Good

Avon and Wiltshire Mental Health Partnership NHS Trust

Substance misuse services

Quality Report

Avon and Wiltshire Mental Health Partnership NHS Trust
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RVN3Q	Blackberry Hill Hospital	Acer Unit (in-patient)	BS16 2EW
RVN1H	Trust Headquarters	Specialist drug and alcohol service, Bournemouth	BH1 3SH
RVN1H	Trust Headquarters	Specialist drug and alcohol service, Bath and North East Somerset (BaNES)	BA2 3ND
RVN1H	Trust Headquarters	Specialist drug and alcohol service Recovery Orientated Alcohol and Drugs Service (ROADS) Colston Fort & Stokes Croft Bristol	BS6 5UB

Summary of findings

RVN1H	Trust Headquarters	South Gloucester specialist drug and alcohol service, Blackberry Hill Bristol	BS16 2EW

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Avon and Wiltshire Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health Partnership NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Outstanding 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Avon and Wiltshire Mental Health Partnership Trust's substance misuse services as **Good** because:

- Staff were following 'Drug misuse and dependence: UK guidelines of clinical management (2007) and National Institute for Health and Care Excellence (NICE)' guidelines for substitute prescribing and psychological therapy, which also informed trust policies and procedures.
- Staff monitored clients in the community safely and regularly throughout the treatment period. Medical cover was available over a 24 hour period and there were emergency procedures in place.
- Staff completed and updated risk assessments. They had a clear understanding of individual risks and were highly skilled and experienced. Risks were managed well both in community and inpatient settings. Recovery care plans involved the client and were clear and holistic and contained detailed information regarding client's care and treatment..
- Environments, including clinic rooms, were clean and well maintained and laid out in a way which protected privacy. Information was freely available specific to substance misuse problems. For example other agencies, social services and advocacy.
- Medicines management was effective throughout the services. Where medicines were kept on site they were stored, monitored and audited safely.
- There were sufficient staff numbers to meet the needs of people using the services. The community specialist substance misuse services (SDAS) had reduced their staffing numbers when they redesigned their service models. Managers had worked creatively to ensure client safety through the redesign of the service.
- Community SDAS and inpatient services provided support for all healthcare needs associated with substance misuse. Staff supported people with blood-borne virus testing. Electrocardiograms were taken for people receiving high doses of methadone to monitor the effects on the heart. Some services provided specialist input into general practitioner (GP) surgeries, which was considered by GP's as a highly effective service.
- Staff were very caring and demonstrated a high level of positive regard and respect to people accessing the services. Staff attitudes towards people were warm, kind, non-judgemental and thoughtful.
- The services were managed by highly committed and inspirational leaders. They demonstrated a clear determination to ensure that needs and safety were not affected by the redesigns and upcoming retendering processes. For example, Avon and Wiltshire Mental Health Partnership Trust provided the South Gloucestershire service. However in the near future other health organisations would have to opportunity to bid to manage this service instead. Staff told us they felt supported, supervised and positive about their place within the teams.
- The trust gave staff opportunities to develop leadership and specialist skills across the different roles within the service. Poor performance issues were managed well.

However:

- Although we saw that risks were discussed, reviewed and updated on Acer Unit, locating where updated risk assessments was difficult in patient records. There was no clear system in place.
- The redesign of the Bristol recovery orientated alcohol and drugs service specialist drug and alcohol service (Stokes Croft) had resulted in pressure and a backlog within the rapid prescribing service. This team was holding high caseloads as they waited to transfer clients to their Colston Fort specialist drug and alcohol service.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as **good** because:

- All services managed risk well. Staff were experienced and competent to identify and respond to risk.
- Staff followed safe prescribing procedures and clients had regular medical reviews throughout their treatment.
- Managers ensured sufficient staffing levels to manage community team caseloads.
- Safeguarding was a high priority and staff were aware of safeguarding policies and procedures.
- Staff knew how to report incidents and there was clear learning from incident reviews.
- Medicine management was safe, and staff carried out regular stock checks and audits of medicines management and prescribing.

However:

- Although risks were reviewed and updated on Acer Unit, the system for recording this was not clear.
- There was pressure on the Bristol recovery orientated alcohol and drugs service (ROADS) SDAS rapid prescribing service and very high caseloads. Managers were aware of this and had contingencies in place for the short term, such as providing staff from other service to support the team, leading to ultimate transfer to the Colston fort service longer term.

Are services effective?

Good

We rated effective as **good** because:

- Structured psychological treatment was offered alongside prescribing as part of the integrated treatment model.
- Assessments were holistic, comprehensive and client-centred, and clinical care records contained clear recovery care plans.
- Staff supported people in line with 'Drug misuse and dependence: UK guidelines on clinical management (2007)' alongside consideration of appropriate NICE guidelines.
- Staff within the multidisciplinary teams were sufficiently skilled, knowledgeable and experienced to carry out their roles.

Summary of findings

- There was very good multidisciplinary and multiagency partnership working within the specialist substance misuse services and inpatient unit, and with external third sector partners.
- Managers provided and ensured staff attended both mandatory and specialist substance misuse training.
- The physical and mental health of clients were assessed and managed well and specific interventions were offered, such as blood-borne virus testing.

Are services caring?

Good

We rated caring as **good** because:

- Staff interacted with people in a warm, supportive and positive way. Needs and preferences were identified and respected.
- Clients told us they felt supported and were treated as individuals by staff. Staff were non-judgmental and understood their needs.
- Staff explained confidentiality matters clearly and respected privacy. On the detoxification inpatient unit safety observations carried out meant clients privacy was sometimes compromised however this was explained to them and agreed to on admission.
- Staff involved clients throughout their treatment pathway. Recovery care plans were created with clients, who told us they felt empowered to contribute to their treatment.
- Staff and managers promoted a client-centred culture in all services.

However:

- Some clients told us they felt the rules, restrictions and boundaries on the inpatient unit, although explained to them by staff and a contract agreed, sometimes impacted on their privacy.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Clients who required treatment were seen promptly. The community specialist substance misuse services had set targets of seeing clients within three weeks; this was being met withmany clients seen sooner than this.

Summary of findings

- Clients could receive a rapid prescribing service and would be seen on the same day. Inpatient detoxification was available for people assessed as a higher risk.
- The services offered specialised support to very vulnerable people, such as street sex workers, pregnant women and the homeless.
- Staff followed procedures for people who did not attend appointments by making attempts to contact them They would then inform the relevant agency of their non-attendence.
- Staff and clients knew how to make a complaint and understood the complaints process..
- Clear discharge plans were developed on admission for people on the inpatient unit

However:

- Discharge planning in the community specialist substance misuse services was not sufficiently robust, which meant that clients could remain in the system for longer than they needed.

Are services well-led?

Outstanding ☆

We rated well-led as **outstanding** because:

- The specialist substance misuse area manager was visible, approachable, open and supportive to the individual service managers.
- The service managers were highly proactive, visible and supportive to their teams.
- The service managers had worked closely with key agencies and commissioners to ensure treatment provided continued to be safe and innovative even though there was some considerable pressures facing the service.
- Staff morale was good despite the recent pressures of redesign and reduction in staffing. Staff we spoke with were positive about their contribution to the services.
- Governance systems were of high quality. Staff and service performance was managed well.
- All managers had excellent oversight of their services. They communicated well with each other to share best practice and resolve issues, including learning from incidents.
- Staff received regular supervision and annual appraisals.

Summary of findings

- Staff received specialist training in order to be confident and competent in their roles.
- Managers monitored and reviewed any poor performance within their teams.

Summary of findings

Information about the service

Avon and Wiltshire Mental Health Partnership NHS Trust provides support to people suffering from drug and alcohol problems across a number of geographical locations.

Services are provided in Bristol, South Gloucestershire, Bath and Bournemouth. Some of these locations have satellite clinics dependent on individual need, including support within primary care settings.

All of the community specialist drug and alcohol services have been subject to a redesign due to reduction in funding.This resulted in less staff and change in delivery models.

The community specialist drug and alcohol services offer specialist prescribing, stabilisation, detoxification (drugs and alcohol), psychological interventions and specialist interventions, recovery planning, rapid prescribing, blood borne virus testing and vaccination, specialist maternity services and work with families and carers through joint working with third sector partners and shared care models.

The trust also provides a 10-bed drug and alcohol stabilisation and detox residential unit (Acer Unit) in the grounds of Blackberry Hill Hospital, Bristol.

Our inspection team

Our inspection team was led by:

Chair: Maria Kane, Chief Executive, Barnet, Enfield and Haringay Mental Health NHS Trust

Team leader: Karen Wilson, Head of Hospital Inspection

Inspection Manager: Anthony Fletcher

The team that inspected substance misuse services consisted of two Care Quality Commission inspectors and four specialist advisors, all with clinical practice experience in substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all five of the sites and their associated locations, and looked at the quality of the service provided
- spoke with 20 clients using the service and collected feedback from 25 clients using comment cards
- spoke with the service managers for all the teams
- spoke with 20 staff members including doctors, social workers, non-medical prescribers, registered and non-registered staff
- interviewed the regional manager with responsibility for these services

Summary of findings

- attended nine multidisciplinary meetings and observed eight episodes of care
- Reviewed 60 care records comprehensively.
- looked at 94 medication records
- carried out a specific check of medication management at all the services including the inpatient detoxification ward
- looked at a range of policies, procedures and other documents related to the safe running of the service
- spoke with other agencies and key stakeholders
- spoke with carers and family members.

What people who use the provider's services say

- Clients told us they felt safe in the specialist substance misuse services provided by Avon and Wiltshire Partnership Mental Health Trust. They felt listened to and respected, and were involved in their care wherever possible.
- Key stakeholders told us that they felt the services provided were safe, professional and innovative.

Good practice

- The Bristol recovery orientated alcohol and drugs service (ROADS) specialist substance misuse service worked with their third sector partners to offer supply Naloxone to clients in the community using opioids and at risk of overdose. Case studies demonstrated powerfully the effectiveness of this and how it had helped to reduce drug related deaths in the city of Bristol.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that updated risk reviews are clear and accessible on Acer Unit.
- The provider should ensure that staff carry out discreet observations as much as possible to reduce impact on privacy.
- The provider should ensure that all community specialist substance misuse services commence and prepare discharge plans upon admission.
- The provider should prioritise safety around the caseloads and transfer of clients using the rapid prescribing service at Bristol recovery orientated alcohol and drugs service specialist drug and alcohol service (Stokes Croft).

Avon and Wiltshire Mental Health Partnership NHS Trust

Substance misuse services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Acer Unit (in-patient)	Blackberry Hill Hospital
Specialist drug and alcohol service (Bournemouth)	Trust Headquarters
Specialist drug and alcohol service (BaNES)	Trust Headquarters
Specialist drug and alcohol service ROADS (Colston Fort & Stokes Croft Bristol)	Trust Headquarters
South Gloucester specialist drug and alcohol service (Blackberry Hill Bristol)	Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff knew the principles of the Mental Capacity Act and its relevance within specialist substance misuse services. They were able to identify clearly how substances could affect mental capacity and how this could trigger issues around consent or treatment.
- Staff recorded consent to treatment and sharing of information with others.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Community

Safe and clean environment

- The buildings and environments we visited were clean, well maintained and accessible. They contained appropriate equipment for physical health monitoring. Clinical areas and sluices were checked regularly.
- The services had up to date health and safety environmental risk assessments, including up to date fire risk assessments.
- All resuscitation and emergency equipment was present and checked regularly and thoroughly. We looked at the checklists and saw they had been completed diligently. ECG machines were in good working order and we saw that the detoxification bags that staff took into the community were well stocked and included a breathalyser and a fridge pack (ice pack) for Pabrinex (an injectable vitamin used to correct a shortage of vitamins associated with heavy alcohol use).
- Blood-borne virus equipment (blood vials, needles, plasters) were stored safely in locked cupboards. These were well stocked and ordered. There were clear procedures for collection and disposal of clinical waste products and sharps.
- The emergency bags contained Naloxone (used to treat an opioid overdose in an emergency), epi-pens, and Quetiapine for Korsokoff's syndrome (prescribed by consultant if indicated). There was always a member of staff available trained in the use of Naloxone, and plans were in place to train more staff.
- The clinic rooms contained appropriate safety equipment including defibrillator and oxygen. However, the Bristol recovery orientated alcohol and drugs service (ROADS) specialist drug and alcohol service (SDAS) Colston Fort team only had one oxygen cylinder whereas the Bristol ROADS SDAS Stokes Croft team had two. We discussed this at the time with the manager who told us they would be getting another for that service..
- Due to an upcoming re-tendering process for the South Gloucestershire SDAS we were told the team would be moving out of current premises as soon as new premises could be sourced. In addition, the Stokes Croft building was not fit for purpose in the long term, However, the team were in the process of moving into the Crofters Lodge building.
- All clinical areas had private rooms for consultation. Conversations taking place in these rooms could not be overheard from outside.Staff had access to alarm systems if clients were identified as a risk. All urine or blood screening was carried out in very private clinical areas. Urine samples could be given in a room in South Gloucestershire SDAS and passed through a hatch to staff, ensuring privacy and dignity.
- All the clinical areas displayed leaflets and information about issues relating to drug and alcohol use. These included safeguarding, mental and physical health issues, medication and treatment advice, safer injecting, local support services and help lines. They also advised clients of the formal complaints process and how to access their clinical records. There was signposting to needle exchanges, although there were also plenty of sharps disposal boxes available in the clinical areas.
- Information regarding out of hours provision, including what to do in an emergency, was clearly displayed. All information was available in easy to read format and different languages as required.
- There were effective systems for the safe management of medication. Where prescribed medicines were kept on site they were monitored and audited, and stored securely. Staff carried out regular stock checks and audits. Prescribing staff kept prescriptions secure in a locked area.
- Medication was dispensed at a specified pharmacy. The client would choose the most appropriate pharmacy and the SDAS worker would contact and liaise with them to confirm they could accommodate them.

Safe staffing

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- All the specialist drug and alcohol services had been subject to subject to a redesign due to reduction in funding.This resulted in less staff and change in delivery models.
- a treatment system funding reduction and staffing redesign. . However, we found this had not impacted negatively upon the safety of the service delivered, and there were sufficient staff to meet the needs of the clients.
- One outcome of the redesign was the decommissioning of the Stokes Croft building, combining the Stokes Croft and Colston Fort teams (Bristol ROADS SDAS) into one building. At the time of our inspection there was still a small team in the Stokes Croft building providing a rapid prescribing detoxification service for people released from prison, but this was only temporary. The majority of the team was already based in Colston Fort.
- The Bristol ROADS SDAS in Colston Fort and Stokes Croft had 27 whole time equivalent (WTE) staff. The South Gloucestershire specialist drug and alcohol team had 6.4 staff and the Bath and North East Somerset (BaNES) SDAS had 17.3 WTE staff. The Bournemouth SDAS had 11.9 WTE and had also been subject to the reductions and redesign.
- Within the overall staffing numbers, the teams had prescribers who were qualified and competent to assess and prescribe for drug and alcohol detoxification. All staff in the teams had the knowledge and skills to recognise and identify signs of deterioration in mental and physical health during detoxification or withdrawal.
- Each service had a service manager, access to a consultant psychiatrist, speciality doctors, nurses and nurse prescribers, health care assistants trained in substance misuse and alcohol, clinical psychologists and social workers. They also had professional leads in criminal justice, blood-borne viruses, drug and alcohol, safeguarding and primary care/general practitioner (GP) liaison.
- The specialist drug and alcohol services overall sickness level was 5.3%. South Gloucestershire SDAS had the lowest sickness levels at 0.7% and the highest was the Bristol ROADS SDAS (Colston Fort and Stokes Croft) at 8% across the service. This was due to some long term sickness and following a period of significant change for the staff. Managers were monitoring sickness and absence levels closely due to impact from the redesign and reduction in staffing.
- Across the specialist substance misuse services 19 staff members (17.7 WTE) had left during the redesign and reduction periodsome of this number due to redeployment to other teams within the trust. Bristol ROADS SDAS (Colston Fort and Stokes Croft) had experienced the highest turnover of staffing at 9.3 WTE overall, followed by BaNES SDAS at 6.4 WTE.
- The specialist drug and alcohol services had further employed 8.7 WTE staff members overall in the same period.
- Staff in all the specialist substance misuse services had complex caseloads. These were due to reduce once the service redesign had been fully implemented. Bristol ROADS SDAS (Colston Fort) overall caseload was 789, which meant staff held no more than 30 clients on average. This did not include the Stokes Croft rapid prescribing service.
- Bournemouth SDAS had 210 clients overall which meant no more than 20 per worker.
- BaNES SDAS had approximately 500 clients overall and an average of 20-35 per worker.
- South Gloucestershire SDAS had approximately 80 clients overall and an average of 12 clients per worker.
- Staff we spoke with told us they had felt the extra pressure of the reduction in staff. However, they felt the caseloads were manageable despite the complexities of the client's needs, and the current redesign meant that the caseloads would eventually reduce.
- All of the records we reviewed showed that a keyworker was allocated by the SDAS teams where they were the primary worker. Due to the new design of the services, the primary keyworker who had overall management of the client could be from the third sector.However, where prescribing practice and monitoring was being carried out the trust SDAS teams were accountable for that client. The overall management and safety of the client was shared between the partner agencies.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- All the teams had competent and supportive administration staff. They demonstrated a high level of understanding and commitment to the services and the clients. Managers told us the administration staff went 'above and beyond' to support the teams.

Assessing and managing risk to patients and staff

- Full risk assessments and risk management plans were in place in all the clinical records we looked at in the community. They were clear and comprehensive. Due to the new clinical models and pathways being used by the different services, not all initial risk assessments were completed by the SDAS teams.
- However, on admission to a service each individual client's risks would be reviewed and updated. Risk was communicated with partner agencies on an ongoing basis. The specialist drug and alcohol teams had overall management for clients with the highest risks.
- All clients had an emergency contingency plan in place, in the case of a sudden unexpected exit from treatment. Risk assessments were of high quality.
- Risk and safeguarding issues were discussed daily within the teams during meetings. Staff told us they felt aware of the risks of other team members' caseloads, so would be confident to cover clinics or one to one meetings with clients if staff were off sick or unavailable. Safeguarding was a high priority and staff had excellent links with the local authority safeguarding teams.
- The services provided prescribing and support to pregnant women who used opioids. They ensured that these clients were involved with the local authority safeguarding teams prior to birth, and maintained contact for a mimimum of three months following birth.
- Risk assessments contained information around mental and physical health crisis management. It was clear in records what plans should be followed in the case of an emergency. Clients receiving medication for opioids or alcohol detoxification were given information on risk and staff ensured they understood their responsibilities throughout the treatment. All clients signed a prescribing agreement.
- All services carried out safe prescribing practices. Staff saw and reviewed the alcohol detoxification clients daily and the opioid detoxification clients every two to three days, dependent upon their complexity. A full medical review of each client was carried out within 12 weeks of assessment as per good practice guidelines.
- The 'rapid prescribing' team were based in the Stokes Croft building. They provided a service for clients on the day of their release from prison or discharge from hospital.These clients were high risk because they were clean of street heroin in prison or hospital, which meant their tolerance to it was low. Therefore the risk of overdose was high if they used heroin on release instead of continuing to receive monitoring and substitute prescription such as methadone.
- This team also included support for rapid access of opioid substitute prescribing for extremely vulnerable people, including street sex workers or pregnant women.
- Such clients would normally commence prescribing and be cared for by the team for two weeks. They would then be transferred to shared-care (GP practice with support from a specialist drug and alcohol worker) or Bristol ROADS SDAS team for continued management. However, due to a backlog in the Crofters Lodge service (because of the near completion of service restructure), the rapid prescribing team needed to hold patients much longer than expected.
- We were initially concerned this was placing extra pressure on the service as they also had a senior registered nurse on long term sick. This team therefore was holding a caseload of 67 high risk clients and receiving up to 17 new referrals per week.
- However, we established that there was always a prescriber available and clients were seen on the very first day, either a doctor or non-medical prescriber. Prescriptions were issued by hand. Safeguarding issues were always screened and updated as clients became regular and well known to the service. We concluded they were providing a safe and professional service under pressure, ensuring clients were only seen at specific times, and that they received cover from Bristol SDAS Colston Fort or South Gloucestershire SDAS when under pressure to ensure safety at all times. Communication between these teams was excellent.
- Although we were assured the rapid prescribing team were providing a safe service despite staffing and

caseload pressures, we discussed our concerns with the service manager who reassured us the rapid prescribing team were a priority in the event of sudden staff sickness, and that the situation as it stood was strictly temporary until the final restructure was complete. Staff we spoke with confirmed this.

- The trust provided all staff mandatory training. This included basic resuscitation, Care Act, Care Programme Approach (CPA) and risk, Deprivation of Liberty Safeguards, fraud awareness, managing conflict, medicines management, Mental Capacity Act, Mental Health Act (MHA), safeguarding adult's level one and safeguarding children levels two and three.
- The Bath and North East somerset (BaNES) specialist substance misuse service completion rate averaged 90%, with the exception of basic resuscitation and managing conflict which was 80%.
- The Bournemouth specialist substance misuse service completion rate also averaged 90%, with the exception of basic resuscitation, care programme approach and Mental Health Act training which was 81%.
- Bristol recovery orientated alcohol and drugs service (ROADS) Colston fort and Stokes Croft service had 74% completion in managing conflict, basic resuscitation, DoLS and MHA.
- The South Gloucestershire specialist substance misuse service had a completion rate of 95% in all but Deprivation of Liberty Safeguard training which had a completion rate of 67%.
- Someome of the gaps in completion of mandatory training were due to some long term sickness and absence issues. We saw thattaff who had training to complete were booked onto appropriate courses where possible.

Track record on safety

- There had been 10 serious incidents (SIRI) reported across the services between 4 June 2015 and 17 March 2016. Four were deaths due to natural causes, two were accidental deaths; the likely cause of which was overdose of opioids and four were due to long term effects of substance misuse or alcohol. We saw that each incident report provided clear information, detailed background information of the incident, the actions taken at the time and learning the trust had taken following the incident.
- There were 11 non-serious incidents reported by the community specialist drug and alcohol services between 1 April 2015 and 12 March 2016. They were reported by type including violence (three reported), abuse (three reported), medication errors (two reported), self-harm (two reported), information governance (one reported), safeguarding (none reported) physical healthcare (none reported) and service provision issues (none reported). Managers had reviewed all the incidents and taken action to prevent a reoccurrence where possible.

Reporting incidents and learning from when things go wrong

- Staff reported incidents using the trust's electronic system. Service managers then reviewed the incidents and escalated them to the trust's governance team.
- Service managers fed back outcomes and learning from incidents. We saw examples of team meeting minutes which demonstrated discussion and learning following incidents. Staff and service managers were keen to tell us they knew of incidents which had happened in the other specialist drug and alcohol services, and on the inpatient unit, and shared learning from these. This was despite the large geographical distance between the teams. Meeting minutes reflected this.

Duty of candour

- Duty of candour is a legal requirement which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong.
- We saw all incident reviews involved other agencies, family members or carers. Staff and family members were offered and given ongoing support following incidents.
- Staff we spoke with understood their responsibilities around the duty of candour. There were clear signs around the clinical and administration areas identifying this responsibility.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Inpatient detoxification

Safe and clean environment

- Acer unit was an inpatient detoxification unit in the grounds of Blackberry Hill hospital. There were nine bedrooms in total.. Male and female sleeping areas were separated. Five patients were in receipt of care at the time of our inspection.
- Staff monitored each patient and knew their whereabouts through formal observations. Staff monitored and documented their observations at time periods that had been identified dependent on individual client risks.
- Potential ligature points (environmental features that could support a noose or other method of strangulation) were assessed and monitored. Staff locked off areas of the ward during the day to reduce the potential risk. Patients consented to this in their pre-admission agreement. Other restrictions that clients had to consent to in admission included not having keys to their rooms or mobile phones.
- The clinic room was clean and tidy. There were handwashing facilities and an examination couch for physical healthcare monitoring. Staff had access to appropriate equipment including blood pressure monitor, scales and electrocardiogram machine. There were facilities for phlebotomy and taking various blood samples.
- Our pharmacist specialist spent time on the unit and looked at the management of medicines , which was generally good. Staff followed recognised good practice by recording patient and product details of Naloxone.
- Medicines were stored in locked cupboards in the treatment room, which had a locked door. Stock was tidy and not overstocked. Staff stored controlled drugs in an appropriate cupboard. The controlled drugs record book was completed in line with legislation and good practice. Pharmacy support was provided by a locality pharmacist (one visit per week). The pharmacy technician resupplied the medicines. Staff had access to an 'out of hour's medicines cupboard' on different units. Staff held the treatment room keys.
- Treatment room and fridge temperatures were recorded daily and records clearly showed this.. Staff completed a medicine audit at each handover and recorded this. This covered 'as required' medicines, checking medicine charts for missed doses, fridge temperatures, and controlled drugs checks. This helped ensure there were very few occasions when clients had missed medication..
- Medicine reconciliation was good. This is the process of making sure that the client's prescribed medication is accurate, including drug name, dosage, frequency and route. The admitting doctor took the medication history and checked medicines for patients admitted from home, and the pharmacist did some medication checks on their weekly visits.
- Staff knew how to respond to an emergency and were trained in basic life support. There was access to fully stocked and regularly checked emergency equipment, including emergency resuscitation equipment.
- There were clear fire alarm and evacuation procedures and staff were confident in explaining these. Emergency exits were marked and staff had completed fire checks.
- We saw detailed environmental risk assessments, which included action plans which the manager had updated.

Safe staffing

- Acer unit had 13.4 WTE. Staffing levels were above the expected level set by the trust during the day cometimes to assist with admissions. There was sufficient staff to cover the night shifts (the period of time a member of staff spent on duty). Staff told us they felt the this was sufficient although when the unit was full it could potentially be busier and more stressful.
- The team consisted of a manager, consultant psychiatrist, speciality doctor, nurses and healthcare assistants and an administrator.
- There had been 3.6 WTE staff leave in the previous 12 months and there was 0.5% vacancies. Sickness overall in the unit was 6.4%.
- Staff we spoke with had a very good knowledge and understanding of safeguarding and abuse issues. They were confident in telling us how safeguarding issues could stem from abuse of substances and what needed to be reported.
- An average of 84%of staff had completed mandatory training. although nine of the mandatory training

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

subjects were at 100%. These included, basic resuscitation, CPA and risk, safeguarding adults and children and medicines management. The training with the lowest completion rates were safeguarding children at 50% and DoLS, fire and conflict management at 75%.

Assessing and managing risk to patients and staff

- Risk assessments were carried out during a pre-admission assessment. These were thorough and covered all relevant detail for admission. We saw all the records contained a risk assessment.
- We found risk was being monitored following admission and documented in the handover paperwork. This was then transferred to the electronic record. This system was not straight forward or obvious so it initially looked like patients were not having risks updated. We fed this back at the time of visit and were assured a clear system would be created.
- Staff transferred risks onto the recovery care plans and identified any change within the clinical records. All staff we spoke with demonstrated excellent knowledge of the individual risks and the management of each patient in their care, both physically and mentally.
- Medical cover was sufficient during working hours. Ward doctors were based at Acer unit or at the South Gloucestershire SDAS location which was part of the same hospital site. There was an on-call system for any medical cover required after 1700 hours. We saw response times were good. Staff would call 999 in an emergency.
- Medicine charts were fully completed with a clients allergy status and weight. The prescriber had signed them and there were no missed doses. Staff completed a competency assessment before administering medicines independently. This was a mock medicine round with errors that needed to be spotted.
- There were policies and procedures in place for supporting people with safe detoxification. The prescribing operational policy was linked to NICE Guidelines.
- There were clear unexpected exit plans in place in all the clinical records. This meant that should a patient decide not to remain in treatment, the team could ensure that there was support and advice available for the patient in the community.

Track record on safety

- Acer unit had the same incident reporting and rating system as the community SDAS. Twenty four incidents were reported between April 2015 and March 2016. These included violence (three), medication errors (four), self-harm (one), personal injury (one), service provision (five), safeguarding (two) and physical health care (eight).
- All incidents had been reviewed and action plans put in place to attempt to avoid a repeat incident, for example as physical healthcare had been identified as a problem, the unit manager had ensured better systems for monitoring this and was creating better links with acute hospital colleagues.
- Patients told us they felt safe in the unit and had confidence the staff could manage incidents quickly and professionally.
- Staff managed incidents of violence and aggression well. Records demonstrated that staff used of de-escalation techniques to manage challenging behaviour. There were clear procedures and support was available from colleagues at the nearby Fromeside hospital through two way radio. Clients signed a contract of behaviour which ultimately could lead to the client being discharged if the contract was not adhered to.

Reporting incidents and learning from when things go wrong

- All incidents had been reviewed and action plans put in place to attempt to avoid a repeat incident.
- Incidents were discussed and reviewed, including lessons to be learned, at a monthly quality drug and alcohol meeting. The outcomes were then brought back to the Acer unit and disseminated to the team.
- Staff we spoke with could confidently explain the incident reporting procedures. Learning had taken place from incidents and practice improved. For example, following medication errors the monitoring of medication administration had become tighter.

Duty of candour

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Duty of candour is a legal requirement which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong.
- Staff we spoke with understood their responsibilities around duty of candour. They were able to explain their responsibilities around being open and transparent when mistakes occurred.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Community

Assessment of needs and planning of care

- All the services worked with their local authority commissioners of drug and alcohol services to ensure they created the best models of treatment that would deliver the best outcomes for clients. The commissioners responsible for the services were Bournemouth borough council, BaNES county council, Bristol city council and South Gloucestershire county council.
- All the services had access to the trust electronic record system. However, they also had their own local electronic systems, and also access in some areas to the general practice electronic system. We saw sometimes the teams had needed to duplicate some work, for example if a client had a co-existing mental health problem, they would also need to access the mental health team records on the trust electronic system.
- All the specialist drug and alcohol teams had individual referral pathway models. The managers had needed to create the most effective models with third sector partners, ensuring safety and quality. This meant there was some layering and shared care elements to the client's treatment journey, and the specialist substance misuse teams were not always the initial point of contact for assessment.
- However, each client was fully and individually assessed when referred in to the SDAS by the team which built on the initial triage and risk assessment. All initial assessments, documentation, records and letters were scanned onto the local electronic system. Staff transferred information in a way that adhered to the trust information governance policy. Staff kept old files locked away securely.
- All the care records in all the teams were comprehensive and clear. Staff assessed the physical and mental health of the clients and continued to review and update the records. All comprehensive assessments had recovery care plans created with the individual.The care records included urine screening results, and detoxification/ withdrawal assessment and monitoring tools.
- Electrocardiograms were completed for all clients receiving over 100 millilitres of methadone per day. This was to check they were not experiencing a lengthened heartbeat cycle, which could result from receiving high dose methadone.
- Prescribers recorded appointments and outcomes on the electronic records and a client's prescribing pathway was clear and legible. We looked at rapid prescribing service records for South Gloucester SDAS and Bristol ROADS SDAS clients and they were of a high standard.

Best practice in treatment and care

- Staff supported people in line with 'drug misuse and dependence: UK guidelines on clinical management (2007)' during detoxification treatment, and followed the trust's 'operational guidelines for alcohol and opioid prescribing' as well as the Royal College of General Practitioners guidelines (1st edition 2011). All the guidelines for interventions and prescribing pathways were adapted from appropriate NICE guidelines.
- Community teams managed the lower doses of medication for alcohol withdrawal (chlordiazepoxide or diazepam) following assessment. The Acer unit (in-patient detoxification) managed the more complex higher doses required by some clients.
- Staff ensured clients accessing the alcohol detoxification services completed the clinical institute withdrawal assessment of alcohol score, Revised (CIWA-Ar) or the Alcohol Use Disorders Identification Test (AUDIT) prior to detoxification.
- Aftercare was provided, where appropriate, with use of oral B vitamins, naltrexone, disulfiram or more commonly acamprosate. A pabrinex prescribing system was also used to aid recommended treatment.
- Clients were routinely offered testing and vaccination for Hepatitis A and Hepatitis B. Screening was also offered for Hepatitis C and HIV.
- The services, under the new treatment models, used psychological approaches alongside prescribing interventions which were based on NICE guidelines. These included skills training for emotional instability and problem solving ('STEPPS' is an approach to treatment for borderline personality disorder), Dialectical behaviour therapy (DBT) and Cognitive behaviour therapy (CBT) and a skills training group

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

programme for individuals with co-morbid trauma and substance misuse issues. The majority of interventions were offered by the third sector parties in collaboration with the specialist substance misuse services.

Skilled staff to deliver care

- All of the teams had a service manager. People using the services had access to staff with a variety of skills and experience. The service was made up of a variety of clinical and support staff including doctors, nurses, non-medical prescribers, clinical psychologist, consultant psychiatrist, social workers, drug and alcohol workers, recovery support workers, healthcare assistants, social workers and administrators.
- There was evidence that staff were offered and completed specialist training in addition to mandatory training to ensure they had the specific, specialist skills to support clients effectively. Further cognitive behaviour therapy training had been arranged in the Bournemouth SDAS.
- There were plans to train staff to deliver dialectical behaviour therapy (DBT) within the BaNES SDAS as the team planned to move towards more structured group interventions and away from one to one work (following a reduction in staff). One to one work would continue for clients not appropriate for group work.
- All new staff received a trust induction and a service specific induction. Staff told us they felt they had sufficient skills, support and training to carry out their roles.
- Staff received regular supervision. Completion rates between January and April 2016 ranged from 76% in BaNES SDAS and 100% in Colston fort and Stokes Croft SDAS. However staff we spoke with in BaNES told us they felt supported and received supervision when required, despite the service redesign and staffing pressures at the time. All staff received an appraisal of their work performance.
- Managers addressed poor performance appropriately and sensitively. Staff in services where performance issues were identified as a problem received support to achieve an appropriate level of performance. We were given examples of how this was being actioned and what plans were in place to support the individual and team where poor performance was a problem.

Multidisciplinary and inter-agency team work

- Service managers of all the SDAS teams and inpatient service met monthly. These meetings were used to discuss team performance, to identify and discuss common issues as well as share performance and learning from incidents. Despite the large geographical distance between some of the services, service managers ensured they supported and learned from each other. This in turn was cascaded to the team members. Staff we spoke with in each team were able to identify issues in the other SDAS areas.
- The SDAS teams had good working relationships and communicated effectively with other agencies, such as social services or the mental health teams. We saw excellent examples of collaborative work in relation to trauma victims, self-harm, dual diagnosis and pregnant women in particular. We were told that there were good relationships with the local children and young people's services.
- All the teams described examples of positive multidisciplinary working. The new treatment models, although still in transition at the time of our inspection, meant shared or layered care was provided by the third sector agencies and SDAS, in partnership with key external agencies. Teams utilised the high level of skill and experience of their own staff, as well as working in collaboration with external agencies to provide the best outcome for the client.
- South Gloucester SDAS had an outreach general practice (GP) based alcohol specialist nurse clinic. This service was described by GPs that we spoke with as excellent and they identified that this has dramatically improved the care of alcohol dependentclients. A GP told us they were happy they could refer directly into the service and as the team were on the premises they could have face to face communication with clinicians.
- The team carried out the prescribing for the community detoxification patients who were assessed as high risk. This supported the GPs when they did not feel confiende to carry out this role. The alcohol specialist nurse attended weekly clinical meetings with the GP team to ensure good communication. Records were kept on the general practitioner electronic system, which the alcohol liaison nurse had access to.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- We spoke with several key stakeholders and partners of the specialist substance misuse services. Bristol ROADS SDAS, South gloucestershire SDAS and Bournemouth SDAS had good working relationships with their partners who attended strategic and operational meetings to continually review the new structure and discuss any issues. The consultant psychiatrist based at Bristol ROADS was very visible in supporting the general practitioners, providing advice and guidance around specialist substance misuse issues.
- BaNES SDAS team worked well within their team and worked collaboratively. There was a daily morning meeting to discuss the day's events, indentify risks and make relevant plans for work during the day. There was also a weekly multidisciplinary meeting with the consultant. BaNES SDAS teams had collaborative multidisciplinary meetings with their third sector partners, and worked alongside the mental health services and social services.

Good practice in applying the MCA

- Staff completed Mental Capacity Act (MCA) training. All members of the teams had completed training except South Gloucestershire SDAS; 83% of staff had completed training and BaNES SDAS where 87% had completed training. Those staff who had not completed the training at the time of the inspection were either booked on to training courses , or were sick or absent.
- Staff we spoke with demonstrated a good knowledge and understanding of the MCA in relation to substance misuse. They told us how mental capacity would be assessed in relation to people under the influence of substances, and that his could trigger issues.For example, that consent to treatment should be reviewed at the earliest opportunity. We saw this was happening in the care records we viewed.
- Staff recorded consent to treatment and to share information with relevant parties, such as other professionals and family. This was updated as required.

Inpatient detoxification

Assessment of needs and planning of care

- There were five patients receiving detoxification treatment at Acer unit at the time of our inspection. We looked at all the clinical records and all contained clear, comprehensive holistic assessments. These had been carried out by the referring agency and the staff on Acer unit had added further information once the client had been admitted.
- Staff updated the assessments following admission and completed any gaps in information that may have been missed during the pre-admission period. Each patient had individual recovery care plans. Risks were identified in these. Care plans were reviewed appropriately.
- Staff assessed and monitored patients' physical health. The unit's ability to manage complex physical health problems was limited. The ward manager was trying to make closer links with the local acute hospital for assistance in this. However, staff assessed, managed and reviewed the physical healthcare of patients well by carrying out baseline physical observations, monitoring and reviewing observations and performing physical screening where physical health was identified as a problem.

Best practice in treatment and care

- Staff followed 'drug misuse and dependence: UK guidelines on clinical management (2007)' during detoxification treatment, and followed the trust's 'operational guidelines for alcohol and opioid prescribing' as well as the Royal College of General Practitioners guidelines. Staff we spoke with were very knowledgeable around prescribing, monitoring and safety guidelines around inpatient detoxification.
- Staff used clinical institute withdrawal assessment of alcohol score (CIWA) and clinical opiate withdrawal scale (COWS) for assessing and monitoring withdrawal symptoms. These were completed regularly and appropriately.
- The service provided basic psychological interventions including motivational techniques and solution based interventions. Longer term counselling was not available due to the short length of stay in the detoxification unit, and would be routinely offered in line with NICE guidelines in the community. There were opportunities to attend Alcoholics Anonymous (AA) meetings and SMART meetings, on site.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Clients using the unit were positive about the treatment and care received. However, some clients stated that they felt that detoxification was too quick, and that there was too much of a '12 step' focus, which not all patients felt was positive to their recovery.
- The unit used 'peer mentors'. Peer mentors are patients who have completed treatment and return to support new patients and offer guidance.
- Activities were planned and led by the group co-ordinator who liaised with external groups such as AA and SMART recovery. All patients were encouraged to attend these although this was not mandatory. There was a good choice of activities to suit individual needs such as the 12 step programme, informal group sessions designed to help clients discuss and improve skills in coping with dependency and avoiding relapse
- Clients could also access physical and leisure activities for example walking or watching films. Staff would step in to cover these activities should the group co-ordinator be absent. Activities were rarely cancelled and ran six days a week.

Skilled staff to deliver care

- Staff were offered and completed training outside of the mandatory requirements. This ensured they had the specific specialist skills to support clients appropriately.
- All staff received an annual appraisal of their work performance.
- Line managers provided regular clinical supervision. Records identified that 94% of the staff had received regular supervisions; the trust target was 85%. Staff told us they found the supervision effective and useful.
- Policies and procedures were in place to support staff performance and disciplinary procedures.

Multidisciplinary and inter-agency team work

- The unit manager met with management colleagues from the community SDAS service on a monthly basis. They discussed performance issues, quality issues, leadership, staffing and resources.. These meetings also enhanced communication, sharing of common issues and learning from incidents.
- The unit worked closely with the third sector partners, external agencies and the specialist substance misuse community services. We were told staff would confidently liaise with the local authority safeguarding team where appropriate.

Good practice in applying the MCA

- All staff at the Acer unit had received MCA training. All staff we spoke with were able to explain the principles of the Mental Capacity Act as related to substance misuse services, particularly around consent.
- Staff recorded consent to treatment and to share information with relevant parties. This was updated as required.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Community

Kindness, dignity, respect and support

- Staff interacted with clients in a respectful and supportive way. Staff attitudes towards clients needing support from substance misuse services were warm, kind, respectful, enthusiastic and inspiring.
- We observed a number of interactions between staff and clients, individually and in groups. Without exception staff demonstrated genuine care and concern, listened carefully to the clients and demonstrated a high level of empathy and support.
- Clients told us they felt supported and guided by staff, and despite the treatment regime and expectations being difficult and challenging, they felt positive about the care provided. We received a large amount of very positive feedback from clients, families and stakeholders involved in all the services telling us the staff went 'above and beyond', that they were approachable and knowledgeable and made them feel respected.
- Clients told us they were treated as individuals and staff supported them to achieve their goals.
- Staff and managers promoted and achieved a strong client-centred culture within all the services. Due to the redesign process and reduction in staffing there was increased pressure on staff and service managers. Staff had not let this affect their attitudes or level of care and visibly prioritised clients' well-being and needs. Staff we spoke with told us there was a clear commitment to continue to not let these pressures affect the care provided.
- Staff and service managers were committed to improving the care and support provided to clients by working in a creative and innovative way under pressure. The redesign of the service had prompted closer partnership working and increased communication with other agencies that ensured care was not compromised.

The involvement of people in the care they receive

- Clients we spoke with told us they had been involved all the way through their treatment pathway. They knew the contents of their recovery care plans and had been empowered to contribute to them. Clinical records we viewed showed involvement with clients and clear communication during progress. Staff worked hard to build positive and meaningful relationships with the clients.
- All the services displayed and provided information about numerous support agencies and signposted people to them. This included advocacy services if people needed extra independent support.
- All the service managers told us they did not tolerate disrespectful attitudes or behaviour within their teams. They were extremely positive and proud of the care and compassion demonstrated by the staff and the high level of involvement of the clients.

Inpatient detoxification

Kindness, dignity, respect and support

- All interactions we saw between the staff and clients were warm, respectful, kind, polite and supportive. Clients we spoke with told us they were always treated with dignity and respect, and that the staff team were knowledgeable and considerate and always available.
- Staff had a clear understanding of clients' needs. Appropriate practical and emotional support was provided where blanket rules allowed.
- Clients we spoke with told us the unit had strict boundaries and rules were made clear prior to admission. One example was everyone had to eat meals together in the dining room. This could be difficult for someone with an eating disorder or anxiety around food.
- Some clients also told us they felt privacy was sometimes affected as they were so closely observed and rooms were locked off during the day. However they also told us they had consented to these blanket restrictions prior to admission and signed a contract agreeing to them.

The involvement of people in the care they receive

- Clients were orientated to the unit environment on admission and supported by staff and a peer mentor. Clients we spoke with were very positive about the care and support provided by the staff.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- Community meetings were held daily. This gave clients the opportunity to find out how other clients were feeling, to make plans for the day and offer opportunities to attend meetings or groups outside of the unit. Staff also discussed the documents in the welcome pack for new arrivals to ensure they felt supported. Clients could freely offer feedback at these times.
- Clients were involved in their recovery care plans. Clinical records showed needs and risk management were discussed and documented. All clients had been offered a copy of their recovery plan.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Community

Access and discharge

- The trust had a set target of less than three weeks from referral to assessment for the specialist drug and alcohol teams. All the teams had met this target 100% over the previous 12 months. The average waiting time was five days. Dependent on the individual treatment needs, clients were seen very quickly and usually received specialist prescribing within the same week, often on the same day as the referral.
- Staff saw urgent and high risk clients very quickly, for example those released from prison, pregnant women or those with high risk safeguarding issues. The teams were flexible and re-prioritised appointments when an urgent issue arose.
- Access into the specialist drug and alcohol services within Avon and Wiltshire Mental Health Partnership NHS trust differed dependent on the geographical area. However, all services provided good access to relapse prevention, community alcohol and opioid detoxification and highly specialist treatment to clients. This not only included high risk clients, but also harder to engage people such as those with no GP, homeless people, and street sex workers; and all had access to inpatient detoxification and stabilisation beds in the Acer unit.

South Gloucester services

- In South Gloucestershire, the initial assessment and preparation work for those fitting the criteria for the more complex highly specialist prescribing was completed by the third sector partners who would then refer into SDAS. Referrals were through the GP, professionals within the trust, other professionals from other organisations or from clients themselves. Clients would attend groups to prepare for detoxification, then be transferred to SDAS.
- South Gloucester SDAS also provided a rapid prescribing service for people released from prison. Referrals were received directly from the prison pending the clients release and an appointment made for day of release. These were managed well and bridging prescriptions were also provided by Bristol ROADS SDAS on occasions if the client released from prison attended their service instead. The prescribing would then be taken over by South Gloucestershire SDAS as planned.
- Clients with alcohol problems could be seen by one of the two alcohol liaison nurses in general practices or at Southmead acute hospital. These nurses would provide clients with support, advice and signpost them to alcohol and harm-reduction services. They also offered support and advice to the acute hospital and GPs.
- Where a client required assessment and treatment for dual diagnosis (where there is a co-existing mental health and substance misuse problem), a referral was made directly to the South Gloucestershire SDAS team who could provide treatment in partnership with the community mental health teams.
- Detoxification treatment was typically provided over a 10 to 12 day period with aftercare provided for the first 12 weeks by the South Gloucestershire SDAS and then care would be transferred back to the general practice.

Bristol services

- Referral into the Bristol ROADS SDAS (Colston Fort and Stokes Croft) had a similar pathway to South Gloucestershire SDAS, although the model they provided had moved from a parallel relationship between shared care and specialist services, to a new layering relationship. This meant several agencies worked together and shared responsibility for the care of the client.
- The new model meant there was a more fluid working relationship between the third sector partner and the Bristol ROADS SDAS. Access was through the third sector partner. However, Bristol ROADS SDAS had specialist teams right across the treatment pathway to support each level of treatment, engagement, change and completion. Bristol ROADS SDAS managed the intensive, rapid and complex cases including the specialist maternity service.
- The Bristol ROADS SDAS Stokes Croft provision was in the process of merging with Bristol ROADS SDAS Colston Fort at the time of our inspection. They still carried out the rapid prescribing element in the Stokes Croft

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

buildingbut planned to move into alternative accommodation in the near future. Clients would access the service on the day of release from prison or day of discharge from hospital.

- Very vulnerable clients such as street sex workers or pregnant women could also access this service. The new model meant that clients would commence treatment for two weeks, and then would be transferred to shared care or the Bristol ROADS SDAS team for continuation. At the time of our inspection there was a backlog within the Stokes Croft service as the new treatment model had not yet reached completion.

Bournmouth services

- The new adult treatment model in Bournmouth accepted referrals from social care providers, GPs, self-referrals (from clients), hospitals and the criminal justice services through a single point of entry. This screened and identified what agency would be best placed to provide the treatment.
- Clients then accessed the most appropriate intervention including the specialist prescribing provided by the Bournemouth SDAS. They offered access to induction and monitoring clinics, key working, chaotic user's clinics, a learning academy, key working groups, counselling, community detoxification and stabilisation.
- Commissioners of this service told us it was dynamic, innovative and flexible, and that since the trust had taken over the contract in 2013 (and following a difficult initial period), the service now supported access to vulnerable groups such as homeless people and sex workers, offered evening groups to people in employment and families.
- However, the Bournemouth probation service felt there was not enough flexibility in their provision to support the criminal justice services in the area, which they felt was due to recent financial challenges and restructuring. The Bournemouth Probation Service felt that the model reflected the need to complete pre-treatment work and did not allow for immediate access to structured day treatment which would be helpful for people leaving prison, or access to residential treatment when requested.
- We found the Bournemouth SDAS service to be highly innovative and creative. The team worked well within their resources and offered a diverse service to opiate users within the locality. The outreach work being carried out for hard to engage clients was inspiring, and client feedback reflected this. We saw good examples of successful achievement within this service.

BaNES services

- The BaNES integrated treatment service was also completing a restructure, managed by BaNES SDAS, who provided the specialist and shared care elements, and third sector partners who provided the recovery. Access into the service was through a single point of entry. There were treatment centres in Bath and Midsomer Norton but in some cases clients could be seen in the GP surgery.
- This whole client approach offered support, in addition to specialist prescribing, to meet client needs. This included housing, physical and mental health, training and education needs. Higher risk clients were managed by the BaNES SDAS as in all the other specialist drug and alcohol teams.
- Across the services there was flexibility in appointment times where possible.
- Staff followed procedures for clients who failed to attend appointments. Attempts were made to contact and re-engage people who withdrew from the system.
- Staff did not follow a clear discharge pathways at the time of our inspection, due to the recent restructuring and introduction of the new models. This meant that clients could potentially remain in the system with no clear exit. We discussed this at the time and it was acknowledged this was a priority moving forward.
- Clients who were discharged had access to ongoing support and signposting to other relevant agencies.

The facilities promote recovery, comfort, dignity and confidentiality

- All the locations had comfortable rooms available for one to one counselling, assessments and therapy sessions, including interview rooms, group and clinic rooms. All rooms were adequately sound proofed, had good lighting and were well kept.
- Each service had a variety of information in waiting areas and interview rooms relevant to substance misuse, such as mental and physical health, medication,

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

treatment and interventions, helplines, safeguarding, harm reduction advice, safer injecting, overdose prevention, advocacy services, groups and local services. There was also advice on domestic violence and counselling services.

- All services provided information on how to make a formal complaint.

Meeting the needs of all people who use the service

- Information was available in different languages if required, and staff could access interpreters if required.
- The buildings were accessible to everyone, and all locations had disabled access.

Listening to and learning from concerns and complaints

- There were six formal complaints received by the specialist substance misuse services (including Acer inpatient unit) between 1 Feb 2015 and 31 January 2016. The most recent was June 2015. The Bristol ROADS SDAS Stokes Croft service received two complaints and BaNES SDAS received one.
- These complaints were investigated formally and only one was fully upheld. This complaint had led to discussion around improvement in service provision and changes made to the process for being discharged.
- Clients we spoke with told us they knew how to make a complaint. However, they also told us when they raised a problem with their worker this would be dealt with quickly.
- Staff we spoke with were able to describe the complaints procedure and what steps would take place if a complaint was raised.
- Service managers communicated complaints in team meetings. This included compliments received. We saw examples of this in team meeting minutes.

Inpatient detoxification

Access and discharge

- Acer unit provided nine inpatient detoxification beds. Bristol ROADS SDAS had access to seven beds on a block contract. South Gloucestershire SDAS could access one bed and Bournemouth SDAS could spot purchase one bed.
- Detoxification treatment was offered for between one and three weeks. The unit admitted clients early in the week to ensure thorough assessment and to ensure clients were stabilised when there was a higher provision of staff to manage any complications before the weekend where there was less medical cover.
- Staff took initial referrals by telephone where pre-admission paperwork was completed. The unit manager oversaw the entire decision making around admissions. All physical and mental healthcare, and medication needs were discussed pre-admission. The referring agency would complete the comprehensive assessment including risk and full physical health check prior to the patient being admitted. This was usually completed by the third sector partner with the community specialist substance misuse service.
- Clear discharge plans were developed at the pre-admission stage. This was completed co-operatively with the patient, based on motivation. Clients signed a pre-admission contract before their admission.
- The Acer unit had received 96 admissions and had a mean bed occupancy of 73% over the previous six months. Average length of stay was seven days over the previous 12 months. Only three clients had required readmission.
- There had been no delayed discharges from the unit over the previous six months.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff carried out the PLACE (environmental, health and safety) checklist weekly and made clear actions and timeframes on any repairs or damage.
- There were rooms available for examination, treatment and therapy. The clinic room provided confidentiality and privacy. Clients could access the outside to smoke if they wished. However, smoking cessation support was also offered on admission.
- Drinks and snacks were available throughout the day.

Meeting the needs of all people who use the service

- There was wheelchair access throughout the unit.
- Bedrooms were single with en-suite facilities. There was one bathroom designed for disabled clients.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

- Clients had access to dining room and kitchen area, a separate quiet lounge and a women only lounge, laundry room and use of a garden. Clients were allowed to smoke in the garden.
- Children were not allowed to visit the unit for safety reasons. If a client had a child they wanted to see during their treatment this had to be planned in advance. Visits would be supervised by either unit staff or a community worker.

Listening to and learning from concerns and complaints

- There were three formal complaints made to the Acer unit between 1 Feb 2015 and 31 January 2016. One had been upheld and related to premature discharge of a client. Full explanation and an apology was offered. All unplanned discharges were reviewed by the ward manager as a result of the complaint, to ensure it did not happen again.
- There were 21 compliments received in the same period. Clients we spoke with were highly complimentary of the staff on the unit.
- Staff we spoke with understood the complaints procedures and handled complaints appropriately. Clients we spoke with knew how to complain. We were told clients generally preferred to raise issues with staff directly so the team could deal with these quickly.

Are services well-led?

Outstanding ☆

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Community

Vision and values

- Staff we spoke with were able to describe the visions and values of the trust. They felt part of the wider trust despite the specialist nature of the services.
- Staff had a clear understanding of the direction of their individual services despite the pressures of the service redesign. Staff and service managers knew the vision and values of each of the other specialist substance misuse services, and shared best practice and ideas in order to improve their own services.
- The service managers and area manager had engaged with other agencies including the commissioners to create a forward thinking, high quality vision for the future.
- All services were flexible and proactive. Staff and managers were keen to provide care based on current best models of practice. The staff teams and managers embodied this attitude throughout.

Good governance

- Mandatory training completion levels were 89% overall against the trust target of 85%, which was a good level to achieve. Service managers had excellent monitoring systems and alerted staff when training was due.
- Staff received regular supervision in line with trust policy. Staff we spoke with told us they felt supported and happy with the level of supervision received.
- All staff received an annual appraisal of their work and professional performance.
- Service managers had a very good oversight across their services. The area manager had excellent oversight of all the services and each service and staff members performance. Clinical appointments were monitored to ensure safety in prescribing and staff told us their work life balance was good.
- Managers were monitoring and reviewing poor performance within the teams. There were clear plans and actions to address staff performance issues and these were communicated well between the management team.
- Managers provided opportunity for the services to review practice and for learning to be shared. Staff told us they felt well informed and were given opportunities to link in with team members from other services. This included through formal team meetings, training, allocation meetings and clinical supervision. We looked at some team meeting minutes and saw clear documentation and actions.
- The services were meeting and exceeding contractual targets set by the commissioners. Performance was monitored and reported back to the trust. Staff provided information required for the national drug treatment monitoring system (NDTMS), (the system which provides national statistics about drug and alcohol misuse). This included referral to treatment times, types of drug misuse and successful treatment outcome statistics. Staff we spoke with understood the importance of collecting these figures and their purpose.
- The services all had sufficient, knowledgeable and effective administrative support in place.
- Service managers carried out audits on all areas of service provision to ensure high quality. There were excellent systems to manage and monitor risk and decision making. The managers monitored the impact of the new strategy and systems closely to ensure financial pressures did not impact negatively on care.

Leadership, morale and staff engagement

- All the service managers were enthusiastic, creative and passionate about their services. Staff we spoke with told us they respected and liked the leadership in their teams and understood that although they were under a lot of pressure, the restructuring was necessary and all actions taken were in the best interests of the clients and the services. There was a determination within all the teams to make the new pathways and models a success.
- Within the Bournemouth SDAS there had previously been unsafe prescribing and monitoring practices within the service. When Avon and Wiltshire Mental Health Partnership NHS trust took over the service the service manager and team had worked hard to turn this around, to challenge negative staff attitudes and drive positive change to ensure safety and effectiveness

Are services well-led?

Outstanding ☆

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

without compromising care and compassion. They had achieved this very well and morale was good and the pride staff felt was evidence at the time of our inspection.

- The service managers told us they felt safe and supported by the area manager. They received regular support and supervision and felt safe to discuss and raise any concerns or problems. The service managers met once a month to discuss their services and provide mutual support.
- Staff morale was good in spite of the anxieties and concerns following the restructuring process and, in some of the teams, the retendering process. Managers monitored stress and morale within the services and they knew their staff teams well. Action was taken to support staff during stressful times, though managers recognised sometimes there were hard decisions to be made. Staff told us although they felt concerned and under pressure sometimes, they were very proud of their services and understood why the changes were taking place.
- The services had achieved a good level of supervision and appraisal. record. Staff we spoke with told us they felt supported and informed, and felt they had a voice in their teams. Staff recognised the hard work put in by the managers, and equally the managers held their staff in high regard for their professionalism.
- Key stakeholders told us the management were innovative, collaborative and proactive. They had a drive for improvement and had been very creative during the redesign period.

Commitment to quality improvement and innovation

- There was a clear drive and passion by the service leaders to provide the highest quality care despite the challenges. The management team were dynamic in their commitment to finding further creative means of innovative partnership working.

Inpatient detoxification

Vision and values

- Staff knew the visions and values of the trust and felt part of the wider trust. Staff were clear on their own role and responsibilities and also that of the wider specialist substance misuse services.
- The staff team was keen to provide care based on current best models of practice. They had a positive attitude towards their unit and were proud of the service provided.
- Staff knew who the senior managers were within the trust, as well as the local specialist substance misuse service managers.

Good governance

- The manager ensured staff completed mandatory training. The completion levels were high. There was an effective monitoring system which highlighted when training was due.
- Staff received regular supervision and appraisals in line with trust policy. Staff we spoke with told us supervision was very useful. All staff received an annual appraisal of their work and professional performance.
- All staff had access to 'our space', the trust's electronic intranet, where they could access all the trust's policies and procedures. All staff we spoke with found this useful.
- The unit manager provided opportunity for the service to review practice and for learning to be shared. Staff contributed to team meetings and shared practice and concerns with others within the team.

Leadership, morale and staff engagement

- Overall leadership was provided by the Bristol recovery orientated alcohol and drugs service (ROADS) SDAS service manager. They provided support and supervision to the unit manager. The unit manager had a very clear management style and maintained good clear boundaries on the unit. Staff felt supported by the local managers and told us they were approachable.
- Staff had good morale and worked as a close team. They told us they felt confident in escalating concerns and that they would be acted upon.

Commitment to quality improvement and innovation

- The unit had access to a peer mentor who was considered 'the face of recovery'. For clients entering the service, recovery may seem extremely difficult. Having someone with cliental experience who could share stories and support clients at the most difficult time

Are services well-led?

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helped clients believe that recovery was possible and recovery a reality. Staff and clients told us having a peer mentor available significantly helped improve the quality of treatment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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