The Gate

Quality Report

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Date of inspection visit: 4-5 November 2019
Date of publication: 16/01/2020

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

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

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

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

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

Summary of findings

Overall summary

We rated this service as outstanding because:

- There was compassionate, inclusive and effective leadership. Leaders and managers demonstrated high levels of experience, capacity and capability to deliver the highest standards of care. Staff were proud of the service as a place to work and spoke highly of the culture. There was strong and effective collaboration, team-working and support with a common focus on improving quality of care.
- There were consistently high levels of constructive and meaningful engagement with staff and people who used the service. People who used the service had access to an extensive range of opportunities to provide feedback on the service and the care they received. Staff used this feedback to make meaningful changes to the service to meet client's needs.
- Feedback from people who used the service was continually positive about the way staff treated them. Clients and carers felt staff 'go the extra mile', and the quality of care and support provided exceeded expectations.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- The service provided safe care. The premises where clients were seen were safe and clean. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.

Summary of findings

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Summary of this inspection

Background to The Gate

The Gate is part of the NECA group. It is a recovery and wellbeing service which supports people who chose recovery as a way out of dependency on drugs and alcohol. The service offers a recovery orientated approach to drug and alcohol misuse including:

- An open access harm reduction service;
- An open access service to advice, information and support;
- Substitute prescribing;
- Psychosocial interventions.

At the time of our inspection, the service had 2,579 registered clients within the harm reduction service and 484 clients in structured treatment.

The Gate was commissioned through Darlington Borough Council. At the time of our inspection, the contract was out to tender.

The Gate has been registered with the Care Quality Commission since 23 January 2012, to provide diagnostic and screening procedures and treatment of disease, disorder and injury. The service has a registered manager.

The service has been inspected four times, the most recent in December 2016. There were no compliance issues identified during the previous inspections.

Our inspection team

The team that inspected the service comprised of three CQC inspectors and a substance misuse specialist advisor.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the location and looked at the quality of the physical environment;
- observed the delivery of care and treatment and how staff were caring for clients;
- spoke with 19 clients and two family members or carers of people using the service;
- spoke with the registered manager of the service;
- spoke with 14 other members of staff including non-medical prescribers, a GP, recovery co-ordinators, health and well-being practitioners and administrators;
- spoke with one volunteer;
- attended an observed a therapeutic activity session, a recovery group and three one to one sessions;

Summary of this inspection

- looked at six care and treatment records, including medicines records, for clients;
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 19 clients and two family members or carers of people using the service. All gave consistently positive feedback about their experience of the service.

Clients and carers spoke of staff members in the service in an extremely positive way. Many people mentioned individual members of staff who they felt had 'gone the extra mile' to support them. Clients said staff in the service had been instrumental in supporting them in their journey to recovery.

Clients and carers had been actively involved in putting forward suggestions for service improvements, which had been adopted.

Clients and carers were active partners in the development of treatment and recovery plans.

We reviewed the findings from the most recent annual client feedback survey, which had been carried out over a 16-week period in 2019. Results of the survey were extremely positive.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

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

Are services effective?

Good

We rated effective as **good** because:

- Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Summary of this inspection

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

Are services caring?

Outstanding ☆

We rated caring as **outstanding** because:

- Clients and carers were truly respected and valued as individuals and were empowered as partners in their care.
- Feedback from people who used the service was continually positive about the way staff treated them. Clients and carers felt staff 'go the extra mile', and the quality of care and support provided exceeded expectations. Annual surveys carried out within the service showed that clients valued the care and support they received from staff.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service and staff were strong, caring, respectful and supported. These relationships were highly valued by clients and staff and promoted by managers.
- Staff recognised and respected the totality of client's needs. The emotional and social needs of clients and carers were seen as being as important as physical needs.

Summary of this inspection

- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.
- People who used the service had access to an extensive range of opportunities to provide feedback on the service and the care they received. This included supporting clients to be active participants in local and regional service user forums. Staff used this feedback to make meaningful changes to the service to meet client's needs.

Are services responsive?

Good

We rated responsive as **good** because:

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs. Systems were in place to meet the needs of clients who were deaf or hearing impaired, blind or visually impaired and those whose first language was not English.
- The service was flexible and responsive to the needs of clients. Staff had established effective partnerships to deliver additional interventions to clients. This included the provision of treatment for blood borne viruses which had resulted in an increase in the number of clients accessing and completing treatment.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Outstanding

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

- There was compassionate, inclusive and effective leadership. Leaders and managers demonstrated high levels of experience, capacity and capability to deliver highest standards of care. Leaders had a comprehensive knowledge of the service and were visible in the service and approachable for clients and staff.
- Staff and clients participated in local, regional and national research programmes.
- Staff developed effective partnerships with external organisations to meet the needs of clients. This included joint

Summary of this inspection

working with the mental health trust to develop pathways between substance misuse and mental health services. Clients were involved in the development of information leaflets on dual diagnosis.

- Staff were proud of the service as a place to work and spoke highly of the culture. There was strong and effective collaboration, team-working and support with a common focus on improving quality of care.
- There were consistently high levels of constructive and meaningful engagement with staff and people who used the service. Services were developed with the full participation staff and clients.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Our findings from the other key questions demonstrated that governance processes operated effectively at service level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a Mental Capacity Act policy that staff could refer to and 97% of staff had completed the mandatory Mental Capacity Act training. Staff could discuss things that could impair a client's capacity or cause a client to have fluctuating capacity, such as intoxication.

Consent to treatment was recorded during the assessment. We looked at six clients' care records which each contained a record that the client had consented to care and treatment.

Outstanding ☆

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Good

Safe and clean environment

All areas of the premises were clean, comfortable and well maintained. Clients said they felt safe when using the service. Cleaning records were complete and up to date. Staff were observed to adhere to infection control principles, including hand washing and disposal of clinical waste. Alcohol-free hand sanitising gel was available throughout the service.

Health and safety related tests, including the control of substances hazardous to health, fire, gas and electrical wiring and personal appliance testing were up to date. There were regular checks of the physical environment and any issues were promptly addressed. There were three fire wardens and five qualified first aiders within the service and their names and contact details were displayed on notice boards. Fire alarms at the service were tested weekly and there was a fire safety and emergency protocol in place which included an emergency evacuation procedure.

Closed circuit television was in operation throughout the building. Signs were displayed to inform clients and visitors about this. All rooms used for client appointments had alarms located within them. Staff knew procedures to follow in the event that an alarm was activated.

Clinic rooms had appropriate equipment in place, including an examination couch, blood pressure monitoring equipment and scales. There were arrangements in place for the safe disposal of clinical waste. Vaccines held by the service for the treatment of blood borne viruses were stored in a fridge at a temperature in line with the Royal Pharmaceutical Society guidance. The expiry dates of vaccines and emergency medicines for anaphylaxis and overdose were checked regularly to ensure they were safe to use.

Staff maintained equipment well and kept it clean.

Prescription pads were stored securely and there were safe systems in place for the destruction and loss of prescriptions to prevent fraudulent use of the forms and prescribed medicines.

Safe staffing

The service had sufficient numbers of skilled staff to meet the needs of clients. At the time of our inspection visit there was:

- one service manager (registered manager)
- one recovery team lead
- two nurses (one lead nurse)
- two sessional GPs
- three young people's workers
- three health and wellbeing coordinators
- seven recovery coordinators
- three recovery coordinators (complex needs)
- three recovery coordinators (harm reduction)
- one family and carer coordinator
- four volunteers
- three administrators.

Staff sickness absence figures for the service were low at 3.8% at the time of our inspection. Staff absences were rare, and the service did not use bank or agency staff. The

service had contingency plans to manage unforeseen staff shortages. Staff rotas were scheduled in advance and accounted for annual leave commitments. Staff worked with flexibility to cover absences or leave.

The service had robust recruitment processes in place. All staff, including volunteers, were subject to a Disclosure and Barring Service pre-employment check. Managers risk assessed any previous convictions or police cautions which included considering the severity and time

elapsed since the date of any offences before deciding if the successful applicant could commence employment with the organisation.

Staff held caseloads of between 25-50 clients, depending on their role. Staff said that caseloads were manageable and regularly reviewed. Managers assessed the size of caseloads of individual staff regularly and helped staff manage the size of caseloads.

Staff completed mandatory training, with compliance rates for all training above 90%. The overall compliance rate for all mandatory training was 96%, Mandatory training programmes included safeguarding children, safeguarding adults, lone working, information handling, professional boundaries, infection prevention and control and equality and diversity.

Assessing and managing risk to clients and staff

Staff completed comprehensive assessments for all clients which included risk assessments. We reviewed six client records containing well documented risk assessments which were regularly reviewed and updated. Staff routinely reviewed risk assessments every 12 weeks as a minimum, more frequently as required. In care records we reviewed, staff had discussed and reviewed risks with clients at each appointment. Client risks were rated (high, medium, low) and flagged on the electronic case management system. Staff had detailed knowledge of risks and how risks were being effectively managed for clients on their caseloads.

Staff identified and responded to changing risks to, or posed by, clients. Clients reported that staff identified changes in their presentation promptly and put in strategies to manage any deterioration in their mental or physical wellbeing proactively. Clients shared their experiences of staff supporting them through episodes of crisis and some clients said the service had "literally saved their lives". One client said that staff had made referrals to mental health services for depression and continued made daily contact with the client to support their wellbeing.

Staff assessed clients' suitability to collect and keep medication at home. The was completed in line with national guidance. The assessment tool took into account the client's length of time in treatment, mental capacity, engagement with treatment, drug testing results and whether there were children living at home. Clients who could keep medication at home were provided with lockable storage boxes to keep medicines safely.

Clients confirmed that staff made them aware of the risks of continued substance misuse. Staff ensured that harm minimisation and safety planning formed part of clients' recovery plans. Throughout the service, harm minimisation information was on display. Staff could recognise and respond to warning signs and deterioration in clients' health. Staff liaised with GPs or mental health services when there were concerns over the deterioration in a client's health.

There was evidence within care records that clients with physical health concerns and complex needs had this discussed at their appointments and strategies were put in place to manage this. For example, staff worked closely with primary care and midwives to support pregnant clients.

Clients that had been identified as a risk to staff, had a staff risk assessment completed within their care record. This specified whether a client should be seen with two members of staff or alongside probation and whether a more appropriate setting had been identified. The service had personal safety protocols in place for staff, including a lone working policy. Staff understood and adhered to these protocols.

The service was delivered from a non-smoking premises. Clients were supported to access the smoking cessation team within the service.

Safeguarding

Staff liaised with external bodies such as the police and probation services and raised concerns about the safety of individual clients, their families or carers when appropriate. The service had robust safeguarding policies for children and vulnerable adults which were available to staff. The

service manager was the designated safeguarding lead for the service. Staff understood the safeguarding procedures and knew what to do if a safeguarding concern arose. Staff gave examples of possible signs of abuse, such as changes in behaviour, bruising, wounds and self-neglect.

Safeguarding training was mandatory for all staff and refresher training was completed annually. At the time of our inspection 100% of staff had completed safeguarding children training and 96% had completed safeguarding adults training.

Staff had strong and positive relationships with local authority safeguarding teams and had received training in the continuum of need indictors, which had been adopted by the local safeguarding children board. All safeguarding issues were documented and flagged on the electronic case management system.

Where staff had concerns about clients, for example if a client failed to attend appointments or missed collection of substitute medications, staff would attempt to contact the client directly. If contact could not be made and there were concerns about the safety of the client, staff would liaise with Police, to arrange a welfare check on the client.

Staff gave examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff confirmed they had received equality and diversity training and the provider had equality and diversity policies in place. The service signposted clients with protected characteristics or who were vulnerable to other

organisations that could help with their care and treatment.

Staff access to essential information

Staff used an electronic record system to record client interactions and care records. This was easy to navigate and use and the staff team used it consistently. All information needed to deliver care was available to all relevant staff when they needed it, and in an accessible form.

Medicines management

The service employed two nurses who were non-medical prescribers. The nursing staff supported two sessional GPs in the prescribing of substitute medication for clients. This included substitute prescribing for opiates and for alcohol detoxification.

The service had a prescribing policy, which was in line with the National Institute for Excellence in Care and the Drug Misuse and Dependence: UK guidelines on clinical management book (more commonly known as the Orange Book) guidance.

Clients were administered medication at their preferred community pharmacy. There were service level agreements in place with all pharmacies who were contracted to provide dispensing of medications.

Staff regularly reviewed the effects of medication on clients' physical health. These reviews were in line with guidance from the National Institute of Health and Care Excellence. Staff also discussed the impact of prescribed medication with clients. For example, clients on substitute opiate prescribing were made aware of possible impacts on their ability to drive.

The service held naloxone kits on the premises to respond to clients overdosing from opiates. Naloxone is an injectable medicine that reverses the effects of an opiate induced overdose.

Track record on safety

The provider reported that there had been no serious incidents in relation to the service in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

The service had an incident reporting policy which outlined procedures for staff to follow in the event of an incident. Staff knew how to report and record incidents in line with this policy. Staff completed an incident form which was reviewed by the service manager. All incidents were discussed at the monthly quality assurance meeting, attended by senior managers and the service manager.

There were low numbers of incidents. We reviewed incident data from May to October 2019 which showed there had been seven incidents. There were no specific themes or trends in the reported incidents.

Outstanding ☆

Community-based substance misuse services

Whilst number of incidents were low, there were robust and effective systems in place to learn from incidents. All incidents were reviewed by the service manager, quality assurance manager and medical director. A lessons learned meeting was held within the service to identify and share areas for improvement. Managers ensured that learning from incidents was implemented and changes were made as a result. For example, an external cleaning operative found discarded injecting equipment in a waste bin in the toilet used by clients. An action plan was put in place to prevent further similar incidents. Actions included the installation of automated hand dryers and the removal of paper hand towels. This meant waste bins could be removed from the toilet facility. The manager also arranged for additional training for staff from the cleaning contractors in the management and handling of discarded injecting equipment.

Staff understood the Duty of Candour. They were aware of the need to be open and transparent, and to offer people using the service a full explanation and apology when something went wrong.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We looked at six clients' care records during our inspection visit. All contained comprehensive assessments, including physical health needs of clients. Staff regularly reviewed and updated assessments, including risk assessments. Records documented that relevant information relating to risk had been shared with other agencies where appropriate.

Records contained personalised information and met the individual needs of the client. All clients had an individualised recovery plan, outlining their treatment goals and steps to achieve these. Care and recovery plans were personalised, holistic and captured information in relation to each clients' strengths, goals and problems. Client care plans included the needs identified during assessment. We saw evidence that equality and diversity considerations had been made in relation to the planning of care and treatment where appropriate. Staff worked in collaboration with clients and family members where appropriate, to develop recovery plans as clients progressed through treatment. For some clients, initial recovery plans were basic in nature, being developed as clients became stable in treatment and considered broader recovery goals.

Clients receiving pharmacological interventions had clinical management plans in place that were regularly reviewed and updated.

Staff used appropriate screening and assessment tools, including Clinical Institute Withdrawal Assessment for Alcohol, the Alcohol Use Disorders Identification Test and Severity of Alcohol Dependence Questionnaires.

The service had guidance in place for unexpected exit from treatment. Clients signed an agreement on entry into the service that identified ways that they were willing to be contacted. Staff used a variety of pre-agreed methods to contact clients, including text, telephone, in writing or via other organisations known to be used by the client.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group. Interventions were delivered in line with guidance from the National Institute for Health and Care Excellence. Clients had access to psychosocial interventions, one to one and group therapies and substitute prescribing, delivered in line with the National Institute for Excellence in Care and the Drug Misuse and Dependence: UK guidelines on clinical management book (more commonly known as the Orange Book) guidance.

The service had policies on relapse prevention, the use of naloxone and a process for alcohol and opiate detoxification.

Staff supported clients to live healthier lives. Clients were signposted and supported into other specialist services where appropriate. The service had strived to develop strong collaborative working with other services to best meet the needs of clients. This included partnership working with the local NHS trust to deliver smoking cessation interventions within the service. The service had also worked closely with the local hospital and treatment

for clients testing positive for Hepatitis C and HIV was delivered within the service. This resulted in a significant increase in the number of clients commencing and completing treatment for these blood borne viruses.

Peer mentors worked within the service, supporting clients and promoting visible recovery.

Monitoring and comparing treatment outcomes

Staff used recognised tools to measure severity and outcomes. These included the Clinical Institute Withdrawal Assessment for Alcohol, the Alcohol Use Disorders Identification Test and Severity of Alcohol Dependence Questionnaires. Staff used the electronic care records system to record the client's journey utilising the National Drug Treatment Monitoring System to evidence improvement through care planning and treatment outcome profiles. The service regularly reviewed interventions to monitor and evidence client progress through treatment.

Skilled staff to deliver care

The team included, or had access to, the full range of specialists required to meet the needs of clients. Staff within the service delivered brief interventions, psychosocial and pharmacological interventions. Clients assessed as requiring psychological support were referred to external services.

All staff received a comprehensive corporate and local induction. Staff said they found the induction process both informative and supportive.

Staff were experienced, qualified and had the right skills and knowledge to deliver high quality care. Managers identified the learning needs of staff during supervision and appraisals and provided them with opportunities to develop their skills and knowledge. Staff had access to specialist training for their individual roles. Specialist training undertaken by staff included national vocational qualifications and additional health and safety related training for first aiders and fire wardens. Staff had completed additional training to meet the needs of clients. This included training in smoking cessation advice, assessment and brief intervention for gambling addictions and C-Card training. C-Card training enable staff to provide sexual health advice and issue free condoms to clients in the service.

All staff received regular supervision and annual appraisals from appropriate professionals. Nursing staff received clinical supervision from the medical director. Peer group supervision was jointly facilitated between the medical director and lead nurse. Staff used this as an opportunity to review effectiveness of interventions against new and emerging research and to share good practice. The compliance figure for appraisals and supervision was 100% at the time of our inspection visit. Staff told us they valued supervision sessions and high priority was placed on ensuring supervision took place and was of good quality.

Staff attended regular team meetings and said they found these beneficial.

The service had a performance management system in place which included processes for addressing poor staff performance in an effective and timely way.

Volunteers worked at the service and had the same access to induction, training and supervision as employed staff.

The service provided a range of development opportunities, including for clients who had successfully completed treatment. We spoke with one staff member during the inspection who had been supported through recovery as a client, progressed to a peer mentor and volunteer and were now employed within the service. Some clients spoke of the benefits they had experienced when being supported by a professional who had lived experience of substance misuse.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary team meetings. This included a weekly case management meeting. Full staff meetings were held monthly.

Staff shared information about clients at effective handover meetings between the team, for example when staff went on holiday. There were effective information sharing arrangements in place with external agencies. Staff worked collaboratively with a range of agencies to meet the holistic needs of clients.

Staff had developed strong links with external partner organisations to meet the wider needs of clients. There were effective relationships with the local mental health trust. Staff from the service provided in-reach into inpatient

wards to raise awareness of substance misuse issues and carry out assessments if required. Staff and clients from the service had worked with mental health teams to develop an information leaflet on managing dual diagnosis.

Staff had accessed training from a specialist gambling service. This meant staff could carry out assessments and deliver brief interventions to clients with gambling issues and support them until additional support was provided by the specialist service.

Staff from the local NHS trust's smoking cessation service provided clinics from the service. This meant clients could access advice from within the service.

Good practice in applying the Mental Capacity Act

The provider had a policy on the Mental Capacity Act which included the Deprivation of Liberty Safeguards that staff had access to. Staff received training on the application of the Act and there was a 97% compliance rate with this training at the time of our inspection. Staff demonstrated a good understating of the Act. Staff gave examples of situations that could impair a client's capacity or cause a client to have fluctuating capacity, such as intoxication.

We looked at six care records which each contained evidence that the client had consented to their care and treatment.

Are community-based substance misuse services caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

Staff were highly motivated and inspired to provide care and support that was kind and promoted dignity and self-esteem. There was a strong and visible culture of person-centred care. We observed interactions between staff and people using the service to be empathetic, strong and supportive. These relationships were highly valued from by staff and clients alike.

The feedback we received from clients and carers was unanimously positive about the way staff treated them. Clients talked about staff in extremely positive terms, saying they were 'amazing' and 'absolutely fantastic'. They said that staff were always kind, respectful and supportive.

Clients felt that staff genuinely cared about them and 'went the extra mile' to support them. Clients gave many examples where they felt staff had demonstrated excellence in their care. This included one client whose support worker had continued to visit them whilst they were admitted as an inpatient to a mental health hospital. One client said that because of the therapeutic relationship with their recovery worker, they had been able to talk about traumatic life events they had not been previously able to share. The recovery worker had supported the client to access counselling as a result. Another client with depression said that their recovery worker called them daily to check on them, which exceeded their expectations.

Three clients commented that without the support and care from staff within the service they did not feel they would be alive.

Staff worked closely with clients and carers to develop meaningful therapeutic interventions to meet the needs of people using the service. This included the development and delivery of group interventions that were appealing to clients.

Staff we spoke with said they would feel able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients without fear of reprisals.

Staff recognised the totality of the needs of clients and always took account of people's personal, cultural and social needs into account. Staff considered the emotional and social needs of clients as being as important as their physical needs. Clients shared experiences of care that showed staff truly had their wellbeing at the centre of care.

Staff directed clients to other services when appropriate and supported them to access those services. The service worked in partnership with specialist services to support the emotional, social and physical needs of clients. The service had developed effective partnerships with external organisations to provide a range of enhanced interventions from the service. This included smoking cessation interventions, sexual health advice and contraception. Treatment clinics for blood borne virus treatments

including Hepatitis C and HIV were delivered from the service. These treatments were previously only available by attending the local hospital, which meant that many clients requiring treatment did not commence or complete treatment. Since providing this treatment from within the service, 19 clients had completed treatment for these blood borne viruses.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients and all staff had completed training on information governance. Care records contained evidence that confidentiality policies had been explained and understood by clients.

Involvement in care

Staff communicated with clients in a way that ensured they understood their care and treatment, including finding effective ways to communicate with clients with communication difficulties.

Staff supported clients and carers to access advocacy services in the area.

We looked at six care records and found each contained an up to date recovery plan that included the client preferences, recovery capital and treatment goals.

Clients and those close to them were active partners in their care. Staff were fully committed to working in partnership with clients and making this a reality for each person. Staff worked in partnership with clients, their families and carers by ensuring they had information needed to make informed decisions about the planning and development of their care and treatment. Clients told us that the service was person-centred, they were given sufficient information to make informed decisions to aid their recovery and they were involved in regular reviews of their recovery plans which were goal-focussed.

We saw evidence within care records that clients were involved in decisions about their care and treatment.

Staff empowered clients to have a voice and realise their potential. The service had a service user charter which outline the rights of clients to give feedback on the service they received. The service also had a service user and carer communication and consultation strategy. This demonstrated the commitment to promote and advocate client and carer consultation and engagement. Staff empowered people who used the service and their carers to have a voice by offering them an extensive variety of ways to give feedback on the service they received. Clients and carers gave feedback via surveys, questionnaires, comments cards, the provider's website and on blackboards located within the service. Clients also had regular opportunities to provide feedback on the quality of care they had received as part of their recovery plan review. Staff provided feedback on actions taken as a result of client feedback through 'you said, we did' noticeboards. Clients were encouraged to attend the local 'members voice' forum, where service developments were proposed and discussed. Clients had the opportunity to attend a regional service user forum.

We reviewed the findings from the most recent annual client feedback survey, which had been carried out over a 16-week period in 2019. The service received 113 completed client feedback surveys and the results showed:

- ninety-seven percent of respondents felt the service provided a safe environment
- ninety-eight percent of respondents were satisfied with the time it took to access treatment
- ninety-seven percent of respondents felt that staff treated them with respect
- ninety-eight percent of respondents said they had a recovery plan in place and that this was reviewed on a regular basis
- ninety-three percent of respondents felt the service had helped them
- ninety-seven percent of respondents would recommend the service to other people.

Staff informed and involved families and carers appropriately and provided them with support when needed. There was a dedicated family and carer support worker, who held a caseload. At the time of our inspection, 20 family members or carers were being supported within the service. Carers were provided with information about how to access a carer's assessment.

Consultation with clients on service developments was done in a meaningful way and resulted in changes to service delivery. For example, as a result of client feedback, the service had extended opening hours to provide access one evening per week and one Saturday per month. In response to client feedback about access to services on Christmas Day, staff worked with clients to develop an

information leaflet on helplines and support services that were available on that day. The service extended opening times for the 'Recovery Hub', which provided open access/ drop-in facilities in response to client feedback.

Clients had been involved in externally commissioned research, looking at pathways into mental health services. As a result, clients and volunteers had developed an information leaflet on dual diagnosis.

Staff also supported clients to take part in external surveys, including local surveys.

Staff strived to provide activities that were meaningful to clients. This included a recovery allotment project, music, and arts and media groups. Clients said they felt that their views were valued, and change happened as a result of sharing their views.

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

Good

Access and discharge

The service had clear criteria for which clients would be offered a service. The criteria did not exclude clients who needed treatment and would benefit from it.

Referrals came from a wide range of agencies including probation service, prison, GPs and mental health services. People could also self-refer.

Staff completed an initial triage assessment for all new referrals to the service. An allocations meeting was held three times each week, to assign new clients onto staff caseloads. All referrals were rated as low, medium or high risk at triage assessment stage. High risk referrals would be allocated immediately, and clients offered an appointment within forty-eight hours. Staff ensured that urgent referrals, for example people leaving prison, were prioritised. Clients referred from prison were seen on the same day of release where medical or pharmacological intervention was required.

Following triage assessment, clients would be given an initial appointment, when staff would complete a comprehensive assessment and commence the delivery of psychosocial interventions.

There was a service target of 21 days from assessment to treatment. The triage assessment had been implemented in August 2019, in response to an increase in referrals which had impacted on waiting times to access the service. Staff also offered assessments via telephone to reduce waiting times. These service developments had been successful and at the time of our inspection, there were no clients waiting to access treatment.

The service had a well-resourced administration team who responded promptly and appropriately when clients contacted the service by telephone and in person.

Clinical decisions were made as a multidisciplinary team and in conjunction with the client and carers when applicable. Clients and carers informed us that they had been able to alter a treatment plan that they had felt was not suited to them, this included changes to medication and therapeutic interventions.

Staff were proactive in contacting clients who did not attend appointments. Clients could sign up to receive text alerts to remind them of planned appointment times. The service had established daily clinics for an hour each day, where clients could be seen without prior appointment. This provided opportunities for clients who may have missed planned appointments or for those who were more chaotic to be seen by staff.

Staff and clients said that planned appointments were never cancelled, and appointments usually ran on time. Clients were encouraged to attend appointments on time. During the inspection, one client arrived late for a planned review of prescribed medication. The doctor saw the client despite their late arrival.

The service operating hours were 9am until 8pm on Monday and 9am until 5pm Tuesday to Friday each week. The service was also open on the Saturday each of each month, 10am until 3pm. Operating hours had been extended in response to client feedback on accessibility. Clients were usually seen on the premises, but staff had a flexible approach could see clients in other community settings if necessary. For example, staff had worked into

domestic violence hostels with female clients who felt unable to attend the service. The young people's team within the service saw all their clients in community settings.

Staff provided emotional and practical support for clients to access external services. For example, clients were supported around housing needs. Clients could use computers within the service to complete on-online housing applications, supported by staff. Staff also made direct referrals to mental health services for clients where appropriate. This pathway had been developed with the local mental health trust and meant that referrals no longer had to be made via the client's GP, which reduced the time for mental health assessments to be completed.

Discharge planning was discussed as an integral part of setting recovery goals. Staff supported clients in advance of discharge, recognising this was a time of vulnerability for some people. Clients had access to a wide range of community-based services to support successful discharge. Many clients continued to attend the service for mutual aid and recovery groups. Clients were encouraged to continue to attend groups including the music group and recovery allotment after discharge from treatment. A number of former clients continued to attend the service as volunteers or peer mentors.

Staff offered follow up contact to clients after discharge. Staff contacted former clients three months and six months after discharge if clients consented to this.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a large number of interview and clinic rooms to support treatment and care. Rooms had adequate soundproofing to maintain client confidentiality.

Communal areas displayed a wide variety of information including smoking cessation advice, information on local services, education opportunities, carer support services, domestic violence services and drug alert information.

Clients' engagement with the wider community

Staff supported clients to maintain contact with their families and carers and to develop and maintain relationships with people that mattered to them. The service employed a family and carer coordinator to provide support, information and advice to carers and family members.

Clients were encouraged and supported to access the local community and activities. Staff, clients and volunteers worked together to produce a Recovery Newsletter. This contained a section on community events, including local vintage car rallies, music festivals and family fun days. Staff, clients and volunteers attended the annual Recovery Walk in Middlesbrough in September 2019 and also the annual miner's gala in Durham.

Clients and volunteers in the arts and media group had created a DVD on the impact of alcohol misuse. Clients had designed the resource, including animation and lyrics. As part of dry January, clients and volunteers facilitated an information stall at a local shopping centre. Clients made 'mocktails' for customers in the centre, as part of an awareness raising campaign on alcohol use.

The service provided recovery meetings and also promoted recovery meetings facilitated from other community venues.

Staff ensured that clients had access to a wide range of education and work opportunities. The service had developed effective links with the local Learning Skills Council. Clients could complete a broad range of accredited programmes including family safety (level one), happy families, functional skills (maths, English, ICT), substance misuse awareness (level one), skills for employment, personal development and understanding healthy living. Clients completing programmes attended graduation and awards ceremonies to celebrate their achievement. Graduates also contributed to the Recovery Newsletter to promote access to training programmes to other clients. Staff promoted distance learning courses to further extend learning opportunities for clients. Clients were encouraged to attend the open access Recovery Hub sessions where staff and volunteers would be on hand to support learning if required.

The service held an annual open day. This provided the wider community with the opportunity to visit the service to experience what was provided and how staff and clients worked together to promote recovery.

Meeting the needs of all people who use the service

The service made adjustments for disabled clients. The service was delivered from a three-storey building with two entrances. Entrances were wheelchair accessible with the support of portable ramps for clients to access treatment. There were sufficient rooms on the ground floor that were

wheelchair accessible. The service conducted equality impact assessments to ensure facilities were accessible to all clients and that no individual was discriminated against or disadvantaged.

One member of staff had been trained in British Sign Language for clients who were deaf or had hearing difficulties. A flashing bell for hearing impaired clients had been installed at the reception area of the service. Staff had developed links with the Royal National Institute for the Blind and had arrangements in place to translate information into braille format for visually impaired clients. A translation service for non-English speaking clients was available. Staff used an online translation tool in the short term, until a translator could be arranged.

Staff demonstrated an understanding of the potential issues facing vulnerable groups such as lesbian, gay, bisexual and transgender people, black, and minority ethnic people and other vulnerable groups. We saw evidence within clients' care records that issues around

equality and diversity, risk and vulnerability had been considered and factored into the client's ongoing care and treatment.

The service worked with local organisations and community groups to widen opportunities for clients. The service offered a range of group activities including an arts and media group, music group, recovery allotment project. Clients were given employment advice and information and supported to access mutual aid, health and wellbeing programmes.

Staff and volunteers facilitated SMART recovery groups. Self-Management and Recovery Training groups are facilitated self-help meetings. There were opportunities for clients completing treatment to access volunteering and peer support roles within the service. For some clients, this route had led to paid employment within the service.

Staff worked with a wide range of external organisations to deliver an extensive range of opportunities to meet the needs of clients. For example, staff had been trained in the identification and delivery of brief interventions to support clients with gambling issues and had developed pathways for more intensive support with a gambling support service.

Listening to and learning from concerns and complaints

Information on how to make a complaint was displayed throughout the service. Clients and carers told us they knew how to make a complaint. Staff understood the complaints process and how to support clients to make a complaint.

In the twelve months prior to our inspection the service received no complaints.

Are community-based substance misuse services well-led?

Outstanding ☆

Leadership

There was compassionate, inclusive and effective leadership at all levels. Managers demonstrated high levels of experience, capacity and capability to deliver high quality, sustainable care. Staff held the service manager and senior leaders in high regard and they were well respected.

The service manager had a comprehensive knowledge of the issues, challenges and priorities in the service and beyond. They could explain clearly how the teams were working to provide high quality care.

Whilst there were limited opportunities for career advancement due to the small size of the service and wider organisation, staff felt that there was a real commitment to professional and personal development.

The service placed a high priority on providing training for staff which ensured they had the skills and knowledge to deliver high quality care. Staff said they could approach managers with requests for additional training and these would usually be considered favourably. The service manager ensured regular training sessions and presentations were facilitated for staff to ensure continued professional development.

Vision and strategy

Staff knew the provider's vision and values and agreed with them. The organisational vision statement was 'to promote the prevention, recognition and treatment associated to use and misuse of substances including alcohol, drugs and gambling'. The organisational values were:

- Respect – we listen and communicate directly and openly. We value diversity,
- Integrity – we do what is right, not what is easiest.
- Empowerment – we work with you as a unique individual,
- Quality – we challenge ourselves to deliver the highest quality of service.
- Partnership – we achieve our best when working together.
- Commitment – commitment comes to life through passion in what we do. As individuals, and as an organisation, we create value.

All staff had a job description which clearly outlined their role within the service and encompassed these visions and values.

Staff had the opportunity to contribute to discussions about the strategy for the service, especially when the service was changing. For example, staff had been involved in discussions to extend operating hours following client feedback.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff felt respected, supported and valued. There were high levels of satisfaction amongst staff who worked at the service. Staff were highly motivated and job satisfaction was high. There were very low levels of stress and sickness within the team. Leaders monitored staff morale and job satisfaction through regular supervision and annual appraisal sessions. Staff spoke with passion about the service and were dedicated to providing the highest standards of care for clients.

Staff were proud to work for the organisation and spoke highly of the culture. Staff were encouraged to speak up and raise concerns. Policies and procedures were in place to support this process. Staff felt able to raise concerns without fear of retribution and knew how to use the whistle-blowing process. The service manager operated an open-door policy and all staff said they spoke freely and openly with managers and senior leaders within the organisation.

There was strong team-working both within the service and with external partners. This resulted in a culture of continuous improvement in relation to quality and sustainability of care.

At the time of our inspection, the contract for the service was out to tender. Staff, although concerned about the future of the service, continued to maintain positive and therapeutic interactions with each other and with clients. Staff saw the delivery of kind and compassionate care as the key priority.

Governance

Governance systems at the service were robust and effective. Care records contained all relevant and essential information about clients, including up to date risk assessments, risk and clinical management plans, care plans and recovery plans. Incidents and complaints were reported in line with the provider's policies, investigated and lessons learned were used to improve practice. There were effective systems and processes in place to ensure the premises were safe and clean; there were enough staff who were trained and received regular supervision. There were no staff vacancies and sufficient numbers of skilled and experienced staff to deliver safe care and treatment.

There was a clear and effective governance structure which provided clarity to all staff on reporting arrangement and lines of accountability. Operational management groups were in place including health and safety committee, integrated governance group, quality compliance group and clinical governance group. There were designated leads for quality, safety, safeguarding and client experience. Operational groups reported into the senior management meeting which in turn reported into the executive committee.

There was a clear framework of what must be discussed at all meetings, including team meetings. This ensured that essential information, such as learning from incidents, was shared and discussed.

Staff undertook or participated in clinical audits. There was an annual audit programme and audits provided assurance on service quality. Staff acted on the results of audits in a timely manner when required. We reviewed five completed audits and saw that where improvement actions had been identified, these had been implemented and reviewed.

Community-based substance misuse services

Staff understood arrangement for working with other teams both internally and with external organisations. Staff had developed a wide range of effective partnerships and networks with external agencies to ensure the wider needs of clients were met.

Management of risk, issues and performance

Staff maintained and had access to the service risk register and could escalate concerns when required. Staff concerns matched those on the risk register. The biggest concern of staff was the future of the service, as the contract was out to tender at the time of our inspection. Staff said that any problems that were identified were addressed quickly and openly.

There were contingency plans in place for emergencies and these were regularly reviewed.

Where cost improvements were taking place, these did not compromise client care. Some of the therapeutic groups generated small amounts of income. For example, donations received for items made in the arts and media group were reinvested back into the groups.

Information management

There were strong and effective monitoring systems in place to manage service performance. The service manager produced a range of performance reports to monitor the effectiveness of the service and client outcomes. The electronic case management system included a performance dashboard, providing real time data on numbers in treatment, treatment effectiveness, length of time in treatment, staff caseloads and client discharges.

Managers used performance data effectively, implementing changes to drive forward performance standards. For example, an analysis of increased referrals resulted in service changes with the introduction of triage assessments and offering clients the option to complete this assessment via telephone. This had seen a reduction in waiting times for the service and that time of our inspection there were no clients awaiting treatment.

Staff had completed training information governance, ensuring the confidentiality of client information and records.

Staff made notifications to external bodies as required, including safeguarding and Care Quality Commission.

Engagement

There were consistently high levels of constructive engagement with staff, clients and carers. Service developments were considered with the active and meaningful participation of clients and carers. Clients and carers had an extensive range of different opportunities to feedback their experiences of using the service. Feedback received was used to make improvements to the service.

Leaders in the service had positive relationships with commissioners and met regularly to review performance and quality of the service. There were strong links with the local Healthwatch. Staff supported clients and carers to contribute to Healthwatch surveys and research in the local area.

Staff encouraged and supported clients and carers to participate in community events to support social inclusion. This included recovery walks, attendance at the local miners' gala, community family fun days and music festivals. Clients, volunteers and staff facilitated sessions in local schools and colleges, to raise awareness of substance misuse. The service held an annual open day, to encourage people from the wider community to visit the service to break down stigma linked to substance misuse.

Clients and carers were supported to attend therapeutic groups, such as 'Rockovery' which was a music group and the recovery allotment project. Clients in 'Rockovery' regularly performed live music at events in the area.

Learning, continuous improvement and innovation

The service participated in accreditation schemes. In June 2019, the service received accreditation with the Approved Provider Standard in Mentoring and Befriending by the National Council for Voluntary Organisations. The Approved Provider Standard is the national quality mark for mentoring and befriending services.

Staff, clients and carers contributed to research projects to better understand the needs of people affected by substance misuse and drive service improvements. Examples included research commissioned by Healthwatch into the challenges faced by clients with co-exiting substance misuse and mental health issues. As a result of this work, clients and staff worked together to

produce an information leaflet on dual diagnosis. The service was involved in a national research project, led by a north east university, on understanding pathways to stimulant use.

Feedback from commissioners confirmed that staff within the service had developed a wide range of initiatives to support the wider needs of clients. This meant that the service was providing interventions beyond those it was commissioned to. Staff worked with clients and carers to identify elements of care that would support their recovery journey. As a result, staff had completed additional training in gambling awareness, sexual health and contraception. This meant that staff could assess and deliver brief interventions to support clients with a gambling addiction as well as provide sexual health advice and condoms.

Staff had developed creative partnerships with the local acute hospital, resulting in staff from the liver specialist team providing treatment for Hepatitis and HIV from the service. This had resulted in an increase in clients who had tested positive for Hepatitis and/or HIV accessing and completing treatment.

Outstanding practice and areas for improvement

Outstanding practice

Staff had developed robust partnerships with a wide range of agencies to meet the holistic needs of clients. This resulted in staff being able to offer a broader range of interventions than the service was commissioned to provide, for example smoking cessation, sexual health, gambling support. Clients were also able to commence and complete treatment for Hepatitis C and HIV within the service, which had increased the number of clients taking up this treatment.

Staff and clients had worked in partnership with the local mental health trust to improve treatment pathways for mental health. Clients had developed an information leaflet to raise awareness of dual diagnosis and how to access support.

Staff had created a broad range of opportunities for clients to promote recovery within the wider community. For example, clients were encouraged and supported to access the local community and activities. Staff, clients and volunteers worked together to produce a Recovery Newsletter.

Clients and volunteers in the arts and media group had created a DVD on the impact of alcohol misuse. Clients had designed the resource, including animation and lyrics. As part of dry January, clients and volunteers facilitated an information stall at a local shopping centre. Clients made 'mocktails' for customers in the centre, as part of an awareness raising campaign on alcohol use.

There was an impressive commitment to client and carer engagement and involvement. Clients and carers had an extensive variety of mechanisms to provide feedback to the service. Service changes had happened as a direct result of client and carer feedback.

Clients had access to an extensive range of programmes, including accredited training, to build their personal skills and recovery capital.