment and incorporated information received from the client's GP at the point of referral. Clients requiring a prescription received a face to face assessment with the service's doctors or non-medical prescribing nurses.

Summary of this inspection

- Staff had policies, procedures and training related to medication and medicines management including prescribing, detoxification, assessing people's tolerance to medication and take-home medication such as naloxone.
- Staff received mandatory training and all sessions had been completed by at least 75% of staff.
- Staff understood local authority safeguarding processes. Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. The service had a safeguarding lead and staff could contact them for advice and guidance.
- Serious incidents were investigated and any lessons learned shared with staff. Staff were offered debriefs following incidents and we were provided details of changes to practice following investigation of incidents.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Staff did not always develop recovery plans that met clients' needs identified during assessment. Three out of five care records did not contain recovery plans. Recovery plans that had been developed contained client's identified needs but did not contain details on how clients would meet their goals or what treatment they were receiving.
- The service did not complete comprehensive assessments of physical health needs and concerns. Staff did not develop recovery plans in response to known or identified physical health concerns. Prescribing staff relied on GP assessment of physical health but the service did not have a comprehensive process in place to ensure this was taking place and physical health needs were being met.

However:

- Clients undergoing an alcohol home detoxification were receiving adequate physical health monitoring.
- All staff received regular supervision and were supported to further develop their skills through personal development plans. Volunteers and peer mentors were recruited, trained and supported by a manager.
- Staff provided a range of treatment and care for clients based on national guidance and best practice. Staff used nationally recognised tools to monitor withdrawal symptoms for clients undergoing detoxification.

Are services caring?

Good

We rated caring as **good** because:

Summary of this inspection

- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care, treatment or condition.
- Staff adhered to and understood clear confidentiality policies and maintained the confidentiality of information about clients.
- The service had a 'flourish café' at the entrance of the building which was accessible to clients throughout the day for informal interaction with peers and volunteers, and to use as a drop in.
- Staff directed clients to other services when appropriate and, if required, supported them to access those services.
- The service provided family and carer group interventions and had two family workers. Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as **good** because:

- The service met the needs of all clients, including those with a protected characteristic. Clients could access services easily. Referral criteria did not exclude people who would have benefitted from care.
- The service employed a hospital liaison worker who worked with clients who presented at the local hospital. They supported and encouraged them to engage with the service and liaise with other relevant agencies, such as police and mental health teams.
- The assessment team completed initial assessments with clients within two weeks of receiving a referral. Urgent client referrals were seen promptly. High risk clients were prioritised, for example pregnant women and clients who misused opiates. Staff monitored clients on the waiting list to detect increase in level of risk or need.
- Staff demonstrated an understanding of the potential issues facing vulnerable groups such as those experiencing domestic abuse or sex workers.

However:

- Staff were not recording informal, verbal complaints raised by clients. This meant that managers could not be assured that complaints were actioned fully, and complaints could not be analysed to determine themes or trends.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

Summary of this inspection

- The provider had some gaps in the governance process. Managers had not ensured that staff were completing risk management and disengagement plans for all clients. The local team care planning audit had not been embedded and managers had not ensured that recovery plans were developed that met client's needs identified during assessment.
- The provider did not have a robust process to ensure staff had an up-to-date Disclosure and Barring Service (DBS) certificate in place. The human resources (HR) department was responsible for ensuring staff had a valid DBS certificate and had not realised when a number of staff DBS certificates had expired. Managers did not have oversight of this process.
- The provider was in the process of updating their clinical policies, due to a recent change in contract. For example, the prescribing 'Did Not Attend' (DNA) policy was still in draft form. Some staff were unaware that there were updated clinical policies.

However:

- Staff felt respected, supported and valued by management. Staff and clients described a change in culture in the last six months and felt optimistic and positive about the future direction of the organisation.
- Leaders had the skills, knowledge and expertise to perform their roles. The registered manager had a good understanding of the service they managed and could explain how the team were working to provide high quality care.
- Leaders were visible in the service and approachable for staff. Staff knew by name who the clinical leads, service manager and CEO were and how to contact them directly.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood and discharged their roles and responsibilities under the Mental Capacity Act 2005. Staff received training and knew where to go to seek advice and guidance if they needed it. Staff gave examples of supporting clients during mental capacity assessments and how to support a client who lacked capacity to make decisions about their treatment.

Requires improvement

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Requires improvement

Safe and clean environment

- The entrance and waiting room at Exeter was welcoming with access to the flourish café and a pool table within the waiting room. The entrance door to the building had control button entry. A volunteer was present in the entrance area to allow access and welcomed clients and visitors on entry into the foyer.
- Staff ensured rooms were clean, and clients had access to a number of private rooms to meet staff in. There were rooms for one to one meetings, group rooms, a clinic room and a needle exchange.

Safe staffing

- Four of the 27 staff employed did not have valid disclosure and barring service (DBS) checks in place. They had been asked to sign a disclosure form stating that they had not committed any offence since their last DBS check, and on the basis of this were continuing to work unsupervised. Staff without valid DBS who did not have a disclosure did not have unsupervised contact with clients.
- The service had enough staff to meet the needs of clients and had contingency plans to manage unforeseen staff shortages. Clients and staff told us that sessions were not cancelled due to staff absences.
- The service provided a range of staff including, non-medical prescribers, a doctor, team leaders, nurses, healthcare practitioners, and recovery navigators. including those for the criminal justice system. Staff and managers told us that a cap on caseloads had recently been introduced which had reduced caseload sizes to 50. Staff felt that this had reduced the levels of stress being experienced. Managers monitored caseloads in supervision.
- The service had 22 substantive staff with one vacancy for a recovery navigator role. The total percent of permanent staff sickness overall for the previous 12 months was 4.9%.
- Staff followed good lone-working procedures. The manager and staff told us that typically clients were not seen in their own homes and that staff adhered to the lone-working policy when working from satellite sites.
- Staff received mandatory training in a range of formats including e learning and face to face training. This included health and safety and safeguarding courses. At the time of the inspection all mandatory training courses had been completed by at least 75% of staff. Staff had recently received specific training in the management of challenging and aggressive behaviour and completion of risk assessments.

Assessing and managing risk to clients and staff

- The clinical assessment service (CAS) staff assessed risk at the point of assessment. When clients were allocated a recovery navigator, they would then complete a comprehensive assessment. The comprehensive assessment included completing a risk assessment and incorporated information received from the client's GP at the point of referral. Clients requiring a prescription received a face to face assessment with the service's doctors or non-medical prescribing nurses.

- The clinical assessment team monitored people on the waiting lists to detect changes in level of risk. The CAS team managed referrals to the service and completed a brief assessment within 24 hours. A member of the CAS team contacted clients over the telephone within two weeks of the brief assessment to complete a comprehensive needs and risk assessment. Clients who preferred a face to face meeting were invited to one of the service sites for their assessment.
- Staff did not always create and make good use of risk management plans. The clinical assessment service staff assessed risk at the point of referral assessment. Once clients were allocated to a caseload, their recovery navigator would complete a more comprehensive assessment of their needs and risks. However, in four out of five care records we found that recovery navigators were not completing comprehensive risk management plans in response to identified risk areas. Where staff had completed a risk management plan this did not include sufficient detail on how to manage or mitigate the risks.
- The clinical assessment team had completed disengagement plans for clients who had been referred to the service since the new contract. However, clients that had been on caseload prior to this team coming into place did not consistently have plans in place. This meant that if a client disengaged with the service staff might not know who to contact including relatives, carers or health professionals and others involved in the clients care to make them aware this had happened. All clients who had disengaged from treatment were discussed with the team leader, who would review the case before a decision was made to discharge the person. The service did not have a sufficiently robust policy outlining the expectations on staff in the event of somebody failing to engage in their treatment.
- Staff updated risk assessments in response to new or changed risks. Staff completed a personalised behaviour contract with clients following any threatening behaviour whilst using the service. The service used behavioural contracts to reduce the need for discharge from treatment.
- Staff were trained in the detection of blood borne viruses. The service had an action plan in place to increase blood borne virus screening and uptake of vaccinations and hepatitis C treatment.
- Staff ensured that clients were aware of the risk of continued substance misuse and encouraged harm minimisation. This was evidenced during the observation of client's medication review with the nurse. Harm minimisation was discussed at all appointments and clients were offered naloxone and training on how to use this. Harm minimisation aims to address alcohol and other drug issues by reducing the harmful effects of alcohol and other drugs on individuals.
- Staff ensured prescriptions were sent to local pharmacies or collected by the client from the service. Staff had formed close working relationships with the pharmacies so that they would be informed if the client did not collect their prescription as normal or if they had a specific concern about a client. If a client did not collect their prescription for three days this would be put on hold or cancelled.
- The service had a process in place for staff to follow if a client gave their medication to a third party. Keyworkers assessed risks through one to one sessions and discussed outcomes with prescribers.

Safeguarding

- Staff understood local authority safeguarding processes. Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. The service had a safeguarding lead and staff could contact them for advice and guidance.
- Staff had received safeguarding training and knew how to identify adults and children at risk of, or suffering, harm. However, staff told us that the training was not specific to their client group.

Staff access to essential information

- Staff used a secure electronic system for client's care and treatment records. All relevant staff had a log-in and accessed the system when required. Staff were using the system to record recovery plans in multiple formats. Managers confirmed they were aware of the concern and had been working to try and reduce the number of forms used.

Medicines management

Requires improvement

Community-based substance misuse services

- Prior to 1 April 2019 the contract for the clinical prescribing practice was held by Devon Doctors. During the inspection this responsibility had been taken over by Together Drug & Alcohol services. As such some policies were still under review.
- Prescribers ensured prescribing of medication was safe and followed national guidance. Staff had relevant policies, procedures and training related to medication and medicines management including prescribing, detoxification, assessing people's tolerance to medication and take-home medication such as naloxone. The clinical policies relating to medicines management had recently been distributed to staff and not all staff had read the updated policies. However, all staff were aware of relevant guidelines such as the National Institute for Health and Care Excellence and the Drug misuse and dependence: UK guidelines on clinical management' (2017), known as the orange book.
- Staff individually assessed the risk of clients storing medication at home and prescribed supervised medication and organised home visits to manage high risks.
- Staff followed good practice in medicines management including transport, storage, dispensing, administration, medicines reconciliation, recording and disposal. Medication was prescribed in line with National Institute for Health and Care Excellence, including methadone for the management of opioid dependence.
- The clinic room was small with no window or examination couch. Medical reviews therefore took place in consultation rooms and physical health observations were not routinely conducted during these. However, the registered manager had submitted a funding application to move the clinic room to a larger more accessible room on the ground floor of the service.
- Although physical health equipment had recently been calibrated, some items such as the oximeter and blood pressure machine were not working and required new batteries..

Track record on safety

- There had been 19 serious incidents in the past 12 months, which had included aggression towards staff and unexpected client deaths in the community.
- All client deaths were reviewed at a serious incident review panel. Staff also attended the local authority's 'drug related and avoidable death' review meetings.

Reporting incidents and learning from when things go wrong

- All staff knew which incidents to report and how to do this on the electronic system. Staff understood the importance of being open and honest with clients when things went wrong, and this was recorded in client records. Learning from incidents was shared across the service locally through supervision, team meetings and bulletins on the intranet.
- Staff described examples of recent learning from incidents and how their practice had changed as a result. This included a recent example of a review of the process for staff when responding to staff panic alarms, and ensuring the implementation of debriefs following incidents.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- The clinical assessment service (CAS) team completed a brief assessment of need and risk assessment at the point of referral. The CAS team also completed a brief disengagement plan. Clients who had been referred to the service before the implementation of the CAS team therefore did not have disengagement plans. Once clients were accepted into the service their recovery navigator completed a comprehensive assessment which included a full history and considered their needs holistically.
- Although staff completed comprehensive assessment of needs, they were not creating recovery plans in response to identified needs. We found that in three of the five care records a recovery plan had not been developed. Although staff had completed recovery plans in two of the care records, the treatment, support being offered, and client goals, were not detailed in these.

- We found that care records did not include assessment of physical health needs and associated management plans for clients with known physical health concerns, such as chronic obstructive pulmonary disease (COPD).

Best practice in treatment and care

- Doctors and non-medical prescribers at the service prescribed in line with the National Institute for Health and Care Excellence guidelines. Non-medical prescribers had access to the 'Drug misuse and dependence: UK guidelines on clinical management' (2017), the service's prescribing policies. Clinical staff used nationally recognised tools to assess the acuity of client's withdrawal symptoms. The service used the Clinical Institute Withdrawal Assessment for alcohol scale (CIWA) and the Subjective Opiate Withdrawal Scale (SOWS).
- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence and National Treatment Agency. These included mutual aid partnership approaches (such as alcoholics anonymous), relapse prevention techniques, harm minimisation and a range of psychosocial intervention groups. Clients undergoing alcohol detoxication treatment at home had their physical health monitored by a nurse and staff recognised signs of deterioration.
- Staff arranged for clients to have tests that they would need such as an electrocardiogram to monitor their heart if prescribed over 100ml of methadone. This would monitor their heart for any abnormalities and was in line with Department of Health, 2007; Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care, Royal College of General Practitioners, 2011.
- Clinical staff routinely offered blood borne virus testing and offered a needle exchange service.
- Staff supported clients to live healthier lifestyles with guidance and information forming part of each appointment and group work. The waiting room had leaflets to ensure clients had the information they needed, and staff could refer to other services as they needed to.
- Staff recorded outcomes for clients using the treatment outcome profile (TOP), which was completed at the start, during and at discharge from treatment.
- Staff provided information to Public Health England through the national drug monitoring system. This helped staff to compare progress with other areas in the country with a similar demographic and to look at areas for improvement.

Skilled staff to deliver care

- Managers provided staff with a range of learning to meet their needs. The service provided all staff with an induction and expected staff to complete mandatory training as part of this. Following this, one to one sessions were used to support staff to identify training relevant to their current role. The service had recently introduced a new competency based induction program.
- The service provided training in topical subjects and staff had attended training in subjects such as domestic abuse and behaviour change, and managing aggressive behaviour. However, in Exeter the uptake of these courses was low with only one staff member completing motivational interview training and three staff attending risk assessment training.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff identified their learning needs and special interests and created individual development plans as part of their appraisal. The service had provided funding for registered nurses to complete their non-medical prescriber training.
- Managers gave examples of poor staff performance and how this had been managed locally with support from the human resources team.
- The service had one nominated member of staff to recruit and train volunteers. Volunteers were trained and supported by relevant staff to take on roles such as supporting groups and meeting and greeting clients when they came in to reception.
- Staff told us that they received regular supervision and appraisal, and this was documented within personnel

files. Staff were provided supervision and debriefs following facilitation of group sessions and incidents. The service also provided psychosocial interventions supervision for staff as a group.

Multi-disciplinary and inter-agency team work

- The service had shared care agreements in place with local GPs and pharmacies. This ensured that clients could access support from each service and utilise the different skills of staff at each service.
- The staff team had the right skills and qualifications to support clients using the service. This included doctors, non-medical prescribers who were nurses, team leaders, recovery navigators and healthcare assistants. The service also provided support to clients within the criminal justice system. We saw from the client records that a multi-disciplinary approach had been taken to support clients and this was recorded appropriately.
- Staff had regular team meetings and minutes were available for staff unable to attend. Agenda items included staffing, safeguarding, policy and procedure updates, case discussions, risks, and client feedback.
- Staff discharged clients when care and treatment was no longer required, and we saw evidence in supervision records of managers supporting these decisions. Clients could drop in to the service when they needed to even if they had been discharged so that they always had somewhere to go at difficult times.
- The service discharged people when specialist care was no longer necessary and worked with relevant supporting services to ensure the timely transfer of information.

Good practice in applying the Mental Capacity Act

- Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and gave examples of when a client's capacity may fluctuate, for example when they were under the influence of alcohol. All staff were required to complete training in the Mental Capacity Act 2005 and at the time of inspection over 90% of staff had completed this. However, staff commented that the training was not tailored to the client group for example substances affecting capacity. Although all staff we spoke with demonstrated an understanding of how this related to the clients.

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Observations and feedback from people who used the service of staff attitudes and behaviours demonstrated compassion, dignity and respect. Staff provided responsive, practical, and emotional support as appropriate.
- We observed staff interactions with clients in a relapse prevention group which were inclusive, respectful and tailored to individual needs. Staff demonstrated compassion, dignity and respect when interacting with and discussing clients.
- Staff supported clients to understand and manage their recovery and treatment. Clients told us that the groups they attended were helpful and provided them with skills for ongoing recovery. Clients felt supported to understand their care and treatment by their recovery navigators and able to access support when they needed it.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to clients without fear of the consequences.
- Staff directed clients to other services when appropriate and, if required, supported them to access those services.
- The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients.
- Clients were offered informal support and interaction through the flourish cafes on site, which could be accessed outside of structured treatment during office hours. A volunteer or duty worker remained within the reception area to offer clients drinks and informal support. We observed clients making use of this resource during our inspection.

Requires improvement

Community-based substance misuse services

- Clients were provided with access to appropriate emotional support through keyworker one to one sessions and access to mutual aid groups.

Involvement in care

- Staff communicated with clients so that they understood their care and treatment, including finding effective ways to communicate with clients with communication difficulties. This included using a Staff provided clients and families with general information about time, frequency and duration of appointments.
- The service had recently developed a role for a community development lead and part of the responsibilities of the role was to create a client forum to involve clients in development of the service. However, the meetings had not yet taken place.
- The service involved families and carers in the clients care planning as appropriate and with consent. There were two family workers at the service who had their own caseload and facilitated family and carers groups.
- There was a "you said we did" board, which the service used to respond to client queries and requests. Suggestion boxes were located in the waiting room, which clients could provide feedback through. Staff signposted clients to access appropriate advocacy when appropriate.

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

Good

Access and discharge

- The service actively engaged with commissioners, social care, the voluntary sector and other relevant stakeholders to ensure services were planned, developed and delivered to meet the needs of the local population.
- The service had a dedicated assessment team and monitored people on the waiting lists to detect changes in level of risk. The assessment team managed referrals to the service and completed a brief assessment within 24 hours. A member of the CAS team contacted clients over the telephone within two weeks of the brief assessment to complete a comprehensive needs and risk assessment. Clients who preferred a face to face meeting were invited to one of the service sites for their assessment.
- The assessment team used a red, amber, green rating system, based on risk, to prioritise allocation of clients to recovery navigators caseloads. Clients on the waitlist were sent a letter containing harm reduction advice, and an offer of access to a weekly drop in and the needle exchange service. The letter also included information on mutual aid groups and a card with access to an online tool for psychosocial interventions.
- The service was accessible to all who needed it and took account of clients' individual needs. The assessment team referred to an exception list for those who could not be assessed via the telephone, such as homeless people. Clients who met the criteria for this list were allocated to a caseload and offered a face to face assessment. The service utilised a worker who was part funded by the street homeless team to facilitate outreach work with clients. Homeless clients could access services via the Exeter site or satellite hubs located in the city centre.
- The service had clear pathways for clients which were explained during the first appointment. However, staff could be flexible to meet the individual needs of clients to ensure they received treatment promptly. This could include a home visit or an appointment within another setting in the community.
- The service told us they used a 'no wrong door approach' and accepted referrals from any source or form, and completed an assessment or signposted individuals as necessary. The service employed a hospital liaison worker who worked with clients who presented at the local hospital. They supported and encouraged engagement with the service and liaised with other relevant agencies, such as police and mental health teams.
- Staff referred clients for additional support to mental health services as required, ensuring that they received appropriate care and treatment and worked in partnership with those agencies. Team leaders from the service attended regular dual diagnosis meetings with the local mental health team.

Requires improvement

Community-based substance misuse services

- The service had a process for staff to follow if clients did not attend their appointments. This included contacting the pharmacy the client used, using emergency contact details and if more than two appointments were missed the client's prescription would be suspended.
- All discharges were signed off by the management team to ensure that discharge was appropriate and that there was a clear aftercare plan in place. The service was monitored through the National Drug Treatment Monitoring System which reports on representations following discharge from treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had accessible interview and groups rooms to see people in, which were well equipped and fit for purpose. The staff had used client art work to create wall displays in the meeting rooms. The service had framed motivational quotes chosen by clients and displayed these around the building.
- The front door was locked and a staff member controlled entry into and out of the building.
- The service utilised four floors in the building and there was a disabled parking space with ramp access to the ground floor. The service ensured that clients that could not use stairs had access to group rooms, consulting rooms and the clinic on the ground floor.
- Interview and clinical rooms had adequate soundproofing and privacy.

Clients' engagement with the wider community

- The service had a 'flourish' café at the front of the building, which was accessible to all clients throughout the day and could be used as an informal meeting space and place to interact with other clients, volunteers and staff. Each site also had a flourish co-ordinator whose role involved taking clients out into the community to engage in activities unrelated to structured treatment, such as rock climbing.
- The service had good links with local rehabilitation and detoxification units.
- Clients were offered volunteer opportunities to become recovery navigators, following treatment and a set period of abstinence from substances.

Meeting the needs of all people who use the service

- The service had specialist teams and workers to support the most vulnerable and complex clients. This included a criminal justice team, family, transition, and outreach workers.
- Clients could access evening sessions if required and a duty worker was able to attend drop in sessions. Due to its rural location the service offered service from satellite locations across the county to ensure accessibility of the service.
- Staff demonstrated an understanding of the potential issues facing vulnerable groups e.g. Lesbian Gay Bisexual Transgender (LGBT), Black and minority ethnic, older people, people experiencing domestic abuse and sex workers and offered appropriate support. This included creating multiagency relationships with relevant charities, such as the Mayday trust, community services, and attending local pride marches.
- Staff reported good links with midwifery services and held monthly pregnant service user groups.
- Clients reported that treatment and care was never cancelled and staff would ensure they were always seen by a member of the team when they needed support or were in crisis. The service provided a duty clinic for clients to access support outside of planned sessions.

Listening to and learning from concerns and complaints

- There was a complaints policy in place and clients and staff were aware of the process for complaints. Staff would attempt to resolve any complaints informally initially and refer these on to managers if they could not be resolved. The service logged formal complaints within their incident recording system which included details of investigation outcomes and lessons learned. The service did not log and monitor informal complaints. Multidisciplinary team meetings included discussion around complaints and compliments as a standing agenda item.
- In the previous 12 months the service had not received any formal complaints.

Are community-based substance misuse services well-led?

Requires improvement

Community-based substance misuse services

Requires improvement

Leadership

- Managers had the skills, knowledge and experience to perform their roles. All managers and team leaders were in the process of completing management training. They demonstrated a good understanding of the clients the service supported and the difficulties that staff sometimes faced. They talked with confidence about the service and the standards expected in the level of care staff were delivering.
- The manager and team leaders had a visible presence in the service and staff could approach them at any time for advice, guidance and emotional support if they needed it.
- The organisation had a clear definition of recovery and this was shared and understood by all staff.

Vision and strategy

- Staff strove to empower clients to be successful, to make positive changes and to take back control over their lives. Staff demonstrated this through the care and support they provided to clients. All staff knew what their role was within the organisation and the boundaries of that role when working with clients.
- The senior management team had revised the organisations mission statement, values and vision following the new contract and this had been disseminated to all staff.
- Managers understood the budgets they needed to work to while still meeting the key performance indicators that had been set by commissioners.
- The senior management team gave staff the opportunity to contribute to discussions about the strategy of the service for example nursing staff had been approached to write operational policies such as the blood borne testing policy.

Culture

- All staff we spoke with felt respected, supported and valued by management. Staff and clients described a change in culture in the last six months and felt optimistic and positive about the future direction of the organisation. Managers had introduced initiatives to improve morale such as arranging team away days.
- The staff group felt positive and satisfied in their roles. Staff members felt they could approach colleagues for support and that they worked well as a team and could challenge each other professionally during case discussions.

Governance

- The provider had some gaps in the governance process. Managers had not ensured that staff were completing disengagement plans for all clients. Managers had not ensured that staff were completing risk management plans for all clients and that recovery plans were developed that met clients' needs identified during assessment.
- The provider did not have a robust and comprehensive local audit programme. Managers received a report stating the number of open care plans. A local care planning audit had not been embedded to ensure managers had oversight of the quality and detail in care plans.
- The provider was in the process of updating their clinical policies. For example, the prescribing 'Did Not Attend' policy was in draft form and the needle exchange policy was not in place. The provider was in the process of updating clinical policies following a change in contract. Some staff were unaware that there were updated clinical policies but were using the 'Drug misuse and dependence: UK guidelines on clinical management' (2017) in line with national guidance.
- A nurse's forum and prescribers' meetings were in place to ensure oversight of medicines management across the services.
- There was a clear framework of what must be discussed at a team and provider level in team meetings to ensure that essential information such as learning from incidents and complaints, was shared and discussed.
- Staff had implemented recommendations from reviews of incidents and complaints. For example, following an incident in one of the services the provider implemented a new risk assessment training.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the clients. For example, team leaders from the service attended regular dual diagnosis meetings with the local mental health team, and recovery navigators attended multi-agency case working for pregnant women.

- Staff were aware of the organisation's whistleblowing policy and how to access it.

Management of risk, issues and performance

- The provider did not have a robust process to ensure all staff had an up-to-date Disclosure and Barring Service (DBS) certificate in place. Staff who worked for the previous provider did not have their DBS status checked when the contract changed. This meant that at the time of the inspection 4 out of 27 staff did not have an up to date DBS certificate. Local managers did not have oversight of this at a local level and relied on the human resources (HR) department. We raised this at the time of inspection and HR advised that staff that did not have an in-date DBS certificate work unsupervised if they signed a disclaimer stating that had not committed an offence since the previous checks.
- Service managers did not have access to staff personnel file as these were held centrally with the HR department. Managers had limited access to electronic records, but we found examples of missing records such as appraisal notes and probation review notes.
- The provider did not ensure that all clients had robust risk management plans and disengagement plans. Risk management plans were found to be missing or were completed in an incorrect form. Managers did not ensure that staff were adhering to the risk management policy.
- Managers maintained and had access to the risk register for all services. However, not all identified risks were detailed, for example a number of staff having out of date DBS certificates.

Information management

- Staff had access to equipment and technology they needed to do their work. Computer systems worked well and staff had access to laptops. The service had a lead administrator and data officer who supported staff with IT issues.
- The service collected data for both their own use to develop the service and to add to the national recording for substance misuse services. The use of data was explained to clients on entry in to the service and all details were anonymised. Managers understood the importance of confidentiality agreements when sharing information and data. Policies were in place to ensure clients information remained confidential and this was stored securely on an electronic system.
- Managers had a dashboard which gave them an overview of the performance of the service and the staff. Information was easy to access in a timely manner and accurate which helped managers to identify areas for improvement and discuss them at regular managers meetings.
- The service had developed information sharing protocols with external organisations including the local authority, probation and mental health services.

Engagement

- Staff, clients and carers had access to up-to-date information about the work of the service. This could be accessed through the organisation's website, social media and via leaflets and posters.
- Clients and carers could give feedback on the service they received. Feedback forms and boxes were available in reception/waiting rooms areas and they could speak to managers on request.
- Managers engaged with other organisations such as commissioners, local GPs, pharmacists and the probation service.
- Staff told us they could meet with members of the provider's senior leadership team to give feedback and attend meetings.

Learning, continuous improvement and innovation

- Each service had a flourish co-ordinator. They supported clients in the community for example by arranging activities such as rock climbing. There was also a flourish café which volunteers and peer mentors ran at set times during the day. These cafes were 'front of house' and clients first contact with the service.
- Each service had recently appointed a community development lead whose role was to involve clients in the development of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clients have a disengagement plan that is regularly reviewed, and that staff have access to the service's Did Not Attend policy. (Regulation 12)
- The provider must ensure that all clients have a risk management plan in place. (Regulation 12)
- The provider must ensure that staff complete clear, detailed recovery plans with clients that include goals and details of the treatment being offered to the client. (Regulation 9)
- The provider must ensure that there are robust governance processes in place to identity areas for improvement. The provider must ensure there is oversight over the expiration of disclosure and barring service certificates. (Regulation 17)

Action the provider SHOULD take to improve

- The provider should ensure that managers record all complaints so that trends can be analysed and to ensure all complaints have been actioned appropriately.
- The provider should ensure that staff consider client's physical health needs when developing recovery plans.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not doing all that is reasonably practical to mitigate any such risks. Staff were not completing disengagement plans with clients who joined the service prior to April 2018. The provider's prescribing DNA policy was still in draft form. Staff were not always completing risk management plans as part of the risk assessment and clients did not have a risk management recovery plan. The provider was not ensuring that there were sufficient equipment to ensure the safety of service users and to meet their needs. This was a breach of Regulation 12 2(b)(f)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was not ensuring that staff completed a clear care and/or treatment plan, which includes agreed goals. Staff were not always detailing clear, agreed treatment and recovery goals in client's recovery plans. Staff were identifying a client's needs but not detailing how the service would support the client to meet this need.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 9 3(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured all gaps in the governance processes had been identified. The provider did not have a process in place to track when staff disclosure and barring service certificates were due to expire or had expired. This was a breach of Regulation 17 2(a)(b)