

# Swanswell Redditch







## Quality Report

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

### Ratings

Overall rating for this location		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive?		Good	
Are services well-led?		Good	

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

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

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

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

# Summary of findings

## Overall summary

### **We rated Swanswell Redditch as good because:**

- The service kept people safe from avoidable harm by ensuring there were sufficient staff with the right training, supervision, knowledge and skills. Risk assessments were completed and care was planned around the client's individual needs. Staff had good awareness of safeguarding issues, they followed the service's lone working policy, incidents were reported, and lessons learnt were cascaded to staff.
- Staff used best practice and national guidance to complete comprehensive assessments, which enabled the development of personalised and holistic recovery plans detailing the appropriate treatment and care.
- Staff worked well together and with external partners to ensure clients received effective and consistent care and treatment, and monitored outcomes regularly.
- Clients told us staff treated them respectfully and with dignity, and they were involved in their own care. They felt they were listened to and both clients and carers were provided with relevant information and support to manage their recovery. The service invited feedback which was shared at a local and national level.
- The service responded to clients quickly and managed their caseload effectively to ensure they could provide care when the client required it. The service was meeting its targets and dealt with complaints effectively.
- The service supported clients to access work, education and mutual aid to enhance their recovery and was accessible to those people protected under the disability and discrimination legislations.
- There were good governance arrangements in place. Experienced managers and staff monitored the quality of the service using audits, client feedback, reviewing incidents and complaints, and key performance indicators. Morale was high amongst staff and they liked working for the service.
- The service encouraged innovation and had implemented quality improvements across the service to enhance the service they provided to their clients.

# Summary of findings

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Good 

# Swanswell Redditch

**Services we looked at:**

Community-based substance misuse services;

# Summary of this inspection

## Background to Swanswell Redditch

Swanswell became part of the Cranstoun group in December 2016. It is a national charity and has been supporting people who misuse substances since 1970. It became the provider of services in Redditch and Bromsgrove in April 2015, as part of the county-wide service in Worcestershire. Swanswell Redditch is in the town centre and offers a service to people in the surrounding area.

The service offers: health promotion, needle exchange, testing for blood borne viruses, vaccinations for hepatitis B, prescribing substitute medication for opiate dependence, community home detoxification, GP shared care, action planning, care co-ordination and key working, group work, referral and assessment for residential rehabilitation and detoxification, supporting alcohol and substance users involved in the criminal justice system, harm reduction and abstinence-based treatment, debt and housing advice, and health engagement and life skills.

The service is funded by local commissioners and provides a free service to those who use it. There is a registered manager for the county service who had oversight over the three area locations: Worcester,

Redditch and Kidderminster. Each location, including Redditch, is led by a team leader. Swanswell Redditch offer a service 9am – 5pm Monday to Friday and open until 7pm on a Thursday. The service offered home visits based on individual need and had a shared care agreement with some of the GP surgeries in the Redditch and Bromsgrove area. Some county-wide specialist roles were delivered in a range of settings by family workers, a blood borne virus nurse, an alcohol nurse, young people's workers, a peer mentor and volunteer co-ordinator, non-medical prescribers and criminal justice workers. The team also incorporated a pilot known as the blue light project which worked in partnership with other agencies to provide interventions to those people with alcohol problems. This report looks at the running of services in Redditch.

The service provides diagnostic and screening procedures and treatment of disease, disorder or injury as regulated activities.

The service was last inspected in February 2018, but was not rated. The Care Quality Commission started to rate substance misuse services in Summer 2018.

## Our inspection team

The team that inspected the service comprised of three CQC inspectors.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

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

- Is it safe?

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

# Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with four clients and one carer who used the service;
- spoke with the registered manager and manager of the team;
- spoke with 12 other staff members including substance misuse workers, criminal justice workers, non-medical prescribers, a doctor, a volunteer and administration staff;
- received feedback from two commissioners;
- attended and observed one clinic, one flash meeting and one Welcome meeting;
- looked at six care and treatment records of clients;
- looked at a range of policies, procedures and documents relating to the service.

## What people who use the service say

Clients we spoke with were complimentary and positive about the service. They said they liked having a consistent staff member as their key worker, which

helped them build up rapport and aid recovery. They said that staff listened to them, provided them with enough information and they could attend appointments when they needed them.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We rated safe as good because:

- We saw that staffing was sufficient to provide clients with safe care and treatment. Staff were supported by specialists who worked across Worcestershire, enabling the service to offer a range of expertise to minimise harm and risk to clients, while maximising their recovery.
- Managers ensured staff received the relevant training for their role and monitored a training matrix to confirm they were up to date with their requirements.
- Staff were aware of the lone working policy and how to keep themselves safe.
- Staff completed and updated risk assessments, ensuring the service highlighted and managed any risks appropriately, including risks to children and vulnerable people.
- Staff knew how to protect clients from abuse and the service worked well with other agencies to do so. Staff discussed safeguarding issues within the multidisciplinary team and good practice was shared across the service as lessons learnt.
- Staff followed best practice when storing, giving and recording medicines. Staff followed the prescription and security policies.
- Staff were aware of what and when they needed to report incidents and staff and managers received appropriate feedback. Incidents were reviewed by senior managers and lessons learnt were cascaded to staff regularly. When things went wrong, staff apologised and gave clients honest information and suitable support.

Good



### Are services effective?

We rated effective as good because:

- Staff completed thorough and comprehensive assessments of their clients which led to holistic recovery plans based on their needs. Recovery plans were personalised, comprehensive and understood by staff.
- Staff provided treatments and care for clients based on national guidance and best practice. This included psycho-social interventions, medicines prescribing, physical health screening and testing, that ensured clients received an appropriate service.
- Managers monitored client treatment outcomes regularly and provided information to the national drug and treatment monitoring service.

Good



# Summary of this inspection

- The service had a good mix of skilled staff that was well supported by clinicians and other professionals in the countywide service.
- Managers made sure staff had the skills needed to provide high-quality care. They supported staff with performance reviews, supervision, opportunities to update and further develop their skills.
- The service worked effectively with other statutory agencies. It had shared care protocols in place to support effective working with GPs and pharmacies. The service also worked well with other agencies and health care providers to ensure clients had all their needs met. The service highlighted the blue light project as an example of working proactively with other agencies to engage clients who could benefit from their help and support.
- Staff recognised when a client lacked capacity and were aware of where to seek guidance and support regarding this.

## Are services caring?

We rated caring as good because:

- Staff treated clients with compassion and kindness. They respected clients' privacy and dignity, and supported their individual needs and supported them to manage their care, treatment and recovery.
- We saw that staff were discreet, respectful and responsive, providing clients with help, emotional support and advice at the time they needed it. Clients felt listened to and staff sought their views. Clients said staff had supported them to reduce their substance misuse and maintain their recovery.
- Staff provided clients with choices regarding treatment options and gave information to aid decision making.
- Staff encouraged client and carer feedback. Service user representatives spoke with clients as peers and collated feedback on the service to inform the local and national service user forums. The service had been responsive to client's suggestions and implemented some of their good ideas.
- The service provided a family and carers service where family members could receive support from staff and could also provide feedback on the service they received.

**Good**



## Are services responsive?

We rated responsive as good because:

- People could access the service closest to their home when they needed it. Waiting times from referral to treatment and to discharge clients were in line with good practice.

**Good**





# Summary of this inspection

- Staff responded to all referrals to the service quickly and triaged them appropriately. The team were flexible and offered clients choice with their appointment times and where they wanted to be seen. Clients did not have to wait for an assessment or allocation of substance misuse workers.
- Staff followed the service's engagement policy when clients did not attend for their appointments to ensure they were safe.
- The service worked effectively with other agencies and teams, and ensured clients were supported during transfers of care and discharge from the service.
- Staff supported clients with activities outside the service, such as work and education and signposted to mutual aid organisations to support recovery.
- Facilities were accessible and supported privacy, dignity and confidentiality. Information was available to clients whose first language was not English or had communication difficulties.
- The service operated an effective complaints procedure. Any learning was shared and discussed within supervision and team meetings.

## Are services well-led?

We rated well-led as good because:

- Managers were suitably skilled, knowledgeable and experienced to effectively lead and manage staff, ensuring they received the right training, supervision and information to provide good quality care to their clients.
- Staff told us they were aware of the service's vision and values and felt respected, supported and valued by senior managers. Staff had opportunity to reflect on their practice and make improvements by regularly attending team meetings, supervision and training.
- Staff monitored the quality of the service using key performance indicators, audits and staff and patient feedback. Senior managers monitored and scrutinised results in regular manager meetings. Managers regularly discussed targets and outcomes with senior leaders within the organisation and with commissioners.
- There was a clear framework of how information would be cascaded down from the board to all staff. Staff received feedback on complaints, incidents and changes being made to the service and lessons learnt had been embedded within the service.
- Senior staff met with external partners to discuss shared issues, thematic reviews and to provide information sharing.

**Good**



## Summary of this inspection

- The service encouraged creativity and innovation. Staff gave examples of quality improvement initiatives they had implemented and attended.

# Detailed findings from this inspection

## Mental Health Act responsibilities

NA

## Mental Capacity Act and Deprivation of Liberty Safeguards

People were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interest, recognising the importance of the person's wishes, feelings, culture and history. When staff had concerns about a person's capacity, they followed the escalation process and discussed specific cases with the senior practitioners and managers.

Staff ensured clients consented to care and treatment, this was assessed, recorded and reviewed when necessary.

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

## Notes

# Community-based substance misuse services

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

## Are community-based substance misuse services safe?

Good 

### Safe and clean environment

The service was situated in Redditch town centre. The front door was locked and accessed by a buzzer system, which was also monitored by CCTV. Visitors introduced themselves and they would be met and escorted by staff into the building. The service was located on the first floor. People with poor mobility could use a chair lift.

The service had several CCTV cameras at various points throughout the building. The CCTV viewing point was in the staff office, which ensured staff were aware of people's whereabouts whilst they were in the building.

The service had accessible rooms to see people in. There were five rooms to see clients in, including two group rooms, a doctor's room, needle exchange and a clinic room. Rooms had alarms which could be activated to summon help and assistance from staff.

The premises were safe, clean, well equipped and furnishings were well maintained and fit for purpose. Equipment used within the needle exchange and by the nurses was in date, and physical health equipment had been checked to ensure it worked properly.

We saw that staff adhered to infection control principles, including handwashing. Hand sanitisers were available across the site. Clinical waste was appropriately stored and managed.

The site had up to date health and safety assessments, including a fire risk assessment and related fire safety plans, monthly building inspection checklists, legionella risk assessment, lift maintenance and panic alarm tests.

### Safe staffing

There was enough skilled staff to meet the needs of clients and there were contingency plans to manage unforeseen staff shortages. Staffing consisted of six substance misuse workers, one team leader, one senior practitioner, administration workers and three volunteers. Other staff worked county wide across the three Worcestershire sites. They included staff from the criminal justice team, young person's team, peer support and volunteer mentor, non-medical prescribers, blood borne virus nurse, family team and an alcohol nurse. There was one vacancy for a senior practitioner as one had just left the service.

The service used agency staff when required to cover sickness and vacant posts, which ensured client safety. One agency worker was working two days each week to meet the service needs due to a recent increase in referrals within the area.

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service kept a training matrix and any gaps in training were identified by the training department and staff were booked onto relevant training courses or provided with an e-learning package to ensure they were up to date. Staff were up to date with their training requirements at 100% when we inspected.

All staff attended mandatory health and safety training which was completed every three years. Staff had awareness of the lone working policy and attended mandatory lone working training. Alarms were available in

# Community-based substance misuse services

the interview rooms. Most clients were seen on the premises or at GP surgeries. On occasion, when necessary, staff did visit clients at home. They followed the lone working policy and were required to telephone the base before and after their visits.

Staff also attended professional boundaries and confidentiality training, including de-escalation techniques, all with a view to keeping them safe.

All staff completed mandatory Mental Capacity Act training every three years. Staff were up to date with this training.

## Assessing and managing risk to patients and staff

We reviewed six client case files. All were completed to a good standard. Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually. They had good awareness of the potential risks vulnerable people and children could be exposed to and acted appropriately. For example, providing home visits when children lived with people undergoing treatment for substance misuse.

Staff responded appropriately to warning signs and deterioration in client's health. They liaised with other services, such as acute hospitals and GPs. Staff were flexible and a duty worker was available to see clients promptly if their health deteriorated.

Staff received training in health and harm reduction. Clients were made aware of the risks of continued substance misuse and harm minimisation and safety planning was an integral part of recovery plans. Staff ensured that clients received advice and information about this and staff told us how they responded to changing risks posed by clients. For example, discussions of how to keep safe when clients were screened for a blood borne virus.

## Safeguarding

Staff knew 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.

The service worked closely with other partners of the multi-agency safeguarding hub as part of the family front door service. Staff attended the multi-agency risk assessment conference when required.

Staff had the opportunity to discuss complex safeguarding cases and concerns with senior staff and the safeguarding

lead during complex care reviews, and with their manager during case management. Any examples of good safeguarding practice were shared through the lessons learnt bulletin. Senior staff monitored staff adherence and knowledge of safeguarding through case file audits.

All staff received safeguarding training for children and adults and gave examples of when they had made referrals to other agencies and applied their safeguarding knowledge in practice.

## Staff access to essential information

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

The service had an information sharing agreement with the neighbouring mental health trust, so they had awareness of the needs of clients and could access information in a timely manner.

## Medicines management

Staff followed best practice when storing, giving, and recording medicines. Staff regularly reviewed the effects of medications on each patient's physical health, to ensure they were not experiencing any side effects and the medicine was at the correct dosage.

An effective system was in place regarding the storage and processing of prescriptions. Staff followed the prescription and security policies and one staff member oversaw the process to ensure consistency and efficiency. Prescriptions were processed by the team administrator and checked and signed by the prescriber. Unused prescriptions were stored safely and staff signed them out as per the Cranstoun policy. There were good lines of communication between the service and pharmacists including when service users did not collect their prescriptions.

The service did not store controlled drugs or other medications, except for naloxone which was dispensed to clients, or used within the building. Staff recorded when they issued, used or trained clients how to use it. Naloxone is a medication used to block the effects of opioids, especially in overdose. The naloxone doses we saw were within their expiry dates and appropriately stored. Staff had received training in teaching clients how to use naloxone.

# Community-based substance misuse services

Nurses in the service administered hepatitis B vaccines. The vaccines were kept within a fridge to ensure their efficacy was maintained. Adrenaline was readily available for injection should clients have an extreme reaction to the vaccine.

Where medicines were stored, we saw that staff checked the room and fridge temperatures daily when the service was open to ensure they remained within range to maintain their efficacy.

Staff provided clients locked boxes to store their medication in at home, if this was required. This meant children, or others, would not be at risk of taking medicines. Staff ensured clients knew how to use them, and clients with children could be visited at home so staff could assess any risk.

## Track record on safety

The service reported 13 deaths in the 12 months up to November 2018. These deaths consisted of people who had received some care or treatment from the service however may not be related to their use of substances. All deaths were reported to the Care Quality Commission and were reviewed through the service incident investigation process. Any actions or recommendations were reviewed at a senior level.

## Reporting incidents and learning from when things go wrong

The service managed patient 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 received feedback when they had reported an incident, and the outcome of incidents was discussed in team meetings and in supervision. Staff received a service wide quarterly lessons learnt bulletin highlighting key learning points and actions to implement into wider practice. The lessons learnt bulletins are discussed in the clinical governance meetings.

Staff gave us examples of improvements that had happened in the service following incidents and lessons learnt. A handover tracking sheet had been developed following an incident when a high-risk client was missed when a staff member went off work unexpectedly.

## Are community-based substance misuse services effective?

(for example, treatment is effective)

Good 

## Assessment of needs and planning of care

We reviewed six client case files. We saw that staff had completed thorough and comprehensive assessments of the client's drug/ alcohol use, injecting history, previous access to treatment and their motivation to change. Staff used specialised and recognised assessment tools. In addition, staff ensured mental health and physical health needs and history were recorded.

Recovery plans were personalised, comprehensive and understood by all the staff. Staff ensured that they included the persons views, their strengths and weaknesses, protective factors and a full range of their problems and needs. They were individualised, and person centred and included practical and achievable goals which were reviewed regularly. Clients we spoke with knew who their key worker was and who to contact when required.

Staff had developed risk management plans that included a plan for unexpected exit from treatment. These were evident in client's case files.

## Best practice in treatment and care

Staff provided treatments and care for clients based on national guidance and best practice. Staff supported clients with their physical health and encouraged them to live healthier lives.

The service used evidence-based psycho-social interventions such as motivational interviewing, solution focused therapy and structured relapse prevention. Staff saw clients mainly in one to one sessions. The service did not facilitate any structured recovery groups, although had implemented a 'Tea and toast' weekly informal drop in session led by a volunteer. Staff had identified they wanted to develop more structured groups in the coming months.

Staff supported clients with housing, education, training and employment and helped them access partner agencies. They also enabled them to access mutual support organisations.

# Community-based substance misuse services

Clients in the service were prescribed medicines recommended by national guidance (Methadone and buprenorphine for the management of opioid dependence, National Institute for Health and Care Excellence (NICE) 2007; DH, 2017; NICE, 2011). Staff told us an electrocardiogram would be arranged for clients taking over 100ml of methadone. The electrocardiogram monitored potential heart abnormalities due to their dose of medicine. This was in accordance with national guidance (DH, 2017; Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care, Royal College of General Practitioners, 2011).

Staff prescribed medicines to clients to assist with their abstinence from alcohol. This was in accordance with national guidance (NICE, 2011). Clients could be offered a community alcohol detoxification. Staff used recommended alcohol audit tools such as SADQ and AUDIT and ensured physical health monitoring was completed before they commenced alcohol detoxification. The alcohol specialist nurse provided home detoxification if deemed appropriate and safe following a thorough risk assessment of the client's environment, physical health and family/carer support. Staff could organise an admission for an in-patient detoxification if required and the risks were high.

At the beginning of their treatment, and whenever else was necessary, clients who took methadone or buprenorphine would be required to pick up their medicine at their local chemist, and be observed taking it. Known as supervised consumption, this is best practice (DH, 2017). Staff would regularly check client's urine samples to ensure they remained abstinent from opioids; if they had not or risks had changed, supervised consumption could be re-activated.

People accessing drug treatment were offered testing and referral for treatment for hepatitis B, hepatitis C, HIV and vaccination for hepatitis B. This was in accordance with best practice (DH 2017). They operated an 'opt out' system and were comparable to the national average for take up at 93% for all new presentations to the service. The service also offered clients hepatitis vaccinations and naloxone training and had recently implemented in conjunction with the local NHS acute hospital trust, the latest treatments in managing and treating hepatitis C.

Clients could attend for a needle and syringe exchange as recommended by Department of Health drug misuse and dependence guidelines. The service had three sessions a week at the site, and local pharmacies operated a needle exchange system.

Staff supported clients to lead healthier lives through healthy living advice and harm reduction and provided basic physical health assessments. The service worked closely with GPs through their shared care arrangements and liaised with healthcare professionals and supported clients with their physical health needs when required. Staff offered a spirometer test for clients at risk of respiratory health problems.

Staff reviewed care and recovery plans regularly with the person using the service. The service recorded client outcomes using the treatment outcome profile. Staff measured outcomes when clients entered treatment and every three months. An outcome measurement took place when the service discharged clients. The service also provided information to the national drug and treatment monitoring service.

The service used audits to identify areas of good practice and where they could make improvements. Staff followed national guidance and best practice and monitored their results with other services within the Cranstoun group.

## **Skilled staff to deliver care**

Managers made sure they had staff with the skills needed to provide high-quality care. They supported staff with appraisals, supervision, and provided opportunities to update and further develop their skills such as further training.

The service employed a range of skilled staff, including a team leader, senior practitioner, substance misuse workers, administration staff and volunteers. A GP with specialised knowledge in substance misuse saw clients within clinics twice a week. In addition, the team received input from staff who worked countywide including a blood borne virus nurse, a detoxification nurse, family workers, young persons' substance misuse worker, criminal justice team for young people and adults, and a peer mentor and volunteer co-ordinator.



# Community-based substance misuse services

All new staff, including volunteers, received a comprehensive induction and met regularly with their manager to support them until they felt completely comfortable and competent within their role.

All staff were provided with mandatory and essential training, and the service ensured that staff completed it and were up to date.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge, for example training in alcohol brief interventions, motivational interviewing, solution focused therapy and health and harm reduction. The managers of the services across Worcestershire had commenced leadership training with an outside organisation.

Every three months, staff received a performance review, clinical supervision, group supervision, observations by senior staff and an audit of a sample of their patient case files. This was in line with their supervision policy.

Managers dealt with poor performance from staff quickly and efficiently and supported them to help them improve by implementing action plans that were regularly reviewed. The team leader, senior practitioner and clinical lead were available to offer advice and support to staff and through supervision and case file audits could identify areas of good practice and where staff required extra support.

The service recruited service user representatives and volunteers. There were three volunteers in Redditch but no service user representatives when we inspected. The volunteers were managed and supported by the peer mentor and volunteer co-ordinator. We saw that they received a comprehensive training programme and regular supervision.

## Multi-disciplinary and inter-agency team work

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.

Managers allocated cases to staff following referral to the service. This meant that care coordinators were identified quickly and clients would know who they would be seeing each session and who to contact when required.

The service had fortnightly complex case reviews. Staff discussed complex cases with senior staff and specialist County wide staff and any recommended interventions

would be care planned. Each morning the service held a 'flash' meeting where they would plan the day's work and any potential risks, safeguarding issues, prison releases or other pertinent items were discussed.

The service had effective protocols in place for the shared care of people who use their services. A few GP surgeries in Redditch had committed to providing a shared care arrangement with the service. Substance misuse workers from Swanswell provided clinics within the shared care GP practices. This enabled staff to liaise quickly and closely with GPs, practice nurses and other professionals and meant that clients could attend their local surgery for their drug/ alcohol sessions, which was often more convenient for them. Swanswell staff who worked within the GP surgeries told us they had built up good working relationships with shared care staff. The service had a shared care lead who liaised regularly with the GP practices and provided audits to ensure quality was consistent and maintained.

There were close links with community services, social services, education, child and family services, criminal justice services including probation and mental health teams. We saw reference within case files of working with other agencies to ensure coordinated pathways of care and observed this within the clinic. The service liaised with specialists such as liver consultants, substance misuse midwives, and alcohol related brain injury experts.

The service was involved in a pilot called the 'blue light' project. The project was developed as part of the Worcestershire health and wellbeing strategy for 'reducing harm from alcohol plan' 2016 – 2021. They worked in partnership with other agencies such as the police, probation, social services, housing and the fire service, with the aim to engage vulnerable people who were alcohol dependent, isolated and had not been successfully engaged in services, ensuring their safety. Staff said the project was working well and there was good liaison between the different services who met regularly to monitor and review the project.

Staff engaged in activities and initiatives to improve joint working and liaison. Staff attended appointments with other professionals when required and meet with the local mental health trust to improve their working relationships. However, staff reported there could be inconsistency in attitudes of staff within the local mental health trust



# Community-based substance misuse services

regarding referrals and whether they were accepted. The service discharged people when specialist care was no longer necessary and provided discharge letters to GPs in a timely manner.

## Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions about their care. Staff understood the service policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly.

Staff presumed capacity of their clients. Staff understood how to support people to make decisions where appropriate and when they lacked capacity, decisions were made in their best interest, recognising the importance of the person's wishes, feelings, culture and history. When staff had concerns about a person's capacity, they followed the escalation process and discussed specific cases with the senior practitioners and managers.

Staff ensured clients consented to care and treatment and sharing of information, this was assessed, recorded and reviewed in a timely manner. We saw this in all the clients' files we reviewed and observed it in the 'Welcome' meeting we attended.

## Are community-based substance misuse services caring?

Good 

## Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They respected clients' privacy and dignity and supported their individual needs.

We observed staff and saw they were discreet, respectful and responsive, providing clients with help, emotional support and advice at the time they needed it.

Staff supported clients to understand and manage their care and treatment and helped them access and engage with other services that could be beneficial to their recovery.

We spoke with four clients who were using the service. All were very positive about the service and the team, and staff had appeared interested in them, their stories and how they could be helped. Staff engaged them by listening,

supporting and offering practical help. They liked having consistency of staff and had built a good rapport, which had helped aid their recovery and reduce their substance misuse. Staff understood their individual needs and were flexible to accommodate their personal, cultural, social or religious needs.

Staff maintained the confidentiality of information about clients. We reviewed six client's files and saw that they had all signed a confidentiality agreement and they had understood it when staff explained it to them. All staff we spoke with understood the importance of confidentiality and we observed them giving reassurance to clients when they spoke about it.

## Involvement in care

Staff involved clients and those close to them in decisions about their care, treatment and changes to the service.

People in drug treatment were given information and advice about harm reduction, maintenance, detoxification and abstinence. Staff communicated with clients so that they understood their care and treatment. Staff were experienced with working with people with substance misuse issues and found ways to effectively communicate with those that may have difficulties understanding the information.

The service empowered and supported people to access an advocacy service if they required it.

We saw in case files that staff involved clients in the setting of relevant goals and in the regular reviewing of progress. We could see that clients had been offered a copy of their care plan and clients we spoke with knew their treatment and goals. Clients told us the service had provided them with plenty of information to support their recovery.

Staff engaged with clients, their families and their carers to ensure they understood their care options and had the relevant information to make informed decisions.

The service asked for feedback through questionnaires, and through the service user representatives. Two service user representatives worked across the three sites across Worcestershire to gain feedback from other clients, often when they are waiting for their appointments in the waiting area. Service user representatives were still undergoing their own recovery so other clients saw them as peers and could talk openly to them about whether they were happy

# Community-based substance misuse services

with their treatment. This information was fed back at local and national service user forums, which were attended by the service user representatives and the peer mentor and volunteer coordinator.

The service user representatives and volunteers had previously used the service and wanted to use their experiences to help and support other people going through recovery. They welcomed new clients to the service and ran groups. The service did not operate a service user forum or group, however staff and clients had suggested through the ROAD (recovery, orientated, audit, development) event that these would be useful.

The service provided a family and carers service where family members could receive support from staff and could also provide feedback on the service they received. Staff involved family members as much as possible so they could offer support and encouragement to their relative.

Staff provided carers with information about how to access a carer's assessment and could be referred to the local authority for a carer's assessment.

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

Good 

## Access and discharge

People could access the service closest to their home when they needed it. Waiting times from referral to treatment and arrangements to access the service, treat and discharge clients were in line with good practice.

The service was available for anyone seeking help to reduce or recover from their substance misuse, mainly illicit drugs and alcohol. It was open Monday to Friday nine to five, and until seven pm on a Thursday. They offered drop in sessions, needle exchange and a duty worker was available to see people quickly and take referrals and phone calls. Staff offered a telephone service on bank holidays and provided outreach services in GPs, community centres, schools and homes. An independent pharmacist prescriber offered a weekly clinic in Bromsgrove for clients local to that area. The service

operated a single point of contact to help increase accessibility for clients and they could be flexible with appointment times and venues. Staff sent out text messages to remind people about their appointments.

The team had developed 'Welcome sessions' which ran three times a week; twice in Redditch and once in Bromsgrove. Staff invited all non-urgent new clients to the service to explain client and staff expectations such as the engagement policy, agreement to treatment, consent to share, confidentiality and other information about the service. Staff reported that they found this useful, as it gave them a better understanding of their new clients. Clients we spoke to told us it helped them get a better understanding of what to expect when they started treatment.

When we inspected, the caseload for the service was 462. An average caseload for a whole-time equivalent substance misuse worker was about 68. Staff said this was manageable. Caseloads were discussed with staff in supervision with the team leader and the senior practitioner, and staff could get extra support from volunteers when required. Complex cases could be discussed within the multidisciplinary reviews. The team leader allocated new referrals and the complexity of individual cases was taken into consideration. They did not operate a waiting list and referrals were allocated quickly.

When referrals were received, they were triaged the same day by the duty worker. Priority clients were seen within 24-48 hours and consisted of pregnant women, people released from the prison service, or people with high levels of mental and/or physical health needs. Typically, clients were invited into the next drop in session which took place three times a week. This meant clients were seen quickly and did not have to wait.

Staff planned for client's discharge and liaised with other agencies and care coordinators beforehand. Staff attended joint visits with future care providers to ensure a smooth transfer of care.

All potential discharges would be discussed with the senior practitioner beforehand. When people were not engaging with the service, staff followed the engagement policy. Staff made several attempts to get contact the client before they would be discharged.

# Community-based substance misuse services

Staff supported clients during referrals and transfers between services, such as mutual aid agencies or physical or mental health teams.

## **The facilities promote recovery, comfort, dignity and confidentiality**

The service had five rooms to see clients in, including two group rooms, a doctor's room, needle exchange and a clinic room. They were located on the first floor. The service was accessed by a flight of stairs. A chair lift was available for people whose mobility was compromised. Rooms were adequately sound proofed so that conversations could not be overheard. A radio played at a low level in the waiting area to ensure privacy and confidentiality was maintained.

Information available in the waiting area included notice boards and leaflets written in Polish, mutual aid groups, domestic violence, and local groups and information.

## **Clients' engagement with the wider community**

Staff supported clients with activities outside the service, such as work, education and family relationships. Staff liaised with other agencies and signposted clients to other organisations when required, such as mutual aid. The service hosted a SMART recovery group once a week which clients could attend. Staff offered practical support such as help with paperwork completion and advice. Many clients were referred or signposted to a local community centre which provided help with CVs, ran adult education courses and development programmes.

## **Meeting the needs of all people who use the service**

The service was accessible to all who needed it and took account of clients' individual needs. Staff helped clients with communication, advocacy and cultural support.

The service understood the complexity of clients' needs and worked with vulnerable people who needed to be signposted to other services that would support their needs. For example, they had good links with charities, food banks and organisations that helped people experiencing domestic violence or homelessness. Staff gave examples of how they had supported people with learning disabilities and older people.

The service had started a weekly 'Tea and toast' group. This was facilitated by one of the volunteers and provided a time where clients could meet informally.

The service provided translators for people whose first language was not English. We saw leaflets in Eastern European languages when we inspected. The Cranstoun group website had an accessibility option that included a text and display function for people with print disabilities, dyslexia, low literacy and mild visual impairments.

Clients we spoke with told us their appointments had not been cancelled or delayed. Staff told us this rarely happened and appointments would be rearranged if required, due to staff sickness for example.

## **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 all staff.

In the 12 months up to November 2018 the service received one complaint, which was not upheld.

Staff we spoke with knew how to manage complaints and ensured that clients could raise complaints without fear of discrimination or harassment.

The service had a clear complaints system to show how complaints were managed and lessons learnt were acted upon to improve the quality of the service. Formal complaints were discussed within clinical governance meetings and all complaints and identified themes were reviewed at board level. Staff received feedback from complaints across the service in the Team Brief and the quarterly lessons learnt bulletin.

Staff and managers resolved low level complaints informally although these would still be recorded so the service could identify any themes or trends.

## **Are community-based substance misuse services well-led?**

Good 

## **Leadership**

Managers at all levels in the service had the right skills and abilities to run a service that provided high-quality sustainable care.

# Community-based substance misuse services

Managers had worked within the service for many years and had the necessary experience, skills and knowledge of working with the client group to provide clinical leadership to other staff.

The organisation had a clear definition of recovery and this was shared and understood by all staff. Their mission statement was 'To empower and support people to make positive changes.'

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.

## Vision and strategy

The service developed a strategy for 2018 that encompassed the Cranstoun group vision, mission and values. Their vision was: 'We believe everyone should have the opportunity to live healthy, safe and happy lives.' Their values were: Ambition, Compassion, Innovation, Integrity and Inclusive. The values were supported by policies and procedures, which set out the expectations of staff members. The vision and values were communicated to staff at induction then reinforced and assessed at performance reviews.

Staff had the opportunity to contribute to discussions about the service. Staff discussed their ideas to make improvements to the service with managers and we heard examples of when ideas had been implemented.

Managers could describe how they were working to deliver high quality care within the budgets available and regularly discussed and made plans with senior leaders within the organisation and with the local authority who commissioned their service.

## Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff told us they felt respected, supported and valued. They felt that the service recognised their contributions. The service promoted an employee recognition scheme. They said they felt positive and proud about working for the service and their team.

Staff met regularly with their managers to discuss performance and training needs, which included career progression. Staff gave us examples of staff who had used the service for their own substance misuse in the past, then joined the organisation as volunteers or service user representatives and progressed within the company.

Staff could access an occupational health department and a telephone line which provided confidential supportive counselling.

Managers monitored staff morale and job satisfaction through regular supervision and meetings with staff. Managers and staff told us that morale was good and staff worked together well and enjoyed working for the service.

Staff said that they had seen improvements in client's outcomes and governance arrangements since the merger with Cranstoun, and staff felt more positive and excited about the future of the company, and any fears about potential changes had been allayed.

All staff completed mandatory equality and diversity training and managers monitored implementation in supervision, performance review processes and case file audits.

The service was accredited in Investors in Diversity: Level 2. This meant that they had taken a structured and planned approach to ensure that equality and diversity was embedded within the service.

Staff sought guidance and support from other disciplines within the team when they needed it and respected each other's roles.

## Governance

Since the merger with Cranstoun, governance policies, procedures and protocols had been regularly reviewed and updated.

There was a clear framework of how information would be cascaded down from the board to all staff. Staff received essential information such as learning from incidents, complaints and changes to the service through team meetings, monthly team brief and supervision.

Senior staff attended the clinical governance implementation group to analyse lessons learnt and implement changes across the service to reduce risks of similar incidents occurring elsewhere.

# Community-based substance misuse services

Staff undertook audits, such as monthly case file audits, blood borne virus testing and vaccinations and thematic audits, for example safeguarding. The audits were sufficient to provide assurance and staff acted on the results when needed.

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

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

The service had a whistle blowing policy in place. No whistleblowing concerns had been received by the Care Quality Commission between December 2017 and November 2018.

## Management of risk, issues and performance

There was a clear quality assurance management and performance framework in place that was integrated across all organisational policies and procedures. The service met regularly with their senior leadership team and the local authority to scrutinise their performance against national and local key performance indicators. The service was meeting contractual requirements.

Staff performance was monitored through key performance indicators. Completion of risk assessments and care plans, client information sharing agreements, hepatitis C testing and hepatitis B vaccinations offered was monitored and reported every month. The service also monitored their closure targets which were reported nationally. The team were within their targets.

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. These included risk registers, contingency plans and various policies, procedures and protocols.

Staff maintained and had access to the risk register at a local level which fed into the organisation risk register. Staff could escalate concerns when required and their concerns matched those on the risk register.

The service anticipated and planned for emergencies and policies and procedures were in place to ensure the continuity of the service during adverse conditions or other disruptions.

The service monitored its sickness and absence rates. Managers referred to the service policies and procedures to support staff appropriately.

The service worked closely with their commissioning partners to ensure any cost improvements did not compromise client care.

## Information management

Managers collected data from the electronic systems that staff used to record all client information. Staff had access to the equipment and information technology needed to do their work.

The electronic client case file system was comprehensive and included confidentiality of client records. Staff told us they found it easy to use and was secure.

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 and was in an easily accessible format. Managers collected information to share with their senior leaders and commissioners which was collated in the Diagnostic Outcomes Monitoring Executive Summary.

The service had developed information sharing protocols and processes with other services and agencies. They attended meetings and joint visits when required.

Confidentiality agreements were clearly explained to clients and carers in relation to information and data.

## Engagement

Staff, clients and carers had access to up to date information about the work of the provider and the services they used. This was accessible through a staff intranet, team brief and a website dedicated to the service.

The service promoted itself to the public and raised awareness of the service they offered in a variety of locations such as supermarkets, gyms, libraries, hostels, universities and schools.

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs, such as face to face with a staff member or through questionnaires which could remain anonymous if they wished.

# Community-based substance misuse services

Senior staff engaged with a variety of external stakeholders to receive feedback, discuss their performance, promote the service, provide education and make links with other agencies/ providers to enhance the client pathway.

Senior staff attended a strategic oversight group every three months. This included all partner agencies such as social services, criminal justice, mental health, police and the job agency. Discussions revolved around shared issues or thematic reviews and information sharing.

## **Learning, continuous improvement and innovation**

The service encouraged creativity and innovation to ensure up to date evidence based practice was implemented and embedded.

The service discussed quality improvements and staff were encouraged to make suggestions, and the service adopted ideas from other teams that had worked well.

The peer mentor and volunteer co-ordinator facilitated ROAD (recovery, orientated, audit, development) events. Staff and clients discussed two of the organisation's objectives: Learn and change together and support community connections. The group discussed how they were meeting the objectives and how staff could improve the service. Action plans were developed and acted upon.

# Outstanding practice and areas for improvement

## Outstanding practice

The peer mentor and volunteer co-ordinator facilitated ROAD (recovery, orientated, audit, development) events. Staff and clients discussed two of the organisation's objectives: Learn and change together and support community connections. The group discussed how they were meeting the objectives and how staff could improve the service. Action plans were developed and acted upon.

The service was involved in a local pilot called the 'blue light' project. The service worked in partnership with other agencies such as the police, probation, social services, housing and the fire service, with the aim to proactively engage vulnerable people who were alcohol dependent, isolated and had not been successfully engaged in services, ensuring their safety.



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.



This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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