Turning Point - Medway

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 Turning Point Medway as good because:

- The service provided safe care. The premises where clients were seen were safe and clean. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the majority of the governance processes ensured that its procedures ran smoothly.

However:

- Staff did not always record risks to clients. We reviewed six risk assessments and found two were not updated or reflective of all risks identified.
- The audit checks on client risk assessments had not identified the concerns we found during the inspection.

Summary of findings

Contents

Good

Turning Point - Medway

Services we looked at: Community-based substance misuse services.

Summary of this inspection

Background to Turning Point - Medway

Turning Point - Medway, known as Medway Active Recovery Service, provides specialist community treatment and support for adults affected by substance misuse. The service is commissioned to provide treatment for people who live in Medway.

The service offers a range of services including initial advice; assessment and harm reduction services including needle exchange; prescribed medicines for alcohol and opiate detoxification and stabilisation; naloxone dispensing; group recovery programmes; one-to-one key working sessions and doctor and nurse clinics which includes health checks and blood borne virus hepatitis C testing.

The service has good partnership working in the local area and with other agencies, including social services, probation, GPs, pharmacies, education services and homeless charities/services.

There is a registered manager at the service.

The service registered with the Care Quality Commission on 4 December 2018, to provide the regulated activity treatment of disease, disorder and injury.

The service had undergone a contract re-structure in April 2018 and was previously registered with the Care Quality Commission under Turning Point Chatham. In December 2018, following several changes including location of service and service name, the provider re-registered.

This was Turning Point Medway's first inspection since re-registering in December 2018, having previously been inspected under Turning Point Chatham.

Our inspection team

The team that inspected the service comprised one CQC inspector, one CQC assistant inspector and one nurse specialist with experience of working in substance misuse services.

Why we carried out this inspection

We undertook an unannounced, comprehensive inspection of this service as part of our routine programme of inspecting registered services.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

Summary of this inspection

- visited the service and hub location, looked at the quality of the environment and observed how staff were caring for clients
- spoke with three clients who were using the service
- spoke with the registered manager and senior manager at the service
- spoke with 11 other staff members; including a doctor, a nurse and recovery workers
- attended and observed a home visit with a client
- attended and observed a complex case review meeting and business performance meeting
- looked at six care and treatment records of clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with three clients. Clients were very positive about the service, they felt that staff were kind and caring and responsive to their needs and always treated them with compassion and respect. Clients told us that staff were easily accessible and provided clients with time to talk, whether on the telephone or in person. Clients had a choice in their treatment pathways and found the group programmes to be effective as well as positive engagement with staff in their one-to-one sessions. They told us they felt staff and the service had benefited their lives and they had received the right support at the right time and it had helped change their lives.

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?

Good

We rated safe as good because:

- All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.
- Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans. This was in line with guidance from National Institute for Health and Care Excellence.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Records of clients' care and treatment was variable in the detail recorded. Most records were clear, up-to-date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each client's physical health.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

However:

- We reviewed six risk assessments and found two were not updated or reflective of all risks identified.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.
- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that the majority of the governance processes operated effectively at service level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance.

However:

- The audit checks on client risk assessments had not identified the concerns we found during the inspection.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards training was set by the provider as mandatory for all staff working at the service. At the time of the inspection, 85% of staff had completed their required mandatory training. The provider had a Mental Capacity Act policy which staff were aware of.

Staff were aware that when clients attended an appointment and were under the influence of drugs or alcohol they needed to reschedule the appointment for a time when the client was not intoxicated. This was so the client would have the capacity to make informed choices about their treatment.

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

Good

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

Safety of the facility layout

We visited two locations within the service. Each building was accessible with a variety of accessible rooms. At the main service location, clients accessed the ground and first floor areas of the building only. Clients with mobility needs were seen on the ground floor, at home or in one of the satellite services.

Staff carried out regular risk assessments of the environment. The service had an externally commissioned fire risk assessment and an internal health and safety audit was completed annually. Any actions required were documented and timescales to complete the actions were monitored.

Maintenance, cleanliness and infection control

The service had a range of rooms including a clinic room, needle exchange room, group rooms and smaller rooms that staff used for one-to-one appointments. All areas were clean, had good furnishings and were comfortable and well maintained.

There was an intercom entry system to the service and clients and visitors were expected to sign in and out. Keyworkers would meet clients in the reception room and support them when in the building. Staff could call for help in an emergency. Rooms that clients had access to had alarms fitted and there were portable alarms available to staff.

The clinic room was clean and tidy. Equipment was in date for calibration and portable appliance testing (PAT).

Medicines were stored in the lockable fridge in the clinic room. Staff locked the clinic room when not in use. Staff completed daily temperature checks to make sure that medicines were kept at the recommended temperature.

All environments contained a medical emergency box that contained a spill kit, sharps bin, emergency kit containing adrenaline, syringes, needles, small sharps box, examination gloves and facemask. Staff regularly checked the boxes to ensure the contents were in-date and restocked.

Staff completed a naloxone log which recorded batch number, expiry date, risk assessment, safe storage and a client signature to confirm they had been trained in its use. Naloxone is a medicine used to reverse the effects of an opiate overdose.

The service had a well-stocked needle exchange in line with National Institute for Health and Care Excellence guidance for needle and syringe programmes. Information was displayed through the building and available for clients to take away about harm reduction and a range of relevant health matters.

Staff adhered to infection control principles, including hand washing and the disposal of clinical waste. There were alcohol gels available and hand washing basins in the clinic room.

The service had appointed staff as health and safety representatives, fire wardens and first aiders. The service carried out quarterly fire drills.

The service had a designated health and safety lead. Their role was to ensure compliance with statutory responsibilities and to evidence improvements to managers and the providers 'Risk and Assurance' department. Performance was tracked via an electronic 'Service Safety Management System' and action plans were put into place to address any identified concerns or issues. During the inspection, we observed a health and safety meeting and saw staff reviewing the electronic dashboard. During the meeting, information between staff was communicated effectively and sharing of ideas was encouraged.

Safe staffing

Staffing levels and mix

The provider had established staffing levels required through consultation with the service commissioners.

The service employed a doctor and non-medical prescriber (NMP). They both held regular clinics so that clients were seen as soon as possible after referral. Between the end of February 2019 and beginning of May 2019, a doctor previously working for the service had left and the current doctor had not yet started. Due to a period where the service had no permanent on-site doctor, doctor-led clinics for complex and high-risk clients had not been taking place regularly and there was a backlog of clients who were overdue their three-month medical reviews. However, during our inspection, the doctor who had recently been recruited, informed us this had now been resolved. Most clients who required a medical review had now been seen, with less than six clients still needing to be seen, but whom had been contacted.

As of the 25 March 2019, the service had a total of 27 substantive staff. This included managers, senior recovery workers, recovery workers and administration staff. At the time of the inspection, there were two vacancies, which had been advertised and interviews arranged. There had been 20 substantive staff leave within the last 12 months, prior to the inspection. The manager informed us this was due to the contract re-structure in April 2018. Reasons for staff leaving were staff moving to other services, resignation or retirement and dismissal. There was a sickness rate of 9.3% amongst permanent staff.

There were enough skilled staff to meet the needs of clients accessing the service. The locality managers managed staff sickness and annual leave to ensure the service had enough staff.

As of the 28 February 2019, the service held a total caseload of 844 clients and was a mixture of alcohol, opiate and non-opiate clients. The individual caseloads per keyworker averaged 70 clients, depending on complexity, risk, staff skill and knowledge and capacity due to hours worked and additional responsibilities. The total caseload was spilt between 12 staff, including recovery and senior recovery workers and the family worker. Staff we spoke with told us that they received good supervision and support to manage their caseloads. Local managers actively monitored the acuity of caseloads with all staff through regular complex case reviews, as part of the referral process and during staff supervisions. The locality managers told us that maximum case limits applied to all staff to ensure their wellbeing and client risk safely managed. This was done through multidisciplinary meeting including clinical case review and safeguarding.

The service carried out pre-employment checks on all staff to make sure they were safe to ensure everyone working in the service was safe to do so. These checks included enhanced disclosure and barring service (DBS) checks, referencing from previous employers, copies of proof of identification and training certificates/proof of qualification.

Mandatory training

The service had lone working protocols and satellite working was risk assessed to manage client and staff safety.

There was a mandatory training matrix for all staff. This enabled staff to see which training they needed to complete and when training updates were required. The service had a training completion target of 85% for all courses. Staff at the service had exceeded this target. The service had an action plan in place to address any of the teams' outstanding mandatory training.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was set by the provider as mandatory for all staff working at the service and was completed annually. At the time of the inspection, 85% of staff had completed their mandatory training which included Mental

Capacity Act. Staff we spoke with understood their responsibilities in relation to MCA and ensuring clients were supported to make informed choices about their care and treatment.

Assessing and managing risk to service user and staff

Assessment of service user risk

We reviewed six care records, including care plans risk assessments and risk management plans. Areas of risk looked at; risk to self and others, physical health, substance misuse and safeguarding concerns including child protection and domestic abuse.

Staff did not always records risks to clients. Out of the six records reviewed, we found two risk assessments had not been updated following a change in risk or were reflective of risks identified during the client's comprehensive assessment. However, the risks identified were documented elsewhere in both of the client's care plan and initial assessment. On the day of the inspection, we observed risks for both clients were discussed as part of the wider multidisciplinary team complex case reviews and appropriate action and support was put in place to support the client's needs. We discussed this with the managers on the day of the inspection, who advised both records had been completed by one member of staff and they would offer additional to support to ensure this did not happen again.

Care records we reviewed, detailed staff monitoring clients' physical and mental wellbeing. We observed a recovery worker discussing risk with clients during a home visit. Staff discussed warning signs and any deterioration in clients' health during the clinical meeting, agreeing actions to respond appropriately.

All the records had a plan for unexpected exit from treatment. This was also variable with some plans more detailed and personalised to the clients' needs and views, whereas some were more generalised. We did see staff clearly recorded discussions with clients about harm reduction and risks of leaving treatment.

In line with National Institute of Health and Care Excellence (NICE) recommendations, staff used a range of tools to assess client's dependence and monitor their withdrawal. For example, the alcohol use disorders identification test (AUDIT) and the severity of alcohol dependency questionnaire (SADQ) was completed by staff with the client to assess their dependence. Recognised withdrawal tools were also completed to monitor and respond to change in risk. These included the clinical institute withdrawal assessment of alcohol scale (CIWA-r) and the clinical opiate withdrawal scale (COWS).

Staff followed their prescribing and treatment policy for clients receiving medically assisted treatment. For example, discussions between the doctor, recovery worker and the client would take place before moving a client from supervised to unsupervised consumption to ensure the client fully understood and ensure support and risk management was in place. Supervised consumption is where a client is observed taking their detoxification medicine to ensure adherence to their agreed treatment pathway.

Management of service user risk

The majority of staff were proactive at identifying and managing risk. There were effective systems in place to ensure the management of clients' risks. For example, staff had a central log of high-risk clients and held weekly complex case reviews for their discussion.

The service had clear protocols in place which staff were aware of and followed if clients disengaged from treatment. Clients who declined to engage with the service were reviewed during complex case reviews, so staff could discuss client risk and the appropriateness of alternative engagement methods.

A vulnerable and high-risk pathway (Blue Light Project) had been agreed with partner agencies in the local area and was managed by all partners involved. The aim of the project was to ensure if an agency identified an individual as being high risk they would be referred to the Blue Light Project. The individual's care plans and needs would then be met by the team.

Staff liaised closely with clients' GPs and requested a summary of prescribed medicines prior to initiating prescribed medicines. However, out of the six records reviewed we could not find GP summaries for two of the clients. We spoke to the doctor who confirmed, sometimes it was difficult to get the summaries from some of the GPs. Where that was the case, the doctor would always prioritise prescribing as the risk to the client was greater if they did not. However, the service always sent a letter to the client's GP to let them know what medicines had been prescribed

Good

Community-based substance misuse services

Safeguarding

There were effective systems in place to ensure that safeguarding concerns were identified, managed and reviewed.

All staff were required to complete mandatory safeguarding training. Safeguarding was fully embedded in staffs' daily work and was a key area of discussion in meetings including daily reviews and referrals, complex case reviews, supervision, regional managers and governance meetings.

There was a safeguarding lead at the service who staff could speak to for advice. Staff discussed and reviewed all clients who were on the safeguarding register during the monthly safeguarding meeting. The safeguarding lead attended monthly safeguarding meetings. Safeguarding information was clearly displayed throughout the service for both staff and clients.

There was a designated member of staff who attended multi-agency risk assessment conference meetings (MARAC) and shared information with the team. Multi-agency risk assessment conference meetings are where representatives from agencies including the police, social services, schools and local authorities come together to discuss high risk cases of domestic abuse.

Staff access to essential information

Client care records were stored securely. They were held electronically. Where paper forms were completed with clients, these were scanned and stored on the client's electronic care record. Prescription information was also available via the electronic care records.

All staff had password protected access to electronic systems.

Medicines management

Prescribing staff demonstrated safe practice around prescribing medicines. This was demonstrated in clinical records and our observation of prescribing procedures and reviewing policies and procedures. Clients receiving a prescription were reviewed by a prescriber at least every three months and prescribers conducted desktop reviews for clients who did not attend their review.

Staff supported clients to access their prescriptions in the community. Controlled drugs were not stored or dispensed on site. Staff contacted a suitable pharmacy for the client to arrange dispensing. Staff provided the pharmacist with essential information prior to prescriptions starting and updated them with any changes and reasons for the change in prescribing if necessary. Staff had a good working relationship with the local pharmacies who dispensed detoxification medicines. Pharmacy staff contacted the service when clients did not attend to collect their medicines so that staff could check on the client's wellbeing.

Staff provided a lockable box for all clients who were prescribed an opiate detox. Staff provided and trained clients how to administer naloxone to reduce the risk of overdose. Training in administering naloxone was also provided to families, carers, support workers and any relevant person involved with a client at risk of opiate overdose. During a home visit, we observed staff speaking with clients about how to store the medicine and how to check the expiry date to ensure it remained safe to use if required.

During a home visit, we observed staff discussing risks and providing harm reduction advice for a client who was pregnant. This was good practice.

Medicine management including dispensing, administration, reconciliation, recording and disposal was all undertaken in line with National Institute of Health and Care Excellence (NICE) guidance**.**

Staff reviewed the effects of medicine on clients' physical health in line with National Institute of Health and Care Excellence (NICE) guidance

There was a clear audit trail and risk management process for prescriptions issued. The service had a dedicated prescription team to process repeat and instalment prescriptions. Prescribers cross referenced people's care records to ensure any changes to prescribed medicines were updated before authorising prescriptions. There was a secure process in place for ordering and storing prescriptions and checks were in place to ensure all prescriptions were accounted for. Medicine management and prescribing was monitored through the provider's clinical governance meetings and the corporate medicines management group.

Medicines incidents were reported, investigated and lessons were shared in monthly governance meetings. Prescribers received feedback during supervision meetings

Good

Community-based substance misuse services

and shared best practice through their prescribers' peer support groups which they attended monthly. The provider's governance and quality team shared trends from incidents to help improve practice.

Track record on safety

There had been no serious incidents reported by the service in the last 12 months, prior to the inspection. However, the service was re-registered with the CQC in December 2018, due to change of service name and location. Prior to re-registering, the service had appropriately reported serious incidents. These were all client deaths. Some were expected deaths due to physical illness. The majority were attributed to overdose of illicit substances. The senior management team thoroughly reviewed all deaths and implemented changes to service delivery as a result.

Reporting incidents and learning from when things go wrong

All staff had access to the electronic incident reporting tool and knew what should be reported. Incidents were thoroughly investigated and analysis and learning from these were shared effectively. The electronic incident report was signed off by management and any immediate actions fed back to the team. Staff participated in debriefs following incidents that occurred within the team.

Managers and medical staff reviewed incidents during weekly complex case reviews and monthly clinical governance meetings. The provider's risk and assurance team looked at themes and learning outcomes from incidents. Managers discussed incidents and shared learning during monthly managers meetings, group supervision, and staff team meetings. The local managers completed and submitted required notifications to the CQC.

The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must adhere to when things go wrong with people receiving care and treatment. The provider had a Duty of Candour policy in place. Staff we spoke with understood the need to be open and transparent when they had made mistakes and to make written apologies when required. At the time of our inspection, we did not see any examples of its use as none of the incidents that had taken place had needed a written apology.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff completed a thorough assessment of needs with all clients. Staff triaged initial referrals for urgency, but all clients received a full assessment and a prescribing assessment with a qualified prescriber, if required. Assessments included information about substance misuse history, physical and mental health, social needs and criminal justice history to ensure that client needs could be met. This was in line with guidance from National Institute for Health and Care Excellence. Assessments were completed within seven days of referral. All referrals were discussed daily in the team allocation meeting to ensure clients' needs were met quickly. Staff liaised closely with clients' GPs and requested a summary of prescribed medicines prior to initiating prescribed medicines.

All care records we reviewed contained meaningful and holistic care plans, including physical and social needs. However, the detail varied depending on the staff member who had completed the care plan. Information relating to identified risks and management of those risks was not always recorded in care plans. Information received from the provider prior to the inspection showed the service were aware of the need to link care plans and risk management plans following a recent audit they had undertaken. Managers at the service told us recovery workers were undertaking further training to support them in doing this.

Care plans were completed with clients during their initial assessment and then on an ongoing basis, a minimum of at least every three months. Staff told us they did not routinely offer clients a copy of their recovery plan, although they would provide a copy if requested. This was in line with guidance from National Institute for Health and Care Excellence.

Staff worked with clients on a one-to-one basis to develop their care plans and in groups where clients were able to share their goals with each other and offer peer support.

Clients receiving low doses of medicine were audited weekly using the caseload management tool. This enabled discharge plans to be made with clients who were on reducing medication regimes. It also ensured that clients did not remain on low doses for long periods with no goal and those clients whose medicines could be increased were. The caseload management tool was also used to monitor high doses of medicines and prolonged supervised consumption. This was in line with guidance from National Institute for Health and Care Excellence.

The majority of staff were proactive at identifying and managing risk. All the care plans we reviewed had information recorded should a client exit the treatment programme unexpectedly. However, the detail was variable, with some more basic than others.

Best practice in treatment and care

We reviewed six client records. The records detailed interventions and practice which were in line with National Institute of Health and Care Excellence (NICE). The treatment offered ranged from brief advice and information through to more structured clinical and group interventions. Interventions offered included one-to-one appointments with the client's allocated recovery worker, following a cognitive behavioural therapy model, mindfulness sessions and harm reduction groups.

Staff followed the provider's policies and procedures, which were adapted from relevant National Institute of Health and Care Excellence (NICE) guidelines and best practice. For example, recovery interventions and treatment pathways, including group work and psychosocial interventions.

Blood borne virus testing was routinely offered by the service or by clients' GPs. This was in line with guidance from National Institute for Health and Care Excellence.

The service had links with nurses who provided hepatitis C testing to clients. The service had strong links with their hepatitis c operational delivery network and supported clients with pre-testing and post-testing consultations. The service focused on promoting hepatitis testing as their local area had been highlighted as a high-risk area. This was in line with guidance from National Institute for Health and Care Excellence.

As part of the client's initial comprehensive assessment, where appropriate and when clients were on high doses of medicines, staff arranged for clients to have an electrocardiogram (ECG). High doses of certain detoxification medicines can have a serious effect on cardiac health. The service did not carry out ECGs on site but referred the clients to their GP or local hospital.

Staff supported clients with a range of issues including their physical and mental health, including information around health issues impacted by substance misuse such as leading healthier lives.

The service had a psychologist who was at the service two days per week and offered advice to staff and therapies to clients, such as couples' therapy.

Monitoring and comparing treatment outcomes

Staff completed a 'Treatment Outcomes Profile' (TOPs) with all clients every three months throughout their treatment. This is a measure of treatment effectiveness for each client where substance use, mental health, physical health, criminal activity, housing issues and overall wellbeing are scored. This was in line with guidance from National Institute for Health and Care Excellence.

The service had recently contacted all clients who had dropped out of their treatment programme prior to completing. Clients were asked to complete a questionnaire, so the service could better understand the client's reasons for exiting treatment early. Information was also given to the clients on how they could re-refer to the service if they wished.

Staff regularly reviewed care plans with the clients and updated them when required. The service had an electronic case management tool, which notified staff and managers when documents such as care plans and risk assessments needed to be updated.

Skilled staff to deliver care

All staff received a comprehensive induction when they commenced employment at the service, which included mandatory training, orientation to the service and shadowing of staff. Staff also completed competencies to ensure they were skilled to carry out their roles.

Staff had a significant level of knowledge and experience with qualifications in substance misuse and counselling. The team comprised of staff from a range of disciplines, which included a specialist doctor, non-medical prescriber, psychologist and recovery workers.

The local managers and staff who carried out supervisions, identified the learning needs of staff in their supervision sessions and provided opportunities for them to develop their skills. For example, management training was available for senior recovery workers to support their development into future management roles.

Data provided by the provider showed that as of the 20 March 2019, 100% of staff received supervision and had a named lead supervisor and 95% of staff had received an annual appraisal.

At the time of the inspection, the service recently recruited a designated family worker. Their role was to take a lead on safeguarding audits and to review and highlight areas for improvement within the teams safeguarding processes and ensure communication between partner agencies. They were a key contact for all staff should they need support or advice also.

All staff received regular, four to six weekly, clinical and managerial supervision and annual appraisals. Recovery workers also attended a monthly group supervision. The doctor and non-medical prescriber also attended group supervision and received peer support. The local managers told us all staff were encouraged to attend a monthly staff forum where concerns and issues could be discussed. Any concerns raised would then be responded to by the managers. Staff we spoke with, were all positive about the support they received.

The manager received support from the providers' human resources department to address staff performance issues promptly, where appropriate.

Multi-disciplinary and inter-agency team work

Staff requested GP summaries from clients' GPs to help inform their treatment and care, prior to and after prescribing medicines. GPs also prescribed medicines to substance misuse clients who were receiving medically assisted treatment. The service offered support and training to GPs. The doctor and non-medical prescriber completed regular medical reviews for clients who were prescribed medicine assisted treatment for opiate or alcohol dependence.

Staff worked with a range of external agencies and professionals including GPs, midwives, police, pharmacies, district council, probation, the community mental health team, young person's drug and alcohol service and supported housing providers to provide comprehensive and holistic care for clients.

The service held regular multidisciplinary meetings where clients' key workers were clearly identified, and any necessary shared care protocols agreed. We observed one complex case review and reviewed minutes of another multidisciplinary meeting and saw evidence of good clinical leadership from the non-medical prescriber and local managers. There was clear identification and plans made to manage client non-engagement and safeguarding concerns.

Clients recovery plans were mostly detailed and clear pathways to other supporting services where additional or next stage support was required was well recorded and specific to the client's needs and wishes. For example, it was not always appropriate for clients who were using a very low level of alcohol or drugs to come into the service. Staff worked closely with a partner agency to ensure such clients could access their service and support.

The local managers told us they were actively working with Public Health England to review all client deaths and implement change as the area of Medway had been identified as having a higher than average mortality rate.

The managers attended quarterly contract reviews and monthly informal meetings with the commissioning team to ensure the service performance against both national and locally set targets.

Good practice in applying the Mental Capacity Act

Mental Capacity Act and Deprivation of Liberty Safeguards training was set by the provider as mandatory for all staff working at the service. At the time of the inspection, 85% of staff had completed their mandatory training. The provider had a Mental Capacity Act policy which staff were aware of and could refer to when needed.

Staff were aware that when clients attended an appointment and were under the influence of drugs or alcohol they needed to reschedule the appointment for a time when the client was not intoxicated. This is so the client would have the capacity to make informed choices about their treatment.

Good

Community-based substance misuse services

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We spoke with three clients. Clients were very positive about the service. They felt staff were kind, caring and responsive to their needs and always treated them with compassion and respect. Clients told us staff were easily accessible and provided them with time to talk, whether on the telephone or in person. Clients had a choice in their treatment pathways and found the group programmes to be effective as well as positive engagement with staff in their one-to-one sessions. They told us they felt staff and the service had benefited their lives and they had received the right support at the right time and it had helped change their lives.

We observed a complex case review meeting. In this meeting we saw staff were non-judgemental and treated clients with respect when discussing their care. Staff were compassionate and keen to maintain clients' dignity. Discussions included considerations about other support available to meet the clients' needs, where appropriate. For example, for one client, support to move them back to their local home town and closer to their family as per their wishes, was discussed.

Staff provided information to clients throughout their engagement with the service to support them in understanding and managing their care and treatment or condition. For example, harm reduction advice.

During a home visit, we observed staff discussing the clients' needs and wishes with them. Staff showed a genuine interest in the client's needs and offered to support them with access to other services and at meetings with other professionals.

The service had clear confidentiality policies in place. Staff we spoke with understood and adhered to them. Staff maintained the confidentiality of information about patients. During the home visit, we observed staff discussing with clients the sharing of their information with other professionals. Staff gave the client time to ask any questions and ensured they understood and agreed. On arrival at the client's home, staff from the service removed their ID badges to ensure the client's privacy was maintained and neighbours were not alerted to the reasons why they were there.

Involvement in care

Involvement of service users

Staff communicated with patients so that they understood their care and treatment. We observed staff speaking clearly and respectfully with clients, making sure they understood what had been discussed.

Care plans and risk management plans mostly showed active involvement and collaborative working between clients and staff and recorded the client's strengths and goals.

Clients could complete feedback forms and questionnaires about their experience of the service to help improve and develop the service. The service carried out targeted surveys to help identify gaps in care and treatment or delivery in service. There was a suggestion and feedback box where visitors to the service could leave any comments, complaints or compliments.

The service hosted a monthly service user council meeting. This was run in partnership with a recovery service and was re-launched in October 2018, following the contract changes to substance misuse services in the area in April 2018. At the time of the inspection, attendance at the forum was low. The provider was looking at ways to support and promote clients to attend. For example, reviewing the day and time and location of the meeting to support people in attending.

Involvement of families and carers

Carers were fully involved in clients' care if clients gave permission for this. Input from carers and family members, where appropriate, was evident in care plans. For example, in one care plan we saw a family member had stated what they felt the client's strengths were and what they needed support with.

There was a nominated carer lead at the service. Carers were fully involved in clients' care, with support from the carers' lead, if clients gave permission for this.

The drop-in service was open to carers for support and advice, although staff ensured that they maintained client confidentiality.

Good

Community-based substance misuse services

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

Good

Access and discharge

The service was commissioned to accept referrals for people who lived in the Medway area.

Clients referred themselves to the service or could be referred by other professionals, such as GPs, probation, prisons, hospitals and social services. The service offered a daily drop in so that people meeting the service's entry criteria could be seen without an appointment.

Staff conducted triage assessments to prioritise clients based on risk. All urgent referrals were seen quickly. All referrals were discussed daily and were assigned to an appropriate recovery worker. Staff contacted clients within 24 hours of allocation and arranged an appointment to complete a comprehensive assessment within seven days, where appropriate. There was no waiting list for assessment for treatment.

Clients could be seen in a range of settings, including at the service, one of the designated satellite services or a home visit, where appropriate. Staff told us this supported clients' needs better and reduced barriers to accessing treatment.

Clients accessed prescribing appointments easily. Clients had access to both routine and urgent appointments with both the doctor and non-medical prescriber.

Staff offered clients a wide variety of treatment pathways at assessment. The service worked with clients who misused any drugs or alcohol. Pathways were based on the substances clients were using. For example, clients who were opiate or alcohol dependent received more structured clinical support, which included prescribed medicines. Clients who used other substances received brief intervention support which consisted of four to five focussed appointments. The level of intensity of treatment the clients were interested in receiving and their end goals were also factors.

Staff followed a positive reengagement pathway for those clients who regularly did not attend their appointments. This was to prevent clients from dropping out of treatment and to maintain safety of their prescriptions. During the multidisciplinary team meeting, we observed staff discussing strategies for clients they were concerned were disengaging. This included staff visiting the client in their home and reallocating the clients care to a different recovery worker.

Staff completed discharge planning with their clients. All discharges were discussed as part of the daily multidisciplinary team meetings to ensure discharge was safe and appropriate. Recovery workers completed a checklist of actions before discharge, including ensuring the client was aware of any aftercare arrangements and support.

The team offered evening clinics to clients once a week who were unable to access services during working hours and to support employed clients to be seen outside of normal working hours. There was a single point of access telephone number for clients to use outside of normal working hours which was manned via the manager on-call rota.

Discharge and transfers of care

Risk management plans reflected the diverse/complex needs of clients and included clear care pathways to other supporting services. Staff told us how they supported clients throughout referrals and transfers, for example to housing, the community mental health teams and social services. Where clients were referred onwards for additional support, staff recorded this.

The acceptance and referral criteria for the service was agreed and set with the commissioners.

Staff completed discharge plans with clients as they were nearing the end of their treatment. There was evidence of good liaison with care managers and other professionals prior to discharge. All the care records we reviewed contained a plan for unexpected exit from treatment. However, the level of detail was variable.

Staff supported clients if they required treatment in an acute or mental health hospital. The service had a lead nurse who attended the local A&E hospitals and relevant wards weekly to see if anyone would benefit from accessing treatment at the service. Good links had been established and staff at the acute hospital could contact the service for advice or referrals when needed.

Good

Community-based substance misuse services

From April 2018 to 15 March 2019, the number of discharges from the service were 411 clients. The provider did not state how many of these discharges were clients who successfully completed their treatment programme.

The facilities promote recovery, comfort, dignity and privacy

The service had a full range of rooms available for clients to be seen in, including private rooms for one-to-one consultation and group rooms. There was a comfortable reception and waiting area with access to a water dispenser. Private areas were available for carrying out urine screening to ensure privacy and dignity of clients.

Clients' engagement with the wider community

Where appropriate staff ensured that clients had access to education, training and paid work or volunteer opportunities. This was in line with guidance from National Institute for Health and Care Excellence.

Meeting the needs of all people who use the service

The service operated late opening appointments one day each week. Local managers and staff told us this was to support all clients and meant they did not put non-opiate and crack cocaine users and non-dependent drinkers at risk of mixing with the dependent users.

Staff at the service worked closely with staff at another recovery service to ensure a safe space was available for everyone to use. Staff told us it was not always appropriate for clients who were less dependent on drugs or alcohol to come into service as their needs could be better met at the recovery service. We observed staff actively discussing this with clients as part of their continued support.

The service had made adjustments to support people with disabilities. Each of the locations the service operated from all had easy access, including ramps. Staff told us clients with a physical disability, which affected their mobility, would be seen in a downstairs room at the service due to the steep and narrow stairs. Appointments at one of the other five satellite services or home visits would also be offered, where appropriate.

Staff were aware of the local demographic and demonstrated an understanding of the potential issues facing vulnerable groups. They supported clients in ways that considered age, gender, sexual orientation and disability. Staff considered other relevant information such as co-morbidities and clients' individual, social and mental health needs.

In July 2018, the service was awarded a nine months outreach contract to support Medway Council to implement the Rough Sleeper Initiative (RSI) in the Medway area. The aim of this contract was identification of rough sleepers in the area and provision of intensive support package to get service users into the right services to address a variety of complex health and social needs rough sleepers face to get into stable accommodation. Substance misuse has been identified as one of the main needs requiring an intensive treatment package. Since the implementation of RSI just over 60 service users have been housed, some helped to go back to their local authorities and some are still supported by multidisciplinary team.

Information about a variety of topics was available to all clients. These included; harm reduction, safeguarding, and risks related to alcohol and substance misuse was clearly displayed in the waiting area. Information about improving physical health, including smoking cessation was also displayed.

Staff told us they would support clients to access treatment when their first language was not English. Staff were able to access interpreters for appointments and to translate letters if required.

Needle exchange provision was easily available including for people who were not engaged in structured treatment. Staff provided harm reduction and safer injecting advice to people accessing this service. This was in line with guidance from National Institute for Health and Care Excellence.

The service had effective systems in place to identify and support vulnerable and at-risk clients through interagency working as part of the Blue Light Project and links with the local police and independent domestic violence support services.

Listening to and learning from concerns and complaints

Good

Community-based substance misuse services

Clients knew how to make complaints, raise concerns and provide feedback to the service. Information was displayed in each of the waiting areas and was clearly visible. Posters were displayed inviting feedback and suggestions from clients', families and carers.

The provider encouraged staff to manage informal complaints at a local level. Clients were invited to come and speak to staff if they had a concern or issue if they wished. A database tracked the complaints process to monitor timeliness of response and trends. Complaints were reviewed at service level and across the organisation.

Complaints about the service were thoroughly investigated and reviewed. Electronic records showed a full audit trail of each complaint received and the response given. The service investigated complaints in line with their complaints policy.

The service fed back the outcomes of complaints openly and acknowledged when mistakes had been made and where the service needed to improve and develop. Staff we spoke with told us complaints were discussed as part of the daily team meetings, so they could reflect upon the incident and any learning that was identified.

The service had received 18 complaints during the 12 months prior to the inspection. Of these, 12 were informal and six were formal complaints. The service upheld one of the complaints fully, two were partially upheld, two were downgraded to an informal complaint and one was not upheld.

The service provided data which detailed that the service received 26 formal compliments during the 12 months prior to the inspection.

Are community-based substance misuse services well-led?

Good

Leadership

The service had a clear staff and management structure. The specialist doctor was the clinical lead for the service and provided clinical leadership across the staff team. Staff reported that support from the clinical lead was good and guidance and advice with complex cases was easily accessible.

The local managers had the skills, knowledge and experience to perform their roles and maintained clear oversight of the staff and service provided. They could both explain clearly how their team worked to provide high quality care and treatment.Staff told us the relationship was good between the local managers and staff teams. Staff said the registered manager was visible, approachable and supportive.

The provider had a clear definition of recovery and this was shared and understood by all staff we spoke with. Staff were clear that their main aim was to reach out to as many individuals as possible, support them to be happy and safe and help them to achieve their life goals.

Vision and strategy

All staff we spoke with described the organisational values and service visions. Staff spoke with immense passion and pride about the services they delivered.

Managers and staff were flexible to change and proactive in making improvements to service delivery. Following the contract changes to substance misuse services in Medway in April 2018, multiple changes happened including a focus on the need for hepatitis C protection. The service offered space within their premises to other outside agencies such as hepatitis nurses and built effective partnerships within Medway to help raise the profile of the service.

Staff had the opportunity to contribute to discussions about the strategy for their service and influence service developments. To improve service provision, some of the staff visited other similar services to see how they could improve their service model.

All managers, including the registered manager, communicated well to share best practice. They met regularly to ensure continuity of services offered remained their focus with an emphasis on driving improvement and development across the staff team and service.

Culture

Staff we spoke with told us they were happy in their jobs, motivated to attend work every day and proud of the service they offered and the positive impact they had on peoples' lives.

Good

Community-based substance misuse services

There was a good working relationship between members of the multidisciplinary team. Discussions observed between colleagues were respectful and supportive in nature.

Managers supported staff to progress in their careers. Several members of staff told us they had progressed in areas of interest to them, such as taking on lead roles in health and safety, safeguarding and family liaison. Senior recovery workers could access management training to support career progression.

Staff told us the service was open to change and improvement. Staff had been encouraged to develop their roles within the team. Staff felt their ideas for changes to service delivery were taken seriously and felt encouraged and empowered to make suggestions.

Staff told us they felt confident whistleblowing and raising concerns to any senior manager within the organisation. Staff felt able to do so without fear of repercussions and that they would be taken seriously.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The service promoted equality and diversity. They had a multi-cultural team which reflected the diversity of the local community.

Governance

The service used key performance indicators set by their commissioners to monitor service performance and productivity.

All staff had access to an electronic case management tool. This supported staff and managers in understanding when care plans and risk assessments were due to be reviewed, next planned and due appointments, number of clients in treatment and type of treatment and case load numbers for each staff member.

The provider had a clear governance structure to ensure the safe and effective running of the service. Policies and procedures were regularly reviewed to make sure they were relevant and in line with national guidance. Staff had easy access to all policies and procedures and were kept updated when changes were made.

The governance and assurance systems in place for client safeguarding were of a high standard. There was an electronic, central safeguarding log that was reviewed by the multidisciplinary team daily to ensure oversight and appropriate actions taken.

The governance systems ensured a comprehensive review of incidents was carried out within set timeframes and to help prevent future occurrence. Managers met quarterly in governance meetings. All governance and risk assurance procedures were structured with data readily available. However, the monitoring of risk was not always effective as the service were not aware of the two risk assessments that had not been updated.

Managers and staff completed audits. The service had an agreed, planned schedule of clinical and non-clinical audits. This included regular audits on high and low doses of prescribed medicines, missing or outstanding care plans and staff files. Managers also audited the quality of work completed, such checking information was linked between care plans and risk management plans. Where issues or concerns were identified, immediate action was taken to make improvements.

Staff and managers reviewed client deaths regularly to identify trends and learning and discussed them at their morbidity and mortality meetings. Managers made changes to service delivery because of these meetings. Learning was shared across staff teams through team meetings.

Management of risk, issues and performance

There was clear quality assurance management and performance frameworks in place that were integrated across all policies and procedures. The service worked closely with the provider's quality and assurance team to ensure consistency across the staff and service.

The service maintained a risk register. Staff concerns matched those on the risk register and all staff were able to escalate issues to the risk register. Risks were regularly discussed, actions and timescales agreed. The management of risk was embedded into the teams' daily work.

Good

Community-based substance misuse services

The service had plans in place to deal with any emergencies that could affect service delivery. The Business Continuity Plan identified what actions should be taken to in the event of adverse weather, fire, flooding and loss of premises.

Staff reported required data to the national drug treatment monitoring service (NDTMS). National statistics around drug and alcohol use are produced through this system.

The registered manager told us that while the service had been impacted by the change of contract in April 2018, careful consideration had been given to ensure this had not reflected on the care and treatment offered to clients.

The service was monitored by the commissioners through quarterly contract reviews.

Information management

Client records were stored using an electronic system. Staff monitored and reviewed all relevant clinical data on a regular basis and managers used the case management tool to ensure oversight of the service. The electronic system provided comprehensive oversight and data relating to client risk and outstanding data.

Engagement

The service hosted an 'Open Day' in October 2018 to promote the new service to the local community, partner agencies, service users and their family and friends. Staff told us this was well attended and included speeches from current service users and presentations to newly trained peer mentors. It was a resounding success and created a hugely positive, motivational effect within the team and service users.

Staff had access to up-to-date information about the work of the provider through electronic communication, discussions at team meetings, supervision and daily meetings.

Learning, continuous improvement and innovation

The local managers told us they were working closely with the commissioning groups and other partner agencies and professionals as recent data had suggested that the numbers of clients in treatment for the Medway area were lower than they could be. They were exploring ways to increase referrals and implement easier pathways for clients to access treatment. For example, introducing a digital platform for clients to access online therapies and information without needing to attend the service.

At the time of the inspection, the service was working towards supporting all clients to access a health check with a doctor or nurse. All prescribed and alcohol dependent clients already had health checks in place, but the service wanted to make this routine practice for all clients.

The service implemented several satellite services within the community to increase treatment access points and reduce the barriers for clients accessing treatment. Staff considered venues that work best in terms of ease of access, close to towns and bus routes and venues that clients would visit for other support, for example, at Job Centres and GP surgeries.

The service had increased their range of psychosocial treatment groups, offering specific groups for non-opiate and crack users and an alcohol well-being group. Feedback from clients and treatment outcomes were used to gauge the effectiveness of the treatment offered.

The service had a lead nurse who linked with the local A&E, acute and mental health hospitals. Public Health England data showed that when people accessed services they left with good outcomes. Staff told us they wanted to ensure they reached as many people as possible who could benefit from accessing the service and at the right time.

Local managers told us the number of opiate users leaving treatment in Medway had decreased within the last year. They were working in partnership with another recovery service to review the causes for this and implement changes. Plans included intense, focussed work with clients on low doses.

Staff were focussed on reducing the stigma of substance misuse and reducing social isolation. Care plans demonstrated staff discussed social inclusion, the client's goals for social interaction and services available to clients.

The service continuously seeks to recruit students and police students to come and support work in the service. Information and best practice were shared, and staff forged good links with other key professionals.

Good

Community-based substance misuse services

The service had recently undertaken a service review, to reflect on what had been achieved since the start of the new contract in April 2018. Areas of improvement and development were identified, such as ensuring staff are aware of all treatment pathways.

Outstanding practice and areas for improvement

Outstanding practice

The services played a key role in the 'Rough Sleeper Initiative' and the Blue Light Project. Both projects continued to be successful in supporting partnership working across agencies and supporting and enhancing the lives of some of the most vulnerable people in Medway.

The service had a psychologist who worked two days per week at the service and could offer advice to staff and therapies to clients, such as couples' therapy.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure they continue to monitor and improve information recorded in both clients care plans and risk management plans. Risk assessments should be updated following a change in risk and reflective of all risks identified.
- The provider should ensure their governance processes and audits for managing risk assessments is effective.