Lifeline Stoke Recovery Service

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Lifeline Stoke mainly operated from two office bases that held a range of clean and well-furnished facilities such as reception, interview rooms and group rooms. Both sites had clean and well-equipped clinic rooms and needle exchange facilities. Interview and clinic rooms had panic alarms fitted and staff knew how to respond to them.
- Lifeline Stoke had a wide range of skilled staff and worked closely with external professionals to meet the full range of clients' needs. The service also had a successful volunteer programme. The provider ensured minimum staffing levels by using agency

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and bank staff to cover vacancies, sickness and maternity leave. All staff, including agency workers and volunteers, received induction, mandatory training and regular supervisions.

- Staff undertook comprehensive assessments with clients from which they developed thorough risk management plans and recovery-focused care plans that took into account clients' social, psychological and physical needs. Discharge planning was central to recovery-based care and treatment, and staff offered aftercare to discharged clients to help them sustain their recovery.
- The provider had information-sharing protocols and good joint working arrangements with other agencies to promote safety. Staff maintained client confidentiality. They conducted interviews in private settings, and stored client information securely.
- Staff had a strong understanding of safeguarding issues, knew how to report incidents and handle complaints. Staff received debriefs and lessons learnt following incidents.
- Lifeline Project had safe medicines management practices that included prescribing, dispensing and storage, supported by appropriate protocols.
- Staff had a strong commitment to person-centred care. They listened to their clients and provided them with appropriate emotional and practical support. Staff identified named workers for each client as a point of contact, and for continuity of care.
- Lifeline Stoke accepted self-referrals and referrals from other agencies and professionals, and staff tried to assess all newly referred clients within 72 hours. Clients had access to telephone contact out-of-hours. Staff offered flexibility in the times of appointments to meet clients' needs and routinely offered services outside of normal business hours. The provider had a policy that set out procedures to manage clients' non-attendance and re-engagement.

However, we also found the following issues that the service provider needs to improve:

- The provider did not notify the CQC of the deaths of any clients in receipt of their services. This was breach of regulation. The provider did not always notify the CQC of incidents in line with the relevant statutory requirements.
- At the time of our inspection, 130 clients had not received medical reviews since the new provider took over the service.
- The provider was new to managing clinical services but did not undertake any audits on clinical practice.
- Clients experienced delays in receiving their prescriptions. There was a risk of loss of blank prescription forms when administrative staff retrieved them for printing or when staff accessed the safe for other items.
- There was a lack of coordination and monitoring of lone working practices across the whole service although individual teams had their own safety protocols.
- Some staff had high caseloads that had an impact on the amount of support they offered clients.
- Clients attending Wood House waited for their urine test results in the corridor outside the designated testing toilets. This did not protect their privacy and dignity.
- Most staff did not know who the senior managers were and some staff felt that senior managers did not consult them enough on their plans when they took over the service.

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Background to Lifeline Stoke Recovery Service

Lifeline Stoke Recovery Service (Lifeline Stoke) is run by Lifeline Project. It provides community-based drug and alcohol services, including detoxification services, recovery groups, relapse management and substitute prescribing. It mainly provides services from two sites in Stoke but the service also uses a number of outreach venues across the city. Lifeline Stoke Recovery Service provides services to adults and young people, and has a specialist service for pregnant women. At the time of our inspection, the service had 1439 clients receiving prescriptions for substance misuse problems.

Lifeline Stoke is funded by Stoke local authority's public health department. It is registered to provide treatment of disease, disorder or injury. At the time of our inspection, the service did not have a permanent registered manager. A registered manager from another service had submitted an application to add the location to her registration for an interim period until the newly appointed manager's application was approved. The service had an accountable controlled drugs officer.

Lifeline Stoke is a large service made up of seven teams:

- clinical team
- administration
- early/brief intervention
- families and young persons
- pregnancy drug users service
- criminal justice
- recovery.

The clinical team comprised detoxification nurses, blood-borne virus nurses, non-medical prescribers and medical practitioners.

We had not previously inspected this service. Lifeline Stoke Recovery Service registered with the CQC on 27 November 2015 having taken over services previously provided by three different providers. The provider's plan was to integrate the three services under a single structure.

Our inspection team

The team that inspected the service comprised a CQC inspector Si Hussain (inspection lead), two other CQC inspectors, a specialist advisor (consultant psychiatrist with experience in substance misuse) and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?

Summary of this inspection

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

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

During the inspection visit, the inspection team:

- visited both units at this location, looked at the quality of the physical environment, and observed how staff were caring for people who used the service
- spoke with six people who were using the service and two relatives
- spoke with the interim registered manager, the new team manager, and two senior managers
- spoke with 15 other staff members employed by the service provider, including nurses, support workers and administrative staff
- conducted two focus groups, one with staff and one with team leaders
- spoke with the psychiatrist and non-medical prescriber
- received feedback about the service from the local commissioner
- spoke with three volunteers
- attended and observed two handover meetings, one clinical review, and one service user group
- looked at 17 care records, including medicines records, for people who used the service
- observed medicines management practices at both sites
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with six clients in receipt of services. These included men and women, drug and alcohol users, a pregnant woman, a client who presented challenges to the service, a newly-assessed client, and clients who used services before the new provider took them over.

Clients expressed positive views about the care and the treatment offered by Lifeline Stoke Recovery Service. Clients spoke positively about the staff. They described them as caring, understanding and responsive. Clients believed this helped them engage with treatment and recovery. Feeling welcome and comfortable in the service was very important to some clients.

Clients described a smooth transition from one service to another, they received information about care and treatment options, and staff told them how to make complaints. Staff made appointments at times that suited clients and arranged to visit them at places convenient to them. None of the clients we spoke with had experienced appointments cancelled by staff.

All clients described a good, safe environment. Clients with a wide range of difficulties including drug or alcohol misuse but also social issues described the availability of support that addressed their specific needs. These included physical and mental health needs, social issues such as housing and debt, family issues such as child protection and personal issues such as bereavement.

We spoke with two relatives. They described the service as responsive to their needs, for example, it ran family groups. One relative had made a complaint. She said staff took her complaint seriously and dealt with it appropriately.

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 do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- The provider did not notify the CQC of the deaths of any clients in receipt of their services. The provider did not always notify the CQC of incidents in line with the relevant statutory requirements.
- Some staff had high caseloads that had an impact on the amount of support they offered clients.
- At the time of our inspection, 130 clients had not received medical reviews since the new provider took over the service.
- There was a lack of coordination and monitoring of lone working practices across the whole service although individual teams had their own safety protocols.
- Clients experienced delays in receiving their prescriptions.
- There was a risk of loss of blank prescription forms when retrieved for printing or when staff accessed the safe for other items.

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

- Both sites had clean and well-equipped clinic rooms. Each site had an emergency bag, resuscitation equipment and held naloxone onsite.
- Interview and clinic rooms had panic alarms fitted and staff knew how to respond to them.
- The provider ensured minimum staffing levels by using agency and bank staff to cover vacancies, sickness and maternity leave.
- All staff, including agency workers and volunteers, received mandatory training that covered a range of courses including safeguarding, confidentiality and health and safety.
- Staff completed a risk assessment for every client and developed thorough risk management plans that they updated regularly.
- The provider had information-sharing protocols and good joint working arrangements with other agencies to help ensure risk assessments were comprehensive.
- Staff had a strong understanding of safeguarding issues and knew how to report incidents and concerns.

Summary of this inspection

- Lifeline Project had safe medicines management practices that included prescribing, dispensing and storage, supported by appropriate protocols. Staff completed clients' medication charts fully and accurately.
- Staff received debriefs following incidents and feedback from investigations at daily handover meetings, team meetings, and in one-to-one supervisions sessions.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff undertook comprehensive assessments with clients from which they developed recovery-focused care plans that took into account clients' social, psychological and physical needs.
- Staff used a range of tools to support assessment and care planning and to monitor outcomes. These included mapping tools and treatment outcomes profiles (TOP) offered by Public Health England specifically for substance misuse services
- Staff ensured safe and effective storage of all care records, whether paper or electronic.
- Staff followed evidence-based practice and the relevant National Institute for Health and Care Excellence (NICE) guidance on prescribing and titration.
- Lifeline Stoke had adopted a psychosocial model of care in line with the
- Lifeline Stoke offered a wide range of groups and interventions to support treatment and recovery.
- Lifeline Stoke had access to a wide range of skilled staff within its service and worked closely with external professionals and agencies to meet the full range of clients' needs.
- All staff, including agency workers and volunteers, received an induction. Staff received regular one-to-one supervision sessions and had access to daily handover meetings and team meetings.
- Staff received training on the Mental Capacity Act (MCA). Most staff had a good understanding of the MCA and the five statutory principles. Staff assumed clients had capacity to make decisions and knew where to get advice if they had any concerns.
- The service supported people with a range of diverse needs appropriately. Staff assessed clients' individual needs, and aimed to provide tailored support to meet those needs. Managers were recruiting to a new lead post for diversity.

However, we found the following issues that the service provider needs to improve:

Summary of this inspection

- The provider was new to managing clinical services but did not undertake any audits on clinical practice.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff had a strong commitment to person-centred care. They listened to their clients and provided them with appropriate emotional and practical support.
- Clients described good working relationships between them and staff. They were happy with the service provided and believed they would get the help they needed.
- Staff knew their clients well and tailored support accordingly. Staff identified named workers for each client as a point of contact, and for continuity of care.
- Staff maintained client confidentiality. They conducted interviews in private settings, and stored client information securely.
- Staff involved clients, and their carers, where appropriate, in assessment and care planning. Staff agreed recovery-focused plans with their clients and offered them copies.
- Staff ran support groups for families and carers and signposted them to other services in the community.
- The service asked clients and their carers for their suggestions for improving the service and acted on them. Staff displayed feedback and actions taken in a 'you said, we did' section on the noticeboard.

However, we found the following issues that the service provider needs to improve:

- Not all staff knew about the advocacy services available to their clients.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Lifeline Stoke accepted self-referrals and referrals from other agencies and professionals. Staff tried to assess all newly referred clients within 72 hours.
- Some teams had access and referral criteria that focused on meeting the needs of a specific client group. For example, the pregnant drug users' (PDU) service fast tracked pregnant women into the service and the young persons' team did not have a lower age limit.

Summary of this inspection

- Discharge planning was central to recovery-based care and treatment and acted as strong motivation to achieve success. Staff offered aftercare to discharged clients to help them sustain their recovery.
- Although the service was not an emergency service, clients had access to telephone contact out-of-hours. The service was available to pharmacists, the police and healthcare services if they needed client information urgently.
- Staff offered flexibility in the times of appointments to meet clients' needs and routinely offered services outside of normal business hours.
- The provider had a policy that set out procedures to manage clients' non-attendance and re-engagement. Some teams adapted these to address any additional risks presented by their client groups such as pregnant women and young people.
- Lifeline Stoke mainly operated from two office bases that held a range of clean and well-furnished facilities such as reception, interview rooms, clinic rooms, needle exchange rooms and group rooms.
- Staff visited clients at home and in other venues such as community centres and homeless shelters. Staff took into account the clients' needs and preferences, and any risks they presented.
- Clients had access to a wide range of information such as easy-read leaflets about specific treatments, physical health issues and community services.
- Clients and their carers knew how to make complaints and felt confident to do so. Staff knew how to handle complaints in line with the provider's policy. Complaints resulted in lessons learnt and changes to practice, where necessary.

However, we found the following issues that the service provider needs to improve:

- At Wood House, following a urine test, clients waited for their results in the corridor outside the designated testing toilets. This did not protect their privacy and dignity.
- The open plan staff office at Wood House was busy and noisy, which made it hard for some staff to concentrate. There were not always enough desks for staff, which meant staff experienced delays in updating clients' records.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- The provider had effective governance systems and processes to help monitor service delivery, team performance, and incidents and risks.
- All staff knew about the new provider's visions and values. Staff agreed with the provider's vision to move from a maintenance model of care to a recovery-focused model.
- All staff, including agency staff and volunteers, received induction and mandatory training. Staff received regular supervision and had access to team meetings.
- Staff recognised abuse and complied with local safeguarding protocols. Staff had a good understanding of the five principles underpinning the Mental Capacity Act and applied them in their practice.
- Staff reported an improvement in morale since the new manager started. We consistently found that staff had a strong commitment to their clients' care and recovery, and felt motivated by the progress they made.
- The provider had plans to improve quality and develop services. They planned to roll out 'take home' naloxone in September 2016, and they had submitted a bid for funding to introduce rapid HIV testing.
- Lifeline Stoke had a successful volunteer programme. The service had seven volunteers who were former clients or carers. They received training, development and supervision. Some volunteers had secured paid employment with Lifeline Stoke.

However, we found the following issues that the service provider needs to improve:

- Most staff did not know who the senior managers were and said they had little contact with managers above team level.
- Staff had yet to receive their annual appraisals from the new provider who took over the service in November 2015.
- Lifeline Stoke did not always submit statutory notifications to the CQC.
- Some staff felt that senior managers did not consult or engage with them enough about planned changes when they took over the service.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training on the Mental Capacity Act (MCA), which was part of the provider's mandatory training programme. The staff we spoke with knew about the five statutory principles that underpinned the MCA.

Medical reviews routinely included assessments of capacity, and staff addressed any issues on a case-by-case basis.

Staff assessed the competency of young people in line with the Fraser and Gillick competence framework. The psychiatrist completed formal competency assessments where there was uncertainty about the young person's capacity.

Staff did not know if there was a local MCA lead but knew they could get advice from the lead nurses.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service operated from two main office bases – Tunstall and Wood House in Hanley. We inspected both sites. The provider recently refurbished Wood House, which it regarded as its main site. At both sites, the reception, the communal areas and the clinic and interview rooms were clean, comfortable and well maintained. The interview and clinic rooms had panic alarms fitted.
- Both sites had well-equipped clinic rooms with a range of equipment to carry out physical examinations, for example, scales and a blood pressure monitor. Each site had an emergency bag, resuscitation equipment and held naloxone onsite. The equipment was clean and well maintained, and had stickers that showed it was in-date. Both office sites had needle exchange rooms.
- Staff adhered to infection control principles including handwashing. The service had an up-to-date infection control policy that included the disposal of clinical waste.

Safe staffing

- Lifeline Stoke took over community-based substance misuse services in November 2015. At this time, although a large number of staff transferred to Lifeline Stoke, there was also a loss of staff. As of 8 March 2016, Lifeline Stoke had a total staffing complement of 74.5 (68 whole time equivalent (WTE)) staff. At this time, 70.5 staff had received disclosure and barring service (DBS) checks. Three DBS checks were outstanding for staff, one of whom was on maternity leave. Checks for three volunteers were also outstanding. By the time of our inspection, the number of staff had increased to 99.5 staff, which equated to an establishment of 77 whole time equivalent (WTE) staff.
- The staffing complement comprised medical staff, non-medical prescribers, managers, team leaders, qualified nurses and recovery workers supported by administrative staff. There were 2.5 WTE doctors, 1.4 WTE non-medical prescribers and 8 WTE qualified nurses. The medical staff comprised two consultant psychiatrist posts and one GP with a special interest (GPSI). The service had a new manager in post three months at the time of our inspection. Most of the teams had a team leader.
- Lifeline Stoke allocated staff to one of seven teams:
  - clinical team
  - administration
  - early/brief intervention
  - families and young persons
  - pregnancy drug users service
  - criminal justice
  - recovery.
- At the time of our inspection, the provider had completed wave one of its recruitment programme, another wave was due at the end of July 2016. As well as increasing its staffing levels, and developing new posts, Lifeline Stoke had reduced its vacancy levels from 15% in April 2016 to nine vacancies (11%) at the time of our inspection. The vacancies were for three specialist roles developed for domestic violence, housing and diversity, one peer volunteer coordinator and five recovery coordinators.

Substance misuse services

- Lifeline Stoke used bank and agency staff to cover vacancies, sickness and maternity leave and help ensure safe staffing levels. The actual figures were not available although data showed there were 11 agency staff employed as of 30 April 2016. Staff commented that managers were prompt at bringing in agency staff when required. Managers assessed agency workers strictly and retained only those it had confidence in.
- As of 30 June 2016, Lifeline Stoke had seven staff leave out of 77 WTE staff, which equated to a staff turnover rate of 9%. Lifeline Stoke was unable to provide accurate staff sickness levels. However, staff said there were high levels of sickness absence caused by the impact of changes, high workloads, and staff shortages.
- At the time of our inspection, Lifeline Stoke had a total number of 1,439 clients. The service reported that each worker had a caseload of 67 as of 30 June 2016, a significant increase from the average caseload size of 39 reported for 30 April 2016. We spoke to staff about their caseload sizes and found they varied greatly according to team and complexity. Recovery workers had large caseloads of 60 to 70 clients, a proportion of whom had complex needs. Recovery workers with only complex cases had caseloads loads of up to 40 clients. The clinical and recovery teams held the most cases with a total caseload of around 1265 clients. The smaller specialist teams, for example, the young people's team had individual caseloads of 11 to 17 clients, and a total caseload of around 32 clients.
- Recovery workers in particular described the challenges they faced coping with their caseloads. One worker said they went into the office on weekends to catch up with their work. Another recovery worker said they could only manage by limiting the time and intervention with each client, for example, there was insufficient time to support clients with housing appointments or meet them at other venues in the community. One worker expressed concern about ensuring safe care for clients. Furthermore, staff held mixed caseloads rather than substance-specific cases. This presented additional challenges for staff who had previously only worked with either drug or alcohol misuse.
- One agency worker described how the same cases transferred from one agency staff to another agency staff member, which meant some clients did not receive continuity of care. One client in receipt of services for over ten years expressed concern about having different keyworkers. We found that continuity of care was an issue more so for people in services a long time because of staff leaving, retiring or becoming ill.
- All staff, including agency staff and volunteers, received mandatory training. As of 30 April 2016, the compliance rates with mandatory training for substantive (excluding staff on maternity leave) were as follows:
  - safeguarding children, 97%
  - safeguarding vulnerable adults, 97%
  - data protection, 96%
  - boundaries, 97%
  - confidentiality, 97%
  - HALO (electronic records system), 96%
  - health and safety, 97%
  - equality and diversity, 97%
  - basic drug and alcohol awareness, 97%.
- In addition, staff working in the families and young persons' team received level three safeguarding training and Gillick competence training used to help assess whether a child under 16 has the maturity to make their own decisions and to understand the implications of those decisions. The provider did not submit complete data for training on new psychoactive substances (NPS) awareness, basic life support, risk assessment, first aid, the Mental Capacity Act (MCA) and mental health awareness. However, most of the staff we spoke with said they had done training on the MCA.

Assessing and managing risk to people who use the service and staff

- We reviewed care records for 17 clients. Staff completed a risk assessment for every client and developed thorough risk management plans. Staff reviewed risk management plans quarterly or when risks changed. All staff and managers met for daily 'flash' meetings. These were brief, well-structured meetings with a standing agenda. Staff and managers discussed new information about clients, significant events and risks. They ensured

cover for clients whose keyworkers were absent. During initial assessment, staff checked if the client was known to social services and if there were any child protection concerns.

- The provider had effective information-sharing protocols with other agencies that promoted safety. The agencies the provider worked with most often were primary care, substance misuse rehabilitation teams, inpatient detoxification services, and children and families social services. There were good joint working arrangements with statutory agencies such as social services.
- Most clients received monthly medication reviews either with a psychiatrist or with a non-medical prescriber. The keyworker for the client attended all reviews. We observed a review and found that the client was treated respectfully, the keyworker updated the clinic on the client's progress and advised of any issues or concerns. The review discussed the client's substance misuse and treatment plan but also looked at their physical and mental health and any social issues. However, the provider maintained a list of clients who had not received a medical review since the new provider took over the service. In the meantime, the service had continued their treatment and prescriptions, and staff monitored the clients.
- Staff and volunteers received mandatory safeguarding training and worked closely with local safeguarding teams. Staff had a good understanding of safeguarding issues and made safeguarding referrals using the multi-agency referral forms (MARF). Staff completed MARFs in all cases before alcohol detoxification took place. The staff and volunteers we spoke with had a strong understanding of safeguarding and abuse, felt confident to report concerns, and dealt with safeguarding on a regular basis in their work. The families and young persons' team routinely contacted social services when a young person entered their service, and monitored children under five years old if there was no social services involvement.
- Lifeline Stoke had two staff designated as safeguarding leads based in the young persons' team who were available to all staff for support and advice. We interviewed the safeguarding leads who had direct access to social workers and close links with the three local multidisciplinary and multi-agency 'cooperatives' in the Stoke area (north, central and south). The leads had developed a safeguarding register, which was a list of all clients who received a service from Lifeline Stoke with actual or potential safeguarding issues. The register provided a summary of the client's family circumstances, and included the age of the child, the child's social services status (child in need or child protection), if any, and if there was a partner in the service. At the time of our inspection, there were over 100 clients known to social services with children in need or on the child protection register, and there were 78 out of 96 children under five years old with no social services involvement. The safeguarding leads planned to add the register to the electronic records system for ease of reference.
- Managers felt lone working practice in the community needed improvement. All staff booked in and signed out as they entered and left the office. All staff had mobile phones. All staff knew when to undertake visits in pairs, or use alternative venues. Staff frequently used the office bases for their appointments, and all meeting rooms had panic alarms. Beyond, this, each team had its own safe practices that worked well but there was a lack of coordination and monitoring of staff safety across the whole service.
- We reviewed the families and young persons' team safety protocol for home visits and outreach working. It specified safe working practices in cases where there were risks, for example, two workers undertaking visits, meeting at alternative venues to home, and maintaining contact with the team (checking in and out). It set out the team's response if contact was lost and there were concerns. Most of the criminal justice team's visits took place at clients' homes or in outreach venues. Staff visited in pairs only, and asked for police support, where appropriate. The alcohol team had a 'buddy' system, used a 'panic word' and staff started and finished work at the office base. Diaries were fully accessible and viewable to the whole team.
- The service had good medicines management practice. It had a range of policies and procedures on prescribing and specific treatments. The service received pharmacy input, and the non-medical practitioner acted as the substance misuse pharmacy lead.
- We reviewed care and medicines records for 17 clients. Staff stored clients' prescription charts in their care files

and not with the prescriptions. However, staff retrieved the prescription charts before the client's review or requests for new prescriptions. Staff fully and accurately completed the prescription charts.

- The service stored medicines and medical supplies such as testing kits in locked fridges and storerooms. Staff checked and recorded fridge temperatures daily. However, the fridge in the Tunstall office was located in a public corridor. Clients received safe storage boxes for home use to store dangerous medicines. In line with the provider's policy, clients had to sign an agreement, and staff checked the boxes every 12 months.
- Some clients had supervised consumption. Clients did not receive their prescriptions until due. Young people under the age of 18 years had to collect their prescriptions on a daily basis unless there was an adult supervising them.
- Lifeline Stoke's prescription-generation process was undergoing review because clients complained about the delays, for example, they waited up to two hours for prescriptions. We reviewed the prescription-generation process. Once authorised by medical staff, administrative staff printed the prescriptions. They printed in batches on a monthly basis at the Wood House office. For clients attending the Tunstall office, staff safely transported the prescriptions by car, in line with the relevant protocols.
- In addition to addressing the delays by identifying and removing unnecessary processes, the service planned to change the way in which clients received prescriptions. In most cases, clients attended one of the bases to collect their prescriptions. The service intended to replace these attendances with an appointment with their keyworker. This would give staff and clients the opportunity to meet, encourage the client to engage with services beyond collecting prescriptions, and help staff to monitor the client's progress.
- At the time of our inspection, the service had 1439 clients who received prescriptions regularly. Medical staff wrote most prescriptions six weeks in advance. They signed and dated the prescription when they wrote it and we noted start dates of up to eight weeks ahead. For example, three prescriptions showed that doctors wrote them on 18 July for start dates of 25 August, 7 September and 10 September.
- Prescriptions changed in line with the client's needs. This resulted in 'void' prescriptions that were printed but no longer required. The provider had a reasonably safe process for the destruction of these voided prescriptions. Administrative staff logged any prescriptions that needed voiding onto a spreadsheet, and kept a separate pile of these in the locked safe alongside blank and printed prescriptions. When medical staff or the non-medical prescriber next attended the office, they retrieved the prescriptions, checked them against the log of voided prescriptions and then scored through them, adding their signature and the date. One administrative staff member then disposed of the voided prescriptions by tearing them up and placing them in the confidential waste bin. However, this final process was not witnessed and there was no note made of the disposal.
- Administrative staff ordered and took delivery of blank prescriptions pads. They checked them, recorded the numbers for each pad and stored them securely in a large safe. This meant the service knew the total number of blank prescriptions it had based on the number of pads received. However, the provider did not monitor the stock of blank prescriptions forms stored in the safe. This posed a risk of loss of forms when administrative staff took out blanks form for printing, and when staff accessed the safe for other items.

Track record on safety

- There were no serious incidents reported by Lifeline Stoke in the past twelve months to 30 April 2016. However, Lifeline Stoke reported 46 incidents in the six months to 31 July 2016. The highest proportion was for client deaths (14; 30%), followed by aggressive behaviour from clients (7 incidents; 15%).
- Commissioners were undertaking a review of all deaths of clients in receipt of services. The provider was also changing its internal reporting process for client deaths.

Reporting incidents and learning from when things go wrong

- Most staff and volunteers knew how to recognise and report incidents. Some staff were not sure which form to use but said they would ask someone. Lifeline Stoke informed commissioners of any serious incidents and

deaths, as required, and referred safeguarding incidents to the local authority appropriately. However, the provider did not inform the CQC of all notifiable incidents and deaths of clients in receipt of services.

- Staff logged incidents on a local reporting system, which fed into a central report. The executive governance teams and clinical governance teams reviewed the incidents for themes and trends and produced reports.
- Staff gave mixed views about receiving feedback from investigations of incidents. Most staff said they received feedback and lessons learnt from incidents from a range of sources, including 'big alerts' (all staff email). Staff gave examples of emails they received about drug errors, confidentiality breaches, lost records and accidents. Staff received feedback from incidents at 'flash meetings' held daily. Managers gave feedback at daily 'flash' meetings, at team meetings and in one-to-one supervision sessions with staff, and welcomed comments from staff. In addition, the service held quality strategy days that covered learning from incidents, changes and new initiatives. However, some staff did not recall receiving feedback or learning from incidents or clients' deaths.
- Managers and team leaders offered debriefings after serious incidents. Some staff occasionally declined offers of debrief sessions because of their workload. Medical staff discussed serious incidents in prescribers' meetings. The staff in the families and young persons' team spoke positively about the support they received from their team leader following incidents or difficult appointments.

Duty of candour

- Managers and staff understood their responsibilities in Staff were open and transparent with clients and carers when something went wrong.

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

Assessment of needs and planning of care

- We reviewed care records for 17 clients and found completed assessments and up-to-date care plans and risk management plans. Records showed that the early/brief intervention team completed initial assessments and documentation, informed clients of their rights and obligations and then allocated them to the recovery teams. Staff from the recovery teams then completed comprehensive assessments and medical staff completed medical assessments. The medical assessment determined whether the client needed inpatient or community-based detoxification. Staff undertook a pre-commitment assessment to assess whether clients were psychologically, physically and mentally ready for treatment, and medically fit.
- Staff drew up care plans that promoted recovery by meeting the individual needs of each client. Assessment and care planning took into account physical, psychological and social needs. Staff referred clients to other services such as housing and debt advice, and worked closely with other agencies such as social services.
- The service used both electronic and paper files. The service ensured safe and effective storage of all care records. Staff stored paper files in lockable filing cabinets located in the staff-only main office. Staff had easy access to their team's records. The service intended to hold electronic records only in the future but was in the process of transition at the time of our inspection. Although all the teams used both electronic and paper records, this was inconsistent across the service. For example, one team might have all their care plans on the electronic system while another team was using paper-based care plans. The staff in each team knew where to locate their clients' records but this was not easy for staff in other teams or managers covering all the teams.

Best practice in treatment and care

- The service followed relevant National Institute for Health and Care Excellence (NICE) guidance when it prescribed medication for substance misuse issues and when it undertook titration (getting people to the most effective dose of medication). We saw prescribing protocols for methadone, benzodiazepines for alcohol withdrawal and buprenorphine. The provider suspended alcohol detoxification between November 2015 and January 2016 because it did not have an appropriate treatment protocol. The service followed evidence-based good practice and established guidelines such as the Birmingham and Solihull

protocols for the treatment of alcohol misuse. The pregnant drug users' service developed pathways in line with the Department of Health's guidance on clinical management of drug misuse and dependence (2007).

- The teams followed the statutory guidance applicable to their roles. For example, the criminal justice team followed legal frameworks associated with the criminal justice system and the probation service. The young persons' team followed legislation and guidance associated with child protection.
- The service adopted the principles of the with a model of care underpinned by a psychosocial intervention approach. This looked at people's needs in context of their social and psychological circumstances. The service offered a wide range of one-to-one and group interventions as well as support with employment, housing and benefits. Therapies included psychosocial group interventions, brief interventions and anger management. We saw a timetable for support groups held at Wood House. These included harm reduction, thinking about rehabilitation, family, recovery, changes, triggers/cravings, safer injecting, SMART recovery (a four-step self-help programme), and alcohol brief intervention. Treatment strategies recognised that complete abstinence was not always achievable for all clients. The service offered advice on harm minimisation and safe injection, needle exchange programmes and foils distribution (to promote safer drug use).
- Staff considered clients' physical healthcare needs and referred any concerns to the clients' GPs. Staff liaised with the client's GP for medical information, which helped them draw up a safe treatment plan. Qualified nurses undertook inspection of injection sites, blood pressure checks, and offered blood-borne virus tests. Staff referred clients to their GPs for electrocardiogram (ECG) tests, and medical staff reviewed the results. Lifeline Stoke had ECG equipment and planned to offer ECGs directly once it had trained the staff. However, there was an absence of other checks such as chest examinations and routine blood screens before commencing clients on treatment programmes.
- Staff used a range of tools to support assessment and care planning and to monitor outcomes. As of 30 June 2016, Lifeline Project had completed treatment outcomes profiles (TOP) for 88% of their clients at the start of treatment and 100% at exit. We saw a number of simple, easy to read mapping tools in care files that staff used to in their work with clients such as restart maps, preclinic maps and goal planners. These simple, easy-to-read tools helped clients make sense of their substance misuse and create a shared understanding of it with staff. The young persons' team used a specialist substance misuse outcome record for young people.
- Managers completed audits in January and June 2016 that looked at the staff files, case files and reception area at the Tunstall site. This resulted in actions to address the identified issues. However, most staff reported an absence of clinical audits within their service. Lifeline Stoke did not have a programme of clinical audits even though it was new to managing clinical services.
- Some team leaders completed file audits for their own teams. They looked at whether case files contained accurate and up-to-date documents. The team leader for the criminal justice team audited files monthly and fed back to staff at team meetings. The team leader for the young persons' team completed audits on files and discussed any issues with staff in one-to-one supervision sessions. The clinical lead for alcohol services undertook audits of files using a case file audit tool.

Skilled staff to deliver care

- Lifeline Stoke had a wide range of staff across its teams. These included psychiatrists, a GP with a special interest in substance misuse, non-medical prescribers, detoxification nurses and recovery workers. The service employed physical healthcare nurses who tested and treated blood-borne viruses. There was a dedicated administrative team, which staff found beneficial. The provider had recruited a clinical director who was joining the service in September 2016. Managers were recruiting leads for specific issues to support the range and complexity of clients they dealt with. The four specialist lead roles covered diversity, domestic violence, homelessness and mental health. Lifeline Stoke had regular access to local community health services, for example, a wound care nurse and a sexual health nurse held weekly clinics.
- Most staff were suitably experienced and qualified for their roles. Although the service had lost staff during the transition period, it had also retained a number of

skilled and experienced staff. These included medical staff, clinical staff, healthcare nurses and non-medical prescribers. The service had specialist teams including the criminal justice team, a pregnancy drug users' team, and a families and young persons' team. Staff working in the specialist teams had good knowledge and experience of how substance misuse affected their specific client groups.

- Since taking over the three services in November 2015, the provider had commenced an integration plan for all teams. This meant that some specialist drug and alcohol staff would become generic substance misuse workers. This caused anxiety to staff as some staff did not feel confident and skilled to work with drug users, and vice versa. Staff had received basic training on new areas and had opportunities to shadow more experienced staff but did not feel this was sufficient to manage the work effectively and safely.
- At the time of our inspection, Lifeline Stoke had seven volunteers. We interviewed three volunteers. Volunteers performed a range of tasks, for example, they liaised with job centres, co-facilitated groups, shadowed home visits, and undertook reception and administrative duties. Volunteers had designated supervisors (team leaders) and received supervision monthly. Volunteers had access to daily meetings and team meetings. Staff shared information with them appropriately. This did not always include full information because of confidentiality. The volunteers we spoke with described working in a safe and supportive environment, and some hoped to secure paid employment in the future.
- All staff, including agency staff and volunteers, received an induction when they started work with the provider. We saw a copy of the timetable for week 1 of the mandatory induction programme that covered diversity, recovery, an introduction to the provider and its vision, how to access policies, performance management, the electronic records system, data protection, and key stakeholders. As of 30 April 2016, 97% of staff had completed the induction.
- At the time of our inspection, 100% of staff received one-to-one supervision on a monthly basis from their team leaders. The provider had since changed its supervision structure, which meant that supervision would take place every six to eight weeks. The non-medical prescribers received supervision from the psychiatrist or the GP with a special interest (GPSI). Staff also had access to clinical supervision, peer group supervision and access to specific groups such as the monthly prescribers' meeting, as appropriate. Managers attended monthly managers' meetings and most teams held their own meetings. We saw notes from meetings for the young person's team and the criminal justice team. There were no clinical team meetings or service-wide meetings held.
- Staff had not received appraisals with the new provider because they were not due until later in the year. Managers were aware that they needed to establish an appraisal programme.
- Staff received specialist training for their roles. For example, staff received training in needle exchange. Team leaders and staff in the young persons' team had access to advanced safeguarding training and managers encouraged all staff to do more safeguarding training. Staff mentioned a number of courses they had access to including basic life support and new psychoactive substances. Staff could request training that supported their roles such as acupuncture and counselling. At the time of our inspection, Lifeline Stoke had trained 18 staff on take home naloxone. Two staff in the young persons' team were completing national vocational qualification (NVQ) level 3 training. However, some staff felt they would find it difficult to attend courses because of their high caseloads.
- Staff had access to web-based resources such as Public Health England's skills consortium and 'Drink and Drug Daily', which helped them stay up-to-date with practice. The provider supported qualified staff with their revalidation requirements.
- Lifeline Stoke addressed poor staff performance promptly. At the time of our inspection, the service relied on agency staff to fill vacancies while it recruited new staff. Managers monitored temporary staff closely and only retained them if they showed competence in their roles.

Multidisciplinary and inter-agency team work

- Staff reported there were no multidisciplinary team meetings held in the service although we found that clients received regular clinical reviews that their keyworkers routinely attended. We observed a clinical review for a client and found that the keyworker made a

strong contribution. These reviews did not always include a review of care plans and risk assessments. However, staff attended multidisciplinary and multi-agency meetings and reviews for complex cases led by other teams such as child protection and mental health.

- All staff and managers met for daily handovers, called 'flash' meetings. We attended two handovers. These were short, well-structured meetings with a set agenda. Staff discussed new information about clients, significant events and risks. They ensured cover for clients whose keyworkers were absent. The chair took notes of the main points of the meeting and made them available to staff who missed the meeting. Staff spoke positively about these meetings as they were regular, short and covered the main points. Staff also enjoyed the opportunity to meet as a whole service.
- The service had strong working relationships and interdependencies with other services such as GPs, maternity services, social services children and family teams, community mental health teams and criminal justice services. Staff attended and contributed to multi-agency meetings. The service had weekly access to a wound care nurse and a sexual health nurse. The sexual health clinic offered basic advice and services such as contraception and chlamydia testing. The service held clinics for hepatitis C testing and treatment, sexually transmitted diseases, pregnancy and wound care. The service had strong links with the local inpatient and rehabilitation centres for substance misuse issues.
- Each team had links to external agencies relevant to their specific service or client group. For example, the young persons' team worked closely with CAMHS and the young women's project. The team leader attended the local safeguarding board subcommittee. The criminal justice team worked closely with the probation service and the police. The pregnant drug users' service had jointly developed pathways with local maternity services, and good links with midwives and the specialist obstetrician at the local maternity unit. Physical healthcare nurses had direct access to the hepatology department at the local hospital.

Good practice in applying the Mental Capacity Act

- Staff received training on the Mental Capacity Act (MCA), which was part of the provider's mandatory training programme. Lifeline Stoke did not supply compliance data for this training as it took place just before our inspection. However, staff we spoke with knew about the five statutory principles that underpinned the MCA.
- We spoke to staff in different teams about how they applied the MCA in their work. All staff assumed their clients had capacity to make decisions. Staff checked if clients understood the information given to them. Staff described how intoxication was the main issue in their client group that gave rise to uncertainty about the capacity to make informed decisions about treatment. In some cases, staff asked the client to return later and recorded their decision in the client's notes. In other cases of uncertainty or concern, staff sought advice from clinical leads.
- Medical reviews routinely included assessments of capacity, and staff addressed any issues on a case-by-case basis. Appropriately qualified staff who occasionally completed mini mental state examinations in their roles found this helped them determine if clients needed further assessment.
- Staff assessed the competency of young people in line with the Fraser and Gillick competence framework. The psychiatrist completed formal competency assessments where there was uncertainty about the young person's capacity. The service involved family members, where appropriate.
- Staff did not know if there was a local MCA lead but knew they could get advice from the lead nurses.

Equality and human rights

- Lifeline Stoke had a strong focus on equality and diversity. Staff received specific training on diversity. Recruitment had commenced for four new lead roles for diversity, domestic violence, mental health and housing.
- The service supported people with protected characteristics appropriately. Staff assessed clients' individual needs, and aimed to provide tailored support to meet those needs.
- Staff accommodated women's needs. For example, they offered women testing by oral swab instead of urine

tests during menstruation. The service had a dedicated team that worked with pregnant clients. Staff referred pregnant clients to the local maternity unit and jointly ran antenatal clinics.

- The service had a dedicated team that worked with children and young people. There was no lower age limit for referral to the service but generally, clients were 14 to17 years old.
- Staff assessed clients' individual health needs that sometimes included physical and mental health conditions. Staff referred clients to appropriate services if they were not already accessing them. Staff also provided some physical health support internally for those conditions substance misusers were at greater risk of, for example, screening for blood-borne viruses (BBV) such as hepatitis and HIV.
- Staff took into account people's ethnic and religious preferences when assessing needs and planning care. For example, staff adjusted one patient's treatment for alcohol detoxification during Ramadan, a month-long fasting period for Muslim people.

Management of transition arrangements, referral and discharge

- The clients we spoke with who had experienced transition between services described smooth handovers. Lifeline Stoke offered aftercare to discharged clients to help them sustain their recovery. Staff also encouraged clients who became drug or alcohol-free to access support services in the community to help them maintain abstinence.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff had a strong commitment to person-centred care. This showed in their interactions with clients, the way they spoke about their work and the shared care planning approach. We observed several interactions between staff and their clients, and found that staff were respectful. They listened to their clients and provided them with appropriate emotional and practical support.
- Clients described good staff and client relationships. One client described the staff as 'brilliant'. Another client said "nothing is too much trouble" for staff. Clients described the staff as professional, attentive and empathic. Clients were happy with the service provided and believed they would get the help they needed.
- Staff had good awareness of people's individual needs and tailored support accordingly. For example, staff adjusted one patient's medication during Ramadan (a fasting period for Muslim people). Staff identified named workers for each client as a point of contact, and for continuity of care. This helped staff and clients develop good working relationships that supported recovery. Staff recognised that some clients had poor social circumstances and helped them directly or referred them to appropriate service such as housing and debt advice.
- Staff maintained client confidentiality. All staff received training on confidentiality and data protection. Staff conducted interviews in private settings, and stored paper documents in lockable filing cabinets that only the specific team had access to.

The involvement of people in the care they receive

- Staff involved clients and their carers, where appropriate, in planning treatment and setting goals that resulted in a recovery plan specific to their needs and circumstances. Clients signed their care plans, and staff offered them copies. Staff provided clients and relatives with information about their treatment to help them make informed choices. The service had a wide range of information available for clients on specific treatments, side effects and risks, as well as a range of information on general physical health wellbeing. For example, at the time of our inspection, the service was raising awareness about hepatitis C.
- The service ran a range of support groups for clients and their carers and also signposted clients and carers to other groups and services in the community that could offer them help. For example, one carer received support and respite from a family support group even though her relative would not engage with services. The carer found the family group helpful. The young persons' team ran groups for carers and 'concerned others'. These ran twice weekly and twice fortnightly at different times and venues throughout the city.

Substance misuse services

- Staff referred clients who needed advocacy services to local advocacy agencies such as PALS, Voices and the Citizens' Advice Bureau. However, not all staff knew about the advocacy services available.
- Staff encouraged clients to make suggestions for developing and improving the service. We observed a meeting in which staff and clients discussed a number of ongoing initiatives such as free gym passes and t-shirts advertising five-a-day healthier lifestyles. Clients suggested new initiatives such as a men's group, a job club and job listings board, and a games room.
- The service gave clients and their carers and relatives opportunities to feed back to the service and influence improvements. The service user group was one forum that sought clients' views of the service. Staff attended the group, recorded discussions, agreed actions and shared outcomes. Clients benefited from seeing changes resulting from their feedback, for example, the group had said the reception area was untidy, which the provider then improved. Lifeline Stoke displayed clients' comments and subsequent actions in a "you said, we did" section on the notice board.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- Lifeline Stoke accepted self-referrals as well as referrals from other agencies and professionals. In most cases, newly referred clients received an initial assessment from the early/brief intervention team, usually within 72 hours. They then referred clients to the appropriate teams for either 'tier 2' or 'tier 3' support. Tier 2 support involved psychosocial interventions for which the waiting list was around five weeks. Tier 3 involved a medical review, which took up to 10 days following the initial assessment. The doctor reviewed all former (discharged) clients who returned to the service.
- Lifeline Stoke staff screened and assessed all referrals for inpatient detoxification and medical staff determined if the client required inpatient treatment. At the time of our inspection, this presented challenges to the service as it had received the same number of referrals in nine months that it normally received in 18 months.
- Some teams had specific access and referral criteria. The pregnant drug users' (PDU) service fast tracked clients into the service in line with the relevant Department of Health guidance. The young persons' service offered an expected response time of five days for assessment and 10 days for treatment. The team had no lower age limit for access but most clients were between 14 and 17 years old, and presented with cannabis or alcohol issues. The team had worked with an eight-year old in the past who misused solvents.
- The criminal justice team followed a specific model of care linked to the national prison release scheme, the test-on-arrest scheme and relevant court orders (such as the drug rehabilitation requirement, known as DRR, and 'required assessment). They worked closely with the police and the probation service. Staff assessed the clients and those taken into the service received supervision for at least twelve months. The probation service managed discharge and non-compliance.
- Staff made clients fully aware of the commitment they expected from them. They gave clients written information on confidentiality, information sharing and other requirements. Clients signed the agreements to show they were aware of them and agreed to them.
- Discharge planning commenced when the client entered the service. Discharge planning was central to recovery-based care and treatment, and acted as a strong motivator towards positive outcomes. Lifeline Stoke had 920 discharges from November 2015 (when it took over the service) to 27 April 2016. The service offered aftercare to discharged clients to help them sustain their recovery.
- The service offered 24-hour cover but was not an emergency service. Clients had access to telephone contact out-of-hours. Staff volunteered to cover the out-of-hours rota. Trained staff covered the service and received calls from clients, pharmacists, the police and healthcare services who needed information.
- Staff offered flexibility in the times of appointments to meet clients' needs and maximise their engagement. Staff made appointments taking into account a client's

substance consumption, for example, offering an early appointment to someone who would be intoxicated by midday. Staff also determined the frequency of appointments to match clients' assessed needs, for example, weekly or monthly.

- Normal business hours for Lifeline Stoke were Monday to Friday, 9am to 5pm, but by appointment only from 4pm. However, staff routinely offered services outside of normal business hours. For example, staff offered late clinics on Tuesdays and Wednesdays from 5pm to 8pm, and the GP with a special interest (GPSI) worked late on Mondays. Clients who had other commitments during office hours had access to the late clinics and staff pre-booked their medical reviews to accommodate their needs. In addition to clinics, staff ran groups in the evenings and held a breakfast club on Saturday mornings.
- The criminal justice team offered appointment times to support the criminal justice system's needs. For example, the team offered a service to the police custody suite from 9am to 10pm during weekdays, and from 9am to 4pm on weekends.
- Appointments generally ran on time and staff rarely cancelled appointments or activities. None of the clients we spoke with had experienced appointments cancelled by staff. Some teams such as the families and young persons' team reported no cancellation of activities due to sickness or staff shortages. However, one recovery worker said they had cancelled home visits and activities because of their workload and other priorities. Another staff member recalled cancelling two groups.
- Lifeline Stoke had 1,825 appointments not attended by clients from November 2015 (when they took over the service) to 27 April 2016. Staff understood that the nature of their service and clientele meant they needed to be proactive and flexible when dealing with non-attendance or poor engagement. Staff routinely sent clients reminders of their appointments by letter or text.
- The provider had a policy that set out the procedures for managing engagement, re-engagement and non-attendance by clients. Some teams adapted the provider's non-attendance policy to address specifically the risks presented by some clients such as pregnant women and young people.

The facilities promote recovery, comfort, dignity and confidentiality

- Lifeline Stoke mainly operated from two offices, Tunstall and Wood House (in Hanley). Staff regularly used the offices to meet their clients. Both offices bases had a reception, a needle exchange room, clinic rooms, group rooms and one-to-one space. Wood House also had an IT suite, family rooms, and a number of multi-purpose rooms. All rooms were furnished appropriately, private and soundproof. Both sites had designated urine-testing toilets. However, at Wood House, clients waiting for their test results waited in the corridor, outside the designated toilets. This did not promote the clients' privacy and dignity.
- Staff facilities at Wood House comprised a large open plan office with a separate kitchen/dining area, and several smaller offices. However, the main office was busy and noisy, which made it difficult to concentrate. Staff 'hot desked' but there were not always enough desks, which, delayed staff in updating clients' records.
- Staff visited clients in locations other than the office bases. These included the client's home, drop-in centres, libraries and homeless shelters. In one case, staff met a client in a busy community-based location because it was safer. Medical staff had access to laptop computers, which meant they could access records remotely. This enabled them to hold clinics in other venues.
- Clients received their rights during the initial assessment process when they decided to access the service. Rights were included in the expectations agreement and associated documents that formed a contract between the service and the client. Clients received copies of these 'contracts'.
- A wide range of information leaflets and posters were available in the reception areas of each office base. This included easy-read leaflets on specific treatments and their side effects. Staff gave clients information about, or referred them to local services such as housing agencies, debt advice and support groups. However, most staff we spoke with did not know about any local

advocacy services. Staff we spoke with had little or no awareness of advocacy services. The service ran awareness campaigns, for example, at the time of our inspection, there was a large display about hepatitis C.

Meeting the needs of all people who use the service

- Staff showed they had good local knowledge. Staff were aware of the social, economic and ethnic make-up of the local populations. The area they served had high levels of economic deprivation and poverty, and a diverse community including people from Eastern Europe and asylum seekers. Staff understood the potential issues faced by specific groups such as black and minority ethnic groups, young people, pregnant women and lesbian, gay, bisexual or transgender people. The service had dedicated teams to meet the specific needs of some groups such as pregnant women, young people, and clients in the criminal justice system.
- Staff offered appropriate support to clients including referrals to other agencies and information on services available in the community. Staff knew where to find support for clients who presented with a specific issue. For example, they referred clients to MIND for one-to-one counselling, Savana for support around sexual abuse, and Dove for bereavement counselling.
- The office buildings and rooms were fully accessible to people with disabilities. The services at Wood House were located on the second floor of the building. The building had a lift, and the offices had wide corridors and spacious rooms. However, at the time of our inspection, the lift was out of order restricting access for some people. This was a temporary situation caused by a power cut.
- Staff made a range of adjustments to meet the needs of people who used the service. During our inspection, we found numerous examples of adjustments made to ensure tailored support for clients' specific needs. For example, staff maintained frequent contact with pregnant women, and held jointly run clinics with the local antenatal unit. Staff adjusted the times of a client's treatment during a religious fasting period. Staff made appointments based on clients' substance consumption, for example, offering an early appointment to someone who would be intoxicated by midday. Staff held regular clinics and groups in the evenings to encourage participation from those who had other commitments during office hours. Staff met a client at a community venue at his request because it created less stigma for him. Staff determined the frequency of appointments to match clients' assessed needs, for example, weekly or monthly.

Listening to and learning from concerns and complaints

- Lifeline Stoke reported receiving no complaints from November 2015 (when they took over the service) to 30 April 2016. New data from the provider showed that since April 2016, they received six complaints (to 30 June 2016). These were still in progress.
- Lifeline Stoke received 77 compliments from clients and carers from November 2015 to 30 June 2016.
- Clients and their carers knew how to make complaints and felt confident to do so. One relative discussed a complaint she made and said the manager dealt with it appropriately and resolved it to her satisfaction. Information about making a complaint was widely available. Staff informed clients about the complaints process at their assessments. There were posters displayed in the reception areas about making a complaint. Clients we spoke with said staff helped them make complaints.
- Staff knew how to handle complaints in line with the provider's complaints policy. Lifeline Stoke acted on the findings of complaints, for example, clients complained about how long they had to wait for their prescriptions. Managers accepted there were delays in issuing prescriptions and planned to review the process. Staff received feedback from complaints at daily 'flash' meetings, team meetings and in one-to-one supervision sessions.

Are substance misuse services well-led?

Vision and values

- The provider had taken over three substance misuse services from November 2015. At that time, there were three distinct teams, run by different providers. There was an alcohol team, a drugs team and a young person's team each with its own dedicated staff. Lifeline

Stoke brought these services together under one new structure. When the new provider took over the services, all staff received a session on the provider's vision and values included in their mandatory induction.

- The provider's vision was to create integrated services underpinned by recovery-based approaches. As such, the service was undergoing a cultural shift from a maintenance model, in which registered clients receive an ongoing service, to one of temporary recovery-focused journeys underpinned by clear expectations for services and clients. The provider defined recovery in the widest sense, which took into account clients' social circumstances and needs.
- The service had a clear definition of recovery that staff shared and understood. Staff had a strong commitment to their clients' care and recovery, and felt motivated by the progress they made. However, some staff struggled to understand their roles in context of the changes implemented by the provider, and expressed concern about the integration of drugs and alcohol resulting in generic rather than substance-specific roles.
- Most staff did not know who the senior managers were although they knew they occasionally visited the office. Most staff said they had little contact with managers above team level. Lifeline Stoke was part of the provider's north-west portfolio, and the senior management team were based in the north-west of England, which made it difficult for frequent visits.

Good governance

- The provider had effective governance systems and processes to help monitor service delivery, team performance, and incidents and risks.
- The provider ensured staff received mandatory training and induction, and achieved high compliance rates. However, Lifeline Stoke did not supply compliance rates for basic life support, risk assessment, first aid, the Mental Capacity Act (MCA) and mental health awareness.
- Staff received supervision on a regular basis. Staff had not received appraisals with the new provider because they were not due until later in the year.
- Staff maximised their time on direct care activities although high caseloads for staff in the clinical and recovery teams meant that they could not always provide all the support that clients needed.
- The service recognised and reported incidents internally and where appropriate informed external bodies such as commissioners or local authority safeguarding teams. However, the service did not always submit notifications to the CQC.
- Staff received feedback and lessons learnt from incidents, complaints, and client and carer comments. Managers gave information to staff via emails, at daily 'flash' meetings and team meetings, and in one-to-one supervision sessions. At the time of our inspection, there were no meetings held for the whole service but managers planned to introduce them.
- Staff complied with the local safeguarding protocols, underpinned by statutory guidance. Staff had good knowledge and experience of the MCA, and followed the provider's procedures.
- Managers completed audits in January and June 2016 that looked at the staff files, case files and reception area at the Tunstall site. This resulted in actions to address the identified issues. However, most staff were not aware of any clinical audits within their service. Lifeline Stoke did not have a programme of clinical audits even though it was new to managing clinical services.
- Lifeline Stoke collated performance data in line with requirements set by Public Health England and commissioners. Lifeline Stoke submitted performance information to the national drug treatment monitoring system (known as NDTMS) on a monthly basis, as required. It submitted information to its commissioners on a quarterly basis. Teams used performance data to monitor their performance. For example, the families and young persons' team had reviewed their referral and treatment times and developed an action plan to improve them. At the time of our inspection, managers were reviewing and revising their performance measures in response to new key performance indicators set by commissioners.
- Lifeline Stoke had a new manager who had sufficient authority and support to lead the service. As well as administrative support within the team, the manager had access to resources within the wider organisation. The provider had dedicated resources to the planning and development of Lifeline Stoke, for example, clinical lead nurse support, governance support and policy support.
- We saw copy of the corporate risk register dated 26 November 2015. This showed a wide range of corporate

and operational risks, including those relevant to Lifeline Stoke, for example, merger issues. Managers submitted risks highlighted by their staff and teams to the risk register.

Leadership, morale and staff engagement

- The new provider, Lifeline Stoke took over services in November 2015 and did not have a dedicated manager until April 2016. This had a significant impact on staff morale with most staff reporting low morale, uncertainty and instability during the transition period. Managers acknowledged the amount of change implemented since they took over the service, and the impact this had on staff, clients and service delivery. For example, the provider had to manage transfers of staff, leavers, recruitment, and sickness absence. Lifeline Stoke did not supply sickness absence rates for its staff so we could not assess this. However, anecdotal evidence from staff and managers suggested the service had experienced high sickness absence levels.
- The provider had made fundamental changes to staff roles that affected staff morale. Roles were no longer substance-specific but generic. This meant staff had mixed caseloads of drug and alcohol misuse clients. Staff expressed concerns about working in a field they were not skilled or experienced in. They relied on support and advice from colleagues.
- Staff morale varied between teams. Most teams had a team leader that staff found helpful as their first line contact. The families and young persons' team described a supportive team with good morale whereas the recovery teams described an unsettled, busy and stressful environment.
- Staff reported an improvement in their morale since the new manager started. We consistently found that the staff were highly motivated and passionate about clients' needs, and feedback from clients indicated that the changes had not affected the care and treatment staff gave them.
- Staff knew about the whistle blowing procedures. Most staff felt confident to raise concerns without fear of victimisation. However, this was not consistent across the staff we spoke with as some staff worried about the possible consequences if they spoke up.
- Staff were open and transparent when something went wrong.
- The service had experienced significant change since the Lifeline Project took over as the new provider in November 2015. Some staff felt that senior managers did not consult or engage with them enough about planned changes. Staff felt more involved in service development at team level.

Commitment to quality improvement and innovation

- The provider expressed commitment to service improvement and shared a number of plans and initiatives. The provider had submitted a bid for funding to provide rapid HIV testing and referral services, and awaited a decision from commissioners. The provider planned to prescribe 'take home' naloxone from September 2016.

Outstanding practice and areas for improvement

Outstanding practice

The provider recruited volunteers into the service. These were often former clients or carers. Volunteers received training and development; some volunteers had secured paid employment with Lifeline Stoke.

The provider recognised the need for lead roles to help address the specific needs of the local population. The provider had commenced recruitment for four new lead roles for diversity, domestic violence, mental health and housing.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure it notifies the CQC of any deaths of clients in line with statutory requirements.

Action the provider SHOULD take to improve

- The provider should ensure the privacy and dignity of clients when they receive urine-tests.
- The provider should ensure that it notifies the CQC of incidents in line with the relevant statutory requirements.
- The provider should ensure it has effective monitoring systems and processes for clinical practice, for example, audits.
- The provider should ensure its prescription service is timely and responsive.
- The provider should ensure that the risk of loss of blank prescription forms is adequately mitigated.
- The provider should ensure that clients have access to regular and timely medical reviews.
- The provider should ensure staff receive appraisals.
- The provider should ensure that lone working practices are monitored effectively across all staff teams.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services • The provider did not notify the CQC of any deaths of clients in receipt of services. This was a breach of regulation 16 (1)(a)(b)