Humankindcharity

Calderdale Recovery Steps Carlton Street

Inspection report

8 Carlton Street
Halifax
HX1 2AL
Tel: 01422383063

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

Ratings

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

Summary of findings

Overall summary

- Staff were committed to working collaboratively with other services and with each other. They found innovative ways of delivering more joined up care to clients, particularly those with complex needs and those that struggled to maintain contact with the service. For example, they could dispense methadone on-site to clients at risk of disengaging from treatment. Clients received seamless care that was tailored specifically to their individual needs. Managers proactively encouraged staff to acquire new skills and recognised that staff skills and competence were integral to providing high quality care.
- Staff were consistent in supporting clients to live healthier lives, including identifying those who needed extra support, through a targeted and proactive approach to health promotion and prevention of ill-health. Young people had access to specialist interventions from a dedicated young persons' service. Teams used assertive outreach and satellite clinics to provide access to treatment in the places where clients lived and socialised. They provided clients with the full range of treatment options suitable to the needs of the clients and in line with national guidance and best practice, for example, they used self-management and recovery training with clients and mapping techniques to help clients engage with care planning. Staff engaged in clinical audit to evaluate the quality of care and continually develop different ways of delivering treatment. They were developing specific risk assessments and targeted interventions to reduce the risk of fatal overdoses related to opioids.
- Clients and carers consistently praised staff for the way they treated clients. Clients from the adult and young persons' service, told us staff respected and valued them as individuals and thought staff exceeded their expectations in supporting their emotional and practical needs. Staff treated people with compassion kindness and empowered them to be active partners in their own care. They understood the individual needs of clients and supported them to understand and manage their care and treatment. Stakeholders, including clients, carers and commissioners thought staff were passionate, highly motivated and the culture of the service was extremely person centred.
- Staff developed innovative, integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. For example, they met frequently with local housing providers, criminal justice agencies, the department for work and pensions, adult social care and others in the local authority to identify ways of fostering and sustaining recovery for clients with social and other needs. Clients could access services flexibly and there was a proactive approach to understanding the needs and preferences of different groups of people. Some clients were offered access to prescribed treatment without having to wait, and, if they dropped out of treatment, staff could re-engage them onto a substitute prescribing regime quickly. The service worked in very close partnership with a specialist service user organisation so clients could see other clients in recovery. They had easy access to recovery activities, such as, peer-led group work, fitness classes, walking and other practical skills, including in the evenings and at weekends. They had an on-site café, staffed by clients in recovery, where clients could get a hot breakfast and other refreshments.
- Leaders at all levels of the service were compassionate, inclusive and effective. They demonstrated commitment to system wide collaboration. The governance processes ensured that its procedures ran smoothly, and staff felt supported, valued, and motivated to do their best.
- The service provided safe care. The premises where clients were seen were safe and clean. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff assessed and managed risk well and followed best practice with respect to safeguarding. Staff were heavily involved in external safeguarding partnership work, which put adults and children at risk, at the centre of safeguarding.

However:

Summary of findings

- Staff did not always record what action they had taken when the room had exceeded the maximum safe storage temperature for medicines.
- Staff did not routinely check that all rooms that needed them had panic alarms available.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Outstanding ☆	

Summary of findings

Contents

Summary of this inspection

Background to Calderdale Recovery Steps Carlton Street

Calderdale Recovery Steps is a community substance misuse service providing care and treatment for people who misuse substances in Calderdale in West Yorkshire. It is part of a large national charity called Humankind. The service provides treatment and recovery services to adults and young people. This includes, pharmacological and psychosocial interventions, recovery activities including groupwork and also individual sessions. The adult service is co-located with a recovery organisation in the centre of Halifax and the service for young people takes place in various locations across the catchment area. The adult service also has a number of satellite clinics across the catchment area.

The service was first registered with the CQC in April 2018 to provide one regulated activity: treatment of disease, disorder or injury. There was a registered manager in post when we inspected the service, and this is the second time we have inspected the service since it was registered. When we last inspected the service, in January 2019, we found it good in all the domains, and good overall.

The service was not required to have a controlled drugs accountable officer in place, but they did have a person within the organisation to oversee controlled drugs governance arrangements and report any controlled drugs related incidents.

We carried out this inspection because the provider told us they had moved the service to new premises.

What people who use the service say

We spoke with seven clients, including two from the young persons' service and four carers. They all told us staff were compassionate, caring and went out of their way to provide person centred care and support. Clients thought that generally, all staff they came into contact with were helpful, responsive and flexible in the way they delivered services. Clients from the young persons' service said, 'it was a really good place' and staff gave them lots of practical help and advice about living a healthier lifestyle. They also got a lot of support with physical health issues. Overall, people felt that staff listened to them and they were involved in their treatment. Clients told us they liked the building and that it was a safe space for them. They said there were lots of activities on offer and their appointments were never cancelled. The only negative comment we received was that sometimes, there was a lack of private one-to-one space available for keywork sessions.

How we carried out this inspection

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

- toured the building and looked at the quality of the environment
- observed how staff were caring for clients
- spoke with seven clients and four carers
- spoke with the registered manager for the service
- spoke with the service manager for the young persons' service
- spoke with the service clinical director, and the clinical services manager
- spoke with 9 other staff members including nurses, support workers and administrative staff
- attended and observed one morning communication meeting

Summary of this inspection

- observed an on-site dispensing clinic
- looked at twelve care and treatment records of clients
- spoke with the lead commissioner for the service and one other stakeholder
- reviewed the management of medicines, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Outstanding practice

- The service had on-site dispensing targeted towards individuals presenting with complex needs who struggled to engage with traditional opioid substitution treatment, (OST), delivered via community pharmacies. This approach allowed the service to engage clients with co-morbidities and offer them health related interventions including blood borne virus immunisation and access to wound care offered by the on-site health and well-being practitioner. Dispensing was administered by on site pharmacy technicians supported by experienced support workers.

- Staff worked in partnership with a large group of local tenants with complex needs including substance misuse and other health needs. In partnership with other agencies, they were working with residents to develop an asset-based community development approach. This is a methodology for the sustainable development of communities based on their strengths and potentials. Staff were working together with private landlords, the police, health services and the department for work and pensions to organise community events and engage residents in harm reduction work and identify where services, including substance use treatment services, could offer help and support.

- Staff in the service were involved in piloting a study led by the provider into identifying risk factors associated with opiate overdose. The pilot was aimed at enabling staff to improve risk assessment and planning by helping them to screen clients for risk factors and offer more targeted interventions aimed at reducing the risk of a fatal opioid overdose. This work was still under review by the provider, but all opiate clients in the service now had a specific risk assessment around overdose and staff had been provided with additional tools to help them deliver more targeted interventions with clients to reduce risk.

Areas for improvement

The provider should:

- ensure staff always record what action they have taken when the temperature of rooms has exceeded the maximum required for safe storage of medicines.
- ensure daily checks are in place to confirm panic alarms are present in all areas where these are required.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Overall	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding

Outstanding ☆

Substance misuse services

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

Are Substance misuse services safe?

Good

Safe and clean environment

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

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. We looked at the provider's latest health and safety report from July 2022, and toured the building to check assessments and risk mitigation plans.

Not all interview rooms had alarms, but staff were available to respond. We toured the building and observed that one of the portable panic alarms was missing from one of the interview rooms. Staff replaced the missing alarm immediately when we pointed this out. Staff checked regularly to see that panic alarms were in good working order, but they did not check every day to ensure each room had an available alarm. The manager said this would be added to their daily checklist.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. We checked two of the clinic rooms, which were very well equipped. For example, they had an examination couch and other equipment used for basic health monitoring.

All areas were clean, well maintained, well-furnished and fit for purpose. We toured the building and saw that client areas were well maintained and furnished appropriately. The clients we spoke with reported the building was always clean and the furnishings were of a good standard.

Staff made sure cleaning records were up-to-date and the premises were clean. The provider contracted with an external company who kept thorough cleaning records, which we checked when we toured the service.

Staff followed infection control guidelines, including handwashing. We checked the provider's health and safety report from July 2022, which included an audit on infection control measures and hand hygiene.

We checked clinic rooms to verify that staff made sure equipment was well maintained, clean and in working order. Staff had procedures in place for monitoring and maintaining equipment, and they had an on-site dispensing machine, that staff had been specially trained to clean and maintain.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep clients safe. There were enough support workers and prescribers to ensure that clients were seen frequently enough and reviewed in line with national guidance. Staff said caseloads were high but not unmanageable. The provider was expecting to recruit additional staff following an uplift in funding, and managers expected that this would decrease caseloads.

The service had low and / or reducing vacancy rates. At the time of our inspection, the provider had vacancies for two full-time recovery workers and one lead practitioner, which was a new role.

The service did not use agency nurses, but they did use agency support staff occasionally to cover long-term absence or vacant posts. When we inspected the service, they had two agency support staff in place.

Managers made arrangements to cover staff sickness and absence. Managers covered long-term staff sickness absence and vacant posts with agency workers. They covered short term absence by re-allocating the workload amongst the team.

Managers limited their use of bank and agency staff and requested staff familiar with the service. One agency member of staff had worked for the provider previously, but all agency staff used were regular and knew the service well.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke with staff to confirm this.

The service had low turnover rates. Managers reported that many of the staff had been in post for a long time. They showed us data to confirm that in the 12 months prior to our inspection, there were eight staff leavers.

Managers supported staff who needed time off for ill health. For example, managers had allowed staff to work from home when their health condition necessitated that.

Sickness levels were about the same as the provider average. Managers monitored sickness absence with support from the provider's human resources department. They had no concerns regarding sickness absence levels but short-term sickness due to COVID-19 remained a challenge.

Managers did not use a recognised tool to calculate safe staffing levels. They were allocated a budget with an associated service specification that came directly from a lead commissioner in the local authority. When we spoke with the lead commissioner, we confirmed that the numbers and roles of staff were in line with what was commissioned.

Outstanding ☆

Substance misuse services

Medical staff

The service had enough medical staff. The service employed a full-time clinical services director and a full-time clinical services manager. They managed a team of three independent prescribers, a specialist medical prescriber, a locum consultant psychiatrist and two pharmacy technicians. In addition, there was a full-time health and well-being nurse.

Managers could use locums when they needed additional support or to cover staff sickness or absence. The service had a locum consultant psychiatrist that could cover in these circumstances.

Managers made sure all locum staff had a full induction and understood the service. The provider only used one locum and they had received a thorough induction.

The service could get support from a psychiatrist quickly when they needed to. Staff had good links with statutory mental health services and referred clients appropriately. The provider employed a locum consultant psychiatrist who offered guidance and support to staff for clients with mental health problems.

Mandatory training

Staff had completed and kept up to date with their mandatory training. We spoke with staff and checked training records to confirm this.

The mandatory training programme was comprehensive and consisted of topics such as unconscious bias training, information governance, health and safety and basic life support, safeguarding, managing challenging behaviour, equality and diversity, and infection control. For staff that were inexperienced in the substance use field, staff could provide specialist substance use training and guidance.

Managers monitored mandatory training and alerted staff when they needed to update their training. We looked at the training spreadsheet which showed staff names and the dates they had completed their training. Staff told us that managers would let them know when they need to refresh their training or there had been a new course added.

Assessing and managing risk to clients and staff

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

Assessment of client risk

Staff completed risk assessments for each client on arrival, but they did not use a recognised risk assessment tool. Staff used a template developed by the provider to identify a range of risks relevant to the client group. When we reviewed client care records, we found staff reviewed the risk assessment regularly, including after any incident. All clients using opioids had a specific overdose risk assessment in place, which had been developed by the provider. Staff used the assessment to help clients identify appropriate strategies for reducing their risk of overdose.

Staff could recognise when to develop and use crisis plans. We checked a sample of records to confirm that clients had appropriate risk management plans in place and, where appropriate, these covered crisis situations. Clients were routinely asked to provide details of who could be contacted if they dropped out of treatment or if the staff were concerned for their safety.

Outstanding ☆

Substance misuse services

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. The team met every morning to develop dynamic contingency plans for particularly complex and vulnerable clients. We observed one of these meetings and saw how staff responded quickly when clients deteriorated and/or dropped out of treatment.

Staff followed clear personal safety protocols, including for lone working. There was a clear lone working policy in place which we checked when we inspected the service. Staff in the young persons' team had access to a mobile phone group so they could check in with managers when they had completed their visits. Staff in the team that carried out assertive outreach always went out in pairs and other staff carried out risk assessments for any home visits. Staff we spoke with confirmed there had been no adverse incidents involving lone working.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. The provider made sure all staff received basic training but managers and those in specialist roles received a higher level of safeguarding training.

Staff kept up to date with their safeguarding training. Training consisted of both adult and child safeguarding. At July 2022, the provider showed us data to confirm that 90% of staff had completed their safeguarding alerter training, and 100% of managers had completed their safeguarding responder training. All staff had completed a basic safeguarding awareness course as part of their induction.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received mandatory training in equality and diversity, but they also had access to unconscious bias training through the provider's in-house training programme. Unconscious bias training aims to reduce discrimination by raising awareness of stereotyping and other unconscious factors that can lead people to make prejudicial decisions.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. We looked in detail at a number of client records and staff gave us numerous examples of joint work with other agencies such as mental health teams, domestic abuse agencies and social care. Managers attended a daily multi-agency meeting aimed at identifying individuals at risk of domestic abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The manager of the young persons' service was also the safeguarding lead, and acted as the main link between the service and the local authority. Staff were trained to make referrals directly to the local authority where necessary and we saw examples of this in client care records. We looked at data to confirm that between the 1 April and 30 June 2022, staff made three external safeguarding referrals.

Managers took part in serious case reviews. We saw an example of changes they had made to their referral processes as a result of a serious case review concerning a suspected non accidental injury to a child. Staff now provided clear feedback to referring agencies so information about client engagement was shared routinely.

Staff access to essential information

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

Client notes were comprehensive, and all staff could access them easily. All client records were electronic, and staff had access to computers and laptops in order to be able to access them. The provider had designed specific templates to gather comprehensive information about clients and their treatment.

When clients transferred to a new team, there were no delays in staff accessing their records. All staff including agency staff had access to the system and could see the information recorded by staff in a different role.

Records were stored securely in the provider's electronic system. Each member of staff had a discrete log-on identity and managers had information governance processes underpinning this.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The service had robust prescribing systems in place overseen by a clinical services manager who was also a nurse prescriber. We looked at medicines management policies, spoke with a number of prescribers and observed an on-site dispensing clinic to confirm that staff followed safe systems to prescribe and administer medicines safely.

Staff checked emergency drugs to ensure they were in date and discarded medicines that had not been stored correctly. One of the records we looked at had not been completed correctly as it did not specify what action staff had taken in response to a rise in temperature of the sterile water supplies. Staff had discarded the medicine but had not recorded this on the appropriate record.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Prescribers saw clients at least every 12 weeks for their medicines review and often, more frequently, depending on need. Clients told us that prescribers would provide medicines advice to them or their carers as needed.

Staff completed medicines records accurately and kept them up to date. All client prescription records were held on the electronic records system. Prescribers and clinical administrative staff checked them to ensure they were correct. As a result, the service had very few medicines errors.

Staff stored and managed prescribing documents safely. While on site, we checked that the provider had robust systems in place for the storage and administration of controlled drug and other prescriptions. The provider's medicines policy and controlled drugs policy had been updated to include procedures for the on-site dispensing facility. The service had an accountable person in place for controlled drugs, stationery, and Home Office licences.

Staff learned from safety alerts and incidents to improve practice. We spoke with the clinical services manager who shared information about safety incidents in clinical team meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a service clinical director, and a clinical services manager supported by a medical director and director of pharmacy at provider level. Together, they carried out checks to ensure that all prescribing was done in line with national guidance.

Staff reviewed the effects of each client's medicines on their physical health according to the National Institute for Health and Care Excellence (NICE) guidance. We spoke with the service clinical director, and with the health and well-being nurse to confirm that appropriate clients had rapid access to electrocardiogram tests which is good practice for clients on higher dose methadone. The service had appropriate patient group directives in place for blood borne virus testing and immunisation.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. We spoke with staff, including a new starter, who confirmed that they had received training in how to recognise and report incidents, including near misses.

Staff reported serious incidents clearly and in line with the service's policy, and this included client deaths, however they were caused.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. Staff understood what the duty of candour was because they received guidance about it. All the staff we spoke with emphasised how open and transparent they were when things went wrong, and, although they had no incidents that met the threshold for duty of candour, they still apologised to the client and explained how adverse incidents had happened.

Managers debriefed and supported staff after any serious incident. Staff confirmed they felt supported and received de-brief, for example, following client deaths.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations, as appropriate. In the 12 months prior to our inspection, the service had not had any serious incidents in the service, but they did have a thorough review process for clients that had died while in treatment with the service.

Staff received feedback from investigation of incidents, both internal and external to the service. We looked at a sample of team meeting minutes to confirm that staff received feedback about incidents. Managers circulated emails to staff about learning from incidents and staff were involved in the death in treatment review process. We looked at a presentation provided to staff about lessons learned from deaths in treatment and serious case reviews.

Staff met to discuss the feedback and look at improvements to client care. Each quarter, managers got the whole team together for practice development days. We looked at a presentation from one of these events, and saw that staff shared learning from incidents, including from drug and alcohol related deaths.

There was evidence that changes had been made as a result of feedback. For example, staff had made changes to the procedures for sending out letters following a number of information governance breach incidents.

Outstanding ☆

Substance misuse services

Are Substance misuse services effective?

Good

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each client. We checked client records to ensure that assessments were holistic and covered a range of relevant domains including, substance use and social/psychological functioning.

Staff made sure that clients had a physical health assessment and knew about any physical health problems. Staff used a range of health questionnaires on their care records system to assess each client's physical health needs. With some clients, they had access to the records held by their GP and could check health information.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. We looked at 12 client care plans to confirm this.

Staff reviewed and updated care plans when needs changed. The provider required staff to update care plans every three months as a minimum, and the most recent case file audit showed that not all care plans reflected the most up-to-date needs. Out of the 12 care plans we looked at on inspection, we saw only one that had not been updated to reflect current interventions.

Care plans were personalised, holistic and recovery orientated. We looked at 12 care plans and saw that they were person centred and focussed on the recovery goals that were the most important to each individual client. Care plans varied in their quality of goal setting, but managers were continuing to provide training for staff in developing smarter goals. They monitored staff progress through regular individual audits of care records kept by each keyworker.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the clients in the service. Clinical leadership, both at the location and provider level ensured that staff provided prescribing and psychosocial interventions in line with guidance provided by the National Institute for Health and Care Excellence (NICE) and the Office for Health Improvement and Disparities,(OHID). We looked at care records and case studies to confirm that staff provided a variety of evidence-based interventions.

Clients had easy access to evidence based groupwork, recovery activities and mutual aid through being co-located with a recovery organisation. The provider and the recovery organisation worked closely together to provide a range of best practice pharmacological and psychosocial interventions appropriate for this client group.

Staff made sure clients had support for their physical health needs, either from their GP or community services. Clients had access to a health and well-being nurse that could provide support and signposting with substance use related health issues, such as wound care. We saw examples in care records where clients had been referred to their GP and other physical health services.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. Clients had access to blood borne virus testing and immunisation. Staff had strong pathways in place so clients could be referred quickly for hepatitis treatment where needed. We saw in care records how staff signposted clients to other health improvement services, such as smoking cessation.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. For example, we looked at a recent care records audit, a safeguarding audit, and audits of when clients on prescribed treatment were due for review. At provider level, quality and performance staff carried out regular audits and quality checks at the location, and supported staff with raising standards locally.

Managers used results from audits to make improvements. We saw first-hand how staff worked with the quality and performance team to make improvements, for example, to risk management and recovery planning.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of each client. The service employed qualified mental health nurse prescribers, reporting to an experienced service clinical director. Recovery workers and staff that carried out harm reduction and outreach work were experienced and well trained. Young people had access to a specialist young person's team, and some staff had specialist criminal justice experience and training.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care. Managers made sure all staff, including prescribers, had completed the Best practice in Optimising Opioid Substitution Treatment (BOOST) learning programme developed by Public Health England. Staff that carried out assessment and psychosocial interventions had access to motivational interviewing and cognitive behavioural therapy training.

Managers made sure staff received specialist training for their role. For example, we saw evidence that nurses had completed immunisation training in order to carry out the blood borne virus work. Staff involved in issuing Naloxone, (a drug that can help reverse the effects of opioid overdose), had received specialist training and trained other staff in the location. Managers made sure that each role had a set of identified required learning and this included any specialist training.

Managers gave each new member of staff a full induction to the service before they started work. We spoke with new members of staff to confirm that they received a structured induction with training tailored to their level of experience. New staff had an induction booklet which they had to complete and, which their manager signed off.

Managers supported staff through regular, constructive appraisals of their work. We interviewed a variety of staff who confirmed they were up to date with their appraisal. We looked at data to confirm that at the time of our inspection, all of the staff had an up-to-date appraisal in place.

Managers supported non-medical staff through regular, one to one supervision, and peer supervision was facilitated through a reflective practice group. We spoke with staff who all told us they had regular management supervision and could request additional sessions as needed. We looked at data to show that managers kept accurate records of the dates staff received supervision and, if a session had to be re-scheduled, the reason for this.

Managers supported medical staff through regular, constructive clinical supervision of their work. The provider's medical director supervised the service clinical director, and, between them, they both supervised the on-site clinical staff. In addition, senior clinical staff had access to regular group supervision and quarterly service development days". Compliance with clinical supervision was 100% and formed part of the revalidation process for clinical staff. The medical staff we spoke with told us they felt they were given time and support for their own continuous professional development.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. The staff we spoke with told us they had access to regular team meetings and were sent notes from the meetings if they could not attend. We looked at a sample of team meeting minutes and spoke with staff to confirm this.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers identified training needs in appraisals, and these were reviewed regularly in supervision sessions. We spoke with a number of staff that had been supported to attend further training, including higher level qualifications. Managers had access to supervision skills training and other leadership training programmes.

Managers recognised poor performance, could identify the reasons and dealt with these. Managerial staff were supported by a regional human resources business partner who could provide specialist advice in dealing with performance issues. We saw evidence that managers had supported individual staff through performance improvement programmes.

Multidisciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss clients and improve their care. We reviewed a sample of minutes to confirm that staff met weekly with prescribers and other internal professionals to review clients with complex needs. The provider had recently recruited a clinical psychologist to provide staff with additional support and guidance. Notes of meetings showed how the teams worked effectively to develop strategies to engage and retain clients in treatment.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. We observed a daily communication meeting where staff met to discuss and share information about, for example, safeguarding issues, clients that might be at particular risk, and which staff would be covering which duties for the coming day. Staff made notes of actions and circulated them immediately after the meeting to all staff and managers. The meeting included managers and admin staff and, the various representatives from the different teams gave verbal feedback to colleagues as an adjunct to the notes.

Staff had effective working relationships with external teams and organisations. For clients with highly complex needs, staff worked with an external multidisciplinary, multi-agency team, consisting of the representatives from the local authority, the police, social care, housing, department for work and pensions and other relevant authorities. In addition,

teams had effective pathways with relevant organisations, such as domestic abuse and public protection agencies. They worked in partnership with these organisations to make sure clients' needs were met and they did not fall through the gaps in care. We spoke with stakeholders, including the lead commissioner to confirm that staff worked well with external teams.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. For staff working in the young persons' team, this included Gillick competence. We spoke with staff to confirm that they had a good grasp of how to apply this to their work. Since our last inspection, the provider had updated their Mental Capacity Act training, and, locally, staff also completed face to face training. At July 2022, the compliance rate for this training was 94%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. The staff we spoke with confirmed they knew how to access the policy, which was on the provider's intranet. We looked at this policy following our inspection and found it to be satisfactory.

Staff knew where to get accurate advice on Mental Capacity Act. Staff could seek advice from managers, including the clinical services manager, who was an experienced mental health nurse.

The service did not monitor how well it followed the Mental Capacity Act, but we found no concerns when we looked at care records and spoke with staff.

Are Substance misuse services caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They understood the individual emotional and practical needs of clients and supported clients to understand and manage their care and treatment and focussed on sustaining their recovery.

Staff were discreet, respectful, and responsive when caring for clients. We spoke with seven clients and four carers who all told us that staff were caring, compassionate and responsive when they needed support. When we spoke with staff they effused about their work with clients and showed genuine empathy with them. Relationships between staff, clients and carers were highly valued by staff and promoted by leaders.

Clients said staff treated them well and behaved kindly. We spent time in the reception and café areas observing how staff interacted positively with clients. Without exception, the clients we spoke with told us that staff were warm, friendly and treated them with the utmost respect.

Substance misuse services

Staff gave clients help, emotional support and advice when they needed it, and in the place where clients needed it. We saw many examples where staff had gone the extra mile in providing clients with practical and emotional support. Staff in the harm reduction team helped clients with practical arrangements, like obtaining food, helping them move to a new house, and providing clean injecting equipment in places where clients lived. They provided support in the places where people lived so they could identify when people needed additional support.

Staff supported clients to understand and manage their own care treatment or condition. We saw that staff interacted with other health professionals to help clients understand and manage associated health conditions, for example, blood borne viruses and wound care. They carried out detoxifications in the community, providing clients with self-help materials and written information. Clients had access to an on-site health and wellbeing practitioner who could provide advice and signposting on a range of health issues.

Staff directed clients to other services and supported them to access those services if they needed help. Staff directed clients to specialist health services where appropriate, and clients could speak with their prescriber about their medicines, including any side effects. They assessed clients' needs for specialist in-patient detoxification and rehabilitation and supported them with attending assessments, including in some cases, travelling with them to appointments.

Staff understood and respected each client's medical and social needs to enhance their chances of sustained recovery. We spoke with staff and clients, and looked at care records to confirm that the treatment being delivered was highly person centred. Staff recognised and respected the totality of people's needs and always took into account personal, cultural, social and religious needs. For example, we saw how staff supported clients to use medicines during periods of religious fasting.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. We spoke with staff including managers, administrative staff and prescribers who all confirmed they would raise concerns about negative attitudes towards clients. We observed how staff displayed a non-judgemental approach and accepted where each client was at in their recovery journey. We saw examples of emails managers had sent encouraging staff to think carefully about the everyday language they used and, whether it could be construed as discriminatory.

Staff followed policy to keep client information confidential. The service had clear confidentiality policies which staff explained to clients at assessment. We looked at care records which showed evidence of staff sharing information with the appropriate consents. Clients had information sharing agreements in place so staff knew who they could share information with, and this included carers and other agencies.

Involvement in care

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

Involvement of clients

Staff involved clients and gave them access to their care plans. We spoke with six clients who told us staff involved them in their treatment and they felt like equal partners in their care. In all the care records we looked at, we saw that clients had been asked if they wanted a copy of their care plan. Staff were committed to working in partnership with people and always empowered people who used the service to have a voice and realise their potential.

Outstanding ☆

Substance misuse services

Staff made sure clients understood their care and treatment (and found ways to communicate with clients who had communication difficulties). In some care records, we saw examples of mapping techniques to help clients develop pictorial representations of their care plans.

Staff involved clients in decisions about the service, when appropriate. Staff were working with an independent local service user forum to develop ways of involving clients in decisions about the service. They had tasked a lead practitioner to take this work forward. In the meantime, staff carried out regular surveys with clients and, as a result of one such survey, staff made significant changes to the way clients could access the on-site needle exchange.

Staff made sure clients could access advocacy. Staff had strong links with a local service user group that could provide advocacy.

Clients could give feedback on the service and their treatment and staff supported them to do this. The service was co-located with a recovery organisation and both providers worked together to ensure clients were supported to express their views about the service. Clients had access to a suggestion box and staff asked all clients who were discharged from the service to provide feedback. We looked at a recent client satisfaction survey and saw that 100% of clients in both the young persons' and adult service would recommend the service to their families and/or friends.

Involvement of families and carers

Staff informed and involved families and carers appropriately. We saw evidence in care records that staff liaised appropriately with families and carers. Where appropriate, they directed them to carers support locally.

Staff helped families to give feedback on the service. We saw examples of compliments and positive feedback from client's families.

Staff gave carers information on how to find the carer's assessment. They directed carers to appropriate sources of support in the local authority.

Are Substance misuse services responsive?

Outstanding ☆

Access and waiting times

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

The service had broad but clear criteria to describe which clients they would offer services to and, and despite the demand for the service, they did not have a waiting list. Staff had developed a separate pathway for children and young people under age 21. This meant young people could be seen separately from adults and in places that were more suitable to meet their needs.

The service frequently saw clients quicker than their target times for seeing clients from referral to assessment and assessment to treatment. In the adult service, they could sometimes offer same-day access to treatment from assessment because of their duty worker system and on-site dispensing facility. The on-site dispensing facility meant that some clients that were at risk of dropping out of treatment were retained because they could quickly access a safe dose of medicine under supervision from specialist staff.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. When the service was open, there were always recovery workers, assessment workers and a prescriber on duty that could respond to walk-in referrals and/or clients who needed to be seen quickly. Staff blocked out appointments every day for urgent referrals, for example, people just released from prison.

Staff succeeded in engaging people who found it difficult, or were reluctant, to seek support from mental health services. We saw some innovative examples of work carried out by staff to engage people with complex needs and/or were reluctant to seek support. For example, staff worked closely with social housing providers and private landlords to provide outreach support and harm reduction services to vulnerable adults. The service employed two complex needs workers to oversee this work. There was an on-site dispensing service that succeeded in preventing clients with multiple and complex needs from dropping out of the treatment programme.

Staff tried to contact people who did not attend appointments and offer support. They had contingency plans in place for clients, which meant they had already gained their permission to carry out assertive engagement, including home visits and contacting their families. Each morning, staff met to discuss those clients who staff were concerned about and/or who had not attended when they should have done. They provided outreach to such clients and, in appropriate circumstances, requested the police to carry out welfare visits. They worked jointly with external multidisciplinary teams to share information about clients at risk and organise joint welfare visits.

Clients had some flexibility and choice in the appointment times available. We spoke with clients to confirm that the service was open one evening per week for those that could not get there during the day. Clients had access to recovery activities and mutual aid sessions, which took place in the building in the evenings and at weekends. Managers told us they were planning to open access to other services on Saturday mornings. Clients in the young persons' and adult service could choose a venue to be seen in, which was closer to where they lived. This meant that people could access services in ways and at times which suited them better.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible. None of the clients we spoke with told us they had ever had any appointments cancelled by the service. Staff told us that if a worker was unexpectedly absent, clients would be seen by another member of the team.

Appointments ran on time and staff informed clients when they did not. Medical staff and key workers had long enough appointment times to ensure they did not overrun. All of the clients and carers we spoke told us their appointments ran on time.

Staff supported clients when they were referred, transferred between services, or needed physical health care. Staff had transition arrangements in place for when young people were transferred to the adult service. This meant additional safeguards for young people who were not always transferred automatically by virtue of their age. Where appropriate, staff accompanied clients when they transferred to other services, for example, residential rehabilitation. The physical healthcare nurse supported people with physical healthcare needs to access secondary care services.

The facilities promote comfort, dignity and privacy

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

The service did not have the full range of rooms and equipment to support treatment and care, but managers had plans in place to address this. The service was co-located with a recovery organisation, which meant clients, including young people, had access to a gym and a café as well as one-to-one rooms, group rooms and clinic rooms. When we spoke

with staff, they told us there were not always enough one-to-one interview rooms. The provider had leased a building across the road that staff could use but this was limited because the young persons' service ran from there some of the time. One of the carers we spoke with mentioned the lack of private one-to-one space. Managers told us they were aware of the issues and were looking to provide alternative means for staff to see clients.

Staff told us that some interview rooms in the service did not have adequate sound proofing and they could sometimes hear noise from the activities elsewhere in the building. However, although the noise could be disruptive, they could not hear anything that would compromise anyone's privacy and confidentiality. None of the clients or carers we spoke with raised any concerns about soundproofing.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. The building had been refurbished to a high standard. It had disabled access and a disabled toilet. The service ran satellite prescribing clinics across the catchment area which meant clients could be seen closer to home. Staff carried out home visits and outreach with clients with specific needs. Young people were seen in places that were more suited to their needs and preferences, for example, at home or at a suitable community venue.

The service had a variety of pathways in place to meet the full range of client need. For example, there was a pathway in place for pregnant women and people who were at risk of domestic abuse. Where clients required residential rehabilitation, or supported housing, staff could provide assessments and sign posting. They worked in partnership with a local recovery organisation to provide community detoxification and recovery support to people in supported housing.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way which met the needs and promoted equality. Staff in the young person's service worked in partnership with other local youth services to engage more people from black and minority ethnic groups who were underrepresented in services. Staff attended various community events aimed at raising awareness about substance use amongst, for example, lesbian, gay, bisexual, transgender, queer plus, (LGBTQ+) groups.

Staff made sure clients could access information on treatment, local services, their rights and how to complain. Staff were extremely knowledgeable about local services and had a huge range of pathways in place to support people to access the right treatment to meet their needs. They had strong links with recovery and service user groups so clients could get advice about their rights.

The service did not have information leaflets available in languages spoken by the clients and local community, but staff did have access to specialist computer software that could translate written material. The service manager confirmed that leaflets in different languages could be ordered from the provider as required.

Managers made sure staff and clients could get hold of interpreters or signers when needed. The provider had a contract with an external company for the provision of interpretation and signing services.

Listening to and learning from concerns and complaints

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

Outstanding ☆

Substance misuse services

Clients, relatives and carers knew how to complain or raise concerns. All clients had an induction to the service which outlined, amongst other things, their right to complain. All the clients and carers we spoke with knew how they could make a complaint about the service they received.

Staff understood the policy on complaints and knew how to handle them. We looked at a recent complaints report and two formal complaint response letters to confirm that staff knew how to deal with complaints and record them appropriately in the provider's system.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint. We looked at two written complaint responses to confirm that clients received a response to identify whether their complaint was upheld or not. Clients received an apology where the service had fallen below the required standard.

Managers investigated complaints and identified themes. The service did not receive large numbers of complaints but one of the themes was around clients being unhappy with clinical decision making concerning their medicines. Staff listened to clients' concerns, but they could not always change their prescribing practices because they were following national guidance.

Managers shared feedback from complaints with staff and learning was used to improve the service. We looked at a recent complaint report to confirm that managers identified learning from complaints and discussed these in quarterly governance meetings. They shared these with staff via supervision, email and in team meetings. As a result of informal complaints, staff had altered the way clients accessed the on-site needle exchange to provide more anonymity for users.

The service used compliments to learn, celebrate success and improve the quality of care. Staff recorded all compliments on the provider's electronic reporting system. Managers discussed these at local governance meetings and could choose to nominate a member of the team to receive a 'thank you' voucher. Other staff knew who had received praise as this was available on the staff intranet.

Are Substance misuse services well-led?

Good

Leadership

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

Staff were supported by three experienced service managers and an area manager. All managers in the service had undertaken leadership training and were very experienced in the field of addictions. We spoke with staff who told us managers were visible and approachable. Together, they had a good understanding of the day to day issues facing staff and were approachable for clients and other stakeholders.

The local management team was supported by the provider's senior management team who visited the location regularly and spoke with staff and clients. We spoke with staff to confirm that senior leaders, including the chief executive officer were visible and approachable.

Outstanding ☆

Substance misuse services

Vision and strategy

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

Staff were aware of the organisation's vision and values which were integrated into their induction process. Each member of staff attended 'welcome to Humankind workshops' and they had a structured induction booklet with information about how the values and the mission of the organisation had come about. When we visited the service, we saw that staff were committed, honest and inventive, which are the values of the organisation. We looked at the latest staff survey which showed that most staff agreed that their own values were aligned to those of the provider. The provider used a 'not for profit' company to clean the building because they employed people with lived experience of mental illness and addictions.

Culture

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

All staff we spoke with during the inspection felt supported and valued. They came across as passionate about their work and proud to work for the provider. Staff said the job was busy and could be stressful, but they had access to a comprehensive employee assistance programme. They described the service as a good place to work. They told us there were good opportunities for further training and for developing specialisms within their roles. Many of the staff we spoke with had been promoted or progressed to different roles within the service. We looked at the results from the latest staff survey, which showed that most staff in the service felt supported and valued by their team, their line manager and by the organisation.

The provider had a whistleblowing policy, which staff were directed to in their induction booklet. All the staff we spoke with told us they would have no hesitation in raising concerns if they needed to and would feel confident that there would not be any reprisals.

Governance

Our findings from the other key questions demonstrated that, on the whole, governance processes operate effectively, and risks were managed well. Performance issues were identified and acted upon.

Overall, the location had strong governance systems in place to ensure clients had clear treatment pathways that were evidence based, and delivered by well trained and experienced staff. Managers had workforce plans in place to ensure staff were recruited safely, supported in their job and received any specialist training for their role. Medicines management and prescribing procedures were robust, and there were enough medical staff to ensure clients' treatment was regularly reviewed, and clients did not have to wait long to get into treatment. There were robust safeguarding processes in place, and serious incidents were investigated thoroughly. Learning from client deaths and serious case reviews was well-embedded in the service.

Staff and managers worked exceptionally well with other agencies to provide innovative responsive care in locations that were close to where clients lived. They ran satellite clinics in various places across their catchment area and undertook outreach visits with clients that found it hard to engage. The service was co-located with a recovery organisation, so clients had seamless access to visible recovery and mutual aid. Staff provided specialist support to young people and made appropriate arrangements where they needed prescribing interventions. Managers worked productively with staff to provide holistic, person centred care.

Managers held monthly operational management meetings and quarterly clinical governance meetings to discuss issues pertinent to the running of the service. They engaged partner organisations in meetings as appropriate and had effective systems in place to manage and oversee shared facilities, such as the building. We confirmed that managers had effective governance systems in place by speaking with staff, looking at minutes from local governance meetings and by speaking with relevant stakeholders, including the service commissioner.

Management of risk, issues and performance

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

Managers and supervisory staff had access to detailed information about staffing, training compliance, incidents, notifications and service user feedback, which they reviewed in quarterly governance meetings. Key working and clinical staff had up-to-date information on which clients were due for review of their medicines and care plans.

The service had an up to date risk register with appropriate mitigation. Managers reviewed risks regularly and updated service improvement plans as a result.

Incidents were reported and appropriate notifications made to external bodies where required. The service commissioner we spoke with confirmed managers kept them up to date with appropriate information about adverse incidents and client deaths. Staff made appropriate safeguarding to notifications to the local authority and Care Quality Commission.

Information management

Staff collected analysed data about outcomes and performance.

We looked at the latest service performance report to confirm that managers monitored progress over time on key performance indicators, such as, numbers of clients in treatment, discharge outcomes and re-presentations. They used this information to make service improvements, for example, developing strategies to engage clients who were reluctant or found it difficult to use the services.

Managers encouraged staff at all levels to continually learn and improve practice, and the whole staff team met together for regular development days. The service held the Investors in People, (IIP), gold standard award, which is a nationally recognised accreditation scheme that demonstrates a positive workplace culture and a strong commitment to developing employees at all levels.