Humankindcharity

County Durham Substance Misuse Service - Centre for Change

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Overall summary

Our rating of this service improved. We rated it as outstanding because:

- Feedback from people who use the service and those who were close to them was continually positive about the way staff treated them. People thought that staff went the extra mile and their care and support exceeded their expectations. Staff actively involved clients, families and carers in care decisions.
- The service developed innovative approaches to meet the needs of a range of people who used the service. This included using a mobile public health facility to engage with people who lived in rural areas with complex needs.
- Staff supported rough sleepers by helping them get COVID-19 vaccination appointments, providing them with clothing, toiletries, showering and laundry facilities and helping them to find housing accommodation. Staff provided sanitary items to clients as they recognised the impact of period poverty and condoms to prevent clients contracting sexually transmitted infections.
- The organisation had created an app called Drink Coach which people could use to assess the level of their alcohol intake and book an appointment at the service if needed. This had resulted in an increase in older people accessing the service for treatment. The service had procured a testing machine to determine if clients had a blood borne virus and needed treatment. The service was developing an initiative with the local university in response to students' drinks being spiked and its recommendations included testing students and confidential one to one sessions with any students who were concerned about being spiked.
- The service had its own safeguarding lead and three supervisors had received National Society for the Prevention of Cruelty to Children training. Staff were up to date with their safeguarding and unconscious bias training which was appropriate for their role and followed good practice.
- The service provided safe care. Clinical premises where clients were seen were safe and clean. Staff caseloads were not high so staff were able to give time to each of their clients that they needed. There were no waiting lists within the service, so clients were seen promptly. Staff were highly motivated, client-focussed, skilled, experienced and up to date with their mandatory training requirements. Staff received appraisals, supervision and a comprehensive induction programme.
- Staff assessed and managed risk well, there were no serious incidents in relation to harm or risk to clients or staff. All incidents, complaints and client deaths were fully investigated, and lessons learned from investigations were routinely shared with staff to improve the service. There were safe and effective processes in place for lone working, clients who did not attend their appointments and cases in which substitute medicines had been passed to third parties for illicit purposes
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration and partnership with clients, families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the clients.
- The teams included or had access to the full range of specialists required to meet the needs of the clients. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Capacity Act 2005. Staff had access to a dual diagnosis nurse within the partner organisation and the local mental health trust from whom they could seek advice and support when there were concerns about a client's mental capacity.
- The service was easy to access. Staff assessed and treated clients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude people who would have benefitted from care. No appointments had been cancelled as a result of staffing issues despite the pressures faced as a result of the COVID-19 pandemic.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly.

Summary of findings

However:

- Seven clients told us they had either not been offered a copy of their care plan or could not recall being offered it. We also noted that two client's care records did not indicate if they had been offered a copy of their care plan.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Outstanding ☆	We rated this service as outstanding: See summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to County Durham Substance Misuse Service - Centre for Change

The County Durham Substance Misuse Service is a community-based service delivered by Humankind Charity.

The local council had commissioned an integrated substance misuse service, combining services between two organisations. Humankind Charity provides psychosocial and recovery focussed interventions for children and adults with alcohol and drug addictions. Substitute prescribing and other clinical-based interventions are provided by a partner organisation.

At the time of our inspection visit in February 2022, the service comprised five sites in Durham, Peterlee, Bishop Auckland, Seaham and Consett.

There are dedicated teams within the service including recovery co-ordinators, a criminal justice team, volunteers and ambassadors, a health, outreach prevention and engagement team, young person's workers and recovery academy and harm reduction teams.

This inspection only observed the Humankind element of the service, and the rating applied is specific to the psychosocial and recovery focussed interventions they provide.

The service has been registered with the Care Quality Commission since 26 April 2018 to carry out the regulated activity of treatment of disorder, disease or injury. The service has a registered manager in place who is also the area manager.

The service was last inspected in October 2018; during which we found breaches of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 service.

Summary of this inspection

This was a comprehensive inspection which included looking to see if the breaches identified during our previous inspection had been addressed. It was a short-term announced inspection for which we gave the provider 24-hours' notice so they could provide us with information about staff availability to allow us to plan which of the five sites we would inspect. Based on the information we received, we inspected the sites at Bishop Auckland, Peterlee, Durham and Consett.

Our inspection team comprised two Care Quality Commission inspectors, a nurse working as a specialist advisor to the Care Quality Commission and an expert by experience with lived experience of substance misuse.

During the inspection visit, the inspection team:

- spoke with the registered manager of the service
- spoke with the director of the service
- spoke with the service's quality and performance manager
- spoke with 11 staff members including project workers, recovery co-ordinators, administrators, ambassadors, a lived experience worker and an aftercare co-ordinator
- spoke with 16 clients and four carers
- looked at eight clients care and treatment records
- looked at the quality and safety of the environment at each site
- observed a daily flash meeting, a board meeting and a multi-agency risk assessment conference meeting to determine whether staff shared essential information and were knowledgeable about their clients
- observed how staff were interacting with clients
- looked at documents relating to the running of the service.

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

Outstanding practice

We found the following outstanding practice:

Feedback from people who use the service, those who were close to them and stakeholders was continually positive about the way staff treated them. People thought that staff went the extra mile and their care and support exceeded their expectations. Clients told us staff were 'amazing' or 'fantastic', 'they couldn't thank them enough', and they trusted staff at the service.

Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff always empowered people who used the service to have a voice and to realise their potential.

The service had purchased a mobile public health facility to facilitate triage and meet the needs of people who lived in rural areas and had complex needs.

Summary of this inspection

Staff within the service were proactive in recognising and addressing issues facing clients within the community. Staff went above and beyond in their efforts to support clients. For example, staff provided clients with sexual health support which included issuing condoms to promote safe sex. They recognised the financial pressures clients were under and offered free sanitary items to combat period poverty.

Staff did sweeps to locate any rough sleepers and supported them by booking COVID-19 vaccination appointments at suitable venues for them; providing them with clothing, toiletries, showering and laundry facilities and helping them to find housing accommodation.

Humankind had completed a series of 'Alcohol Round Tables' of which the County Durham service contributed to refresh its approach to alcohol interventions. The aim was to have a core alcohol model which was consistent throughout the organisation, with local variations if needed to best serve the local population or to adhere to specific commissioning requirements. The new model was developed in draft pending a consultation with clients.

The service had procured a testing machine which was used by staff within the service and partner organisation to determine if clients had developed antibodies which would indicate they had a blood borne virus and required treatment. At the time of our inspection, staff had referred nine clients for treatment after they had tested positive.

The provider had created an online self-audit tool called Drink Coach that people could complete to ascertain the extent of their alcohol intake. The outcome score denoted the advice they received around managing their drink problem. The tool also included the facility to book an appointment with the service. Over 4,700 people had used the tool and the service had seen an increase in adults aged 45+ accessing the service for treatment through its open access route.

Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. They had embedded and promoted a culture in which the focus was on a positive client experience and in which staff felt motivated to deliver high quality care and treatment.

There were high levels of satisfaction across all staff. Staff felt respected, supported and valued. They felt proud, positive, satisfied, part of the organisation's future direction and spoke highly of the service's culture. Throughout our inspection, we noticed that staff were smiling, and we heard laughter when staff members were in conversation with their peers and managers which evidenced there was a happy and positive culture within the service.

The provider's website supported accessibility by being compatible with a range of on screen reading and translation software. Staff ensured that subtitles were switched on for any videos it uploaded to its website or social media platforms. Staff used imagery or video to help illustrate information wherever possible. The provider's website was configured so that people who were unable to use a mouse could navigate around the site using just their keyboard.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that all clients are offered a copy of their care plan and that the client's decision as to whether or not to accept it is always recorded within the client's care record.

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	Outstanding	Good	Outstanding
Overall	Good	Good	Outstanding	Outstanding	Good	Outstanding

Outstanding

Community-based substance misuse services

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

Are Community-based substance misuse services safe?

Good

Our rating of safe improved. We rated it as good.

Safe and clean environment

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

Staff completed and regularly updated risk assessments of all areas and removed or reduced any risks they identified. We looked at health and safety information during our inspection and staff or the local authority responsible for the buildings undertook environmental risk assessments, health and safety audits and ensured gas, fire, electrical, personal appliance and legionella testing was undertaken.

All interview rooms had alarms and staff available to respond.

All clinic rooms had the necessary equipment for staff to carry out sufficient tests of clients such as urine and blood tests.

All areas were clean, well maintained, well-furnished and fit for purpose.

Staff followed infection control guidelines, including handwashing.

Staff took measures to reduce the risk of COVID-19 transmissions within the service. Staff wore masks and adhered to social distancing guidelines. Rooms used for meetings had been risk assessed to determine the maximum number of people who could use the room safely. The provider's health and safety team conducted onsite inspections to ensure all buildings remained COVID secure in line with guidance and government requirements. There were posters throughout the service buildings about the importance of social distancing.

Staff made sure equipment was well maintained, clean and in working order.

Clinic room and equipment

The service's clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

The service had equipment and medicines for dealing with emergency situations. Each service kept stocks of naloxone for use in the event of a client overdose. Naloxone is a medicine used to reverse the effects of an opioid overdose. There was also adrenaline for people experiencing anaphylaxis at the sites blood borne vaccines were used. Sites also had a defibrillator, blood pressure monitor, oxygen saturation meter and ambu bag and venti-masks for ventilating. The service also kept stock of medicine for dealing with deficiencies in vitamins B and C due to alcohol misuse.

Safe staffing

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

The service had enough staff to keep clients safe. These included:

- 29 whole time equivalent recovery co-ordinators
- five whole time equivalent project managers
- nine whole time equivalent recovery academy workers
- six whole time equivalent aftercare workers
- 9.5 whole time equivalent lead practitioners
- three whole time equivalent criminal justice co-ordinators
- six whole time equivalent health, outreach, prevention and engagement co-ordinators
- one whole time equivalent domestic violence worker
- two whole time equivalent harm minimisation workers
- one whole time equivalent quality and performance manager
- one whole time equivalent area manager and,
- one whole time equivalent service director.

Other posts included a data analyst, think family lead, safeguarding lead, prison link liaison worker, rough sleeper outreach workers, police liaison workers and administrators.

There were five vacancies within the service and candidates had been shortlisted for four of these posts and were at the interview stage.

The establishment figures for each service had been determined by the specification of the contract awarded to the provider. Managers reviewed staffing numbers regularly to assess if they were appropriate.

Managers monitored caseloads; aimed to keep them below 60 and if they increased, used agency or fixed term contract staff accordingly. The average caseload at the time of our inspection was 29. Staff had access to case management discussions with their managers during supervision sessions.

Managers were able to redeploy staff to other services in County Durham if necessary.

Managers made arrangements to cover staff sickness and absence. Due to the service being well staffed, most staff shortages were covered within the teams.

Agency staff had been used to cover sickness and gaps in recovery co-ordinators and an administrator post. The total usage of agency staff amounted to 134 weeks over 12 months. The agency staff were familiar with the service. Four of the roles that agency staff were covering had since been permanently filled. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The average turnover rate in the service was 22.65% in the last 12 months. We were told the reason for the high turnover was due to long-standing staff leaving due to changes within the service. There were five vacancies within the service at the time of our inspection and candidates had been shortlisted for four of these posts and were at the interview stage.

Managers supported staff who needed time off for ill health. Staff told us that managers were very supportive; they were helped to return to work and could come back on a phased return when necessary.

The average staff sickness rate in the previous 12 months was 6.65%.

All staff within the service carrying out regulated activities had up to date Disclosure and Barring Service checks in place to ensure they were suitable to work with vulnerable adults and children.

Nursing staff

There were no nurses in the Humankind service. However, nurses and non-medical prescribers were employed by the partner provider, who provided advice and support to staff within Humankind when necessary.

Medical staff

Medical staff, including nurses and non-medical prescribers trained in basic life support within the clinical service were employed by the partner agency.

The service could get support from a psychiatrist quickly when they needed to. The service had forged links with the local mental health trust who could arrange for clients to receive support when necessary. There was also a dual-diagnosis nurse employed within the clinical service provided by a partner agency who could provide advice and support to staff when there were concerns about a client's mental health or mental capacity.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The provider's target for mandatory training compliance was 85% and this had been exceeded in all areas. The overall compliance at the time of our inspection was 98%.

The mandatory training programme was comprehensive and met the needs of clients and staff. Training included fire safety, Mental Capacity Act, safeguarding, unconscious bias (including equality and diversity), information governance, health and safety, e-learning modules, infection control and welcome to Humankind.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received updates from the provider's human resources department in relation to staff compliance with their mandatory training.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in a client's health. There were no waiting lists within the service, so clients were seen quickly. Staff followed good personal safety protocols.

Outstanding ☆

Community-based substance misuse services

Assessment of client risk

The assessment of client risk had improved since our last inspection of the service. Staff completed risk assessments for each client on admission, using a tool built into the care records system. The tool was in-line with those recognised within the substance misuse field. Risk assessments were reviewed every 12 weeks as a minimum or following any changes in circumstance, presentation, medicine or any other issue that could affect risk or recovery.

We looked at eight care records during our inspection and found risk assessments were in place for all eight clients; were regularly reviewed and were up to date.

Management of client risk

We saw evidence in care records that staff created risk management plans to mitigate the effects of risks that had been identified. These included plans to address intolerance to alcohol as a result of reducing alcohol intake, risks in relation to clients' children and no lone working when clients were known to be violent, aggressive or on the sex offenders register.

Staff responded promptly to any sudden deterioration in a client's health. Staff were able to identify the signs that clients' health may have deteriorated and respond accordingly.

Staff made clients aware of the risks of continued substance misuse and safety planning was an integral part of recovery plans. We saw evidence in care records that harm minimisation advice was provided to clients. There was a harm minimisation lead practitioner and a harm minimisation outreach worker employed within the service. Staff gave clients a leaflet in relation to family safety. This included advice and guidance around child safety, support available to the client, child supervision and telephone numbers for each site within the service and the National Society for the Prevention of Cruelty to Children.

There were no waiting lists within the service despite the restrictions and pressures caused by the COVID pandemic.

The service had effective lone working processes in place. These included:

- the use of signing in and out books in the reception areas
- visual boards in the reception office to inform staff of their colleagues' whereabouts
- the use of electronic calendars and,
- a buddying system by which a colleague contacted the person working alone in the community to check they were safe if they had not returned to the service when expected.

The service had a process for staff to follow when clients unexpectedly exited from treatment. This formed part of the provider's 'did not attend' policy. Staff made numerous attempts to contact the client, contacted pharmacies, families and carers, probation services, social care and arranged for the police to undertake welfare checks.

The service had a process in place to respond to suspicions or evidence that clients had passed their substitute medicine to a third-party for illicit purposes (an act commonly known as diversion). This included testing clients to ensure they were complying with their medicine, discussing possible diversion with the client and placing the client back on supervised consumption when necessary.

Staff recorded any conflicts between clients within their records which flagged as alerts when opened. This meant staff could ensure they booked appointments for these clients at separate times to each other.

Outstanding ☆

Community-based substance misuse services

Safeguarding

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

People who used the service and their loved ones were at the centre of safeguarding and protection from discrimination. This was evidenced by:

- the service having its own safeguarding lead
- staff being up to date with safeguarding and unconscious bias training which was appropriate for their role
- there were three supervisors who had received National Society for the Prevention of Cruelty to Children training and
- staff had made 19 adult and 67 safeguarding referrals to the local authority in the last 12 months which included themes around concerns over children being at the home of clients who were under the influence of drugs and/or alcohol and abuse within the home.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There had been no serious case reviews in the 12 months prior to our inspection.

Staff access to essential information

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

Client notes were comprehensive, up to date and all staff could access them easily.

Records were stored securely. Staff needed a username and password to gain access to the care records system.

Medicines management

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

The medicines management arrangements were the responsibility of the partner organisation.

Track record on safety

The service had a good track record on safety.

The provider had a sustained track record of safety supported by accurate performance information.

Staff reported serious incidents clearly and in line with the provider's policy.

There was ongoing, consistent progress towards safety goals reflected in a zero-harm culture. There had been two serious incidents in the last 12 months, neither of which were in relation to clients nor staff being harmed.

The first was in relation to a staff member's supervision notes being missing from their personnel file. This was reported to the Information Commissioner's Office.

The second was in relation to the temporary loss of access to the service's care record system following works carried out by the local authority's IT department. The service had not been made aware of the works being carried out. The local authority agreed that moving forward, the service would be informed of any works which may result in disruption; works would be undertaken outside of the service's working hours and the care records system would be tested following work being completed.

Managers debriefed and supported staff after any serious incident. The staff member whose supervision notes were missing was debriefed and supported once the issue was identified.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. These included client deaths, safeguarding issues, concerns about clients' welfare and any concerns about mental health or mental capacity.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

There had been no never events within the service. Managers shared learning with their staff about never events that happened elsewhere via flash meetings and monthly all staff meetings.

There was a genuinely open culture in which all safety concerns raised by staff and people who use service were highly valued as being integral to learning and improvement. All staff were open and transparent, and fully committed to reporting incidents and near misses.

Learning was based on a thorough analysis and investigation of things that go wrong. All staff were encouraged to participate in learning to improve safety as much as possible. For example, the quality and performance manager provided feedback and lessons learned from incidents to all staff via quarterly learning loops.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations. The system used for logging incidents required staff to record all interested parties related to the incident to ensure they were involved and kept informed of any progress.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong.

The service had made two duty of candour reports in the last 12 months. Both of these were in relation to information governance. Further guidance was issued to staff via learning loops, staff meetings and supervision sessions. Staff involved in the data breaches were given further targeted information governance training. Both incidents were reported to the Information Commissioner's Office and feedback was given to the service on improvements.

Outstanding ☆

Community-based substance misuse services

Staff met to discuss the feedback and look at improvements to client care. We observed two flash meetings and a regional board meeting and these included feedback from incidents and lessons learned.

There was evidence that changes had been made as a result of feedback. For example, managers had identified a concerning number of incidents in which clients had exhibited behaviours that challenge at the Durham site. When they reviewed the reception area of the Durham building, they identified the décor was very bright and 'loud' and there were too many posters and leaflets on walls and noticeboards. The décor was changed to a more relaxing and subdued colour and leaflets and posters were kept to a minimum. This calmer environment resulted in the number of incidents involving behaviours that challenge significantly reducing.

Are Community-based substance misuse services effective?

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all clients. They worked with clients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-orientated.

We saw evidence in care records that staff completed comprehensive mental health assessments and care plans for each client that met their mental and physical health needs. Staff regularly reviewed and updated care and recovery plans when clients' needs changed.

The quality of care and recovery plans had significantly improved. We looked at eight clients' care records and found that care and recovery plans were personalised, holistic and recovery-orientated. Care plans had improved since our last inspection. We reviewed eight care plans and found they included clients' strengths and goals, motivation to change and equality and diversity information pertaining to the client. Recovery plans identified who the client's recovery co-ordinator was.

We saw evidence in care records that the partner organisation carried out ongoing reviews of clients' physical health.

Best practice in treatment and care

Staff provided a range of treatment and care for clients based on national guidance and best practice. They ensured that clients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in quality improvement initiatives.

The percentage of adult clients who had successfully completed their care and treatment in the last 12 months was 50% and the figure for children and young people was 81%.

Staff provided a range of care and treatment suitable for the clients in the service which were in line with best practice and national guidance. These included drug misuse prevention, needle and syringe exchange programmes and psychosocial interventions.

Staff made sure clients had support for their physical health needs, either from their GP or community services. There were also two full time harm minimisation workers within the service who provided advice and support to clients and staff around safe injecting and other physical health issues.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. This included advice around reducing substance use; exercise, diet, getting access to outdoor green spaces to encourage better mental health, smoking cessation, harm minimisation advice and sexual health support.

Staff used recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes. Staff used red, amber and green ratings to denote the status and current risks of clients. Staff also used the recognised treatment outcome profiles tool to monitor clients' substance use, injecting risk behaviours, criminal activity and health and social functioning.

Staff used technology to support clients. This included the use of online meeting platforms, phone-based appointments, client access to online recovery groups and issuing clients with phones and tablets.

There was an integrated clinical audit programme led by the partner organisation.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of the clients. This included GPs, mental health teams, harm minimisation workers, recovery co-ordinators, criminal justice co-ordinators, recovery academy workers, aftercare workers, lead practitioners, a domestic violence worker, a think family lead and rough sleeper outreach workers.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Staff received an in-depth induction which included all mandatory training requirements; shadowing opportunities, not only with staff within the same role but other roles within the service. Ambassadors and volunteers received very similar induction and were treated the same as regular staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection, all staff eligible for an annual appraisal had received one in the last 12 months.

Managers supported staff through regular, constructive clinical supervision of their work. The provider's target for supervision compliance was every 12 weeks. However, the service had exceeded this target as staff received supervision every four to six weeks.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff had objectives focused on improvement and learning.

Managers made sure staff received any specialist training for their role. Examples of specialist training undertaken by staff included motivational interviewing, cyber-safety and the International Treatment Effectiveness Project.

Managers recognised poor performance, could identify the reasons and dealt with these. The provider had a performance management system in place which included a process for addressing staff performance issues.

Managers recruited, trained and supported volunteers to work with clients in the service. We spoke with a volunteer who was training to aid people with their recovery as they had lived experience of addiction. Another volunteer worked in the needle exchange service at the Durham site and also provided clients with advice around alcohol and drug use.

Multidisciplinary and interagency teamwork

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

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings were held monthly within each site. There were also operational management group meetings each month. These were led by the area manager to review service delivery and performance, safety, quality standards, incidents, client deaths, human resources and finance issues and the service business plan. There were also monthly quality and performance meetings attended by managers, death in service review meetings and daily flash meetings.

The multidisciplinary team had input into clients' comprehensive assessments. Professionals included project managers, nurses and non-medical prescribers from the partner organisation, recovery co-ordinators, substance misuse social workers, children's services, probationary services, the police and other criminal justice services.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. For example, we observed a multi-agency risk assessment conference between the Bishop Auckland service and other professionals including social services, mental health professionals and adults and children's safeguarding teams. The staff member from the service had a good knowledge of each client being discussed and the risks associated with them. The staff member also took notes of any updates from the other attendees to add to the clients' care records.

Recovery plans included clear care pathways to other supporting services. Staff worked with health, social care and other agencies to plan integrated and coordinated pathways of care to meet the needs of different client groups.

Staff had effective working relationships with other internal teams in the organisation and external services. Staff shared clients' treatment plans with their GP when the client had consented for them to do so.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for clients who might have impaired mental capacity.

Staff received and were consistently up to date with their Mental Capacity Act training and had a good understanding of at least the five principles. At the time of our inspection, 98% of staff within the service had completed their Mental Capacity Act training.

There was a clear policy on the Mental Capacity Act, which staff could access via the provider's intranet.

Outstanding ☆

Community-based substance misuse services

Staff knew where to get accurate advice on the Mental Capacity Act. There was a dual diagnosis nurse within the partner organisation who provided advice and support to staff when there were concerns about a client's mental health. Project managers regularly reviewed care records to ensure staff followed the Mental Capacity Act and associated processes correctly. The service also worked closely with a local mental health trust.

Staff within the service assessed capacity at each client's appointment and recorded this within their care record. We saw evidence in care records that clients signed consent to treatment forms.

Staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so.

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

People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

Staff treated clients with compassion and kindness. They went the extra mile and above and beyond expectations in order to support and meet the needs of clients.

During our inspection, all interactions we observed were kind, caring, respectful, discrete and compassionate.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treated them. People valued their relationships with the staff team and felt that they often went 'the extra mile' for them when providing care and support. Staff recognised and respected the totality of people's needs. They always took people's personal needs into account, and people's emotional and social needs were seen as being just as important as their physical needs. For example, clients told us they had been helped by staff to deal with social services which had resulted in their child being able to live with them; staff had proactively helped them to become a foster carer and their recovery co-ordinator accompanied them to appointments with their GP and community psychiatric nurse to advocate on their behalf. Others said their recovery co-ordinator had helped them build their confidence and self-esteem and were supportive when they were feeling anxious.

We spoke with 16 clients who were using the service. Clients said staff were always kind, treated them with dignity and respect, were compassionate and supportive. They praised staff for standing up for them and helping them manage their addictions. Clients told us staff were 'amazing' or 'fantastic', 'they couldn't thank them enough', and they trusted staff at the service.

Staff found innovative ways to enable people to manage their own health and care when they could and to maintain independence as much as possible. Clients told us recovery co-ordinators kept in touch with them regularly via face to face appointments, phone or video link. Clients told us staff provided harm minimisation advice and reminded them of the service's needle exchange provision.

Staff directed clients to other services and supported them to access those services if they needed help. These included housing, mental health and primary care services. One client said their recovery co-ordinator had supported them by providing contact details for services who could help them with moving home. Another client said staff had communicated with their supported living service and social worker to assist them with living independently in the future.

Staff who spoke with us said they felt they would be able to raise concerns about disrespectful, discriminatory or abusive behaviour without fear of reprisals. They said managers encouraged a culture of openness and transparency as it ultimately led to the service improving its care towards the people who used the service.

Staff understood and respected the individual needs of each client.

Staff received information governance training which included the need to ensure client confidentiality was maintained at all times.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of clients

Seven clients told us they had either not been offered a copy of their care plan or could not recall being offered it. We also noted that two client's care records did not indicate if they had been offered a copy of their care plan. However, all clients we spoke with told us they felt involved in decisions about their care and treatment. We saw evidence in clients' care records that staff involved them in the creation and ongoing development of their care and recovery plans.

Staff always empowered people who used the service to have a voice and to realise their potential. Individual preferences and needs were always reflected in how care was delivered. Staff involved clients in decisions about the service, when appropriate. Clients were consulted on service changes and developments to ensure they were fit for purpose and met their needs. Clients were also involved in the process for recruiting new staff to the service.

Clients could give feedback on the service and their treatment and staff supported them to do this. Feedback could be provided face to face, via comments cards, the use of the service's complaints process and also via exit interviews when clients were discharged.

Staff recognised that people needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensured that people's communication needs were understood, sought best practice and learned from it. Staff produced leaflets in different languages using online translation services, in braille and easy read. Staff told us they could arrange for clients to be supported by signers and translators and independent advocates quickly.

Outstanding ☆

Community-based substance misuse services

Involvement of families and carers

Staff supported, informed and involved families or carers. We spoke with four carers who said they felt supported by staff at the service.

One carer said staff were always there for them when they had struggled with their child's addiction; that the ongoing contact from their child's recovery co-ordinator was excellent and their recovery co-ordinator had kept their child alive.

Other comments included 'everyone has been spot on', 'I can't praise them enough, nothing is too much trouble', 'the recovery co-ordinator is a massive support to me as a parent', 'they've been a really big help' and staff were 'fantastic'.

Staff helped families to give feedback on the service. Feedback could be provided face to face, via comments cards and the use of the service's complaints process.

Staff gave carers information on how to access a carer's assessment. A carer's assessment is used to determine whether a person qualifies for support from their local authority in their role as an unpaid carer.

Are Community-based substance misuse services responsive?

Outstanding ☆

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

Access and waiting times

The service was easy to access. Its referral criteria did not exclude clients who would have benefitted from care. Staff followed up clients who missed appointments.

The service had clear access criteria that had been agreed with key stakeholders and other relevant services. The admission criteria for the service was that the client had an issue with either drug or alcohol misuse.

Humankind's innovation team had created an online self-audit tool called Drink Coach that people could complete on the internet or via a downloadable app. The tool helped the user to identify the extent of their drink problem. The tool also encouraged people to seek help as there was a facility to book an appointment with the service. The service had seen an increase in adults aged 45+ accessing the service for treatment through its open access route since this tool was implemented.

People could access services and appointments in a way and at a time that suited them. The service was open access and could undertake a triage either via face to face, phone or video link on the same day.

The service developed innovative approaches to meet the needs of a range of people who used the service. For example, the service had purchased a mobile public health facility to facilitate triage and meet the needs of people who lived in rural areas and had complex needs.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. For example, the service had robust alternative care

pathways and referral systems in place for a range of other support services. These included bereavement support, domestic abuse, sexual abuse and rape and links with a suicide prevention service. The service worked in partnership with criminal justice teams in supporting clients with behaviours that challenge and were difficult to engage with, by offering joint appointments at partner premises.

Staff offered clients alternative treatment options when they were unable to comply with specific treatment requirements. Clients who were unable to attend the recovery centre in person, due to physical or mental health issues were offered home visits or visits at alternative locations. Clients who were unable to comply with the requirements for community detoxification were offered the alternative of inpatient detoxification or a community alcohol reduction programme.

The service had processes in place for when clients arrived late or failed to attend their appointments which were fair and reasonable and did not place the client at risk. Staff made efforts to see clients, even when they arrived late, and the registered manager had promoted a culture in which client care and welfare was always the first consideration.

Staff tried to contact people who did not attend appointments and offered support. Staff were proactive in their attempts to re-engage with clients who had failed to attend their appointments and there was a clear 'did not attend' process in place that staff could follow which advised them of who they needed to contact such as friends, families, pharmacies and the police.

Clients had flexibility and choice in the appointment times available and appointments ran on time. Clients told us that staff were flexible in relation to appointment times. The service opening times were 9am to 5pm on Mondays, Tuesdays and Fridays. Following the easing of COVID restrictions, the Durham and Seaham sites remained opened until 7pm on alternate Wednesdays. The service also promoted an online recovery support programme as a support tool for clients to use during evenings and weekends.

No appointments had been cancelled in the 12 months prior to our inspection as a result of staff shortages. Staff we spoke with said that they would never refuse to see a client and if there were staff shortages on a particular site, managers would redeploy staff from other sites or arrange for agency staff to cover.

The service consistently reviewed the time taken to access treatment. Managers increased staffing levels either via fixed term recruitment or the use of agency staff when there were surges in clients accessing the service to minimise the time taken to access treatment.

There were no waiting lists within the service.

Staff supported clients when they were referred, transferred between services, or needed physical health care. We saw evidence in clients' care records that staff had supported them to access mutual aid and relapse prevention groups and mental health crisis teams.

The facilities promote comfort, dignity and privacy

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

The service had a full range of rooms and equipment to support treatment and care. These included private rooms for blood borne virus and urine testing, fully equipped clinic rooms, one to one rooms for client appointments and larger rooms for team meetings.

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

Managers within the service recognised that the building at the Peterlee service was not in-keeping with a therapeutic environment as the acoustics made it noisy, and the building was tired and dated. The provider had secured new premises in Horden which the local authority had reconfigured to the service's requirements which staff were due to move into the following month. We visited the new premises during our inspection. We found the layout to be spacious, calming and a more therapeutic environment for both clients and staff. The building was discrete as its design blended in well with the residential areas surrounding it.

Meeting the needs of all people who use the service

The service met the needs of all clients – including those with a protected characteristic. Staff helped clients with communication, advocacy and cultural and spiritual support.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met their needs, which was accessible and promoted equality. This included people with protected characteristics under the Equality Act and people who were in vulnerable circumstances or who had complex needs.

People's individual needs and preferences were central to the delivery of tailored services. Staff within the service were proactive in recognising and addressing issues facing clients within the community. Staff provided clients with sexual health support which included issuing condoms to promote safe sex. They recognised the financial pressures clients were under and offered free sanitary items to combat period poverty.

Staff did sweeps to locate any rough sleepers and gave them support such as providing clothing and toiletries. Each site had shower and laundry facilities. This meant rough sleepers could be given fresh clothing and take a shower whilst their dirty clothing was being laundered. Staff also worked with the local authority to support rough sleepers to be housed and booked COVID-19 vaccination appointments at suitable venues for them.

Clients had fed back to the service that they would like the timings of the recovery academy sessions to be changed as they had caring commitments. This was taken on board and the sessions were changed so they finished at 2pm so clients could pick up children from school or nursery.

Clients also identified the need for activities outside of the recovery academy hours. The service's community development worker responded by helping clients to access a number of other organisations offering courses and activities. The service also promoted an online recovery support programme as a support tool for evenings and weekends. The service also provided clients with tablet computers so they could access this and other online support and therapy tools.

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

The service had accessible rooms to see people in. There were accessibility lifts within the service buildings at Durham and Bishop Auckland and clients with mobility issues could be seen on the ground floor at the other services.

Staff made sure clients could access information on treatment, local services, their rights and how to complain.

The service provided information in a variety of accessible formats so the clients could understand more easily. These included information in braille and easy-read and the provider's website included software to convert text to speech which highlighted each word as it was spoken in a high quality, human-sounding voice.

The service had information leaflets available in languages spoken by the clients and local community. Staff were able to produce information in different languages using online translation services.

Managers made sure staff and clients could get hold of interpreters or signers when needed. Staff we spoke with said interpreters and signers could attend the service quickly when they were needed.

Listening to and learning from concerns and complaints

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

Clients, relatives and carers knew how to complain or raise concerns. There were posters on walls and noticeboards throughout the service buildings which informed people how to make a complaint.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint. The system used by staff to log complaints included the requirement to indicate any interested parties which included clients. This ensured clients were kept informed throughout the investigation process and of the outcome.

There had been 17 complaints within the last 12 months, of which six were partially upheld.

Managers investigated complaints and identified themes. The main theme from complaints over the last 12 months were in relation to communication between the service and clients. In each case, issues were able to be rectified or remedied by further discussion and addressing any issues raised.

Staff protected clients that had raised complaints or concerns from discrimination or harassment. Where possible, complaints and concerns about staff were dealt with through discussion and mediation between the associated parties. If the complaint related to a dispute between clients, notes were made on each clients' care records and appointments were scheduled so that the clients attended the service at different times.

Managers shared feedback from complaints and concerns with staff and learning was used to improve the service. An example of this was following the release of a report which contained sensitive and personal information pertaining to a third party. Staff received feedback that any third-party information, unless intrinsically pertinent to the case, should be redacted within publicly released documents.

The service used compliments to learn, celebrate success and improve the quality of care. In the last 12 months, the service had received 55 compliments.

Are Community-based substance misuse services well-led?

Outstanding ☆

Community-based substance misuse services

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

Leaders had the skills, knowledge and experience to perform their roles. Leaders had previously worked in probation services, in prisons and had worked with people with addictions for many years.

The provider had a clear definition of recovery. This was:

to support people affected by substance misuse, helping them to understand that recovery is for life

- that recovery starts as soon as the client steps through the door
- identifying what success looks like for the client as an individual
- agreeing realistic and achievable goals and milestones for the client
- devising appropriate relapse prevention work and strategies and,
- ensuring there are suitable accessibility standards in place for clients and their carers and families.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for clients and staff. During our inspection, we noticed senior managers within the service knew clients waiting in reception areas by their name and had a good rapport with them. Staff spoke highly of the managers within the service.

Vision and strategy

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

Humankind's vision was to envisage a compassionate society where the inherent value of every person is recognised, where families are healthy, and communities where everyone can prosper. Its values were service, integrity, teamwork, excellence, developing potential and diversity.

Staff knew and understood the vision and values of the team and organisation and what their role was in achieving them.

All staff had a job description.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Managers within the service welcomed feedback and encouraged staff to share their ideas as to how the service could be improved. For example, staff had identified a need to provide clients who were facing financial

hardship with sanitary products. Staff also suggested that the service kept a stock of clothes for rough sleeping clients. Managers agreed to implement these suggestions. The service received donations of clothes and sanitary products from a local supermarket and staff from the local authority and opened up the offer of providing clothing to all clients who needed it.

Culture

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.

Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. They had embedded and promoted a culture in which the focus was on a positive client experience and in which staff felt motivated to deliver high quality care and treatment.

There were high levels of satisfaction across all staff. Staff felt respected, supported and valued. They felt proud, positive, satisfied, part of the organisation's future direction and spoke highly of the service's culture. Throughout our inspection, we noticed that staff were smiling, and we heard laughter when staff members were in conversation with their peers and managers which evidenced there was a happy and positive culture within the service.

The key themes from Humankind's 2021 annual staff survey were that people felt valued and aligned to the organisation and their teams. There was some feedback around the need to improve and streamline staff communications. Managers reviewed and simplified workforce communications based on this feedback.

Another theme was around pay. In order to retain staff and in recognition of the benefits of a stable and experienced staff group for clients; the provider was undertaking a full review of its pay scales with external consultants. This was to ensure its salaries remained competitive in comparison to similar services within the substance misuse sector.

Managers monitored staff morale, job satisfaction and sense of empowerment.

The provider had staff award and recognition schemes. These included 'thank you' cards sent to teams and individuals; virtual money awards to spend on an online catalogue and away days at which staff were given bags to take home. For example, staff were given bags at a Christmas-themed awayday in 2021 containing kits to make gingerbread houses. The service's quality and performance manager had received a staff award in 2021 in recognition of their contribution to the service and organisation.

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

Managers who spoke with us said they actively encouraged staff at all levels to speak freely about any concerns they had as by doing so, this ultimately could be used to improve the client's treatment journey and make a better culture for clients and staff alike. This was corroborated by the fact that all the staff members we spoke with said they would feel able to raise concerns without fear of reprisals and policies and procedures positively supported this. The provider had a whistle blowing policy in place that was accessible to all staff on its intranet. There was a freedom to speak up guardian within the service.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The provider had a health and wellbeing strategy which was tailored to its staff. There was a schedule of health and

wellbeing campaigns which met the needs of staff as it was based on monitoring trends within staff diversity data; support staff had requested and from the Mental Health First Aid network which collected feedback from staff. The provider had a work/life balance policy. Managers encouraged and supported people in their requests for flexible working arrangements as they recognised how these benefited staff health and wellbeing.

There were webinars on key topics that had been identified in relation to staff health and wellbeing. There was also a dedicated wellbeing support email address for people to request support and advice about health and wellbeing tools that were available. The provider's intranet featured a wellbeing portal called 'Happy Healthy You' that included information about the provider's employee assistance programme; support networks available, policies and forums for staff to access, and educational and promotional programmes available around health and wellbeing. Managers also had access to health and wellbeing toolkits to help support their staff.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. There were equality and diversity policies and staff received unconscious bias training. All policies and procedures had been subject to equality impact assessments to ensure they did not place vulnerable groups or people with protected characteristics under the Equality Act at a disadvantage. There were dedicated client groups for women and people who identified as LGBTQ+.

The provider's website supported accessibility by being compatible with a range of on screen reading and translation software. Staff ensured that subtitles were switched on for any videos it uploaded to its website or social media platforms. Staff used imagery or video to help illustrate information wherever possible. The provider's website was configured so that people who were unable to use a mouse could navigate around the site using just their keyboard.

The service had its own equality and diversity champion; there were regional champions and a regional lead. The service maintained a database of staff who could speak in multiple languages so they could be called on to assist with communicating with clients, carers and family members for whom English was not a first language.

There was strong collaboration, teamworking and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. Staff told us that both the Humankind and staff within the partner organisation worked together as one big team that supported each other and were confident managers would deal with any difficulties appropriately.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance systems, policies, procedures and protocols were proactively reviewed and reflected best practice. For example, staff within the service had identified that its process for addressing clients who had exhibited behaviours that challenge was too punitive as it led to warnings and possible removal from the service. It was developing a new process that was more supportive to the client and was more focussed around staff/client engagement. The process was in draft at the time of our inspection pending agreement by senior managers within the organisation.

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. There was a strong record of sharing work locally and within the wider organisation.

There was a clear framework of what must be discussed in meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Quality was a standing agenda item at governance meetings. Quality managers maintained audit schedules and provided quality reports to management to highlight areas for improvement. These reports were discussed and action plans to address any issues were developed and any actions were reviewed and completed.

Humankind's integrated governance policy set out the integrated governance approach. There were joint meetings between the provider and partner organisation which helped to support shared responsibility for delivering good quality care, share good practice and learning.

The governance arrangements both within the service and wider organisation were clearly effective. Despite the restrictions in relation to the COVID-19 pandemic, no client appointments had been cancelled as staffing was appropriate and regularly reviewed. The sites within the service were clean, safe, well equipped and staff followed infection prevention control measures well. Staff were up to date with their mandatory training, supervision and appraisals and had the skills and experience appropriate for the client group to whom they were delivering care to. Client feedback was positive, and clients commented how amazing and supportive staff were. There had been only two serious incidents within the service; neither of which related directly to the care and treatment of clients.

The service used an electronic system to record and monitor incidents, complaints, safeguarding referrals and client deaths. The system ensured all relevant parties such as clients, family members, social services and senior managers within the organisation were involved and kept informed, actions were completed, and lessons learned were identified. Lessons learned were then shared with staff through monthly learning loops to improve practice within the service.

The issues in relation to care records we had previously identified had been addressed. The quality and performance manager had developed a tracker system which was updated in real-time as staff updated the care record for any client they had dealt with. This allowed them to monitor information recorded in care records by site, team or individual staff member. This governance tool was effective as we found care records were now holistic, contained all information pertinent to the client such as strengths, goals, motivation to change and any equality and diversity considerations.

Staff within the partner organisation undertook local clinical audits on behalf of Humankind. The audits were sufficient to provide assurance and staff within both services acted on the results when needed.

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

Management of risk, issues and performance

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

There was a clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures.

Staff had access to the risk register via the provider's intranet. There were national and local risk registers which were reviewed at service board level. Staff were able to submit items to the provider's risk registers and their concerns matched those on them. Managers at each of the service sites discussed the risk registers with their staff in team meetings and took any new concerns they had for possible inclusion on the risk registers to the service board level meetings.

The service had plans for emergencies such as adverse weather conditions, loss of IT services, pandemics and other issues that could negatively impact on service delivery. Each site within the service had a business continuity plan which included contact details for who to notify if there was an emergency, and contingency plans were in place to mitigate adverse effects on care and treatment.

Managers monitored staff sickness and absence rates.

The service had not been asked to make cost improvements and had actually had additional funding to deliver care and treatment.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff.

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

Information governance systems included confidentiality of client records. Staff ensured the service confidentiality agreements were clearly explained to clients in relation to the sharing of their information and data.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff submitted data and notifications to external bodies as needed such as the local authority and Care Quality Commission.

All information needed to deliver care was stored securely within the service's care records system which required staff to use a username and password to access.

The service had developed information-sharing processes and joint-working arrangements with other services where appropriate to do so.

The provider encouraged creativity and innovation to ensure up to date evidence-based practice was implemented and embedded. For example, the service's sustained recovery project manager had participated in research to improve outcomes for women. A task and finish group had been formed to look at the current service offer through consultation with wider partners and stakeholders to meet the holistic needs of women. The recommendations from this consultation were being implemented across the service.

Outstanding ☆

Community-based substance misuse services

The service had procured a testing machine which was used to determine if clients had developed antibodies which would indicate they had a blood borne virus. Staff from Humankind and the partner organisation then referred any clients who tested positive to a local external health service for treatment. At the time of our inspection, staff had referred nine clients to this service after they had tested positive.

Humankind's innovation team had created an online self-audit tool called Drink Coach that people could complete which was available on the internet or via a downloadable app. The score the person using the tool received denoted the advice they received around managing their drink problem. The tool also included the facility to book an appointment with the service. Over 4,700 people had used the tool and the service had seen an increase in adults aged 45+ accessing the service for treatment through its open access route.

Humankind had completed a series of 'Alcohol Round Tables' of which the County Durham service contributed to refresh its approach to alcohol interventions. The 'Alcohol Round Tables' was an organisation-wide project led by the provider's director of nursing. Consultations were held in each region and frontline staff throughout the country were invited to take part to analyse current alcohol pathways. This included identifying any barriers to treatment and finding ways to remove them. The aim was to have a core alcohol model which was consistent throughout the organisation, with local variations if needed to best serve the local population or to adhere to specific commissioning requirements. The new model was developed in draft and the next stage was to undertake a client consultation around it which was planned for the near future.

The area manager attended quarterly board meetings around reducing re-offending which was also attended by criminal justice agencies, including representation from the Police, Crime and Commissioners office. The focus of these meetings was to look at the strategic processes and issues affecting re-offending across the area. This included any specific substance misuse issues, concerns, hot spots and other factors. It also served as an opportunity for the service to have a voice with more statutory partners and influence decision making. The Police and Crime Commissioners office was involved in the development of roles within a Universal Funding grant application which the service was subsequently awarded. The Universal Funding grant was used to fund 14 new posts and improve the offer of naloxone across the County. The new posts included criminal justice workers, harm minimisation workers, police liaison workers and offender management workers.

The service was developing a pilot initiative with the local university in response to recent issues raised by students around drinks being spiked whilst on nights out which was due to rolled out 21 March 2022. The service had proposed confidential one to one sessions with any students who were concerned about being spiked. It also proposed to offer a testing service so students would know if they had been spiked and if so, receive support from staff at the service.