Lifeline York Integrated Recovery Service

Quality Report

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

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

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

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

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

Overall summary

We found following areas of good practice:

- The service had ensured that arrangements were in place to cover staff sickness and leave. This was important, as the criminal justice system required some clients to attend the service on a daily basis.
- Staff had a good understanding of safeguarding procedures and knew how and when to make a referral to the local authority safeguarding team. Each team prepared weekly safeguarding information for the team leaders to action.
- Staff had a clear awareness of best practice in treatment and care and used evidence based therapies and interventions to support their clients.
- Clients were actively involved in the planning of their care. Staff used mapping techniques, which enabled clients to identify their recovery capital. The use of mapping tools directly involved clients in their care. Recovery workers used a similar approach to engage and assess young people.
- The service had a clear policy on confidentiality and revisited consent to share information every three

Summary of findings

months. Staff recognised that clients might change their minds about whom they wanted to share information with as they progressed through treatment.

- Staff provided a late night service twice a week for clients who could not make daytime appointments. Clients could contact staff either by telephone or sit and wait for an unscheduled appointment if the need arose.
- The service had clear governance structures in place. Staff carried out a series of clinical and performance related audits throughout the year. This meant the service manager received information on performance that supported the development of the service.
- The service manager reviewed complaints and incidents in order to learn from them. Negative feedback from clients led to an apology and action to improve the services performance.

We also found the following areas that the provider needs to improve:

- Mandatory training was minimal and some staff lacked in-depth knowledge in key areas of psychosocial interventions. This could affect the care and treatment provided to the client. The provider has acknowledged the lack of core skills training available to staff and was developing training plans to remedy this.
- Some clinical equipment had passed its expiry date. For example, urine test strips, alcohol wipes, saline, eyewash and blood collection bottles. Out of date urine test strips have the potential to affect drug test results, which could impact on decisions made by social services and the treatment provided by the service.
- Staff did not keep the medicines fridge locked, as they did not know where the key to lock it was. They had not reviewed the security around the storage of medication but accepted that the key was missing.
- Risk assessment and risk management plans showed that staff awareness about how to mitigate risks and document them was variable. This meant that staff might not provide appropriate harm reduction advice or manage the risks in a safe manner.
- Staff did not always record electronically if their clients had given consent to share information. This had the potential to lead to a breach of confidentiality.

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Background to Lifeline York Integrated Recovery Service

Lifeline York Integrated Recovery Service is a drug and alcohol treatment service for people with substance misuse issues who are resident in York. The service is provided by the Lifeline Project and has a registered manager.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

Lifeline York Integrated Recovery Service works with people in the community and those involved with the criminal justice system. The service accepts self-referrals and referrals from external agencies such as the probation service. There are 746 clients currently registered with the service and staff see approximately 300 clients each week.

The clinical team provides a prescribing service for alcohol detoxification and opioid substitution therapy, with clinics held twice daily. Opioid substitute therapy is a medical treatment that seeks to reduce the use of illicit opioid drugs. It replaces an illegal opioid, such as heroin, with a prescribed opioid such as methadone or buprenorphine. In addition, the team provides screening for blood borne viruses and basic wound care.

The team comprises of a clinical lead, non-medical prescribing nurses, a health improvement nurse and sessional GP's. Clients engaged with clinical prescribing have a named recovery worker who supports them with psychosocial interventions. Psychosocial interventions are talking therapies that aim to encourage a self-reflective approach to a person's behaviour and support people who are affected by drug and alcohol use.

In October 2015, a service restructure introduced four psychosocial teams; Inspire, Change, Empower and Young People. Each team has a team leader, a senior worker, recovery workers and support from the clinical team. In addition, an administrative team supports the whole service.

Inspire team supports clients who have a recent history of substance misuse and high recovery capital. Recovery capital is the resources that are necessary to achieve recovery from addiction, for example, housing, relationships, mental and physical health, personal beliefs and skills. Clients have access to a range of group therapy sessions and one to one intervention. This team leader also managed the young people's service.

Change team works with those clients who have a history of substance misuse of more than one year and less recovery capital. Their clients also have access to group therapy sessions as well as one to one interventions.

Empower team supports clients who have a long history of substance misuse through one to one psychosocial interventions.

The young people's service is outreach based and is for clients aged up to 18 years. Clients could remain with the young people's service up to the age of 25 years, depending on individual need. The service works alongside schools and the youth offending teams.

The service also provides a discrete needle exchange programme. Clients could exchange used hypodermic syringes for sterile ones. Needle exchanges are designed to decrease the spread of diseases (like HIV and hepatitis C) that are transmitted by the sharing of contaminated needles and injecting paraphernalia.

The Care Quality Commission has not previously inspected the service.

Our inspection team

Team leader: Jacqui Holmes, Care Quality Commission.

The team that inspected Lifeline York Integrated Recovery Service comprised four CQC inspectors and a lead advance nurse practitioner in substance misuse.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive substance misuse inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Looked at the quality of the service environment and observed how staff were caring for clients.
- Spoke with nine clients who were using the service.
- Spoke with the service manager.
- Spoke with 14 other staff members including the clinical lead, nurses, team leaders and recovery workers.
- Attended and observed two client group sessions.
- Visited a school with a member of the young person's team and observed one to one sessions and a group session for children aged 12 to 13 years.
- Looked at 16 care and treatment records.
- Looked at the process for generating prescriptions for opiate substitute medications.
- Looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with nine clients in total. Eight of the clients were complimentary about the service, one client less so as they were required to attend the service by the magistrates court. Clients praised the support they received from attending the group sessions. One client said that the group sessions helped keep them balanced.

Clients spoke highly about their relationship with their recovery worker and appreciated the efforts they made on their behalf. Clients were made to feel at ease from the start of treatment and given help and support with their family situation, mental and physical health needs and housing.

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 found the following issues that the provider needs to improve:

- Mandatory training was minimal and some staff lacked in depth knowledge in key areas of psychosocial interventions.
- We observed out of date equipment in the clinic rooms, which if used had the potential to affect drug-testing results.
- Staff did not keep the medicines fridge in the clinic room locked, as they did not know where the key was.
- Risk assessment and risk management plans showed that staff awareness about how to mitigate risks and document them was variable.

However, we also found the following areas of good practice:

- The service had ensured that arrangements were in place to cover staff sickness and leave.
- Staff had a good understood of safeguarding procedures and knew how and when to make a referral to the local authority safeguarding team.
- Staff knew how to report incidents. The service investigated all incidents and shared lessons learned with the team to prevent the same incidents happening again.
- Staff issued clients on a prescription with a lockable box in which to store their medication.

Are services effective?

We found the following areas of good practice:

- Staff considered their clients recovery capital from the start of the assessment.
- Where appropriate, clients received physical health assessments along with a comprehensive assessment.
- Staff adapted their assessment techniques when dealing with young persons.
- Staff offered evidence based interventions and therapies in line with best practice in treatment and care.
- Clinical audits informed and lead to improvements in practice.

Are services caring?

We found the following areas of good practice:

- Clients described staff as friendly, approachable and supportive.

Summary of this inspection

- Clients were actively involved in the planning of their care. Staff used ITEP mapping techniques, which enabled clients to identify their recovery capital.
- Some clients were training to become facilitators for mutual aid groups.

Are services responsive?

We found the following areas of good practice:

- Nurses made time at the end of each clinic to see those clients who were late or had missed for their appointment.
- Re-referrals of young people were low.
- The service had a clear policy on confidentiality and revisited consent to share information every three months.
- Staff provided a late night service twice a week for clients who could not make daytime appointments.
- The service had a clear protocol, with time constraints for dealing with complaints.

Are services well-led?

We found the following areas of good practice:

- The service had clear governance structures in place. Managers received information on performance that supported the development of the service.
- All staff received regular supervision and yearly appraisals in line with organisational policy
- The service manager reviewed complaints and incidents in order to learn from them. Negative feedback from clients led to an apology and action to improve the services performance.
- Staff were positive about the service they provided and job satisfaction was high.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had undergone Mental Capacity Act training in the two weeks prior to our inspection. Staff had an understanding of the basic principles of mental capacity.

If staff thought that a client did not have the capacity to make informed decisions, they would make a referral to the client's GP for an assessment.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

We found the environment to be safe and clean. All interview rooms and group rooms were fitted with alarms. The service had up to date health and safety and fire risk assessments. All portable electrical equipment met safety regulation standards. Clients said they felt safe accessing the service. Staff handled incidents well and were quick to respond when situations arose.

The clinic room had the necessary equipment to carry out physical examinations. There was emergency equipment onsite, for example, facemasks, naloxone and adrenaline. Some of the equipment was out of date such as urine test strips, alcohol wipes, saline, eyewash and blood collection bottles. Nurses monitored the pharmacy fridge temperature daily to make sure medicines were stored at the correct temperature. However, nurses did not lock the pharmacy fridge, as they did not know where the key was. They had not reviewed the security around the storage of medication or identified any subsequent risk because of the missing key.

The service had arrangements in place for the safe management and disposal of clinical waste. However, nurses had not signed and dated sharps boxes when assembling them in line with good practice.

The service offered a discrete needle exchange provision, which clients could access during their one to one session with their recovery worker.

Safe staffing

The clinical team comprised of five qualified nurses; three of whom were non-medical prescribers. The organisation's clinical director and two GPs supported them. A student nurse was also on placement with the service.

The service had 25 staff providing psychosocial interventions and four support staff. Seven volunteer counsellors complemented this and attended the late evening sessions, which took place two nights a week.

Vacancy levels in the last 12 months were 25%. However, several staff had moved to take up new posts within lifeline at different locations. The service had recruited to all vacancies at the time of our inspection. The minimum daily staffing level for the service was 50% of the total staffing complement.

Sickness levels for staff averaged 9% over the last 12 months, with no staff absent long term.

Team leaders ensured that cover arrangements were in place for sickness and leave. This was particularly important for those clients who had to attend daily as they were subject to a drug rehabilitation requirement (DRR) or were high risk. A DRR is a community based court sentence up to a maximum of six months.

All staff had completed a basic level safeguarding children e-learning module. This was the only mandatory training requirement. New staff attended health and safety awareness training as part of their induction. Nurses received annual basic life support training. The Federation of Drugs and Alcohol Professionals (FDAP) recommend key areas of learning to underpin the treatment and support provided to substance misuse clients. FDAP mapped these key areas against the Drug and Alcohol National Occupational Standards. A self-audit of training undertaken by staff highlighted gaps in knowledge in key areas. For example, cognitive behavioural therapy, brief solution focused therapy and relapse prevention. This meant that not all recovery workers had the necessary knowledge and skills to provide certain interventions safely. The provider

for this service acknowledged the lack of core training available to those staff delivering psychosocial interventions and had plans in place to introduce a structured training programme.

The service had a safety protocol requiring two staff to be present when seeing clients who staff had assessed as high risk. The duty officer monitored staff movements for those staff working with clients at different locations such as schools.

Assessing and managing risk to patients and staff

Staff undertook a risk assessment of every client at their initial appointment. Lifeline policy states that staff should review clients' risk assessments every three months or sooner if the risk level changes. We looked at 14 client risk assessments, out of these only one was not up to date. The risk assessment tool used was comprehensive. It included offending behaviour, safeguarding children, physical health, poly-drug use, injecting history, relationships and domestic violence.

Risk assessments included a management plan to mitigate identified risks in most cases. However, these were not always clear and the effectiveness of the plan was very much dependent on staff awareness of risk. For example, a client had two children regularly staying at his home. The recovery worker had recorded how the client managed his drug taking behaviour during this period in the client's case notes. However, this information had not been included in the risk management plan. Any colleague working with this client in the future would not know this information unless they read all the previous case notes.

Harm reduction advice was evident throughout keyworker notes. Harm reduction advice looks at practical ways to keep a client safe and reduce the risk associated with using specific drugs and alcohol. One example was a young person who was contemplating using substances other than cannabis. The recovery worker looked at the drug box with them, highlighting the different types of risks for the range of drugs in the box.

The service provided a discrete needle exchange. Clients who shared any type of injecting equipment were at risk of contracting blood borne viruses. Accessing a needle exchange for clean equipment helped reduce this risk and gave staff the opportunity to give harm reduction advice.

Prescription records were stored securely with nurses logging and signing for them at the beginning of the week. This meant staff accounted for all blank prescriptions providing a clear audit trail. The clinical team did not provide a dispensing service onsite. Staff arranged for their clients to collect their medication from their preferred pharmacy. The service had recently added a reminder to their prescriptions, requesting pharmacy staff to contact the service when a client missed collecting his medication for three days. This was because of the increased risk of overdose due to reduced tolerance levels after this period.

Staff issued all clients on a prescription with a lockable box in which to store their medication as a safety measure. Medication such as methadone can cause accidental poisoning if taken by other people, especially children.

Nurses reduced the risk of diversion by prescribing supervised consumption, when appropriate, for those clients on opioid substitute treatment (OST). Pharmacy staff were required to watch these clients take their medication. This made it difficult for the client to transfer any legally prescribed controlled substance to another person for illicit use. Only clients with a direct connection to the York area were prescribed OST, reducing the possibility of double dosing. This happens when a client seeks prescriptions for a controlled drug from two different sources.

The service had a protocol in place for managing risks between clients who used the service. Staff offered clients appointments at different times to avoid such meetings. If necessary, clients could use a different exit from the building.

Lifeline had clear processes in place for reporting safeguarding concerns. Staff had a good understanding of procedures and were confident in applying their organisation's policy, giving examples of safeguarding referrals they had made. Key workers completed weekly safeguarding sheets for consideration by their safeguarding leads. This could lead to a safeguarding or child protection plan, depending on the level of need. Staff told us they had good relationships with social services and that the referral process was straightforward and easy to follow up. All staff received basic safeguarding children training. Staff did not receive any safeguarding adults training. Despite this staff had a good understanding of the types and effects of abuse on adults, particularly in relation to older people. We saw from managers' team minutes that clinical staff would be

receiving safeguarding adults training in the near future. From the records we looked at, it was the key worker rather than the nurse who recognised and initiated the safeguarding referrals. If staff were worried about a client whom they felt was particularly vulnerable, they could request that the police carried out a welfare check on their client.

Track record on safety

In the last 12 months, 11 clients that used the service had died. More recently, there had been an incident where a client had brought a weapon into the service. All reports of incidents and client deaths were reviewed by the organisation's clinical governance lead, and serious incidents and deaths were investigated using root cause analysis or similar methodology. Root cause analysis is a method of problem solving used for identifying the root causes of faults or problems. Investigations in to the death of a client would focus on known risks, the levels of engagement and the cause of death. Following an investigation, the service manager would provide feedback to staff any learning points arising.

Reporting incidents and learning from when things go wrong

All staff knew what constituted an incident and how to report it. Staff had reported 51 incidents in the last six months. These fell into 13 different categories and ranged from equipment failure to client death. We looked at two specific incidents involving violence and aggression and found that staff had followed procedure and dealt with them appropriately. Staff received feedback from incidents in team meetings and supervision. Following the recent serious incident, the service manager and team leaders debriefed and offered support to their staff.

Staff did not receive feedback from incidents that occurred elsewhere within the organisation. However, the organisation did inform staff about any changes to working practice resulting from lessons learnt either by emails or in team meetings.

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

Assessment of needs and planning of care

The service received referrals from a variety of sources including probation, social services, GPs and self-referrals. Each client attended a comprehensive assessment with a recovery worker, following the initial referral. During the initial referral appointment, staff asked their clients some basic physical health questions. They linked these to their client's history of problematic substance use to rate their physical health needs as a red, amber or green rating. All clients rated red or amber were then booked in for a physical health assessment with the health improvement nurse as well as their comprehensive assessment. Physical health issues associated with substance misuse include deep vein thrombosis, hepatitis C, HIV, leg ulcers, lack of GP/dentist, endocarditis, alcohol related liver disease and diabetes.

We looked at 14 care records and saw that staff carried out comprehensive and timely assessments. The service had recently changed the in house assessment tool they used. This meant there was limited detail available for those clients in the Empower team as staff had filed the original assessment records.

The new assessment paperwork considered recovery capital from the start of the assessment. Recovery capital looks at the resources an individual had available to them and was strength based. It included a recovery matrix that guided staff as to which team would benefit the client best. For example, clients with limited recovery capital would require more one to one support than someone who had a job, housing and family support.

There was an initial generic care plan completed on assessment, which included engagement plans, appointments and positive community engagement. When clients attended their first appointment with their recovery worker, they updated the initial generic care plan to a personal care plan. This was present in all the records we looked at. The care plan looked at strengths, how clients would know when they no longer needed treatment and how the client would achieve their goal. All clients' care plans were individual and holistic. However, staff did not always record the intervention plans in sufficient detail. Six of the fourteen care plans were lacked detail as to how clients would achieve their goals.

Staff used mapping techniques to engage young people in a dialogue to assess their needs effectively. This technique involves using a series of visual, personal maps to

represent the clients' thoughts and helps clients discuss their issues honestly, and improves engagement and motivation. All young people met the goals they had agreed on their care plan at the time they exited treatment.

Care plans in the Empower team included re-engagement plans for clients who had missed their appointments. These detailed how staff would try to contact the person. Staff had sent follow up letters to contacts and/or contacted pharmacies to reach their clients. It was unclear how long these re-engagement plans would be followed without further action. All one to one case notes were detailed and personalised. We saw referrals for domestic violence support and referrals for counselling following sexual exploitation.

The clinical team provided an active screening and vaccination programme. Staff offered this to those clients they believed to be at risk of contracting blood borne viruses. The clinical director authorised patient group directives, which allowed nurses to administer a course of vaccinations to protect their clients. York did not have a treatment pathway for hepatitis C or HIV, so nurses referred their clients to services in Leeds, accompanying them to their first appointment if necessary.

The recovery worker identified any mental health needs and made appropriate referrals to the single point of access as they built up a relationship with their client.

Recovery workers used the Alcohol Use Disorders Identification Test (AUDIT) to assess if their client had a problem with alcohol dependence. They assessed all clients who identified alcohol as their primary or secondary drug of choice. Any client who scored above 20 using AUDIT then completed the Severity of Alcohol Dependence Questionnaire. This allowed workers to offer the right type of interventions to their clients.

Team leaders checked on 10% of their staff's work using a compliance tool. The compliance tool looked at risk management, sub interventions, diagnostic screening, consents, waiting times, recovery orientation and treatment outcomes. However, two of the records we checked showed that the compliance audit had not picked up a lack of detail in the clients risk assessments. Recovery workers held a caseload of approximately 40 clients each although there was a greater emphasis on group work under new treatment model.

Best practice in treatment and care

Staff had a clear awareness of best practice in treatment and care. All staff we spoke with mentioned interventions recommended by the National Institute for Health and Care Excellence guidance, the Department of Health **Drug Misuse** and Dependence: UK **Guidelines** on Clinical Management 2007, the Strang report 2012 and the Governments Drug strategy 2010 as best practice in substance misuse.

We looked at eight prescription records. The records were up-to-date and clearly presented to show the treatment people had received. The service had medicines management policies and procedures in place, including prescribing and detoxification guidance that staff followed. The clinical team gradually adjusted the client's medication until they reached their ideal dose. This took into account the clients use of other drugs and alcohol. Nurses reviewed their clients' medication as they became more stable and engaged with their recovery worker. Staff carried out drug testing at least every six months, using urine screens to identify illicit substance misuse and monitor progress of services users' treatment.

Nursing staff considered their clients' physical healthcare needs. This included checking injection sites for infection and viability, cardiac monitoring for clients prescribed high doses of methadone, vaccinations for hepatitis B and screening for blood borne viruses such as hepatitis C and HIV.

Clients attended group and individual therapy sessions facilitated by recovery workers. Staff used recognised treatment approaches combined with medication to engage and support their clients' recovery. However, the provider did not ensure that staff received training in psychosocial interventions as part of their mandatory training. This meant that there were no assurances that clients were receiving appropriate or up to date interventions to aid their recovery. Psychosocial interventions included cognitive behavioural therapy, contingency management, motivational interviewing, brief focused solutions therapy and mapping techniques. Mapping involved either free mapping or the use of International Treatment Effectiveness Project (ITEP) templates. Interventions also include support for employment, housing and benefits.

Substance misuse services

The service did not currently have any peer mentors or champions. The service was currently training some clients in the role of group facilitators and former clients attended group sessions to encourage and inspire recovery in other clients.

The service measured outcomes every three months using treatment outcomes profiles (TOPs), which is a national tool for substance misuse treatment as part of the national drug treatment monitoring system (NDTMS). Successful completions for all clients engaged with the service for the12 month completion period ending June 2015 was 36.9%, which was similar to the national average.

The clinical lead had carried out clinical audits and analysis, completing an audit of opiate dose adjustment in February 2015 and alcohol detoxification audit in July 2015. This allowed the organisation to compare their results to the national average and see if they needed to make improvements in their delivery of treatment. For example, following an audit of supervised consumption in March 2015, the organisation identified that levels were higher than the national average. As a result, nurses recorded the rationale behind their decision to keep clients on supervised consumption.

Skilled staff to deliver care

A team of multi-disciplinary professionals provided care and treatment. These included GP's, nurses, recovery workers and volunteer counsellors. Lifeline recruited and appointed staff with substance misuse experience and relevant qualifications. New staff underwent an induction programme to familiarise them with Lifeline policies and procedures. In addition, a team meeting took place once a week, where staff received an overview of a specific therapy or intervention to improve their knowledge.

Recovery workers had in house training in relation to drug overdose and anaphylaxis. Specialist training regarding blood borne viruses was available to staff through the Royal College of General Practitioners Website. The recovery workers we spoke to were not aware of this at the time of the inspection.

Nurses had access to drugs and alcohol training online through the Royal College of General Practitioners website. In addition, a nurse had undertaken a dual diagnosis course with University of York. Nurses could also apply for a non-medical prescribing course. This helped fulfil the nursing requirement for continuous professional development, which is necessary for maintaining their professional qualification.

Staff told us and records showed that staff received monthly supervision in line with organisational policy. This enabled team leaders to check the quality of care and treatment staff provided and offer support if needed. All staff had a yearly performance appraisal, where they could discuss their training and development needs with their team leader. This meant staff had clear goals and objectives to achieve. It also identified the need for a cohesive approach to training. The service held monthly team meetings for all staff and involved them in developments in the service. For example, the recent restructure into four separate teams.

Multi-disciplinary and inter-agency team work

The clinical team held a fortnightly multi-disciplinary team meeting to look at clients with complex needs. Recovery workers identified and discussed those clients about whom they had concerns with the clinician in order to move their treatment forward.

Staff helped and supported clients with their social needs as part of their recovery, making referrals to outside organisations as needed. The service had good working links with social services, pharmacies, local GP services, probation, hostels and local housing associations.

The young people recovery workers liaised with education professionals and the youth offending team to deliver drug awareness sessions and one to one support to young people.

Good practice in applying the MCA

All staff had undergone Mental Capacity Act (MCA) training in the two weeks prior to our inspection. Staff had an understanding of the basic principles of mental capacity. The organisation had a policy on MCA, to which staff were aware of and could refer. Mental capacity can vary with chaotic drug users from hour to hour depending on the use of illicit substances.

If staff thought that a client did not have capacity, they would make a referral to the client's GP for an assessment, particularly for cognitive impairment in alcohol users. For example, a client may present with symptoms associated

with Wernike Korsakoffs syndrome such as confusion, lack of mental activity and memory. This brain disorder is due to thiamine (vitamin B1)deficiency, which is common in people with alcoholism.

Are substance misuse services caring?

Kindness, dignity, respect and support

We spoke with nine clients using the service. They described staff as kind, compassionate, approachable and supportive. We observed positive interactions between clients and staff during group therapy sessions. Staff had a relaxed attitude and engaged well with their clients.

We observed the young peoples' worker behaved appropriately at all times with their client group. They engaged effectively with the young person and were flexible to maintain their motivation and involvement. Feedback from this client group praised the worker for being easy to talk to and their listening skills.

The involvement of people in the care they receive

Clients were actively involved in the planning of their care, identifying strengths and areas for development. Staff used ITEP mapping techniques with clients during assessment and care planning, which meant that treatment was more personalised. For example, the 'me today' maps enabled clients to identify what resources they had or did not have. The amount of detail gathered was dependent on how competent the staff member was in using the tool and how motivated the client was to engage in the process.

Clients were able to choose and prioritise which group therapy sessions they attended. Clients who had to attend as part of the drug rehabilitation requirement had less choice of activities.

Nurses reviewed prescribing options with their clients regularly. We looked at a recovery oriented medical review that encouraged a client to reduce their medication at a pace they felt comfortable with, which empowered the client to take ownership of their recovery.

Staff formally reviewed the confidentiality agreement and consent with their client every three months or sooner, as they recognised that clients might change their minds as their treatment progressed. Clients signed their care plans, with the exception of the re-engagement care plan for those in the empower service, and told us they received a copy of them.

The service had entered clients into the 'recovery games' which were held in Doncaster in 2015. The recovery games focus on competitive team building exercises. One client we spoke with had been involved in the games and felt they benefited from positive interactions.

Families and carers were involved in the care and treatment of the client, where it was appropriate and the client had given permission. One client said their mother came to the group sessions and this helped them to understand and support their child.

The service ran SMART recovery groups (self-management and recovery training) for their clients. A few clients were currently training to become SMART recovery facilitators to help other clients manage their recovery from addiction.

Recovery workers supported young people to reflect on situations and use rating scales, enabling them to become involved in their care. A rating scale measures attitude, for example how strongly a person feels about something.

Traditionally, the service sought client feedback through surveys. Following feedback from a client earlier in the year, the service redesigned its business cards to make them discrete. They had recently introduced a dedicated feedback tree displayed on the wall in the reception area. Clients were able to add their comments to the tree.

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

Access and discharge

The service was achieving its 'referral to first intervention' target, with staff seeing 84% of clients within three weeks. The first intervention could be clinical if the client needed prescribing treatment or psychosocial if clinical treatment was not required. NDTMS data showed this was higher than the national average although the numbers involved for this period were low. Staff addressed motivation at each

stage of the referral and assessment process. If a client presented in crisis then staff would see them sooner. Referrals from GPs were predominantly for clients suffering from alcohol misuse.

The service did not plan for unexpected exits. For example, the client declining treatment or moving away and losing contact with the service or the client going to prison. They focused instead on lapses and disengagement and were proactive in trying to re-engage with their clients. In the last 12 months, clients had failed to attend 2035 appointments. Staff attempted to contact clients through phone calls and letters to offer further appointments. Nursing staff kept a 15 minute slot available at the end of each clinic for clients who had turned up too late to be seen or had failed to turn up for their appointment on a previous day. On these occasions, nurses made their clients a new appointment and gave them a script that only covered a few days. This prevented the client from falling out of treatment.

The service introduced the Lifeline York Distance travelled tool in October. Staff used this to assess the progress a client had made. The tool combined the cycle of change with psychosocial interventions (PSI) and medical interventions.

The service had discharged 585 clients in the last 12 months. They did not follow up once a client was discharged having successfully completed treatment. Current re- presentation rates were not yet available. Re-presentations within six months after exit were 5.8% up to June 2015 compared with the national average of 7.4% for this period.

Four clients we spoke with said they were not ready for discharge yet. They had made positive progress with their treatment, three clients were happy to continue to seek support by attending groups. The other client no longer needed medical interventions but still needed support from their recovery worker.

The service engaged with 34 young people between April and June 2015. Cannabis accounted for 91% of substance misuse and alcohol 47%.This closely reflected national demographics. Education services, hospitals, school nurses, youth justice services and relatives had all made referrals into the service. Waiting times for first interventions were all under three weeks. All the young people received PSI support only. The average treatment length was 24 weeks; by comparison, the national average is 22 weeks.

The service had a 13% unplanned exit rate during this period, one young person disengaged and the other was transferred into custody. Current re-presentation rates were not available. The previous half-yearly re-presentation rate within six months after exit was 8% for young people compared to the national average, which was 6%.

The facilities promote recovery, comfort, dignity and confidentiality

The service provided interview rooms, group rooms and two clinical rooms to support treatment and care. All rooms had adequate soundproofing. The reception area lacked privacy as other clients in the waiting area could hear discussions taking place. However, clients told us that they could ask to speak to someone in private.

The service had a clear policy on confidentiality, which recovery workers explained to their clients. Recovery workers shared clients' information and data with NDTMS, GP's, probation and social workers as appropriate. Substance misuse services submit specific data to NDTMS, who produce reports on the service outcomes to the service commissioners. The commissioners and Public Health England can then monitor the effectiveness of these services and ensure they meet the needs of the local population. Consent to NDTMS has a specific format, which informs the client about the role of NDTMS. The service had the correct protocols in place for clients to consent to this. In addition, clients could consent to sharing information with relatives or relevant interested parties.

Consent to share information was sought from the person at assessment and a signature obtained. However, staff had not scanned all assessment paperwork to the electronic system so the actual signature was not present. Furthermore, the paper copies of these signatures were not available. The electronic system enables staff to tick boxes where clients had given consent to share information. Where staff had left a tick box blank it was unclear whether the client had not consented to sharing information or staff had just missed completing it.

At the time of the inspection, the service had recognised this design flaw and was adding a further box to tick stating no consents given.

Substance misuse services

Meeting the needs of all people who use the service

Staff told us and clients confirmed that appointments were rarely cancelled. Staff either offered clients an appointment with the duty officer or rearranged the appointment if this was what the client preferred. Staff provided a late night service twice a week for those clients who struggled to make appointments during the daytime. Two clients told us that staff would work around their commitments and arrange suitable appointment times. Clients told us they were able to talk with their recovery worker over the telephone if they needed to or could sit and wait if they felt they needed an unscheduled appointment. If a client could not make a group session, their keyworker would update them about the session by either email or telephone.

A duty officer was available on a daily basis to cover any unexpected sickness or leave and to deal with any unplanned issues that clients might have. A different member of staff provided duty cover each day.

Staff did undertake home visits if necessary but these were the exception rather than the rule.

The service ran mutual aid recovery groups. The Strang report 2012 and the Governments Drug strategy highlighted that clients who actively participated in mutual aid (people with similar experiences helping each other to manage or overcome issues) were more likely to sustain their recovery.

Recovery workers had strong links with hostels and housing associations. Clients with low recovery capital were often homeless and needed support to secure basic accommodation to begin their recovery.

The service had recently developed a working relationship with the York MESMAC group (men who have sex with men - action in the community) and was leading on a piece of work around the growing chemsex cohort. Chemsex is the practice of shared drug use and unprotected sex with multiple partners over a 72 hour period, usually the weekend. Staff were looking at running a Monday morning group to reduce the harm caused by this trend.

Clients had access to information leaflets about harm reduction, treatment and care. The service used pictorial graphic design leaflets as these appealed more to their clients.

Staff could accommodate those clients with mobility issues either on or off the site.

The service had access to interpreters through the local authority if the need arose. They could also access a signer for any client with hearing problems.

We observed a recovery worker respond to the individual needs of a young person. The worker brought blue tack for one individual who said he was a 'fiddler' and liked to have something to play with.

Listening to and learning from concerns and complaints

Staff explained the complaints procedure to their clients at the assessment stage. The reception area also displayed information about how to make a complaint. In the last 12 months the service had received six complaints from clients, one was upheld. The service manager dealt with all complaints and reported them through the organisation's central reporting system. Complaints reported through this system were included in the clinical governance report at board meetings as a standing agenda item. The organisation had a clear protocol with set times for dealing with complaints and any learning resulting from investigation of a complaint was fed back to staff at team meetings.

The service had also received 69 compliments during this period.

Are substance misuse services well-led?

Vision and values

Lifeline's vision statement was 'to provide alcohol and drug services that we are proud of; services that value people and achieve change'. Their values were a series of statements about improving lives, effective engagement, exceeding expectations and maintaining integrity.The provider had displayed their visions and values on corridor walls throughout the building. Staff discussed these at team meetings and we observed them in practice. The service recognised that the definition of recovery was individual to each client. Staff knew who the organisations' senior managers were as they visited the service on a monthly basis.

Good governance

There was a structured governance system in place. We saw that performance management and quality assurance audits took place, although these still missed some quality

checks. Clinical management meetings were held every month. The operational management group also met monthly. The minutes showed the organisation held an overview of the safety of the service, reviewed key performance indicators and maintained an oversight of performance.

The service had supervision and appraisal systems in place to ensure the effective management of staff. Staff received supervision on a monthly basis. The lack of basic training affected the safety and effectiveness of the service although plans were in place to address this.

Staff followed safeguarding, incident reporting and Mental Capacity Act procedures.

The service manager stated she had sufficient authority to carry out her role and there were adequate levels of administrative support.

Leadership, morale and staff engagement

We saw evidence of clear leadership at local level and the manager was accessible to support and guide staff.

Feedback from staff was positive and morale was good. Staff appeared enthusiastic and told us they enjoyed their jobs and felt supported by their colleagues. Staff told us they were able to suggest and implement improvements to the service. For example, reviewing and improving needle exchange paperwork.

They felt able to raise concerns without fear of victimisation.

Staff were aware of the whistle blowing process and said they would be prepared to use it if the need arose.

At the time of our inspection, there were no grievance procedures or allegations of bullying or harassment within the service.

The service responded to any negative feedback received from clients, apologised for poor performance and outlined remedial actions to improve the services performance where appropriate.

Commitment to quality improvement and innovation

The service is part of the North Yorkshire and City of York local drug and alcohol related death protocol, which reviewed all suspected adult drug related deaths in the area and relevant alcohol related deaths. The aim of the review was to establish if there were any learning points that would help local health and social care service provision reduce the number of drug and alcohol related deaths occurring in the future.

The service was working on a project with York University, who were reviewing qualitative data from clients who have been in treatment for more than two years. Lifeline would consider any recommendations arising from the research in the future development of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that staff receive training appropriate to the role they are carrying out.
- Staff must ensure that no clinical equipment exceeds its expiry date.

Action the provider SHOULD take to improve

- The service should review the security around the storage of medications to ensure they are held safely.
- The provider should ensure that staff have a clear understanding of risk and interventions to mitigate identified risk. This should be documented in sufficient detail in the risk management plan.
- Patients care plans should contain sufficient detail to show how clients would achieve their goals.
- Staff should clearly record electronically whether or not clients have given consent to share information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive the necessary in depth training required to provide psychosocial interventions or regular updates in practice necessary for the safe care and treatment of clients.** **Staff did not receive any training in safeguarding adults.** **This was a breach of regulation 18 (2) (a)**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Some clinical equipment had passed its expiry date. For example, urine test strips, alcohol wipes, saline, eyewash and blood collection bottles.** **This was a breach of regulation 12 (2) (e)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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