Compass Milton Keynes

Quality Report

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Date of inspection visit: 4 and 5 September 2018
Date of publication: 09/11/2018

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	**Good**
Are services safe?	**Good**
Are services effective?	**Good**
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.

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 rated Compass Milton Keynes as good because:

- All interview rooms and group therapy rooms had integrated alarm call systems. The service was clean and tidy with appropriate waste management.
- Caseloads were regularly reassessed and managed in weekly clinical team meetings and supervision.
- Mandatory training had a compliance rate of above 75% completion for every course undertaken.
- All clients received an initial assessment exploring a broad range of assessments. All new clients were given a full physical health screening during their first initial appointment.
- The service followed national guidance when assessing treatment need and prescribing medicines.
- The service held weekly clinical team meetings with the multidisciplinary staff team. We saw appropriate sharing of information within these meetings and discussions around best practice and risk.
- Staff spoke about clients in a sensitive, caring and professional manner at all times. We saw staff interacting positively with clients and they appeared responsive and respectful at all times.
- The service had a daily rota of duty workers and open access appointment system in place to see clients promptly and manage their risk. The service ran two evening clinics a week for clients who couldn't attend in the day.
- All staff we spoke with felt supported in their role and valued as part of the team.
- Incidents were appropriately recorded, escalated and investigated.
- There was a clear clinical governance structure in place to ensure that clinical risk was escalated and managed within the service.

However,

- The service failed to notify the Care Quality Commission (CQC) of statutory notifications of changes, events or incidents that affected their service or the clients who use it. Senior staff were unaware of their responsibilities regarding notifications. A requirement notice was issued in relation to this issue. Please see 'actions we have told the provider to take' for more information.
- The service did not have appropriate or consistent management oversight of staff supervision levels. Senior management did not seek assurances that supervision was taking place or that missed supervision sessions were being followed up.
- The quality assurance team at the service had not undertaken quality audits of the care records for over 12 months. Team leader care record checks did not demonstrate actions taken when issues were noted and there was no system in place to address poor performance in relation to client notes.
- Recalibration dates of physical healthcare equipment was not recorded centrally. There was no oversight to ensure recalibration occurred and we found equipment requiring calibration to be over a year out of date.
- Not all risks identified in the risk assessments were included within risk management plans.
- Recovery plans were not personalised, with little evidence of client views being recorded. Not all issues identified within client assessments were addressed in recovery plans in a holistic manner.

Summary of findings

Contents

Good

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Background to Compass Milton Keynes

Compass Milton Keynes is a substance misuse service providing community based substance misuse treatment and care from a single location. They provide on-site support and treatment for adults and an in-reach service for young people affected directly or indirectly by substance misuse.

The service provides clients with individual and group support sessions, opiate substitute prescribing and detoxification, alcohol detoxification, needle exchange clinic and blood borne virus testing.

Central Bedfordshire council commissions the service.

The service registered with the Care Quality Commission in September 2017 for the regulated activity of treatment of disease, disorder or injury. The service offered a range of groups, one to one key working sessions, medically managed alcohol detoxification and substitute prescribing for opiate detoxification for adults. The service had not previously been inspected.

Our inspection team

The team that inspected the service comprised of two Care Quality Commission inspectors and two specialist advisors with experience of working in substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked the provider to submit a range of data relating to the service.

During the inspection visit, the inspection team:

- visited the Milton Keynes site, looked at the quality of the environment and observed staff interactions with clients;
- spoke with the interim service manager and clinical lead nurse for the provider;
- spoke with the consultant at the service;
- spoke with two team leaders and three other staff members including link workers, recovery workers and hospital liaison workers;
- spoke with four clients;
- reviewed eight care records;
- observed two group therapy sessions;
- carried out specific checks of the clinic rooms and medicines management at the service;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

Clients we spoke with were all positive about their experience at the service. All clients stated that the staff were respectful and polite and that they did not feel judged when using the service.

Clients felt that their keyworkers were always available when needed and that they could access the service at short notice. Clients told us that their key workers helped them understand their drug and alcohol use and always felt welcome as staff knew clients' names when they attended the service.

Other clients commented that the service felt well run, the groups and one to ones were facilitated well and that the service was invaluable to them.

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?

Good

We rated safe as good because:

- All interview rooms and group therapy rooms had integrated alarm call systems. The service was clean and tidy with appropriate waste management.
- The service had an appropriate number and mix staff to deliver client sessions. All staff and volunteers were appropriately vetted with Disclosure and Barring checks renewed every two years.
- Caseloads were regularly reassessed and managed in weekly clinical team meetings and supervision.
- Mandatory training had a compliance rate of above 75% completion for every course undertaken.
- Staff undertook thorough risk assessments of every client at their initial assessment, and these were regularly reviewed.
- There were appropriate safeguarding procedures in place and safeguarding referrals were regularly monitored.
- The service liaised with local pharmacy teams, GPs and general hospital staff concerning medicines and there were procedures in place to monitor clients' prescription use.
- There were clear policies in place to ensure appropriate drug screening and alcohol level testing were in place before commencement of opiate substitute therapy to reduce the associated risks.

However,

- All equipment requiring calibration was out of date by over a year with no local or central system in place to ensure this was booked annually.
- Not all risks identified in the risk assessments were included within the risk management plans.

Are services effective?

Good

We rated effective as good because:

- All care records reviewed demonstrated that clients received an initial assessment exploring a broad range of assessments. All new clients were given a full physical health screening during their first initial appointment.
- The service followed national guidance when assessing treatment need and prescribing medicines.
- The service utilised national outcome tools to measure outcomes and effectiveness of treatment.

Summary of this inspection

- The service held weekly team meetings to discuss issues and provide peer support.
- Staff received regular supervision from their line managers.
- The service had a 100% completion rate for staff appraisals.
- The service offered additional specialist training to staff members when specific needs were identified.
- The service held weekly clinical team meetings with the whole multidisciplinary staff team. We saw appropriate sharing of information within these meetings and discussions around best practice and risk.
- The service had a 79% completion rate for Mental Capacity Act training.

However,

- Recovery plans were not personalised, with little evidence of client views being recorded. Not all issues identified within client assessments were addressed in recovery plans in a holistic manner.

Are services caring?

Good

We rated caring as good because:

- Staff spoke about clients in a sensitive, caring and professional manner at all times. We saw staff interacting positively with clients and appeared responsive and respectful throughout our inspection. Staff understood the needs of their clients and appeared to have a genuine interest in their wellbeing.
- All clients we spoke with were extremely positive about the service and the impact it had on their lives.
- Staff gave sufficient information to clients and their family members, if clients permitted this, to understand their care and treatment.
- Staff supported clients to access other services when appropriate such as the job centre, college and the local housing association.
- The service held quarterly user forums to ensure clients and family members could give feedback on the service they were receiving or had received.
- The service held weekly family and friend's groups to provide sufficient support and offered one to one sessions to clients' family members.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- The service did not have any waiting lists for clients and all client records demonstrated the service saw clients within the three-week national guideline.
- The service had a daily rota of duty workers and open access appointment system in place to see clients promptly and manage their risks. The service ran two evening clinics a week for clients who could not attend in the day.
- The service had an appropriate 'did not attend' policy in place that staff followed to re-engage clients.
  The complaints policy did not include an appropriate appeals process for complainants.

However,

- The complaints policy did not include an appropriate appeals process for complainants.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The service failed to notify CQC of statutory notifications of changes, events or incidents that affected their service or the people who use it. Senior staff were unaware of their responsibilities regarding notifications. A requirement notice was issued in relation to this issue. Please see 'actions we have told the provider to take' for more information.
- We did not see appropriate or consistent managerial oversight of staff supervision levels within the service. Data confirming supervision levels were pulled from various sources with no single location recording overall supervision rates. Senior management could not be assured that supervision took place or that missed supervision sessions were being followed up.
- The quality assurance team at the service had not undertaken quality audits of the care records for over 12 months. Team leader care record checks did not demonstrate actions taken when issues were noted and there was no system in place to address poor performance in relation to client notes.
- Recalibration dates of physical healthcare equipment was not recorded centrally. There was no oversight to ensure recalibration occurred and we found equipment requiring calibration to be over a year out of date. This meant that staff could not be assured that readings given by the equipment was reliable.

However:

Summary of this inspection

- Service leaders could clearly explain their roles and demonstrated a high understanding of the services they managed. They explained how the teams worked to provide high quality care.
- Leadership opportunities were available for all staff members.
- Staff demonstrated an awareness of the service's vision and values.
- All staff we spoke with felt supported in their role and valued as part of the team.
- Incidents were appropriately recorded, escalated and investigated.
- There was a clear clinical governance structure in place to ensure that clinical risk was escalated and managed within the service. The service had a risk register document that was visited regularly.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity training formed part of mandatory training at the service and had a staff completion rate of 79%.

Staff demonstrated a good basic understanding of the Mental Capacity Act and had an appreciation of the potential fluctuating capacity of their clients.

Staff were happy to approach managers for information, support and guidance regarding the Mental Capacity Act.

The service had a relevant policy in place regarding the Mental Capacity Act for all staff to access for information.

Good

Substance misuse services

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

Are substance misuse services safe?

Good

Safe and clean environment

All interview rooms and group therapy rooms had integrated alarm call systems. The alarms rang throughout the building and a panel within reception highlighted which room the call was coming from where assistance was needed. All staff within the service were expected to respond in the event of an alarm call for help.

The service had two dedicated clinic rooms and the consultant doctor's room which could be used to undertake physical examinations. All rooms contained the necessary equipment needed to carry out basic examinations such as screens, couches, scales, pulse oximeter and blood pressure monitoring equipment.

However, all equipment requiring calibration was out of date by over a year, such as blood pressure monitors. We were told the responsibility to book re-calibration was with the lead physical health nurse but there was no system in place to ensure this occurred, locally or centrally, by the service.

All areas of the service appeared clean, tidy and contained well-maintained furnishings.

An external cleaning company was hired to undertake daily cleaning of all areas of the service including clinical areas. The service manager told us how they spoke with and met with the company to ensure the expectations and standards of cleanliness were communicated and maintained.

The service demonstrated evidence of safe storage, handling and removal of clinical waste with a weekly collection by an appropriate external company.

Staff adhered to infection control principles with clear evidence of its consideration and importance during appointments, team meeting minutes and entries on the risk register.

All equipment at the service was appropriately portable appliance tested.

Safe staffing

The service had an appropriate number and mix of staff. These included a consultant doctor, non-medical prescribers, nurses, recovery workers, link workers, hospital liaison workers and peer support volunteers. There were sufficient numbers of staff on duty with appropriate senior support throughout the service's opening times of 9am-5pm three days a week and 9am-8pm two days a week.

All staff working at the service, including volunteers, were required to have Disclosure and Barring Service checks completed before commencing work. We saw evidence that these were all up to date and completed every two years, in line with the service's policy.

Key workers held caseloads of around 50 clients with a whole service caseload of 671 clients. Caseloads were reviewed regularly and managed in weekly clinical team meetings and supervision. Staff we spoke with said their caseloads felt manageable and that they received good support to manage any risks.

Good

Substance misuse services

The service appropriately utilised agency staff where required. When agency staff were used, they were placed at the service on long term contracts and were familiar with the service and their clients.

Mandatory training included Safeguarding adults and children, infection control, equality and diversity, manual handling, health and safety, mental capacity and basic life support and anaphylaxis. All courses had a compliance of above 75% completion and where staff needed refresher training, we saw this booked into future dates.

The central quality assurance team held responsibility for mandatory training and staff said that they received emails from them when they were due to be updated. We saw similar practices by the service for revalidation for the consultant and nurses at the service.

Assessing and managing risk to patients and staff

Staff undertook a risk assessment of every client at their initial assessment. Policy stated that a review of each client's risk must be made at least every 3 months, unless circumstances changed or incidents occurred when it should be reviewed earlier. All clients were given a risk 'severity' level on referral that was discussed during clinical supervision to ensure clients were reviewed as necessary in medical reviews or weekly clinical team meetings.

We reviewed eight care records and found all clients had a current risk assessment that had been recently reviewed or updated, except for one client who was 2 weeks overdue for a review.

Risk assessments considered a range of risks including self-harm, neglect, risk to others and safeguarding concerns. However, we found that not all risks identified in the risk assessments were included within the risk management plans. We saw examples in two care records where risks such as self-harm or domestic violence was identified in the risk assessment and not included in the risk management plan. We did see evidence within the progress notes however of liaison with local mental health teams and local authorities.

Team leaders told us they reviewed and signed off all risk assessments when completed or updated and that the quality assurance team reviewed random samples of risk assessments. However, where team leaders identified issues, there was no indication or recording of the actions taken. Additionally, the quality assurance team had not sampled risk assessments for over 12 months. There was no system in place to highlight and address performance issues relating to the recording of risk assessments.

Crisis management plans were included as part of clients' care planning. Staff at the service also followed the service's re-engagement policy when clients did not attend their appointments and worked with clients to re-engage them with the service.

The service utilised a duty system with emergency appointments available and had two staff members available for open access drop-in clients daily.

The service had a safeguarding procedure in place with appropriate young persons and adult safeguarding policy. The adult and young person teams had safeguarding leads and there was a central provider safeguarding contact for the teams. Staff knew who to contact within the service to discuss safeguarding issues.

Staff knew what to do if a safeguarding concern arose. Staff gave examples of the possible signs of abuse of a client such as changes in behaviour, bruising, wounds and self-neglect.

The service had a safeguarding tracker on their electronic care plan system and we saw evidence of safeguarding cases being discussed and actioned within clinical team meetings and clinical governance meetings.

However, the service failed to notify CQC of allegations of abuse and safeguarding as required. Staff and senior staff were unaware of the requirement to inform CQC of these notifications.

Safeguarding training formed part of mandatory training with separate courses for safeguarding adults and safeguarding children. Both courses had a completion rate of 94%, with only one newer member of staff having not completed the training yet.

The service had a lone working policy in place for their adult and young person's teams. All staff were aware of the policy guidance and adhered to it. The adult service mainly provided care and treatment on site, however when visits outside of the service were agreed, this was individually risk assessed and usually undertaken as part of a joint visit with other agencies or staff members.

Good

Substance misuse services

The service prescribed opiate replacement and relapse management medicine to clients, however it did not hold medicines on-site other than emergency medicine. The service held emergency adrenaline and Naloxone for trained staff to use in the event of an accidental opioid overdose. Some clients, carers and family members were also risk assessed, trained and supplied with Naloxone by a trained member of staff, in the event of an emergency occurring in the community. There was appropriate recording in place for this and clients and the family members received sufficient relevant information. The service had a medicines management policy in place that staff adhered to with appropriate reconciliation and stock taking of emergency medicines practices in place.

The service additionally offered Hepatitis B vaccinations and had a cold chain storage policy in place to manage this. However, we were told that due to a national shortage of hepatitis B vaccines, there were currently none on site. As a result, the fridge temperature checks were not recorded as it was not in use.

We saw good liaison with local pharmacy teams, GPs and general hospital staff concerning medicines and there were procedures in place to monitor clients' prescription use. When clients did not collect their prescription, the dispensing pharmacy contacted the service immediately, who in turn contacted the client for assessment. If clients missed prescribed medicine for three days in a row, their prescription was terminated and the client was booked in for a medical review.

The service had a medicines policy in place which covered prescriptions made by non-medical prescribers. Policies around prescribing medicine followed the National Institute for Health and Care Excellence guidelines (QS120).

There were appropriate processes in place for the safe delivery and allocating of prescription pads at the service. Prescriptions were issued to members of staff 50 at a time (in sequential order). The date, name of the staff receiving the prescriptions, the prescription number issued, and the staff issuing the prescription was documented and signed for. All prescription sheets were locked in a safe when not in use and Staff were not permitted to share prescriptions between each other.

When issuing a prescription to clients, it was clearly documented and signed for by both the staff member and client. Any void prescription were recorded on the staff prescription recording form and void was scrolled across the prescription and destroyed each day. The lead nurse for the service undertook regular audits of this process.

Clients underwent an initial period of supervised prescription consumption for newly prescribed medicines. Staff risk assessed clients to see if they were ready to have a regular prescription to take home and self-dose. We reviewed documentation where considerations given to those clients with children at home and the use of lockable storage boxes given to clients.

There were clear policies in place to ensure appropriate drug screening and alcohol level testing was carried out before commencement of opiate substitute prescribing to reduce the associated risks. Additionally, the service had procedures in place and liaised well with partner agencies to reduce the risks of 'double scripting' or diversion of medicines. This is when clients are involved in the transfer of any legally prescribed controlled medicines from the individual for whom it was prescribed for, to another person for illicit use.

Staff access to essential information

The service was in the process of transferring all paper care records onto their electronic care records system. On inspection, the service was utilising both paper and electronic systems. The paper records were securely and appropriately stored and all staff had a secure usernames and passwords to access client electronic records.

Paper records included client risk assessments, care plans and medical reviews. Correspondence, one to ones and progress notes were stored within the electronic care record system.

All information required to deliver client care was readily available to all staff. Substantive and agency staff had access to both paper and electronic care records.

Staff did not express any frustration or negativity towards the use of both record systems, however did state that moving to an electronic care records system would provide a more streamlined and time effective approach to document storage.

All staff had or were going to receive specific training on the electronic care records system from senior members of staff and we saw future protected dates to allow staff to upload current paper notes onto the electronic system.

Good

Substance misuse services

However, in one client's paper records we found a separate client's most up to date risk assessment and a copy of a third client's medical report. The service immediately rectified this when highlighted to them.

Track record on safety

We were told of eight incidents by the service that happened in the last 12 months. All incidents related to deaths of clients either still in active treatment or recently discharged and the service suitably notified the CQC of these incidents.

Reporting incidents and learning from when things go wrong

The service implemented an incident reporting policy that staff were aware of and followed. Staff gave good examples of what to report and could explain the process clearly.

The service had a standard incident reporting template that any staff could access and complete. This was then sent via email to the service manager for review and next steps and forwarded to the quality assurance team for information. If an incident needed escalating, the service lead nurse was informed and conducted the review. There was an appropriate system in place to ensure serious incidents were reviewed by staff members not directly involved with the service it related to.

We saw evidence that incidents and themes of incidents were discussed in clinical working groups, attended by the service manager and clinical lead, and were reviewed quarterly by the clinical governance committee. Feedback and learning was disseminated to teams via weekly team meetings and monthly supervision.

The service was in the process of implementing electronic reporting software. This software aimed to streamline the approach to incident reporting and investigating and to give more responsibility to local service teams in the end-to-end approach of incidents.

Staff understood the duty of candour and explained they were open and transparent to clients and families if things went wrong. The service had a thorough a duty of candour policy and procedure and was considered as part of the standard incident reporting form

Are substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed 8 care records and all demonstrated that clients received an initial assessment exploring a broad range of assessments including drug and alcohol use, injecting history, blood borne virus assessments, physical health information, mental wellbeing and employment history. All new clients were given a full physical health screening during their first initial appointment.

There were appropriate policies and protocols in place to work with the local mental health trust when mental health needs were identified. The service also referred patients to their GPs requesting access to Improving Access to Psychological Therapies (IAPT) services.

Clients' physical health conditions were considered as part of client assessments and 'health and wellbeing clinics' were held daily for new and existing clients to attend in addition to their booked appointments at the service. The clinic undertook basic physical health monitoring such as weight and blood pressure and also offered blood borne virus vaccinations and a needle exchange clinic.

The service was also commissioned to run annual flu vaccinations for its clients. We saw plans from the service looking to extend this to client family members too in the future.

Recovery plans were not personalised. There was little evidence of client views being recorded. Despite multiple issues being identified in assessments, not all issues were addressed in recovery plans in a holistic manner.

Best practice in treatment and care

National Institute for Health and Care Excellence guidance (CG51) on detoxification and psychosocial interventions was followed when assessing treatment need and prescribing medicine at the service. We saw evidence that the consultant and non-medical prescriber at the service delivered regular training to staff members regarding NICE guidance and prescribing.

Good

Substance misuse services

Staff ensured that clients physical health needs were being met and assured themselves when needed by obtaining medical health reports from clients' GPs.

We saw liaison with client GPs to ensure that electrocardiogram scans were undertaken at least every six months for patients who were deemed to be on high doses of methadone (100mls or more).

Staff supported clients to lead healthier lives. The service held substance misuse harm reduction clinics and we saw evidence of staff engaging with clients regarding healthy eating, smoking cessation and exercise.

Additionally, we saw plans from the service to extend training on harm minimisation to their local community pharmacies to upskill pharmacy staff to pass harm minimisation guidance onto clients attending their services.

The service utilised a national outcome tool 'Treatment Outcome Profile' (TOP) to measure outcomes and effectiveness of treatment. This tool was collated every 12 weeks and fed into monthly service performance meetings.

Skilled staff to deliver care

The service had a sufficient mix of suitably qualified and experienced staff members to meet the needs of their client group. The service held weekly team meetings to discuss issues and provide peer support.

All staff were sufficiently inducted to the service and undertook a period of shadowing before holding a caseload. We were told that there were no differences in inductions, training or supervision offered between substantive staff or agency staff.

There was a supervision tree in place that delegated supervision responsibilities between the service manager and team leads. The service manager and non-medical prescriber received supervision from the service lead nurse and the consultant received external supervision. The service utilised a standard template to record all staff supervision and copies were kept by both the supervisor and the supervisee.

Staff regularly received supervision from their line manager and staff reported that managers were always available for discussions and informal supervision sessions. For June and July 2018 staff supervision completion rates were beyond 90%. However, the service could only provide these figures post inspection after looking through key workers and team leader's diaries and did not have a single source to record supervision.

The service had a 100% completion rate for staff appraisals. Appraisals were aligned to service values and the service management policy stipulated the on-going yearly process of appraisals that included mid-year reviews.

Specialist training was available to staff at the service. Where the need was identified, a range of training was provided both internally and externally. Additionally, the service provided funding for specific staff members to undertake university courses where the need was identified.

We saw evidence that additional training was offered to staff members when specific trends from safeguarding or incidents had been noted, for example domestic abuse.

The service recruited a volunteer to help with administrable tasks and were in the process of introducing peer support volunteers. We saw appropriate vetting, induction and training plans in place to support this transition.

Multi-disciplinary and inter-agency team work

Staff held weekly clinical team meetings that the whole multidisciplinary staff team were expected to attend. We saw appropriate sharing of information within these meetings and discussions around best practice and risk.

The service manager told us of the plans to create two team meetings in the future, with one for clinical matters and the other for business matters.

There was an effective handover between teams that discussed risk and the days agenda. In the morning a team leader disseminated an email to all staff members explaining the roles of everyone for the day and the days schedule.

The service contained a dedicated criminal justice worker who liaised well with the magistrate's office and attended court hearings of clients. The worker also worked closely with the police and local custody Sargent to become aware of any clients that may have been placed in custody.

The hospital liaison worker for the service attended the local general hospital everyday to offer advice and support to staff regarding opiate substitute therapy. This meant that

clients in hospital were placed on a therapeutic dose and the liaison worker then oversaw their titration whilst in general hospital. Upon discharge, the liaison worker ensured the client engaged with the Compass service to continue treatment.

Additionally, the service worked closely with other partner agencies including GP's, local authorities and housing providers.

Good practice in applying the Mental Capacity Act

The service had a 79% completion rate for 'assessing mental capacity' training that formed part of mandatory training. All staff we spoke with had a good basic understanding of mental capacity and understood their role in assessing this both formally and informally.

The service had a relevant policy in place regarding the Mental Capacity Act for all staff to access for information.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff spoke about clients in a sensitive, caring and professional manner at all times. We saw staff interacting positively with clients and appeared responsive and respectful at all times.

Staff held one to ones in individual rooms to ensure confidentiality. Interventions such as drug screening were carried out in a dignified and private way.

Staff gave sufficient information to clients and their family members to understand their care and treatment. Staff demonstrated a good knowledge of medicine choices and shared this information with clients to enable them to make informed choices about their treatment. The service had clear and detailed information leaflets available that they gave to clients, including information about their medicine.

Staff supported clients to access other services when appropriate such as the job centre, colleges and the local housing association. Additionally, the service had four computers with internet and printer access that were free for clients to use during week day business hours.

All clients we spoke with were overwhelmingly positive about the service. All clients expressed a great gratitude to the service and explained that their key workers were always available when needed. Clients commented that they felt staff never judged them and that this was an important part of their recovery.

Staff understood the needs of their clients and appeared to have a genuine interest in their wellbeing.

Clients had regular one to one sessions with their keyworkers. The frequency of this was assessed on an individual basis and took into account other responsibilities such as work or children. The service offered two late night clinics a week to facilitate greater attendances.

Staff mostly maintained client confidentiality and followed appropriate protocol with regards client notes and sensitive information. However, we found client notes in paper format that were wrongly filed. This was immediately rectified by the service when highlighted.

Involvement in care

Clients reported that they felt very supported, informed and involved within their treatment decisions and care planning. All clients reported that they had seen their care plan and were happy with it.

There were quarterly service user forums held by the service to ensure clients could give feedback on the service they were receiving. The feedback covered topics including treatment pathways, group structures, feedback on specific areas of delivery and generalised feedback on client experiences.

The service had a feedback box within reception that allowed clients to feedback on the service. The service also logged complaints and compliments from service users to continually improve the service offered to clients.

The service had commissioned and were implementing a peer mentoring programme and recently recruited one previous client.

Involvement of families and carers

Staff informed and involved family members in the care and treatment of clients when appropriate. The service held weekly family and friend's groups to provide sufficient

support and would always endeavour to offer 1:1s with family members when requested. The service also trained close family members on overdose and Naloxone use to reverse opioid overdose in the community.

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Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

The service did not have any waiting lists for clients. Referrals arrived from a variety of sources including GPs, hospitals, hostel managers, social services and self-referrals. The service aimed to see clients for an initial assessment within five working days and all care records we reviewed had clients seen within the three week national guideline. Higher risk clients (pregnant women, high dose medicine, mental health conditions, high risk injection sites) were seen by the consultant at the service.

The service had a daily rota of duty workers and open access appointment system in place which meant clients presenting without an appointment or referral had quick access to support and an initial assessment. This meant that their risks could be quickly assessed.

The service ran two evening clinics a week that ran until 8pm. This ensured that clients who could not attend day time appointments could still access the service in the evening time.

The service had an appropriate 'did not attend' policy in place that stipulated the process for staff to follow to re-engage clients to the service. All staff were aware of their responsibilities and followed the guidance. We saw staff liaising with external partners, family members and the local police to ensure welfare checks could be made, before re-engaging the client with the service.

The facilities promote recovery, comfort, dignity and confidentiality

A range of rooms were available to support the delivery of care and treatment in group and individual therapies to clients. This included many individual rooms, group rooms, clinic rooms and a consultant's office.

The service had adequate room and seating for clients in the waiting area which additionally had a open plan kitchen available for use by clients and four computers with internet and printer access. This area was always appropriately supervised by a member of staff and access throughout the building was by secure key fob only.

Interview rooms were not fully soundproofed and conversations could be heard between adjoining rooms. However, the number of rooms were vast and we saw staff take precautionary measures to ensure that two interview rooms, side by side were not used at the same time whenever possible.

Meeting the needs of all people who use the service

The whole service was based on the ground floor which meant that all areas were accessible for those requiring disabled access.

Internal information leaflets were available in a range of languages that were most common for the location of the service and could be accessed and ordered by staff when required.

Where language differences were identified, the service could access a translation service to assist clients to access treatment. Additionally, for clients who had visual or hearing impairment, the service was able to provide appropriately adapted communication and a sign interpreter support.

The provision of daily open access clinic slots alongside the drop-in service, open kitchen and computer use encouraged engagement from clients who otherwise may have been hard to engage.

Listening to and learning from concerns and complaints

The service had a complaints policy in place and clients we spoke with said they knew how to make a complaint and would feel confident to do so. Clients were given information on making a complaint on their first visit to the service and there was a poster in the reception area.

Good

Substance misuse services

The service had a dedicated complaints and compliments email address for clients and family members use. This also allowed anonymity for those not wishing to disclose their name.

Complaints could be raised formally and informally and effort was made by the service to ensure local resolution was sought wherever possible. Clients received feedback on their complaint and the stage of the process.

The service had received 11 complaints over the previous 12 month period, of which 4 were fully upheld.

Staff knew how to handle both formal and informal complaints appropriately and received feedback from investigations in team meetings.

However, the complaints procedure did not include a clear appeals process. The policy did not direct clients to an appropriate independent complaints advocacy or ombudsman service. This meant that it was not clear to clients and family members what action they could take if they were not satisfied with the internal outcome or handling of their complaint.

Are substance misuse services well-led?

Requires improvement

Leadership

Leaders could clearly explain their roles and demonstrated a high understanding of the services they managed. They could explain how the teams worked to provide high quality care. There were monthly local clinical working group meetings that fed into service wide clinical governance meetings to ensure oversight of the service risks and performance.

Staff we spoke with said that immediate and senior leaders were visible and approachable within the service.

The service manager periodically worked clinically at the service to further support staff and understand and respond to the daily challenges staff face.

Leadership opportunities were available for all staff members and we saw evidence of funding from the service given to upskill and train staff members.

Vision and strategy

Staff demonstrated an awareness of the services vision and values. Staff attitude and performance was plotted against the service values during annual appraisals.

However, some staff did not feel connected to other services delivered by the provider and there was no evidence of learning from other services or sharing of good practice.

Staff had the opportunity to discuss and contribute to the strategy and direction of the service. Staff felt confident to raise issues or discuss ideas for change with their service leads and peers.

Culture

All staff we spoke with felt supported in their role and valued as part of the team. Staff explained they felt responsibility was shared equally amongst staff members and that they worked well as a team.

Staff were aware of and could explain the whistle-blowing process and felt confident to follow it.

There were no issues of poor staff performances or staff grievances at the time of our inspection.

The team worked well together and there was appropriate management structure in place. The interim service manager was very new in post but had identified areas for improvement within the service and demonstrated plans to improve different areas.

Staff appraisals included conversations on individual staff career development and staff were encouraged to attend training on specialist subjects relating to their career interests.

Governance

We did not see appropriate or consistent oversight of staff supervision levels within the service. Supervisors and supervisees held responsibility to ensure that supervision occurred as per policy with the emphasis on them to book next sessions into their personal diaries. There was no single recording system to ensure that supervision took place or that missed supervision sessions were followed up.

Data submitted by the service demonstrated high levels of supervision were occurring, and staff confirmed this, however the data was only able to be pulled from various sources including staff and manager diaries and

supervision notes with no single method of recording overall supervision rates. This meant that there was a risk of supervision reducing if there was staff sickness or departures in the service.

The quality assurance team at the service had not undertaken quality audits of the care records for over 12 months. We found two other client records held within one clients paper records. This was not identified by the service until highlighted by the inspection team.

Recalibration dates of physical healthcare equipment was not recorded centrally. There was no oversight to ensure recalibration occurred and we found equipment requiring calibration to be over a year out of date. This meant that staff could not be assured that readings given by the equipment was reliable.

There was an appropriate system in place to ensure incidents were escalated, investigated and learned from. We saw plans in place to improve and streamline this function with the introduction of electronic incident reporting software.

There were a range of standard operating procedures in place which had been developed in line with trust policies to ensure consistency amongst the team.

Management of risk, issues and performance

There was a clear clinical governance structure in place to ensure that clinical risk was escalated and managed within the service. Minutes from these meetings demonstrated clear actions to be taken to protect clients and ensure managerial oversight of issues.

The service had an appropriate risk register in place that contained a number of risks relating to clinical risk, information governance risk, health and safety, business disruption, safeguarding and human resources issues. The risk register was discussed in clinical governance meetings to ensure regular reviews. Each risk was either accepted and mitigated for or actioned against to improve.

Individual service data was reported to the providers board bi-monthly to oversee effectiveness of delivery. The board reports included health and safety, staff attrition, incidents, compliments and complaints as well as client activity data.

The service had a business contingency plan in place to account for emergencies that would ensure client risk was managed during these times.

Information management

Staff had access to the necessary equipment and information technology to undertake their role. All staff had their own laptops and there was plenty of office space to undertake their duties. For client notes, the service operated both paper and electronic systems which was in the process phasing over to electronic only. Staff were being trained on the system and time booked out of the diary to ensure all paper copies could be uploaded onto the new system.

Client confidentiality was explicitly explained to clients on their initial assessment, in addition to consent to share information with other relevant agencies. Consent to treatment and sharing of information was revisited frequently during client visits and was well documented and recorded within client care records.

A central team within the service produced monthly performance reports that the service manager could access. This gave access to data such as service performance, human resources information and quality assurances.

The service failed to notify CQC of serious incidents, allegations of abuse or safeguarding. Senior staff were unaware of their responsibilities regarding this, despite serious incidents being discussed with the quality assurance team, senior management team and at board level in a variety of formats. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). A requirement notice was issued in relation to this issue.

Whilst policies and procedures were in place for the service, staff expressed that they could not easily access them. Policies were stored on the shared drive in addition to being held on a secure software platform that required usernames and passwords. Staff told us that this made accessing the correct documents time consuming and difficult. On inspection, staff could not always access the correct policies required or could not always locate the policies on the shared drive.

Service leads identified policy access as an issue and we saw plans to implement a ‘standard operating guidance’ document onto every staff members home screen to include direct links to relevant policies that could be

accessed without passwords and when offline. This was being piloted by the services young person's service and was due to be implemented into the adult's team in November 2018.

Engagement

Clients and family members had opportunities to offer feedback on the service they received. We saw feedback being discussed and changes being considered within the service. The service held regular forums and feedback sessions for clients and their family members.

Service leads engaged with external stakeholders such as commissioners and presented key performance indicators when required.

Learning, continuous improvement and innovation

The service implemented both external and internal training opportunities for staff to ensure an up to date evidence based practice was implemented. The service utilised the skillset of the staff within the teams to run learning sessions based on identified areas of need.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that CQC are notified without delay of all notifiable incidents including allegations of abuse, safeguarding and incidents reported to police.

Action the provider SHOULD take to improve

- The provider should ensure that there is managerial oversight of supervision levels within the service
- The provider should ensure that appropriate quality assurance checks are routinely undertaken for care records to ensure oversight and consistency within the service.
- The provider should implement systems to ensure physical healthcare equipment is calibrated in line with guidance.
- The provider should consider implementing systems to fully support the service manager to review management data relating to their team.
- The provider should ensure that all identified risks to clients are included within risk management plans.
- The provider should ensure that recovery plans are personalised, include client views and wishes and address all areas identified within assessments in a holistic manner.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: Notification of other incidents The provider did not ensure the CQC were notified of other incidents occurring at the service. This included safeguarding and other incidents. This was a breach of regulation 18 (1)(2)