The Forward Trust

East Kent Substance Misuse Service - Ashford

Inspection report

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

Ratings

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

Summary of findings

Overall summary

East Kent Substance Misuse Service - Ashford provides specialist community treatment and support for adults affected by substance misuse. We rated the service 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 completed comprehensive assessments for clients on admission to 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. They provided a range of treatments suitable to the needs of the clients and in line with national guidance and best practice. For example, staff monitored clients undergoing detoxification to ensure they took their medicines safely and appropriately, and staff escalated any withdrawal symptoms appropriately. 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 patients 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 cared for and treated people with kindness and compassion. Staff went the extra mile to care and support clients. For example, staff drove clients to and from other services where they could receive appropriate care and treatment and provided accommodation as part of their aftercare. Staff provided emotional support to clients who were grieving, and clients felt empowered to overcome their grief without resorting to using substances.
- Feedback from all the clients we spoke to were overwhelmingly positive. Clients told us they staff respected their dignity and privacy and spoke to them in a kind and compassionate way. Staff provided holistic care to clients ensuring all aspects of their needs were being met including personal and social care needs. They understood the individual needs of clients and supported them to understand and manage their care and treatment. Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions with the client's permission.
- The service was easy to access. Staff planned and managed clients discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet. The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- Leaders had the skills, knowledge, and experience to perform their roles. The service leaders had a good understanding of the service and could clearly describe how the teams worked together to provide good quality care. Staff felt respected, supported, and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear of retribution. Staff collected and analysed data about outcomes and performance.

However:

- Although we saw that the governance processes were largely effective, the service had not ensured that staff all knew to keep fire doors closed even though monthly audits stated that all fire doors were kept closed, we found fire doors wedged open on inspection.
- Cleaning rooms and clinic rooms were left open when not in use. The cleaning room contained cleaning products which could pose a risk to health. Although staff told us that the cleaning room door was always closed and there were no clients in reception at the time of our inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	East Kent Substance Misuse Service - Ashford provides specialist community treatment and support for adults affected by substance misuse.

Summary of findings

Contents

Summary of this inspection

Background to East Kent Substance Misuse Service - Ashford

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

The service is one of four 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 accepts referrals from a range of professionals and people could also self-refer.

The service offers 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.

The service was last inspected on 26th September 2019 where it was rated good overall. The key questions are services safe, are services effective, are services caring, are services responsive and are services well led were all rated good.

There was a registered manager at the service.

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

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:

- are services safe?
- are services effective?
- are services caring?
- are services responsive?
- are services 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 environment and observed how staff were caring for clients
- spoke with nine clients who were using the service
- spoke with the registered manager
- spoke with eight other staff members: including nurses, keyworkers, team leaders, volunteers, and admin staff
- attended a group session with keyworkers
- observed assessment of a client
- looked at six care and treatment records
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The team that inspected the service comprised of two inspectors and a specialist advisor.

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

Outstanding practice

We found the following outstanding practice:

- Staff took account of people's personal, cultural, social and religious needs and found innovative ways to meet them. For example, the service had a weekly Nepalese opiate group facilitated by a full time Nepalese recovery worker, in order to remove barriers for people accessing services and to meet the needs of the local community which accounted for around 35% of opiate users.
- The service worked with local charities to provide clothes for service users including a service user whose accommodation had been destroyed by an arson attack. Staff were collecting personal items including toothpaste, toilet rolls and sanitary products from charity organisations to deliver to clients and families across Ashford. Staff had driven a service user to a rehabilitation service in Gloucestershire and collected them after their rehabilitation placement was completed. The service also provided accommodation in their Forward recovery house following their rehabilitation as part of their aftercare.
- All the clients we spoke to told us passionately how caring and supportive staff were. Some clients told us that timely intervention from staff had saved their lives. For example, clients told us how they were supported during grieving following the death of a family member. Staff kept in touch with them throughout offering emotional support and they were able to overcome their grief and was now coming to the end of their treatment. Some clients also reported how staff had supported them with social care housing, otherwise they would have homeless.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that there is robust governance process around fire risk, and that they kept up to date with relevant legislation (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure cleaning room and clinic room doors are locked when not in use.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Good	Good	☆ Outstanding	Good	Requires Improvement	Good
Overall	Good	Good	☆ Outstanding	Good	Requires Improvement	Good

Good

Community-based substance misuse services

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Requires Improvement

Are Community-based substance misuse services safe?

Good

Our rating of safe stayed the same. We rated it as good.

Safe and clean environment

East Kent Substance Misuse Service Ashford occupied a multi-storeyed building, and the service was arranged over three floors. Clients visiting the service were met by reception staff at the main entrance where they were signed in and let into the reception room via electronically controlled double doors. We saw that the reception areas were clean, tidy, and well maintained. There was a separate entrance for staff with a sign in and out book, so that the teams knew who was in the building.

An electronic system kept the building secure, and staff held key fobs. Key fobs were numbered and signed in and out by reception staff. Clients visiting the service were escorted by staff to their appointment rooms.

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. Staff offices and kitchen were on the upper floor. There was a room booking system in place, and staff were required to book suitable rooms for their appointments or sessions. All rooms that clients were seen had emergency alarms, and there were also portable emergency alarms available for staff, all of which were regularly tested.

There were information, leaflets and handbooks displayed on the walls and shelves in the reception area including a safer injecting handbook, services that were available to clients and safety alerts. There was a water dispenser in reception and staff also offered clients tea and coffee.

The service had a cleaning room and visitor's toilet with disability access for wheelchair users. We saw that the cleaning room door was unlocked during our inspection, and it contained cleaning products. Staff told us that the door was always locked, and that the doors had been left opened briefly. There were no clients in the reception area during this time.

Staff followed the infection control guidance, including handwashing. There were signs in the toilets reminding clients and staff to wash their hands. Staff made sure cleaning records were up to date. Cleaning was done by an external

agency. The chairs in the reception room were well spaced to encourage social distancing and there were social distancing signs around the building. Staff and visitors were required to wear a face mask whilst in the building. There were alcohol based hand sanitisers throughout the building. Staff were required to do lateral flow test (LFT) for COVID-19 twice weekly, although this was not mandatory. Clients attending appointments were required to have a negative COVID-19 test status before entering the building.

The provider had arrangements in place for the collection and disposal of clinical waste. There were clinical bins for disposing of face masks.

The service had an up to date fire risk assessment. The service had a Fire Marshall. Fire extinguishers were in date. There was a list of staff with key responsibilities in the office including who the fire warden was. However, we saw that there were four fire doors which were wedged open with plastic door stoppers. Staff told us the doors were left open to reduce the frequency of contact of the door handles and to increase air flow due to reduce the risk of COVID-19. This was not in line with current health and safety guidance. We also saw that there were cluttering of empty cardboard boxes in the hallway on the third floor.

Safe staffing

The service had enough staff, who knew the clients well and received basic training to keep them safe from avoidable harm. Staff told us the number of clients on the caseload was manageable and they could get support from colleagues when needed. 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 patient the time they needed.

Caseload was reviewed during supervision and complex cases were discussed. The team leader also held a small caseload to ensure the workload was spread evenly. Staff told us the average caseload was between 55 to 60 clients per recovery worker.

There were two vacancies across the teams for one assertive outreach worker and a trainee recovery worker and we saw that the service manager was actively recruiting for these roles.

The service had a low turnover rate in the last 12 months. Staff told us that although it had been challenging during the COVID-19 pandemic, staff had pulled together and supported one another.

Managers told us they could get extra staff when needed. The service hardly used agency staff as recovery workers and had not done so in the last 12 months. Managers told us there was a six-month probationary period for new starters. Managers informed us that it would normally take between three to six months for a recovery worker to gain the skills and knowledge required to support people who were at risk of drug and alcohol use. The service had trained agency nurses who were also non-medical prescribers on long term contracts.

Managers made arrangements to cover staff sickness and absences. Managers supported staff who needed time off for ill health. The service reported low sickness rate. Staff told us that the sickness rates had been reducing even at the peak of COVID-19 outbreak.

Manager told us the service was rarely short of staff. In the event that there were gaps in the rota, or when there was an absence or sickness, other staff members could do extra shifts. Managers could also get staff from other hubs to cover shifts. Managers informed us that staff recruitment process was very robust and attracted staff that were experienced and knowledgeable about the type of service.

Good

Community-based substance misuse services

Managers made sure all new staff had a full induction and understood the service before taking on a caseload. The induction programme Staff informed us that a trainee social worker would be joining the team in November 2021. was comprehensive and structured. New staff were required to shadow more experienced staff to learn about the roles and responsibilities. All new staff were required to read and understand the provider's and procedures and how they applied to their roles.

The service staffing consisted of a service manager, who works at the Ashford hub two days a week, one full time team leader, two full time alcohol workers, two full time drug workers, one assessment worker, two criminal justice workers, one volunteer, one peer mentor, one clinical staff nurse who is also a non-medical prescriber (NMP) and one admin staff. Staff told us they were actively looking to recruit volunteer admin staff to support with some of the administrative tasks. There was always one trained nurse available Monday to Friday.

There were two medical doctors on the provider's rota that provided medical support to the teams across the four hubs in East Kent. Staff told us some complex cases requiring clinical advice and guidance were first reviewed by the nurses and then referred to the doctors.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had a system that informed them when staff mandatory training were due.

The mandatory training programme was comprehensive and met the needs of clients. The mandatory training included drug and alcohol and harm reduction, suicide and self-harm, data protection and GDPR and health and safety essentials. The mandatory training consisted of e-learning and face-to-face training.

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient on arrival and reviewed risks regularly. Staff used recognised assessment tools in line with national guidance and best practice such as the alcohol use disorders identification test (AUDIT) and the severity of alcohol dependency questionnaire (SADQ) to assess dependence.

Risk assessments were thorough and up-to-date, and included risks to self and others in all six care records we reviewed. Risk assessment covered physical and mental health of the client, safeguarding, substance misuse and related risks.

Staff completed risk management plans for all clients. Key workers involved clients in completing risk management plans. Risk management plans included information about what increased and decreased their risks. Staff also completed risk management plans for unexpected treatment exit.

Staff managed drug and alcohol detoxification safely. Staff carried out pre detoxification checks for clients to assess safety prior to detoxification. Staff monitored withdrawal symptoms effectively and were knowledgeable about what actions to take if a client's health deteriorated during detoxification. Staff involved the client's GPs in the detoxification programme and GPs were informed when detoxification commenced.

Good

Community-based substance misuse services

Staff identified and responded to changing risks to, or posed by, clients. We saw safety plans which provided clients guidance for managing suicidal thoughts. Staff worked closely with other agencies including GPs, social workers, community mental health teams around changes in risk levels. Clients were made aware of the risks of continued substance misuse. Harm minimisation was an integral part of client's recovery. Information was displayed and available for clients to take away about harm reduction and an extensive range of relevant health matters.

Staff did not undertake any restrictive interventions. Staff told us that if a client was becoming violent or aggressive and they could not manage them via verbal de-escalation, they would immediately call the police. The service had a clear zero tolerance policy to violence and aggression with signs displayed in the reception and meeting rooms.

Staff responded promptly to sudden deterioration in client's health. Staff were trained to deliver naloxone training to clients and their family members or carers. Naloxone is a medicine that can be given to someone if they overdose on opiate based drugs. Doctors assessed clients before prescribing detoxification medicines. Staff monitored the physical health of clients undergoing detoxification.

Staff offered clients lockable storage boxes to store these items so as to minimise the risk of children and carers accessing medicines or substances that could cause them harm. There were posters in reception with up to date information about drugs that may be contaminated or put clients using them at an increased risk.

Staff continually monitored clients on waiting lists for changes in their level of risk and responded when risk increased.

Staff responded promptly to any sudden deterioration in a client's health. For example, staff responded promptly to a client who was having an overdose by giving them naloxone. Staff told us there was always a staff member in the day who was emergency first aid trained.

Staff followed clear personal safety protocols, including for lone working.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. The service had a safeguarding policy and staff were aware of this. The safeguarding policy was available on the intranet and there were posters across the building reminding staff about need to protect people from harm and abuse.

Staff kept up-to-date with their safeguarding training. All staff we spoke explained clearly what safeguarding was and process for making a safeguarding referral in line with the providers policy. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Safeguarding was a standing agenda item in the weekly team meeting, and monthly governance meetings. Managers cascaded learning from safeguarding concerns from other teams and enquiries to staff via staff meetings and one to one supervision.

The service had a safeguarding lead who attended safeguarding meetings with other leads from other hubs within the region, and also attended meeting with other stakeholders including adults and children's safeguarding teams and social services.

Staff access to essential information

Patient notes were comprehensive, and staff could access them easily. The service used an electronic records system which was kept up to date. The systems were password protected and each staff member had their own unique log in credentials.

Paper records were scanned and uploaded unto the systems. The providers policies, procedures and operational documents were stored in a shared drive which staff could access easily. There were also print outs of policies and procedures which were displayed in offices and reception area.

Each staff member had a laptop, and there were additional desktop computers available in staff offices.

Medicines management

The clinic, needle exchange and storage rooms were clean, tidy and appropriately maintained. There was adequate space in the clinic to prepare medicines and for clinical procedures to take place, for example taking bloods from clients. However, we saw that the clinic room was not locked when not in use in line with guidance. Staff told us the clinic room area was a secured area and clients could not access the clinic room without a member of staff present. The clinic room could be locked via a lockable keypad.

Cleaning records were available and audited in line with the provider's policy. Actions from cleaning audits were recorded and followed up. Room temperatures were recorded daily, and staff knew how to escalate concerns when temperatures went above 25°c. The medicine fridge was checked, and temperature recorded daily. All entries were within range and appropriate action was taken if not within range.

The service had a well-stocked needle exchange in line with National Institute for Health and Care Excellence guidance for needle and syringe programmes. There was a dedicated member of staff who was responsible for checking stock levels and recording this on the system to ensure the service did not run out. The needle exchange policy was easily accessible in the needle exchange room. There was a clear safety process for disposal of sharps. The sharps bins were not overfilled.

The service audited medicines well. Nurses were responsible for checking of expired medicine. There was an up to date stocklist. The service did not have excess stock, and all stock medicines were in date. Expiry dates were checked monthly through a clinical audit. They check all documentation around prescription and script records were properly audited. Nurses and clients sign when prescription was given to the client. When the script changes, this was recorded in the script change form.

The service had a robust medicine disposal policy. Only the service manager and team leader could destroy prescriptions that were void. Medicines disposal bin were available inside locked room.

Staff stored and managed prescribing documents in line with the provider's policy.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Medicines were reviewed at least once every three months. Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. There were posters on the wall that detailed any specific drug alert. We saw that there was a notice in the reception area about a dangerous batch of a particular drug in the local area.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Clients received specific advice about their medication, and they were also given information leaflets about their medication.

The service did not keep any controlled drugs. Stocks of naloxone were stored in the needle exchange room, and we saw that they were all in date. Pharmacy and nurses signed for vaccines and naloxone.

There was a lead pharmacist who managed pharmacies across East Kent. We did not see pharmacy contact details in the clinic room, but they were in the admin office. Staff told us that the pharmacist did not visit but they could get support from pharmacist when required

Clinical equipment were in good working order. Equipment were calibrated annually. There were grab bags in the clinic room and in the admin office. There was no defibrillator on site. The service manager told us they were in process of procuring one as they were quite expensive. Clinic rooms had the necessary equipment for patients to have thorough physical examinations.

However, at the time of our inspection, staff could not locate the key to the medicine's fridge and there were no spare keys. Staff told us the keys were normally stored in a locked cabinet. Staff told us the only medicines that were stored on the fridge were hepatitis B vaccines. There were no hepatitis B vaccinations scheduled on the day of our inspection. Managers informed us following the inspection that the keys were returned next day and that a second key had been secured, labelled and stored in a locked cabinet.

Track record on safety

The service had reported two incidents that met their serious incident criteria in the last 3 months. There were related to deaths of clients. The providers policy required that all deaths were subjected to full root cause analysis and lessons learned from the investigation were shared with the teams.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them in line with the provider's policy. Incidents were reported through an electronic incident management system which was monitored by leaders. Records showed that incidents were appropriately managed, and learning undertaken where possible.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were reviewed and discussed during weekly team meetings and in governance meetings.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations. Clients and their families were offered support following a serious incident.

Managers shared learning from the investigation of incidents with the teams. Learning from incidents were shared with staff during staff meetings and one to one supervision. Individual hubs shared learning from incidents in the regional governance meetings

Good

Community-based substance misuse services

Managers debriefed and supported staff after any serious incident and everyone also had access to external supervision.

Staff understood the duty of candour. Staff told us it was about being open and transparent, and giving people who used the service and their family members a full explanation when things went wrong. Staff told us clients were informed by the person dealing with the incident.

Are Community-based substance misuse services effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff completed a comprehensive assessment for all clients on admission to the service. Staff carried out assessments either face to face or over the phone. The assessment covered areas such as the clients physical and mental health, employment status, substance misuse history, blood borne virus status, relationship, and social status.

Staff developed comprehensive care plan for each client which met their physical and mental health needs. The second appointment following the initial assessment was a care planning appointment with a recovery worker. We reviewed six clients care and treatment records and saw that care plans were detailed, holistic, personalised and recovery oriented. Staff ensured that all clients were offered a copy of their care plan.

Staff regularly reviewed and updated care plans regularly. Staff told us care plans were reviewed every three months or when the client's needs changed. All clients we spoke to understood what their care and recovery plan was, and they were actively involved in planning all aspects of their care. All care records we reviewed contained a plan for unexpected exit from treatment.

Staff ensured that clients' consent to care and treatment were clearly recorded during the initial assessment. Although staff told us that consent was not routinely documented for people who transferred to or reengaged with the service.

Best practice in treatment and care

Staff offered a range of care and treatment suitable for the clients based on national guidance and best practice from relevant bodies such as National Institute for Health and Care Excellence. The intervention offered included brief advice and information, or more structured clinical and group interventions including medication and psychosocial therapies.

Medical treatment included prescribing medicines to clients for alcohol and opioid detoxification. The teams had access to medical doctor who supported non-medical prescribers and reviewed clients during their treatment. Prescribers conducted high quality assessments and reviews of clients and appropriately monitored clients undergoing detoxification regimes. Staff ensured that any physical health concerns or withdrawal symptoms during detoxification were escalated appropriately.

The interventions were either on one to one basis or delivered in groups. Some of the groups included worth, a gender specific violence reduction programme, stepping stones, an 18 session psychosocial intervention for service users using

alcohol and or other drugs at harmful and dependent levels, and a family support service that supported people who were struggling with a friend or family members substance misuse even if the drug or alcohol user was not ready to get help. The group also supported people receiving treatment for drug and alcohol use to rebuild relationships with loved ones. Staff told us due to COVID-19 some of the groups were now done online. The service had started reintroducing face to face group session such as the Nepalese opiate group.

Staff made sure that patients had support for their physical health needs, either from their GP or community health services. Staff documented on clients records when referrals had been made to GPs. However, the service did not keep copies of the referral letters and therefore, we could not review the content of the letters. Staff told us letters sent to GPs were copies of medical reviews and medical assessment records.

Staff supported patients to live healthier lives by encouraging them to take part in programmes or giving advice such as participation in smoking cessation schemes, healthy eating advice, and dealing with issues relating to substance misuse. The service has access to a volunteer trainee counsellor. Staff made regular referrals to external IAPT (NHS psychological therapies services) for counselling therapy sessions.

The service offered advice and information about a range of health and well-being matters. There were information leaflets and handbooks in the reception area advising people how to live healthy and staying safe. 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 for people to take away.

Staff offered blood borne virus testing during assessments. The service ran an incentive scheme for blood borne virus appointments. Records were kept of money given to clients who participated in the programme.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Staff told us they benchmarked themselves against other hubs and against other similar services. Managers used results from audits to make improvements.

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. Staff told us that the service was now delivering training on how to administer naloxone to family members as a outcome of learning from serious incident where family member did not realise that the client had overdosed.

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

The service had access to a range of specialists to meet the needs of each client. There were two doctors and three non-medical nurse prescribers who worked across the four hubs in East Kent. The teams could refer to other specialist teams including community mental health teams, GPs dieticians and pharmacists when required. Staff told us that some very complex cases were reviewed by nurses and referred to medical doctors for clinical guidance and advice. Doctors had clinics for complex clients.

Good

Community-based substance misuse services

Managers made sure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care. Staff received training in vaccine/ anaphylaxis, CPR, naloxone, MCA, data protection and safeguarding. Staff knew their clients well, understood their conditions and had clear plans for how they would meet their needs.

Each of the teams across East Kent had a team leader that line managed the recovery workers. For example, the drugs and alcohol team had one team leader and the criminal justice teams also had a team leader who reported directly to the service manager.

Managers provided new staff with appropriate induction to the service before they started work. There was a six month probationary period where the inductee learned the role of a drug and alcohol worker. Manager told us that it takes about six months for a person to become fully equipped for the role.

Managers ensured that all staff were supported staff through regular, constructive appraisals of their work. All staff have had an appraisal in the last 12 months.

Team leaders provided recovery workers with supervision. These were structured meetings to discuss case and calendar management, to check in on staff wellbeing, to reflect on and learn from practice, and for personal support and professional development. Staff had monthly supervision and quarterly reviews of their work and performance.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meetings were held on a Tuesday afternoon when the service was closed to clients to ensure all staff could attend.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Caseload were reviewed during the monthly supervision and complex cases were also discussed in team meetings.

Managers ensured that staff received the necessary specialist training for their roles. There was a training panel and staff could put in request for any specialist training they would like to undertake. The service was supporting a member of staff to undertake the non-medical prescribing course next year. Recovery workers were trained on how to collect blood from clients.

Managers told us the teams were largely performing well. We saw on staff files that managers and team leaders had an in-depth reflective conversation with staff on how to improve their work. For example, we saw that gaps in recording were reviewed during supervision and staff were asked to review and make changes to ensure documentation were of top quality.

Managers recruited volunteers when required. Managers trained and supported them for the roles they undertook. The service had two volunteers who supported the teams.

Multidisciplinary and interagency teamwork

Staff held regular multidisciplinary meetings to discuss clients care and treatment, and ways to improve their care.

The multidisciplinary team was made up of doctors and detox nurses that worked across East Kent, the service manager, team leaders, recovery workers, criminal justice workers, admin staff and volunteers. Team meetings covered a range of areas including staffing, safeguarding, incidents, any risks or performance issues. Staff made sure they shared clear information about clients and any changes in their care.

Good

Community-based substance misuse services

Staff had effective working relationships with other teams in the organisation. For example, the criminal justice teams worked closely with other teams across the South East, East of England and the Midlands via the probation support, a specialist wellbeing and accommodation probation service that help prevent re-offending among male prison leavers and those on community orders.

Staff had effective working relationships with external teams and organisations. The teams were closely linked with community services, social services, educational institutions, mental health teams, GPs and other teams including children and adults safeguarding teams and the police.

The service had leads for a wide range of areas including safeguarding leads, health and safety leads. The service had a lead who attended the MARAC (multi agency risk assessment conference) meetings to discuss clients and review client's death on a multiagency level.

Good practice in applying the Mental Capacity Act

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Signs about the Mental Capacity Act and its five Principles were on display around the building.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access the policy, and they applied this in their role. Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. For example, if a client was intoxicated or under the influence of substances, staff would reschedule their appointment for when they had the capacity to make decisions.

Staff sought consent from all new clients before they started treatment.

Are Community-based substance misuse services caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Kindness, privacy, dignity, respect, compassion and support

Staff went the extra mile to care for clients undergoing treatment and recovering from substance misuse, and feedback from clients were continually positive. All clients we spoke to told us passionately how caring and supportive staff were. Some clients told us that timely intervention from staff had saved their lives. Clients told us how they were supported during grieving following the death of a family member. Staff kept in touch with them throughout offering emotional support and they were able to overcome their grief without resorting to using substances, and they were now coming to the end of their treatment.

Good

Community-based substance misuse services

There was a strong, visible person centred culture. We saw several examples where staff had gone over and beyond to care for clients throughout the COVID-19 pandemic. For example, we saw that the service worked with a local charity to provide clothes for a service user whose accommodation had been destroyed by an arson attack. Staff were collecting personal items including toothpaste, toilet rolls and sanitary products from charity organisations to deliver to clients and families.

Staff had driven another service user to a rehabilitation service in Gloucestershire and collected them after their rehab placement was completed. The service also provided accommodation in their Forward recovery house following their rehab as part of their aftercare.

Staff provided holistic care to clients ensuring all aspects of their needs were being met including personal and social care needs. Some clients reported how staff had supported them with getting accommodation from the local council, otherwise they would have been homeless.

A client told us that they had been reluctant to get support having been to other services without much success previously but felt at ease from the initial contact with the teams because of how extremely caring, supportive and non-judgemental they were.

Staff interacted with people who used the service in a kind and respectful way. We observed an alcohol group session and saw that staff were compassionate and understanding, and they gave everyone the opportunity to speak freely and openly. The session was one hour long, and clients were not rushed. Everyone was given time to share good and bad experiences since their last session in a caring, safe and inclusive way.

Staff were keen to learn from people's experiences and also explored ways on how they could support them better. All clients we spoke to said staff listened to them, understood them and that staff were always professional.

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. We also saw during the initial assessment of a client that staff discussed with them appropriately, and respectfully in a caring, compassionate, and non-judgemental way.

Staff and people who used the service said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fearing negative consequences.

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 during discussions. Staff ensured all conversations were confidential protecting people's privacy and dignity during assessment and during group sessions. There was a paper shredder in the manager's office for shredding confidential information.

Involvement in care

Involvement of clients

Staff worked with clients to create a recovery plan and risk management plan specific to them. They involved clients in the setting of relevant goals and in the regular reviewing of goals, progress and outcomes.

Good

Community-based substance misuse services

Staff supported clients to understand and manage their care and treatment. Clients told us staff empowered them to take control of their own recovery in a honest, kind and supportive way.

Staff offered clients copies of their care plans and staff regularly reviewed their plans with them when things changed.

Staff communicated well with clients so that they understood their care and treatment. They found effective ways to communicate with clients whose first language was not English, and those with communication difficulties.

The service supported people who used the service as well as families and carers to access to advocacy. There were posters and leaflets explaining how to access advocacy, in the reception room and around the building. Advocacy services included general advocacy and also services specialising in supporting with issues relating to human rights and equality.

Clients could give feedback about the service in one to one meeting or by using the suggestions box in reception. The service regularly undertook service user satisfaction surveys. For example, the provider regularly asked service users if they were being kept up to date about changes in the service and invited suggestions on how the service could improve. Result of the last service user survey completed in June 2021, showed that 77.8% of service users were satisfied with the overall service they received. One client feedback stated that they appreciated the trust of their keyworker to overcome their addiction which gave them the strength also. The service was in process of carrying out another service user survey. Staff told us their aim was to get 100% service user satisfaction. Service user surveys were done quarterly online or via a paper feedback form.

Involvement of families and carers

Staff informed and involved families and carers appropriately, with the client's permission.

Staff provided families and carers with support when needed. For example, there was a family support group that supported people who were struggling with a friend or family members substance misuse even if the drug or alcohol user was not ready to get help. The service had a volunteer family support worker who provided support and advice to families and carers.

Staff enabled families and carers to give feedback on the service they received. For example, via satisfaction surveys or using the suggestion box.

Are Community-based substance misuse services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access, waiting times and discharge

The service operated five days of the week open from 9am to 5pm Mondays, Wednesdays and Fridays, 9am to 7pm on Thursdays and closed at 12.30pm on Tuesdays. The service was easy to access, and it was within walking distance from the high street, train station and bus stops.

Good

Community-based substance misuse services

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 had clear criteria for those they will offer a service, the referral criteria did not exclude clients who would have benefitted from care and treatment.

The service operated a daily drop-in service, so people could have an immediate chat with a staff member and request immediate assessment. Staff told us the service was opened to people who needed help with drug and alcohol problems throughout the COVID-19 pandemic.

The service used systems to help them monitor waiting lists. The commissioners set a waiting time of 10 days from referral to assessment. At the time of our inspection, there were 19 people waiting to be assessed. Although the current waiting time was 11 days currently, staff told us this was not a true reflection of the waiting times, that they were meeting and surpassing their targets. The reason why they were not within the 10 day target was due to several factor including not being able to contact some clients and some clients missing their appointments. In response to improving on the waiting times, the service had a full time assessment worker. Managers had also recorded not meeting their waiting times on the risk register.

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.

Patients had some flexibility and choice in the appointment times available. Appointments ran on time and staff informed patients when they did not. Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff told us there had not been any cancelled appointments in the last 12 months. All staff had an online dashboard for each appointment.

Staff tried to contact people who did not attend appointments and offer support. When staff could not contact clients who may be at risk, they informed the police to carry out welfare check.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from other services including mental health services.

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

Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet. Staff began planning for discharge when the clients first entered treatment. Staff worked with clients to develop a continued recovery plan which included areas such as physical health, mental health, relationships, support services, social activities employment and education. Discharge plans included post discharge treatment support groups available to the client.

The facilities promote comfort, dignity and privacy

The service had a full range of rooms and equipment to support treatment and care.

All group and one-to-one rooms were clean and comfortably furnished.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

The reception area was large, bright and airy with plenty of comfortable chairs for seating. There was a water cooler and toilet facilities, including wheelchair accessible toilets.

There was a privacy curtain in the clinic room to protect people dignity and privacy.

Meeting the needs of all people who use the service

The service could support and make adjustments for people with disabilities, communication needs or other specific needs.

Managers made sure staff and patients could get hold of interpreters or signers when needed. The service used a third party organisation for interpretation and translation services.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service provided information in a variety of accessible formats so the patients could understand more easily.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us that about 35% of opiate users in the area were from Nepalese communities. In other to meet the needs of the people in the local community, the service now ran a weekly Nepalese opiate group that was facilitated by a very experienced Nepalese recovery worker. Staff told us the group had been a huge success story as the needs of a lot of people were being met. Feedback from service users was overwhelmingly positive.

Staff demonstrated knowledge of protected characteristics and vulnerabilities, such as the potential needs of clients identifying as black and ethnic minority or lesbian, gay, bisexual or transgender (LGBTQ+). Staff understood and respected the religious and cultural needs of clients.

Listening to and learning from concerns and complaints

The service had a complaints policy and staff knew and understood how to handle complaints. Staff told us that they tried to address all concerns in the first instance, and if the client was still unhappy, they would support them to make a formal complaint.

Managers investigated complaints and identified themes and shared this with the teams. Clients received feedback from managers after the investigation into their complaint.

The service had received one formal complaint between July and August 2021, and the complaint was upheld. The complaint was related to information sharing and the service had done a learning review following this complaint and made changes to practice.

All client's we spoke to knew how to make a complaint or raise a concern. Clients told us if they had a concern, they would initially raise them with their key worker and could also speak to the team leaders or managers and complete the feedback form. There were complaints and compliments forms, and a suggestion box in reception area.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Good

Community-based substance misuse services

The service used compliments to learn, celebrate success and improve the quality of care. The service had received a huge amount of compliments in the last 12 months.

Compliments and complaints were discussed regularly in team meetings and supervision. The office had multiple thank you cards on display that had been received from clients.

Are Community-based substance misuse services well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. Service leaders had a good understanding of the services they managed. They could explain clearly and confidently how the teams worked together to provide high quality care and support to clients. Staff knew who their managers were, and they told us leaders were approachable and supportive.

Service leaders had a good working relationship with the teams, and we saw that the teams worked well together. Leaders gave staff were given autonomy to do out their work, encouraged creativity and drove the team to increase their effectiveness. We saw that the service had systems and processes in place to ensure staff were performing at high standard.

Leaders prioritised staff wellbeing and promoted a positive working environment. There were a range of financial and health scheme benefits for staff, including a therapy allowance.

Vision and strategy

Staff knew and understood the provider's vision and values and they applied this in their day to day work. The providers vision and values were on display throughout the building, including in reception and hallways.

Staff could explain clearly how they were working to deliver high quality care within the budgets available. They had the opportunity to contribute to the discussions about the strategy of the service which could be in team meetings and staff surveys.

Culture

Staff felt respected, supported, and valued. Staff felt positive and proud about working for the provider and their team.

Staff reported that the service promoted equality and diversity in daily work and. The provider was a signatory of the armed forces covenant and a Disability Confident employer. The provider also encouraged staff to become members of the equality, diversity, and inclusion panels where they could make positive changes to equality and diversity.

The service provided opportunities for development and career progression. For example, staff appraisals included conversations about career development and how it could be supported

Staff felt they could raise any concerns without fear of retribution. 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.

Leaders were extremely proud of their teams. Managers told us all of their staff were largely performing well. We saw that leaders encouraged and informed staff there was always room for improvement and innovation. For example, we saw that team conversations involved thinking about new and innovative ways of working.

Staff had access to support for their own physical and emotional health needs through a health scheme. This included discounted gym membership, confidential counselling session and 24 hour access to a GP.

The provider recognised staff success within the service and celebrated them. Staff consistently told us that was a fantastic place to work. The service celebrated people achieving good outcomes and client recovery were real and measurable.

Governance

Although we saw that the clinical governance processes were largely effective, the service had not ensured that all aspects of the audits were robust enough to remove or mitigate risks.

During the inspection we noted that four fire doors were wedged open. Staff told us the doors were left open to reduce the frequency of contact of the door handles and to increase air flow due to COVID-19, which was not in line with guidance.

The monthly fire checklist stated that all fire doors were not wedged open, and the walkways were free from trip hazard, but we saw empty cardboard boxes in the hallways. The storage cupboard on the second floor was cluttered with empty boxes and broken items.

There were concerns identified on the monthly departmental workplace inspection from previous months that have still not been resolved in subsequent months.

We raised these concerns with the provider at the time of inspection. Following our inspection, the provider informed us that all fire doors were now closed, and the fire risk assessments were being updated. The provider also informed us that two fire wardens were receiving updated fire training.

However, we saw that there was a clear framework of what would be discussed at staff and clinical governance meetings to ensure that essential information, such as learning from incidents and complaints, partnership working, and safeguarding were shared and discussed.

Staff were given opportunity to contribute to shape and improve the service via different platforms including in governance meetings. For example, we saw that the proposal for evening appointments were being discussed, and managers invited ideas from staff on how to improve on the waiting times. Actions from meetings were clearly allocated with timeframes for them to be completed. Managers encouraged staff to attend meetings and we saw good staff attendance at governance meetings. Every fourth governance meeting was a training day for staff.

Staff participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. For example, managers regularly audited clients' clinical records to ensure they were thorough and complete.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

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

Management of risk, issues and performance

There was clear quality assurance management and performance framework in place. The service manager cascaded information to staff in team meetings, and to senior managers in governance meetings. Staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities.

The service kept a register of risk which was regularly reviewed, and we saw mitigations in place to reduce risks. Staff could escalate any operational risk which would then be added to the risk register.

There were two risks on the risk register, and these were related to COVID-19 and waiting times between referral and assessment. We saw that the service was working hard to remove or reduce risks, for example, the service had recruited one full time recovery worker who carried out assessment in order to reduce the waiting times for referral to assessment. We saw that this had had an impact.

The service had specific plans for emergencies including loss of staff, loss of IT and COVID-19 outbreak. There was a COVID-19 manual which details how the service would continue to operate daily and in the event of an outbreak or national lockdown. There was always a member of staff available who was first aid trained in case of a medical emergency.

Team leaders told us that they previously used an allocation tracker to manage staff caseload, but this had since stopped because staff also received an email when they were allocated a new client. Team leaders informed us that this was a duplication of work and staff were now only sent emails. There was a monthly report of caseload and performance that was sent by the data analysts.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure and telephones worked well and helped to improve the quality of care.

Staff understood and worked according to the providers information governance policy. The information governance systems included confidentiality of client records and all staff received information governance training and knew how to keep data secure. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and service user care and treatment.

The provider provided staff with information via emails, intranet and bulletins. The provider made good use of social media to keep the public informed of the work they were undertaking to support clients and their families. The provider provided clients with updates about their services through information on the website. Staff and clients also received regular newsletters.

All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. The service had procedures for storing files and managers audited information governance.

Staff made notifications to external bodies as needed.

Engagement

The service engaged well with people and actively encouraged people to give feedback about the services. Staff collected feedback after groups and when clients exit treatment. Client feedback from surveys and on this inspection was generally positive. Managers and staff had access to the feedback from clients, carers and staff and used it to make improvements.

Staff met regularly 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.

The service had signed up an information sharing system with the ambulance service, for people who were frequently admitted to hospital, from frequent overdose and those that were suicide risks.

Learning, continuous improvement and innovation

The teams regularly discussed ways of improvement and how to improve outcomes for clients. Manager encouraged staff to continually improve and find new and better ways of working. Staff spoke of having autonomy and flexibility to work with clients in a way that enabled them to fully utilise their skills and experiences.

All staff had objectives focused on improvement and learning. This was reviewed at their supervision, reflective practices and appraisal.

Staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities. Staff told us the service was in process of redesigning the opiate pathway as part of a quality improvement work to improve outcomes for opiate users.

The service had a clear framework of meetings in place which facilitated sharing of learning from incidents, complaints and safeguarding 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 service was continually reviewing and learning from serious incidents and making changes to practice both internal and external to the service. For example, the service had undertaken a learning review following a serious incident were a service user overdosed. The service was now undertaking training for family members in naloxone administration as timely intervention could have saved their life.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not ensure there was robust governance process around fire risk, and that they kept up to date with relevant legislation (Regulation 17 (1)(2)(b))