

East Kent Substance Misuse Ashford







Quality Report

Transport House
Drum Lane
Ashford
TN23 1LQ
Tel: 01233 655360
Website: www.rapt.org.uk

Date of inspection visit: 26th September 2019
Date of publication: 11/11/2019

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?	Good	

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.

Summary of findings

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

Overall summary

We rated East Kent Substance Misuse Service - Ashford as good because:

- 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 good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under

their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.

- Staff treated clients with compassion and kindness, and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

However:

- It was not recorded in all records we viewed that clients had been offered a copy of their care plan.

Summary of findings

Contents

Summary of this inspection

	Page
Background to East Kent Substance Misuse Ashford	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the service say	6
The five questions we ask about services and what we found	7

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards	10
Overview of ratings	10
Outstanding practice	21
Areas for improvement	21

Good 

East Kent Substance Misuse Ashford

Services we looked at; Substance Misuse Services

Summary of this inspection

Background to East Kent Substance Misuse Ashford

East Kent Substance Misuse Service Ashford provided specialist community treatment and support for adults affected by substance misuse and was commissioned to provide treatment for people who live in East Kent.

The service was one of five in East Kent provided by The Forward Trust. The Kent Drug and Alcohol Team funded treatment for the majority of clients at the service. The service accepted referrals from a range of professionals or people could self-refer.

The service offered a range of services including initial advice; assessment and harm reduction services including needle exchange; prescribed medicine for alcohol and opiate detoxification; naloxone dispensing (emergency reversal of opiate overdose); group recovery programmes; family support groups; one-to-one key working sessions and doctor and nurse clinics which included health checks and blood borne virus testing.

There was a registered manager at the service.

The service was previously inspected on 9 November 2017 which was its first inspection since it registered with

CQC on 1 May 2017. We issued the provider with one requirement notice. This related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing

This was in relation to our inspection finding that staff did not receive appropriate support, training and development to enable them to fulfil the requirements of their role.

A requirement notice is issued by CQC when an inspection finds that the provider is not meeting fundamental standards of quality and safety.

On this inspection in September 2019 this requirement was met.

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

Our inspection team

The team that inspected the service comprised of one CQC inspector, one CQC assistant inspector and a specialist advisor with knowledge and experience of working in substance misuse.

Why we carried out this inspection

We undertook an unannounced, comprehensive inspection of this service as part of our routine programme of inspecting registered services.

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?

Summary of this inspection

- Is it well-led?

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

During the inspection visit, the inspection team:

- undertook a tour of the service premises and facilities, including the clinic room, medication storage area and needle exchange room
- observed how staff were interacting with clients
- spoke with the registered manager
- spoke with 11 other staff members including a team leader, two recovery workers, an agency recovery worker, two nurses, an alcohol recovery worker, a criminal justice worker, two volunteer peer family support workers and the administrator.
- spoke with two clients
- spoke with three family members
- reviewed the medicines management of the service
- observed a family support group meeting
- looked at five client care and treatment records
- reviewed policies, procedures and other documents relating to the running of the service.

What people who use the service say

Feedback about the service from clients and family members was very positive. All clients and family members we spoke with said staff were friendly, supportive and genuinely cared about them. Clients liked that, even after they had completed their recovery, they could still drop in and speak to someone if they felt they needed to. Clients told us treatment options were discussed, and that staff supported them to make

decisions about their care and support without trying to tell them what to do. Clients were very confident in the care and support they received from the service, and told us they always felt safe when at the service. Family members told us that the service helped them develop coping mechanisms in a non-judgemental setting, and that the support they received was invaluable.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- 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.
- 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.
- 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 kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- 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 physical health.
- The service had a good track record on safety. 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.

Good



Are services effective?

We rated effective as good because:

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

Good



Summary of this inspection

- 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 used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- 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.
- 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 supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Are services caring?

We rated caring as good because:

- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.
- 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.
- Staff informed, involved and supported families and carers appropriately.

However:

- It was not recorded in all client records we viewed that clients had been offered a copy of their care plan.

Good



Are services responsive?

We rated responsive as good because:

Good



Summary of this inspection

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

We rated well-led as good because:

- 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 knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider 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.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance.

Good



Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a mental capacity policy which staff were aware of. Staff received training in mental capacity as part of their induction. There were signs in staff offices and other locations around the building, detailing the five

principles of the Mental Capacity Act. Staff we spoke with were able to outline their responsibilities around the Mental Capacity Act and understood how the Act could apply to their service.






Overview of ratings

Our ratings for this location are:

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

Notes

Substance misuse services

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

Are substance misuse services safe?

Good 

Safe and clean environment

The service was arranged over three floors and was very clean, tidy and well maintained on the day of our visit. Effective systems were in place to ensure any environmental risks were identified and mitigated. The service had a health and safety lead.

A satellite location was used to make services more accessible to clients. This was individually risk assessed.

Staff were present in the reception area at all times and there was a double door system with electronic entry once people had entered the main door, with the internal door access controlled by reception staff.

Staff had a separate entrance, with a sign in/out book.

Clients were met in reception by staff and escorted around the building. An electronic system kept the building secure and staff held swipe fobs. Swipe fobs were numbered and signed in and out by reception staff.

Toilets facilities were available in the reception area, including accessible facilities.

The service had a range of rooms available including large meeting or group rooms, a variety of smaller rooms for one-to-one or keyworker meetings including accessible rooms, toilet facilities on all floors including accessible facilities on the ground floor, kitchen facilities, staff offices, storage rooms and clinical rooms.

Staff followed safety protocols at all times and did not rush people, despite the service being busy, with lots of people around the entrances and in reception throughout the day,

All rooms that clients were seen in had emergency alarms, and there were also portable emergency alarms available, all of which were regularly tested.

The service had up-to-date fire risk assessments, identified and trained fire wardens and a fire lead.

Clinic rooms and medicines storage areas were clean, well ordered and appropriately equipped. Medicines were properly stored, and a good range of clinical and health information was available on the walls.

The service had a well-stocked needle exchange in line with National Institute for Health and Care Excellence guidance for needle and syringe programmes. Information was displayed and available for clients to take away about harm reduction and an extensive range of relevant health matters. The needle exchange policy was easily accessible in the room, and an appropriate process around the disposal of sharps was in place.

Stocks of naloxone were stored in the needle exchange room. Staff checked them regularly to ensure they were in date. Naloxone is a medicine used to reverse the effects of an opiate overdose.

The provider had an appropriate infection prevention and control policy, and infection control and handwashing policy. Each handwashing area had proper facilities and antibacterial hand gel was available.

The provider had arrangements in place for the collection and disposal of clinical waste.

Safe staffing

Substance misuse services

The service has had a high turnover of staff in the past year, with five staff members leaving. This represented a turnover rate of 56%. The service manager interviewed each leaver to ensure this wasn't reflective of something within the service and was assured that it wasn't, as staff were leaving for personal reasons or for internal promotions. However, staffing was on the service's risk register to ensure managers regularly reviewed the situation, and put strategies in place to ensure remaining staff weren't negatively impacted.

Most of the vacancies had been filled, and the service manager was recruiting to the two remaining vacant full-time recovery worker posts at the time of our inspection. To ensure there were enough skilled staff to meet the needs of clients in the meantime, the service had employed an agency worker on a three-month contract and a recovery worker from another location was also providing cover. Staffing was monitored at weekly staff meetings.

The staff group was made up of a service manager who worked half of the week at this location, a full time team leader, one full time and one part time administrator, one doctor and two nurses – one a non-medical prescriber and one alcohol detox nurse - who were all employed by the organisation and split their time across the four hubs, four full time recovery workers, one criminal justice worker, plus one volunteer counsellor, two volunteer family workers, and one volunteer recovery worker.

Staff told us caseloads were stable and manageable. Managers allocated cases dependent on a range of factors including the staff member's background and experience. The team leader held a small caseload to ensure staff were not overloaded.

Lone working protocols which staff were aware of were in place and satellite premises were individually risk assessed to manage client and staff safety.

Staff had completed induction, mandatory training and related compliances, including health and safety, safeguarding and Mental Capacity Act training. Training compliance rate was 93% at the time of our visit. Staff told us they felt the induction and training equipped them to do their jobs properly.

Assessing and managing risk to patients and staff

We reviewed five client care records. All had a completed and up-to-date risk assessment which looked at risk to self and others, physical health, substance misuse and safeguarding concerns including child protection and domestic abuse. The risk assessment tool rated risks to help staff identify which risks were highest priority. Risk assessments were reviewed and updated by staff when appropriate, but quarterly as a minimum.

Staff used the electronic system to highlight clients who required a specific approach, such as staff of a particular gender or being seen by two staff, to manage individual risks.

Staff used recognised assessment tools in line with National Institute for Health and Care Excellence recommendations, such as the alcohol use disorders identification test (AUDIT) and the severity of alcohol dependency questionnaire (SADQ) to assess dependence.

Doctors assessed clients before prescribing detoxification medicines. Staff supported and encouraged clients to attend group work and one-to-one appointments alongside taking their medicines. Staff monitored the physical health of clients undergoing detoxification.

Staff supported clients so they were aware of the risks of continued substance misuse. Harm minimisation information was delivered as part of all initial assessments, treatment interventions and in clients' recovery plans.

Clients prescribed opiate substitutes were given lockable boxes to store medicines, to reduce the risk of carers or children taking this medicine.

Staff referred clients to their GP for ongoing physical health monitoring. The service had links with health trainers, who would provide lifestyle improvement information and support, such as smoking cessation and healthy diets.

Staff discussed warning signs and any deterioration in clients' health during weekly team meetings, agreeing actions to respond appropriately.

The service had a generic disengagement policy and protocol which outlined the process staff should follow when clients unexpectedly exited from service. Clients also had an individual disengagement plan, which contained information such as who to contact and people's preferred strategies for managing relapse.

Substance misuse services

The service had a clear zero tolerance policy to aggression to manage client and staff safety. This was detailed in the client engagement agreement and there were signs in the reception and corridors.

Safeguarding

The service had a clear safeguarding policy and protocol which staff are aware of. These were available on the staff intranet, and paper copies were on display in the staff office and in the reception area.

Staff received basic safeguarding training as part of their induction. Additional training which looked in depth at various types of safeguarding issues was undertaken on an ongoing basis. The compliance rate of safeguarding training was 100%. Staff we spoke with were confident of how to spot safeguarding concerns and what to do about them.

A large safeguarding board was on the wall in the staff office. This had lots of information relating to safeguarding issues, including a flowchart, definitions of safeguarding categories and relevant contact details.

Staff made referrals to the local authority as appropriate and monitored these as per the provider policy.

The service had a safeguarding lead who met quarterly with the regional safeguarding lead and leads from other hubs within the region.

Safeguarding was an agenda item in the weekly team meeting, the quarterly clinical meeting and the organisation's quarterly governance meeting where any learning was shared.

Managers cascaded learning from safeguarding concerns and enquiries to staff via staff meetings and one to one supervision.

The service had good links with the local children's and adult's safeguarding teams.

Staff access to essential information

Staff stored essential information concerning clients on electronic case management system. Paper documents were scanned and uploaded to the system and the paper copies destroyed.

All staff had their own unique multiple password protected access to the systems. Each staff member had their own laptop, and there were additional desktop computers available in the staff offices.

All policies, procedures and other organisation documents were stored on a shared drive which staff had access to. In addition, copies of many of the policies were displayed in staff offices, the reception area and around the building.

Medicines management

Staff managed medicines, including dispensing, administration, reconciliation, recording and disposal, in line with National Institute for Health and Care Excellence guidance.

The service had effective policies and procedures relating to medicines management, of which paper copies were available in the clinic and needle exchange rooms. Records were clear and up to date.

Storage areas, the clinic and needle exchange rooms were clean, tidy and appropriately maintained. Staff monitored room and fridge temperatures appropriately.

Staff were trained in administering medicines and signed off as competent by a manager before being allowed to administer medicines alone.

Monthly clinical audits were carried out by the hub nurses and action plans taken to monthly clinical meetings for discussion. The clinical audits cover a number of areas such as cold chain process (which is to ensure that vaccines are stored and transported within recommended temperature ranges) and infection control measures. In addition, a more in-depth MAT (medically assisted treatment) audit and case management audit was completed annually.

All clients were offered Naloxone, which is a medicine used to reverse the effects of opiate overdose, and supplies were available in the needle exchange room.

Track record on safety

The service had reported three incidents that met their serious incident criteria in the 12 months prior to our inspection. These were related to deaths of clients. The service manager informed us that all deaths are subject to a full root cause analysis, and records showed that a review meeting is held by managers to see if lessons could be learned following the death of a client.

Substance misuse services

Reporting incidents and learning from when things go wrong

The service had a clear incident policy which staff were aware of. Incidents were reported using the electronic system, which was newly introduced and facilitated closer regional management, investigation and analysis of incidents.

All staff we spoke with knew what types of incidents to report and how to report them.

Records showed that incidents were appropriately managed, and learning undertaken where possible.

Incidents were an agenda item in the weekly team meeting, the quarterly clinical meeting and in the organisation's quarterly governance meeting.

Managers cascaded learning from incidents to staff via staff meetings and one to one supervision. Individual hubs shared learning from incidents in the regional governance meetings.

The service had an appropriate duty of candour policy which staff understood. This meant they were open and transparent, and gave people using the service and families an apology and a full explanation if something went wrong. Copies of the policy were displayed in the reception area, staff offices and around the building.

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

Good 

Assessment of needs and planning of care

All clients received a comprehensive assessment on admission to the service. The assessment covered topics including physical and mental health, relationships, and substance misuse history.

We reviewed five care and support records during our inspection. All records were clear and well completed. They were reviewed regularly and included a recovery plan.

All records recorded consent from clients to care and treatment.

All clients we spoke with told us they had been actively involved in their care and treatment planning and all decision making. This was recorded in the clients' records.

Best practice in treatment and care

Staff offered a range of care and treatment interventions suitable for the client group. The records detailed interventions and practice in line with National Institute for Health and Care Excellence guidance. Treatment offered included brief advice and information, or more structured clinical and group interventions. Interventions included one-to-one key working appointments, mindfulness sessions, harm reduction groups and fellowship meetings.

Staff used a range of recognised tools in risk and care assessments.

Medicines management including dispensing, administration, reconciliation, recording and disposal was all undertaken in line with National Institute for Health and Care Excellence guidance.

Staff always offered blood borne virus testing during assessments.

A qualified counsellor provided therapy for clients who needed it.

The service engaged with health trainers who supported patients to live healthier lives – for example, through participation in initiatives such as smoking cessation schemes or providing healthy eating advice.

The service offered advice and information in the reception area about a range of health and well-being matters. It also detailed any specific local drug alerts, and on the day of our inspection there was a notice in the reception area about a dangerous batch of a particular drug on the local streets. A wide range of other information was available such as advice for people who may be subject to domestic abuse, missing persons organisations, flu jabs, debt advice, counselling and help for victims of sexual assault.

The service had copies of a directory of local support services available in the reception area for people to take away.

The service provided naloxone to opiate using clients and trained them how to use it safely. Naloxone is a medicine used to rapidly reverse the effects of an opiate overdose.

Substance misuse services

Staff provided clients with lockable boxes to store medicines, to reduce the risk of carers or children taking this medicine.

Skilled staff to deliver care

All staff received an appropriate induction and ongoing training, which they told us what very effective and equipped them for their roles.

Training was at 94% compliance and the shortfall is accounted for by staff who are still in their induction period, and were booked on any courses that were outstanding.

The organisation had a learning and development team who were responsible for coordinating training and for sourcing specialist training. The learning and development manager visited the site and attended team meetings to work with service staff to identify learning needs. Managers also used supervision to identify learning needs.

Examples of specialist training provided were suicide awareness, hepatitis C awareness and alcohol awareness.

Staff were provided with opportunities to develop their skills and knowledge where possible. A budget was available for specialist training which staff could apply for. Dependent on the type of training requested funding was provided in full or in part.

Volunteers received training and support relevant to their role.

All staff, including volunteers, received regular supervision appropriate to their role. Additional clinical supervision was provided by an external professional, and all staff had access to monthly group supervision provided by an external supervisor. All staff had annual appraisals. At the time of our inspection 100% of staff supervision and appraisals had been completed.

Issues around staff performance were addressed promptly and effectively, with support available from the human resources department for managers.

Multi-disciplinary and inter-agency team work

The service held weekly multidisciplinary clinical team meetings. The multidisciplinary team was made up of the doctor, nurse/non-medical prescriber and the detox nurse, (all of whom were employed full time by the organisation and shared between the four hubs) the service manager,

team leader, recovery workers, criminal justice worker, admin staff and volunteers. This meeting would cover a range of subjects including client reviews, safeguarding, incidents, complaints and staffing.

Effective protocols were in place for the shared care of clients and staff had good links with a wide range of other stakeholders and professionals. This included GPs, local mental health professionals, probation officers, housing professionals, homeless organisations, the police, ambulance services, children's and adult's safeguarding teams and the crime safety unit.

The service manager also attended other meetings within the community, such as regular meetings with local GP surgeries to look at clients who frequently attended the surgery or called ambulances.

The service had a MARAC (multi agency risk assessment conference) lead who would attend local MARAC meetings to discuss clients and review client deaths on a multi-agency level.

The service had leads for a wide range of areas, such as safeguarding, health and safety, and fire safety. Each lead linked with services and organisations relevant to their lead area.

Good practice in applying the MCA

Staff we spoke with were aware of the service's mental capacity policy. There were signs in staff offices, and other locations around the building, detailing the five principles of the Mental Capacity Act.

All staff received training in the Mental Capacity Act as part of their induction and regular refreshers thereafter. At the time of our inspection, compliance with Mental Capacity Act training was 100%.

Staff we spoke with were able to outline their responsibilities around the Mental Capacity Act and understood how the Act could apply to their service.

Staff ensured that clients consented to care and treatment and that options were discussed.

Substance misuse services

Are substance misuse services caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

During our inspection we saw staff consistently interacting with clients in a kind, respectful and non-judgemental way. We also saw staff discussing clients appropriately and respectfully in a confidential setting.

Staff provided information to clients about the prevention of drug and alcohol related harm in their assessments and during one-to-one meetings. There was also a wide range of information on the walls in the reception and around the building, informing people about health advice, support services, how to protect themselves and drug alerts.

On our visit we saw staff protecting people's privacy and dignity during testing and assessments.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fearing negative consequences. One staff member said an issue they raised with the service manager was dealt with quickly and effectively.

The organisation provided a range of financial and health scheme benefits to staff, including a therapy allowance.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Information about these was available on noticeboards in the staff offices. Staff maintained the confidentiality of information about patients. At the beginning of a family support group, we saw the facilitator remind attendees of the anonymity statement to ensure all family member's confidentiality was respected.

Involvement in care

Staff supported clients to understand and manage their care and treatment. Clients told us staff explained options around treatment, and encouraged them to make decisions about their recovery without telling them what to do.

Each client had a recovery plan and risk management plan that demonstrated the person's involvement in their own recovery. However not every record we viewed evidenced that clients had been offered a copy of their care plan.

The service empowered and supported access to appropriate advocacy for people who use services their families and carers. Advocacy services available included a general advocacy services, and also services specialising in supporting with issues relating to human rights and equality, and in advocating for people with a learning disability. There were posters explaining how to access advocacy in the reception area and around the building.

Clients could comment or make suggestions about the service in one-to-one meetings or by using the suggestions box in reception.

A 'You Said We Did' board was in reception, outlining changes made following client suggestions and feedback. Examples of these changes were introduction of late-night opening for clients who were unable to access the service during working hours, and changes to the allocations system to ensure people's key worker didn't change unnecessarily.

A bi-annual client magazine was issued. Any client could submit a story or piece for inclusion in the magazine.

A peer led recovery network, Reach Out and Recover (ROAR), was in place and provided an opportunity for clients to share experiences and support each other.

The service manager held regular drop in surgeries where people could speak to her personally about any issues. These were well advertised in the reception area.

Surveys were circulated to clients on a regular basis and were usually focused on a specific area of the service, such as the effectiveness of care pathways.

Involvement of families and carers

Carers and families were fully involved in clients' care if clients gave permission.

In response to a high volume of requests for support from family members the service recruited and trained two volunteer family support workers, who provided support and advice to families and carers.

Substance misuse services

A carer/family recovery support group was held regularly. Family members who attended the group told us it was invaluable in providing support and helping them develop coping mechanisms in a non-judgemental setting.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good 

Access and discharge

The service was commissioned to provide services to people who lived in East Kent. The service accepted referrals from agencies and professionals including GPs, social services, hospitals, local counselling services prisons and probation. People could also self-refer.

The service operated a daily drop-in service, so people could have an immediate chat with a staff member and request a full assessment.

The average wait time for a full assessment was just over 15 days. Referrals were reviewed and prioritised by the team leader, so wait times for people with urgent needs would be much less, often the same day. People who were unable to accept the first available appointment were also included in this figure, increasing the average time.

People whose wait time was longer were offered access to Break Free On-line - a digital recovery programme which provided support whilst they waited for a full assessment.

Staff, including the medical team, saw clients in a range of settings, including home visits where appropriate, to reduce barriers to treatment.

Staff showed a good understanding of the local demographic and sought to reduce specific barriers. This included offering appointments in the evenings due to the high volume of clients in full time work, and employing a Nepalese recovery worker when it was identified that people from this community were not accessing services.

Managers had regular monitoring meetings with the commissioners and stakeholders involved in the service to review performance.

Recovery and risk management plans reflected the needs of the client including clear pathways to other supporting services, such as GPs, the local authority, mental health teams, careers advice services and the housing department.

Discharge planning began when clients entered treatment, and was an ongoing discussion during individual and group meetings. This included identification of risks and plans to manage these and planning for practical needs such as housing, training and preparing for work.

All of the care records we reviewed contained a plan for unexpected exit from treatment. This contained information such as who to contact and people's preferred strategies for managing relapse.

Clients who were not successfully re-engaged following an unexpected exit from treatment were referred to the team leader, who would decide whether enough attempts to re-engage had been made or whether additional attempts should be made. Only the team leader had the authority to discharge someone from treatment. This meant there was proper oversight of people leaving the service and consistency of efforts to re-engage clients across the service.

The facilities promote recovery, comfort, dignity and confidentiality

All group and one-to-one rooms were clean and comfortably furnished. Rooms were soundproof, and afforded dignity and confidentiality for one-to-one discussions.

The reception area was large, bright and always staffed. There was plenty of comfortable seating, a water cooler and toilet facilities, including accessible toilets.

Patients' engagement with the wider community

Where appropriate staff ensured that clients had access to education, training and work opportunities. The service linked with a provider who supported clients in areas such as curriculum vitae writing and computer skills. The service had previously trialled having someone come in to deliver group sessions, but these were not utilised, so the service reverted to referring people individually as they needed it.

Substance misuse services

The reception area had a good range of information leaflets and posters about support groups, education, volunteering and work opportunities and well-being activities such as yoga and mindfulness.

Clients were signposted to mutual aid and support groups, such as 12-steps, in the local community.

Meeting the needs of all people who use the service

All staff were trained in equality and diversity, and understood the potential issues facing vulnerable groups, such as the LGBTQ+ community, minority ethnic groups, older people, people experiencing domestic abuse and sex workers.

Services were offered flexibly in terms of times – as the service operated a late night opening one night per week, and location - as staff could make home visits if needed. Clinics were also offered in a satellite location for easier access.

There was disability access to the service and accessible toilet facilities were available.

Interpreters could be accessed if necessary.

Handouts and leaflets are available in easy read or illustrated for people with literacy needs.

There was a hearing loop for hearing impaired clients in reception, which could be moved around the building if needed.

Peer mentors with lived experience of substance misuse were available to provide support if needed.

The hepatitis lead engaged with the Hepatitis Trust, establishing a protocol for joint working which enabled hepatitis nurses to reach a greater number of people affected by the condition and increase treatment rates.

The service had links with the National Careers Service, so that at an appropriate point in their recovery clients could access support with work opportunities, CV writing and interview techniques. Specialist assistance could be provided for people with a criminal justice background.

Clients requiring intensive support were given packs with workbooks, which had been designed in line with best practice guidelines, and access to Break Free On-line, a digital recovery programme which provided support and assisted therapy to increase the likelihood of successful recovery.

Staff told us groups and one to one meetings were never cancelled due to staff shortages.

Listening to and learning from concerns and complaints

The service had a complaints policy which was explained to clients at point of engagement. A new electronic system was recently introduced which facilitated closer regional management, investigation and analysis of complaints.

A comments box and feedback forms were positioned in the waiting area. Posters were displayed inviting feedback of a client or carers' experience of the service.

The service manager held drop in 'surgeries', which were widely advertised, where clients could drop in for a chat about anything they wished to discuss.

Clients told us they knew how to make complaints, raise concerns and provide feedback to the service. Staff viewed complaints positively, as an opportunity for improvement.

Where possible, complaints were managed at a local level, but were escalated appropriately if necessary. If the complaint concerned a specific staff member the assistance of the human resources department was available to provide support.

In the twelve months prior to this inspection, the service had five complaints, three of which were upheld, and 36 compliments. Many of the compliments related to staff.

Learning from complaints was cascaded to staff via staff meetings and one to one supervision. Individual hubs shared learning in the regional governance meetings.

Are substance misuse services well-led?

Good 

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Service leaders had a good working relationship, and worked together effectively to ensure the service was safe and well-led. The service manager had recently attended leadership training.

The organisation had a clear definition of recovery and this was shared and understood by staff we spoke with.

Substance misuse services

The manager and team leader had a good understanding of the services they managed and had clear insight into what was going on at any time. They could explain clearly and confidently how the teams were working to provide high quality care.

Staff we spoke with knew who the managers in the service and the organisation were, and said they were approachable and supportive. Senior managers visited the service regularly.

Vision and strategy

Staff knew and understood the vision and values of the team and organisation, and understood their role in achieving that.

Staff had the opportunity to contribute to discussions about the strategy for their service.

Staff could explain how they were working to deliver high quality care within the budgets available. The service manager told us budgets were discussed regularly across the regional management team.

A copy of the vision and values was displayed in the reception area.

Culture

Staff told us that they felt valued and respected by managers and each other, and the culture of the service was supportive and positive.

Staff told us they were proud of the service and the work it did.

Staff appraisals included conversations about career development and how it could be supported.

All staff we spoke with knew how to use the provider's whistle-blowing process and felt they could raise concerns without fear of victimisation. One staff member told us about an issue they had raised and said it was dealt with effectively and quickly.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Governance

There were effective governance policies, procedures and protocols, which were regularly reviewed. The service manager used the risk register and the service improvement plan effectively to monitor the service.

The service manager had enough authority to do their job and had access to admin support.

The service used a range of key performance indicators set by their commissioners to gauge performance and productivity. These included treatment outcomes, incomplete treatment episodes and referral numbers.

There was a clear framework of meetings within the organisation that ensured that there was proper accountability, and facilitated appropriate sharing of learning and good practice across the organisation and services.

Staff had implemented changes as a result of learning from reviews of deaths, incidents, complaints and safeguardings.

Data and notifications were appropriately submitted to external bodies and internal departments as required.

Staff understood the arrangements for working with other teams, both internally and externally, to ensure the needs of clients were met.

The service had a whistle blowing policy in place and posters in staff offices about this.

Management of risk, issues and performance

There was clear quality assurance management and performance frameworks were in place. The service manager cascaded information to staff in team meetings, and to senior managers in quarterly governance meetings.

The service maintained a risk register which was rag rated to identify the level of each risk. The manager reviewed the risk register regularly.

Staff were able to submit items to the risk register as necessary.

Information management

Staff had access to the equipment they needed to do their job, and all had a laptop issued to them. There were also plenty of desktop computers in staff offices.

Managers and staff had oversight of dashboards to monitor caseload, risk, recovery plans and clients' care and treatment.

Managers had access to information to support them with their role. This included information about the performance of the service.

Substance misuse services

All information was secured with multiple passwords and an effective information governance policy, which staff were aware of, and which was displayed on the walls in the clinic rooms and staff office.

Engagement

Staff, clients and carers had access to up-to-date information about the work of the provider and the services they used, such as through the intranet, information leaflets and a monthly bulletin.

Patients and carers had opportunities to give feedback on the service in a variety of ways to accommodate different needs.

Leaders engaged with external stakeholders – such as commissioners, the local authority, the police, GP surgeries, probation services and homelessness organisations. Staff also attended a range of external meetings including multi agency risk assessments conferences (MARACs), Crime Safety Unit meetings and community mental health teams.

Learning, continuous improvement and innovation

A clear framework of meetings was in place which facilitated sharing of learning from incidents, complaints and safeguardings across the organisation.

Staff met regularly with external stakeholders including local ambulance service, hospitals, and commissioners to review all drug and alcohol related deaths to identify learnings, trends and opportunities to reduce these incidents.

The organisation analysed internal client surveys covering areas such as early treatment exits, opiate overdose reversal medicine (naloxone) effectiveness, and clients with 15 years or more treatment history.

Meeting minutes showed that the organisation welcomed feedback from other professionals and used it to make improvements.

Innovative new opiate pathways and an alcohol detox programme were being trialled by the organisation. These were developed by the research and development team in conjunction with managers, in accordance with best practice guidelines and were being monitored for effectiveness.

Outstanding practice and areas for improvement

Outstanding practice

Staff showed a good understanding of the local demographic and worked hard to reduce specific local barriers. An example of this was employing a recovery

worker who spoke Nepalese when it was identified that people from this community were not accessing services. This was a clear example of a service going the extra mile for all people using services.

Areas for improvement

Action the provider **SHOULD** take to improve

The provider should ensure that it is recorded when clients are offered a copy of their care plan.