Horizon Drug and Alcohol Recovery

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?	Requires improvement
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.

Summary of findings

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

Overall summary

We rated Horizon Drug and Alcohol Recovery as good because:

- Clinical premises where clients were seen were safe and clean. There were polices and procedures regarding the safety of medicines. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- The service provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the clients. The service was working well with other agencies. Managers ensured that staff received training, supervision and appraisals.
- There were enough staff who were suitably trained. Staff understood the services vision and values. Staff felt supported.
- Clients were encouraged to live healthier lives. Clients described staff as kind and they involved them in their care. Families and carers also had access to support.
- The service was easy to access. Complaints were dealt with appropriately and fairly. Leaders were visible in the service and available to staff and clients.

However,

- Recovery plans had not improved since the last inspection. Recovery plans remained brief and with insufficient detail. Recovery plans did not contain all information regarding clients care and treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	See overall summary

Summary of findings

Contents

Good

Horizon Drug and Alcohol Recovery

Services we looked at;
Community-based substance misuse services;

Summary of this inspection

Background to Horizon Drug and Alcohol Recovery

Horizon Drug and Alcohol Recovery provides community substance misuse services for the Blackpool area. The service is commissioned by the local authority as part of a wider service pathway. Horizon Drug and Alcohol Recovery provides support for clients who have recently been referred or have self referred for substance misuse support and treatment. This includes a triaging process that involves completing assessments, risk assessments and initial recovery plans for each client. Clients are transferred to another part of the pathway depending on each client's needs. The wider pathway includes two other services that provide;

- prescribing for detox and stabilisation
- support with abstinence
- volunteering opportunities
- employment and education options
- key working and group work

The wider parent organisation fed into the service and provided some group work. This included:

- harm reduction and motivation programme groups
- my recovery groups

The service was registered to provide the regulated activity of treatment for disease, disorder or injury. There was a registered manager in post. The service had been registered since April 2017. The service had received a comprehensive inspection in January 2018 and a focussed inspection in September 2018. At the focussed inspection in September 2018 we issued the following enforcement action:

- warning notice, Regulation 9 (3) (b) The provider did not ensure that recovery plans were comprehensive and up to date.
- warning notice, Regulation 12 (1) (2) (a) (b) The provider had not ensured that risk assessments were fully completed for all clients. They had not done all that could be reasonably practicable to mitigate risks to clients.

We also issued the following requirement notice:

- Regulation 17 (1) (2) (a) Staff were not receiving regular supervision and supervision compliance was not sufficiently monitored and improved.

At this inspection we found that risk assessments now contained detailed risk management plans for each individual client. All staff had received supervision, and this was monitored by senior managers.

However, recovery plans still did not contain detailed information about clients' care and treatment. This was a breach of regulation and you can read more about this within the report.

Our inspection team

The team that inspected the service comprised one CQC inspector and two assistant inspectors.

Why we carried out this inspection

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

Summary of this inspection

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with five clients who were using the service;
- spoke with four carers of clients who were using the service;
- spoke with the registered managers;
- spoke with four staff members; including recovery workers and a psychologist;
- received feedback about the service from commissioners;
- attended and observed two keyworker sessions;
- looked at 14 care and treatment records of clients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients described staff as caring and supportive. Clients said access to the service was good and that they could contact key workers easily between planned appointments. Clients and carers were positive about the care and treatment they were receiving. Clients felt involved in their care and they had contributed to their recovery plans.

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:

- The premises were clean, well maintained and provided adequate spaces to see clients in.
- There were enough suitably qualified staff to meet clients' needs.
- Staff carried out comprehensive risk assessments and clients had a risk management plan in place which corresponded with the identified risks.
- Staff were all up to date with their training.
- All staff had received safeguarding training and were aware of their responsibilities in relation to safeguarding. A safeguarding lead was in place and staff met weekly with adult social care staff to discuss complex clients.
- Policies and procedures were in place to ensure the safe prescribing and handling of medicines.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Recovery plans were brief, lacked detail and were not holistic. Recovery plans did not contain enough information about clients care and treatment.However:
- The service provided a range of evidence-based care and treatment options.
- All staff received regular supervision and managers provided staff with a yearly appraisal.
- Clients were supported to live healthier lives and clients were offered blood borne virus testing as part of a range of interventions offered to help improve client's health.
- Staff worked closely with other agencies to increase the support they could offer clients.

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, treatment or condition.

Summary of this inspection

- Staff involved clients in recovery planning and risk assessment and actively sought their feedback on the quality of care provided.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access. Its referral criteria did not exclude clients who would have benefitted from care. Staff assessed and treated clients who required urgent care promptly and clients who did not require urgent care did not wait too long to start treatment. Staff followed up clients who missed appointments.
- The service met the needs of all clients including those with a protected characteristic.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

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.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act which staff were aware of and could refer to. Staff knew who to contact if they had concerns about a clients' capacity.

Staff understood the principles of the Mental Capacity Act; all staff had received training and there were posters containing prompts displayed on the walls.

Staff ensured clients consented to care and treatment and that this was assessed, recorded and reviewed in a timely manner.

Overview of ratings

Our ratings for this location are:

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

Good

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Good

Safe and clean environment

The service had accessible rooms to see clients in. There was a ramp for disabled access and an accessible toilet. Staff carried personal alarms when seeing clients. The fire risk assessment was up to date and staff carried out regular fire alarm checks. There was a suitably equipped clinic room and prescribing room and the service had rooms where clients could see staff for individual sessions. The reception area was comfortable and contained information leaflets for clients and a folder with volunteering opportunities.

Areas that clients had access to were clean, comfortable and well-maintained. Client art work was displayed on the walls. Staff adhered to infection control principles, including handwashing and the disposal of clinical waste. Aprons and gloves were available for staff. The cleaning rota was up to date. Medical equipment had been checked and calibrated where appropriate.

Safe staffing

The service had eleven staff consisting of a manager, four keyworkers, two nurses, two support workers, a care coordinator and an admin worker. Staff also had access to a psychologist who worked with staff and clients. One member of staff was absent due to sickness. This post was covered by the staff team. Staff felt their caseloads were manageable and told us the team worked well together. Staff said clients were still seen when a member of staff was off. Clients told us they could see members of staff when they needed support.

The service also used volunteers and peer mentors to support the staff team and meet the client's needs. Management were reviewing staffing levels and looking for creative ways to increase client access to staff.

Mandatory training

There was a comprehensive training programme and staff had completed all mandatory training including health and safety awareness training. Staff told us there were opportunities for extra training where this was identified as beneficial.

There was a local procedure that ensured staff did not lone work whilst completing home visits. If home visits were required due to clients physical or mental ill health issues, these were conducted by the keyworker, accompanied by a non-medical prescriber.

Staff had completed training in and understood their responsibilities in relation to the Mental Capacity Act 2005. Staff told us they had a form they could use if they were concerned about a clients' capacity but said they had not needed to use it.

Assessing and managing risk to patients and staff

We reviewed 14 care records during our inspection. Staff carried out thorough risk assessments with clients and there were risk management plans in 13 out of the 14 records we looked at. Risk assessments and management

plans were in date and staff updated them regularly when they became aware of new risks. Risk management plans detailed how to mitigate issues that were identified in the risk assessment.

Health care was overseen by the client's GP. The service had a nurse who carried out some health and wellbeing assessments. Prescribers records were thorough and identified health issues. Staff followed up on health concerns and made referrals to appropriate health professionals and encouraged clients to keep their appointments.

Clients were made aware of the risks associated with their continued substance misuse. Harm minimisation / safety planning was not an integral part of recovery plans, but there was evidence of safety planning in client's notes and in risk management plans. Staff identified and responded to changing risks to, or posed by, clients and responded promptly to sudden deterioration in clients' health.

The building had a no smoking policy. There were leaflets and posters promoting smoking cessation available in the waiting area. Harm reduction advice was promoted by staff in relation to smoking. The service was aware there was a high percentage of clients with chronic obstructive pulmonary disease. The service was working in partnership with the local health trust to offer chronic obstructive pulmonary disease clinics within the service in the future.

Clients were issued with Naloxone where appropriate. Naloxone is a drug to counteract the effects of overdose. All staff were trained in issuing Naloxone. Naloxone had also been given out to friends and family of clients and places where it may be needed such as soup kitchens and hostels.

Safeguarding

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff had received training on safeguarding both adults and children, equality and diversity and bullying and harassment. There was a designated safeguarding lead who had oversight of all safeguarding activity. Staff explained they discussed all safeguarding concerns with the safeguarding lead.

Staff worked effectively within teams, across services and with other agencies to promote safety including having systems and practices with regards information sharing. The service worked closely with the local hospital and midwife services to ensure pregnant clients received all necessary care in one place.

Staff implemented statutory guidance around vulnerable adult and children and young people safeguarding and all staff were aware of where and how to refer on as necessary. There was a safeguarding adult's policy and a safeguarding children's policy. Both incorporated statutory guidance and referral processes. Staff understood local children services processes and there was regular liaison with children services duty teams. However; both policies lacked specific detail and timescales although a new safeguarding policy was in draft and due to go to the governance meeting.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff took part in a weekly adult social care meeting to discuss complex clients. There had been no referrals made to children's services as all children identified as at risk were already known to services. Staff regularly attended multiagency meetings in relation to child safeguarding. There was evidence of staff attending a range of child protection meetings. Clients with children were issued safe storage of medication boxes if prescribed a controlled medication.

Staff access to essential information

Records were kept on the computer system. Keyworkers filled out paper-based recovery plans with the clients and these were scanned onto the system.

Relevant staff had prompt and appropriate access to care records that were accurate and up to date.

Medicines management

The service had numerous policies to support safe prescribing and medicines management. These included supervised consumption policy, withdrawal guidance and a prescribing guide.

Staff had access to effective policies, procedures and training related to medication and medicines management including: prescribing, detoxification, assessing people's tolerance to medication, and take-home medication e.g. Naloxone.

Medications were prescribed by the doctor and completed prescriptions were transferred to another site which

provided part of the patient pathway. This was under the control of the prescribing administration team. Prescriptions were collected by each individual pharmacy and a copy of the prescription was stored on file for the purposes of auditing. Horizon Drug and Alcohol Recovery had an additional minimal supply of prescriptions sheets that were logged, accounted for and required countersignature. There was no medication stored at Horizon Drug and Alcohol Recovery apart from flu and hepatitis B vaccines, adrenalin and Naloxone, a drug to counteract the effects of overdose. Medicines were checked regularly to ensure they were in date and stored correctly. Fridge temperatures were checked daily and were in the correct range. The clinic room could only be accessed with a code.

Staff reviewed the effects of medication on clients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when the client was prescribed a high dose medication. Prescribers liaised with other medical professionals where necessary including referring clients for cardiograms.

Clients attended regular medication reviews with the doctor or non-medical prescriber. During medication reviews, staff took account of changes to clients physical or mental health needs and potential impact on prescribing choices.

Track record on safety

Managers recorded 18 incidents on the serious and untoward incident log between March 2018 and February 2019. In addition to these six deaths were recorded. There were no other serious incidents which resulted in harm.

Incidents included prescribing errors and client aggression. All incidents were investigated and learning from the incidents was shared with the team.

The service had identified themes which included chronic illness such as chronic obstructive pulmonary disease and poor mental health. The service had plans to target clients with dual diagnosis and offer increased support for specific needs. This included offering chronic obstructive pulmonary disease clinics within the substance misuse service and closer links with the mental health service.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report. Staff described examples of incidents and explained how they are reported on the incident reporting system. The service had adopted a new electronic incident reporting system that had been in place since April 2019.

Staff were clear about their roles and responsibilities for reporting incidents, encouraged to do so and reported in a consistent way.

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

All incidents were investigated and reviewed, and lessons were learned were shared with staff where appropriate. Incidents where clients had made a complaint were investigated separately through the complaint's procedure.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed 14 care records during our inspection. The service was assessment focused and staff completed a comprehensive assessment in a timely manner. Staff used a Red, Amber, Green system to identify areas of concern and prioritise client needs.

We looked at 14 records, all records contained an up to date recovery plan, but they were brief and lacked detail. Areas of risk that were identified in the assessment were planned for in the risk management plans but not covered in the recovery plan. There was some evidence that recovery plans were person centred as client's long-term goals were recorded. However, recovery plans were not holistic. Steps taken to achieve goals were not detailed or specific. Information gathered in clients' assessments about issues including complex and untreated mental health problems, overdose and suicidal feelings, homelessness, and clients' children were not carried forward into the recovery plans. These issues were addressed in the risk management plans. Information about a client's progress could be seen in the clients notes but was not evident in their recovery plans.

Not all risk management plans contained a plan for unexpected exit from treatment. However, staff followed a general procedure when clients exited treatment unexpectedly which included contacting housing services, GPs, hospitals and pharmacies and using the outreach team to try and re-establish contact with a client.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. This included substitute prescribing, psychosocial interventions and counselling. Staff also facilitated access to structured group work, activities, training and work opportunities intended to help clients acquire living skills. Doctors and non-medical prescribers were available to offer substitute prescribing and other medical treatments. A full-time psychologist (based at another location) was available to provide talking therapies to clients who had suffered trauma or abuse. A range of activities were available to support clients to develop interests such as short IT courses and art groups. Employment workers were available to support clients with career aspirations. Fifteen clients had succeeded in gaining paid employment.

Blood borne virus testing was routinely offered. Testing was offered during the assessment process and at reviews.

Clients were supported to live healthier lives through several initiatives such as:

- Free dental provision (48 clients treated by mobile dentists)
- Pregnancy partnership (a midwife attended the service to provide care to pregnant clients)
- Hepatitis C community clinic
- Joint working with primary care services.

Future planned initiatives included:

- Chronic obstructive pulmonary disease screening
- Sexual health clinic for cervical screening and contraception.

Technology was being utilised to improve client care. New oral drug screening equipment had been purchased that gave instant results. Electronic devices were due to be purchased for the waiting room. The purpose of the devices was to engage clients to give feedback and for the provider to share information about the service with clients. It was hoped this would increase client feedback and information sharing.

Skilled staff to deliver care

All staff completed a comprehensive induction. An induction template was used to ensure staff completed all tasks identified. Agency staff completed the same induction process.

The service provided and ensured that all staff had completed mandatory training. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. This included specialist training such as family mediation training and chronic obstructive pulmonary disease screening training.

There was a robust recruitment process for managers to follow. Staff underwent regular Disclosure and Barring Service checks. There was also a process in place relating to the recruitment of volunteers.

All staff received regular supervision and yearly appraisals from appropriate professionals. Management supervision rates for the last 12 months were 100%. A supervision tree had been introduced and staff had been trained to deliver supervision. Weekly clinical case management supervision had also been introduced. Each staff member had five client records audited to share good practice and check the quality of the care record.

There had been issues with poor staff performance which had been addressed promptly and effectively. Mangers gave examples of how staff were supported to improve or had been disciplined due to poor practice.

Volunteers had been recruited and supported the running of the service. Volunteers supported administration duties and greeting clients as they entered the building. Volunteers were encouraged to develop their skills into peer support workers.

Multi-disciplinary and inter-agency team work

Managers were working to improve multi-disciplinary input into client's comprehensive assessments. Staff were working more closely with GPs and the safeguarding team to improve the information gathered at assessment stage. Staff also worked with mental health services, maternity

Good

Community-based substance misuse services

services, criminal justice services, homeless hostels and employment services to improve support and opportunities for clients. Staff worked alongside the outreach team to support clients who were not accessing the service.

Staff had weekly multi-disciplinary team meetings with the clinical lead, service manager, recovery worker and the psychologist where they could discuss client treatment plans.

The service had effective protocols in place for the shared care of clients. Staff took part in multi-disciplinary reviews including with social services. Meetings were held with the Multi-Agency Safeguarding Hub where safeguarding concerns were raised. Staff also attended the drug related death panel monthly.

Most recovery plans did not include clear care pathways to other supporting services. However, client notes showed that referrals were regularly made to supporting services including health and employment services.

Monitoring and comparing treatment outcomes

Horizon participated in several research projects. These included the drug related death audit for the Home Office, an injecting survey, community rehab vs residential rehab and a PhD project looking at 'Alcohol treatment pathway from a continuity of care perspective'. Staff also completed treatment outcome profiles with clients and submitted them to the national drug treatment monitoring system. Treatment outcome profiles are used to monitor clients progress.

Good practice in applying the MCA

The service had a policy on the Mental Capacity Act which staff were aware of and could refer to. Staff knew who to contact if they had concerns about a clients' capacity.

Staff understood the principles of the Mental Capacity Act, all staff had received training and there were posters containing prompts displayed on the walls. However, staff and managers told us they had not supported anyone who lacked capacity to make their own decisions.

Staff ensured clients consented to care and treatment and that this was assessed, recorded and reviewed in a timely manner.

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours towards clients were respectful, warm and responsive. We observed staff listening and responding appropriately to clients concerns and feedback. Clients reported that staff were caring, supportive and always available to contact for advice.

Staff supported clients to understand and manage their care, treatment or condition. This was completed through scheduled meetings with their key workers and clinical staff where there was an identified need. Clients stated that they could contact their recovery worker in between scheduled appointments if needed.

Staff directed clients to other services when appropriate and, if required, supported them to access those services. Carers told us that clients were supported to access multiple services including alcoholics anonymous and mental health services. The service was involved in trialling the Individual Placement and Support programme which helps clients seek employment. There had been fifteen successful outcomes which resulted in clients securing part- or full-time employment.

The service had clear confidentiality policies in place that are understood and adhered to by staff. Staff maintained the confidentiality of information about clients. Clients signed a confidential agreement at the initial assessment allowing staff to contact third parties and share information.

The service had a record that confidentiality policies have been explained and understood by clients.

Staff we spoke with told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fear of the consequences.

Involvement in care

Staff communicated with clients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication

difficulties. This included the use of interpreters for clients whose first language was not English. The service also had a member of staff who was proficient in British sign language.

The service empowered and supported access to appropriate advocacy for clients, their families and carers. Staff were very knowledgeable about local advocacy services. Staff were aware of many advocacy services for general advocacy and more specific advocacy issues.

Recovery plans and risk management plans were in place for all clients. Staff and clients told us that risk, recovery and goal setting formed part of ongoing discussions however there was limited evidence of this in the care records. Clients we spoke with told us they did feel involved in planning their care.

Staff engaged with clients, their families and carers to develop responses that met their needs and ensured they had information to make informed decisions about their care. Families and carers were involved in treatment where appropriate and could attend appointments at the client's request. One carer told us that appointments were very informative, and carers could ask a variety of questions about the client's treatment.

Staff actively engaged clients, families and carers in planning their care and treatment. All recovery plans were completed with clients. Clients were offered choices regarding treatment options.

Involvement of families and carers

Staff enabled families and carers to give feedback on the service they received. There were feedback forms and a suggestion box available in the waiting area for clients, families and carers to submit ideas, comments or concerns. The service also had an online feedback system. Families and carers could give verbal feedback to staff members.

We spoke to four carers and relatives of clients who were using the service. All gave positive feedback about the service and said they felt supported and were involved in the treatment process.

Staff provided carers with information about how to access a carers assessment. Staff were aware of local carers organisations who had been commissioned to provide carers assessments.

The service offered a family and carers support group. The content of the group had been accredited and rolled out formally with high numbers of attendance.

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

Good

Access and discharge

The service had alternative care pathways and referral systems in place for clients whose needs could not be met by the service. Clients with mental health needs were referred to other appropriate services such as primary care and secondary care mental health services.

All clients were offered a range of alternative treatments if they were unable to comply with an agreed plan. Clients had choices of groups or individual sessions and detox or maintenance on substitute medication.

The service accepted all referrals into the service promptly. The referral criteria was broad and did not exclude clients with complex needs.

Clients were offered appointments with doctors or non-medical prescribers where appropriate with 14 days. Clients were offered assessment appointments within seven working days. Due to continued high demands of the service, some clients were being offered motivational sessions prior to beginning the assessment process. This was due to the increasing number of clients who did not engage with the service. The motivational session was a short assessment of the client's circumstances and willingness to accept treatment.

There was a duty system in place to allow for any unplanned work. A duty worker was available to see clients who attended or telephoned unexpectedly. Urgent referrals could be seen immediately by the duty worker if needed.

Risk management plans reflected the diverse and complex needs of clients including clear care pathways to other supporting services. However, this was not reflected in recovery plans. Recovery plans did not include information on dependent children, social circumstances, housing or mental health needs.

Good

Community-based substance misuse services

Staff planned for clients' discharge, including good liaison with other services. There was a discharge pathway that clients could clearly aim for. The service had access to another pathway that supported clients who had reached abstinence. The freedom pathway supported abstinent clients to build social networks and engage in activities to support recovery. There were internal employment support workers who could help with employment opportunities. This service was available to all clients throughout their recovery journey.

The support clients received whilst transferring between services such as inpatient mental health services was improving. Staff were being invited to ward meetings at the local mental health unit. There was a system in place for the acute hospital trust to contact the service and inform them of any clients who had been admitted to hospital. Staff liaised with hospital staff regarding medication whilst being an inpatient.

The facilities promote recovery, comfort, dignity and confidentiality

There were enough rooms to see clients individually or to conduct group sessions. There was a specific room for the doctor or non-medical prescriber. There were private urine screening facilities.

Leaflets were available in the reception and waiting areas. Leaflets included information on treatment options, health and wellbeing and volunteering opportunities. There was box for feedback comments on the service provided.

Patients' engagement with the wider community

Staff supported clients to maintain contact with their families and carers. There was a family worker who offered support to families and carers. A family and carer support group was also available. The group delivered structured support sessions. Staff had recently received mediation training to help them manage difficult family dynamics.

Staff encouraged clients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Staff had links to local community activities and encouraged clients to become involved.

Clients had access to education and work opportunities during all aspects of their recovery journey. There were employment support workers available to help clients get back into work. Employment support workers could signpost clients to the relevant educational course, volunteer post or job. Support was available to develop CV's and job interview techniques.

Meeting the needs of all people who use the service

Vulnerable clients were identified and targeted using approaches appropriate to their needs. Outreach workers supported clients who were homeless, female staff delivered interventions specific to women's issues such as female criminality, domestic violence and sexual violence.

The service linked with partner agencies who delivered health and wellbeing support to clients of the lesbian, gay, bisexual and transgender community. Young people were seen in a designated young person's centre where they received clinical interventions relating to substance misuse.

The service did not have a waiting list. There was a duty system in place that allowed clients to be seen immediately should they present unexpectedly to the service. There was a prescriber available each day to provide emergency prescriptions if needed. Clients reported that care and treatment was rarely cancelled or delayed. Clients said appointments were not cancelled by staff and ran on time.

Listening to and learning from concerns and complaints

Staff protected clients who raised concerns or complaints from discrimination and harassment. We examined the complaints over the last 12 months. There had been seven complaints of which five were upheld. All complaints were about staff. This included staff attitudes and behaviours. Complaints were dealt with fairly and information fed back to complainants.

Managers had taken appropriate action regarding each individual complaint and followed the service's complaints policy. There was evidence of themes from complaints being addressed and responded to.

Good

Community-based substance misuse services

Are community-based substance misuse services well-led?

Good

Leadership

Managers provided clinical leadership to staff. Managers were visible in the service and approachable for clients and staff for advice and guidance.

Leaders had the skills, knowledge and experience to perform their roles. Managers had been successful in improving the quality of the risk management plans and other aspects of the service. Managers were aware of the shortfalls regarding the quality of recovery plans and were planning to focus on improvements in the immediate future.

The service had a clear definition of recovery and this was shared and understood by all staff. The service worked towards a vision of alcohol and drug abstinence. However, the service was also aware that client's recovery goals were individual. Client's were encouraged to develop their own recovery goals. There was a clear recovery pathway.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Managers had identified areas of efficiency saving and had plans to implement changes.

Vision and strategy

The service's values were:

- person centred
- accessible
- sustainable
- accountable.

The services vision and values were embedded into the service via the induction process and discussed during team meetings. The service was due to adopt the parent organisations values and integrate them into the service. An annual away day was planned to seek input from staff.

Staff and clients had the opportunity to contribute to discussions about the strategy for the service. We saw evidence of clients being consulted on several occasions regarding possible changes to the service. Staff were consulted about changes during internal meetings.

Culture

Staff felt respected, supported and valued. Staff described positive working relationships with colleagues and managers. Staff felt that morale was improving, and stress levels were reducing. Staff felt positive and proud about working for the service.

The provider recognised staff success within the service through a staff awards scheme. There was an annual Delphi day to celebrate staff success and revisit the services goals and values.

Staff appraisals included conversations about career development and how it could be supported. Staff were encouraged to participate in training courses to develop new skills and career opportunities. Staff could access courses provided by the service or the wider parent organisation.

There had been no instances of bullying or harassment in the last 12 months. The service had a policy for staff to follow. A human resource team was available to oversee the bullying or harassment process.

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

Staff morale and job satisfaction were monitored via the annual staff survey and within supervision sessions. The latest staff survey reported that overall staff said their wellbeing was good and this was reflected in staff interviews.

Staff reported that the service promoted equality and diversity in its work. Equality and diversity training was mandatory and all staff had completed it. Staff had access to specific policies on equality, diversity and human rights.

Internal staff teams worked well together and where there were difficulties managers dealt with them appropriately. There was evidence of managers addressing poor staff performance appropriately. There was a human resource team available for advice and support.

Governance

Good

Community-based substance misuse services

Governance policies, procedures and protocols were regularly reviewed and improved. The service linked with external bodies to ensure policies contained the latest guidance.

There was a clear framework of what must be discussed at service and senior management level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Themes from incidents and complaints were shared at manager and governance meetings.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. The service was part of a local death review panel with other external organisations. The service was implementing recommendations made by the panel to reduce the number of deaths. This included stronger information sharing with the police and hospitals. Several initiatives were underway.

The service regularly audited the quality of client's recovery plans. However; the audits had failed to improve the quality of recovery plans. Whilst risk management plans had clearly improved, recovery plans still did not contain detailed information about the clients care and treatment. Managers were aware of this issue and planned to focus on recovery plan improvements. Other audits were sufficient to provide assurance and managers had acted on results where necessary.

The service submitted notifications to the Care Quality Commission regarding deaths, safeguarding and allegations of abuse. The service was submitting referrals to the local authority relating to safeguarding concerns. The service submitted data to the national drug treatment monitoring system. The service collated data requested by commissioners. The service made regular internal referrals to psychology, counselling, employment support and outreach departments.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the clients. The service was strengthening links with the local mental health provider to establish a joint working agreement for clients who also have a secondary care mental health need.

There was a whistle blowing policy in place. Staff described feeling confident to raise concerns and felt any concerns would be acted upon.

Management of risk, issues and performance

There were quality assurance management and performance frameworks in place that were integrated within policies and procedures. The service had systems and processes in place to manage risk and understand performance. The service was aware that the quality of recovery plans had not improved. The service collated key performance indicators that were discussed within team meetings, manager meetings and management supervision.

The risk register was maintained by the clinical lead who had responsibility for clinical risk. Information within the risk register fed into senior leadership meetings, governance meetings and managers meetings. Outcomes from these meetings fed into team meetings. Staff were aware of the risk register and could escalate concerns.

The service monitored staff sickness and absence rates. Absences were discussed during staff supervision sessions.

The service was making some cost improvements. The initial assessment process had been reconfigured due to the high volume of clients not attending. Some clients were being offered shorter motivational assessments to save time and money. Client safety had been fully considered and assessed. The service had received considerably less funding for inpatient detoxes. Some clients were being considered for home detox instead. The service had not compromised client safety. There was a plan to offer home detoxes to clients who were only eligible for inpatient detox due to a lack of community care. The service was considering employing a care agency to provide care at home. Other alternatives included considering home detoxes for higher risk clients and employing a nursing agency to oversee some aspects of the care and treatment. The cost of some opiate substitute medication had increased considerably. An alternative medication had been sourced and offered to clients.

Information management

The service used systems to collect data that was not over-burdensome for frontline staff.

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

had prompt access to client information when they needed it. Information was stored securely, and information governance systems included confidentiality of client records.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care. Managers monitored performance data, staff absence rates and audits of client records. This information was used to improve the service.

Staff made notifications to external bodies as needed. The service made notifications to the Care Quality Commission and referred clients to the local authority safeguarding service when required.

Information-sharing processes and joint-working arrangements with other services were being developed. Information sharing with GP's was being improved. A new client information sheet and central email box had been created. The service met regularly with police, ambulance service, adult social care and the mental health trust. The police and ambulance service were sharing information about clients who had overdosed recently. The service was able to target these clients who were most at risk. The service was meeting with the local mental health trust to establish better working practices for clients who had dual diagnosis of substance misuse and severe and enduring mental health needs.

Engagement

Staff, clients and carers had access to up-to-date information about the work of the provider and the services they used. Staff had access to the intranet and electronic policies. Clients and carers had access to leaflets, a website and social media. Managers met with clients and carers to discuss changes and seek opinions.

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Clients and carers could give feedback via comment cards, group feedback, the complaints process or informally to a member of staff.

Managers engaged with external stakeholders such as commissioners to monitor and improve the service.

Learning, continuous improvement and innovation

The service encouraged creativity and innovation to ensure up to date evidence-based practice was implemented and imbedded. A new post had been created to review and improve the psychosocial interventions delivered by keyworkers during individual sessions. A more structured approach was planned with a range of tools for keyworkers to use with clients.

There was a mediation project available for families, carers and clients. Another provider was offering families a programme of mediation over a two-month period. Staff had been training in basic mediation skills to support families and clients with difficult family dynamics.

There was a pilot scheme looking at the effectiveness of a long-lasting opiate substitute medication. A long-lasting injection was being trialled specifically aimed at clients who were in employment or other circumstances who would benefit from this method.

There was a review underway of clients who present at accident and emergency departments with alcohol related problems. The service was looking at how to improve the communication between local accident and emergency departments and the service.

The service was involved in a hepatitis C audit for Public Health England. Blood samples were taken and sent for analysis.

External staff had been seconded to the service to deliver employment support to clients. The project aimed to support clients to consider employment opportunities at any stage of their recovery journey. Support included education, volunteering and career guidance.

Clients newly released from prison who were prescribed low doses of opiate substitute medication were offered supported accommodation. The service had made links with a housing provider to create this joint project.

Information gathered from GP's was being improved. A one-page client information sheet was being developed to share with GP's. A central email box had been created for GP's to forward medical history information to the service.

Outstanding practice and areas for improvement

Outstanding practice

The service strived to offer a variety of supplementary support to clients. This was in addition to Horizon's core purpose. Clients holistic needs were considered, and the service endeavoured to meet those needs in creative ways. This included:

- employment support workers had been seconded from another organisation to deliver career opportunities to clients at any stage of their recovery
- an independent mediation service was delivering family mediation sessions to clients and their families and carers
- a new depot injection medication was being trialled for clients prescribed opiate substitute medication. Clients with work or family commitments would benefit from the more convenient treatment
- housing opportunities for clients newly released from prison had been created in partnership with a housing provider. The purpose was to reduce reoffending rates.

Areas for improvement

Action the provider MUST take to improve

- The provider must improve the quality of recovery plans. Recovery plans must contain detailed information regarding clients care and 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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Recovery plans were still not holistic and did not contain all information regarding clients care and treatment. This was a breach of regulation 9 (3) (b)