Change, Grow, Live

Southwark Adult Substance Misuse Service

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated this service as good because:

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

However:

- Community alcohol detoxification treatment provided by the service did not follow best practice guidance. There was an increased risk clients could overdose or medicines could be diverted.
- The turnover of staff and agency workers in the service led to some clients having frequent changes of key worker which affected their experience.
- Only some of the consultation rooms where staff met with clients had alarms to summon additional staff in an emergency.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Southwark Adult Substance Misuse Service

We undertook this unannounced comprehensive inspection of Southwark Adult Substance Misuse Service as part of our ongoing monitoring and inspection of registered services.

Southwark Adult Substance Misuse Service is commissioned by the London Borough of Southwark to provide community substance misuse services for adults living in the borough. At the time of the inspection, the service was providing care and treatment to 972 people. Southwark Adult Substance Misuse Service is operated by a national provider of substance misuse services Change, Grow, Live.

Southwark Adult Substance Misuse Service is registered to provide Treatment of disease, disorder or injury.

There was a registered manager in post at the time of the inspection.

We have not inspected this service previously.

What people who use the service say

Three clients described staff as thoughtful, committed, caring, and willing to go the extra mile. One client was very positive about the service describing the huge difference it had made to their life.

How we carried out this inspection

The inspection team for this inspection consisted of two CQC inspectors, a CQC inspection manager, a CQC pharmacist specialist and a specialist advisor who is a senior nurse and non-medical prescriber in substance misuse.

This inspection involved on-site visits on two days. We also undertook interviews by teleconference due to COVID-19.

During this inspection, the inspection team:

- visited the service and observed the environment and how staff were caring for clients
- spoke with the registered manager
- spoke with 25 staff including the deputy service manager, recovery co-ordinators, team leaders, registered nurses, administrators, an addictions consultant, a consultant psychologist, a regional data co-ordinator, an associate specialist doctor and an assistant psychologist
- spoke with a registered nurse from another provider, who worked with clients from the service
- spoke with four clients
- reviewed 13 clients' care and treatment records
- observed an integrated governance team meeting
- reviewed prescribing and the medicines prescription process
- reviewed other documents concerning the operation of the service
- spoke with the commissioner of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Outstanding practice

- During COVID-19, the provider requested staff ensure clients having treatment for opiate misuse were supplied naloxone to prevent overdose. Staff identified that this group did not include clients who were not receiving a prescription for opiate substitution treatment, or were receiving GP shared care. Staff reviewed these clients and assessed they were at increased risk of overdose. Staff prioritised these clients to be supplied with naloxone. When this was fedback to the provider, the provider reviewed and changed its guidance for all of its services nationally.
- Managers had developed a system whereby community pharmacies were given a warning if they treated clients or staff in a disrespectful manner. In some cases, the service no longer sent prescriptions to specific pharmacies because of the way they had treated clients or staff.
- On a few occasions, the service offered treatment to clients it was not commissioned to treat, at its own expense. If clients and their partners lived in separate boroughs and both wanted treatment, the service treated both of them. This was to support both people and maximise the success of treatment. Following a period when the clients were stable in treatment, the service started the transition of moving one of the clients to treatment in their own borough.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that community alcohol detoxification treatment follows best practice guidance.

Action the service SHOULD take to improve:

- The service should monitor and limit the number of named workers clients are allocated to during treatment at the service.
- The service should ensure that all areas where clients are seen have alarms.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Good	Requires Improvement	Good	Good	Good	Good
Overall	Good	Requires Improvement	Good	Good	Good	Good

Good

Substance misuse services

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

Are Substance misuse services safe?

Good

Safe and clean environment

The environment was visibly clean. Furniture was in good condition and and the building was well maintained. Next to the reception area were five consultation rooms. Three of the five consultation rooms had alarms.

The waiting room and consultation rooms were visibly clean. The waiting room was deep cleaned by contracted cleaning staff every day. Cleaning requirements had increased since the pandemic. Chairs in the waiting room were set apart and there were floor markings to promote social distancing. Hand cleansing gel was available in the reception area and disinfectant wipes were available in consultation rooms. The service had arrangements in place for the safe disposal of waste. Waste bins were not over-filled and were operated with a foot pedal. The service had blood spillage kits.

Clients were offered face masks when they arrived at the service but could choose if they wanted to wear one. The service manager told us that when staff saw clients in consultation rooms, they were expected to wear a face mask.

Safe staffing

The service had a number of staff vacancies which were actively being recruited to. Staff caseloads were manageable and were actively monitored by the management team. Agency staff were used to cover vacancies. Staff undertook mandatory training to perform their roles and and protect clients from harm.

The vacancy rate in the service was 19%. Five of the 14 vacancies had been recruited to and pre-employment checks were being carried out. The other posts were being advertised.

Of the 40 recovery co-ordinator posts, seven (17.5%) were vacant. Three of the five nursing posts were vacant. Two were non-medical prescriber posts and the other was for the rough sleepers project. Two of the posts had been recruited to. There was a consultant addictions psychiatrist in post and a total of two WTE other doctors with no vacancies. Of the seven administrative staff, two posts were vacant and had been recruited to. Two of the four psychology posts were vacant. There were no vacancies for the family worker and hidden harm worker posts.

Each year the management team reviewed staffing levels, staffing roles and caseloads. The opiate team and shared care team had been combined to provide a more even distribution of staff caseloads. Staff caseloads for the new criminal justice and homeless teams had been reviewed. The last staffing review had occurred in September 2021 and resulted in no changes.

Staff members' caseloads were reviewed with team leaders. This review included how many clients were complex or with increased risks and those preparing to be discharged. For each team in the service there was a maximum caseload number for each staff member. The highest maximum caseload for a staff member was 66 clients in the opiate team. Two staff said that their caseloads were manageable. Managers adjusted staff members' caseload sizes appropriately, such as for new staff or staff returning from long term sickness who had a reduced caseload size.

The service used agency staff to cover vacancies and sickness. Agency staff had a two week induction period. At the end of this the service and agency worker decided if they would continue working in the service. Although staff turnover had been relatively low, there had been four staff on long-term sick leave in the previous 18 months. Due to the nature of agency work, some agency workers left the service with little notice. This meant there had been a number of agency workers covering staff sickness. Clients and staff spoke of the disruption this caused to clients' treatment. Clients had difficulties establishing and maintaining long-term trusting relationships with staff and staff spent additional time supporting the induction of new agency workers.

When the service was open there was always a doctor on-site.

Staff were required to complete a range of mandatory training. The completion rate for all staff undertaking mandatory training was 91% compared to the provider average of 83%. The completion rate for mandatory training had recently gone down due to the arrival of new staff who were undertaking their induction which included mandatory training.

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

Assessment of client risk

Clients had a thorough risk assessment when they were first seen at the service. Risks concerning clients' physical and mental health were assessed, in addition to specific risks regarding substance misuse. Additional information requested and received from clients' GPs also informed clients' risk assessments. The risk assessment of clients misusing alcohol included assessing the risks of alcohol withdrawal seizures and delirium tremens. With clients using opiates, the risk assessment included the risk of overdose. Staff reviewed clients' risk assessments on an ongoing basis and updated the risk assessment after incidents or changes.

Management of client risk

Staff effectively managed risks to clients.

Staff regularly offered clients who used opiates naloxone, a medicine which reverses the effects of an overdose. Staff also trained clients how to use naloxone. During COVID-19, staff also trained hostel staff, street wardens, pharmacies, police officers and outreach teams how to use naloxone. The service provided naloxone to a range of other organisations and agencies, including 400 doses of naloxone to hostels. When homeless people in the borough were moved to hotel and bed and breakfast accommodation outside London, staff provided naloxone kits and training to the hotel staff.

Good

Substance misuse services

During COVID-19, the provider asked staff to ensure clients having treatment for opiate misuse were supplied naloxone to prevent overdose. Staff in the service identified that this group of clients did not include clients who used opiates but were not receiving a prescription for opiate substitution treatment, or those who were receiving GP shared care. Staff assessed these clients were at increased risk of overdose so they prioritised these clients to be supplied with naloxone. When this was fedback to the provider, the provider reviewed and changed its guidance for all of their services nationally.

Clients receiving opiate substitution treatment, such as methadone, had varying levels of medicines supervision, based on assessed risks. Some clients attended a community pharmacy daily for a pharmacist to supervise them taking medicine. Other clients, with lower assessed risks, collected their medicine every week or two from the pharmacy. When clients took methadone home they were provided with lock boxes to minimise the risk of children or others getting access to it. At the start of the COVID-19 pandemic, the provider advised all services that clients taking their medicine under the supervision of a pharmacist should have their prescription changed so that they could collect it once a week or fortnight. Operational and clinical leaders in the service identified some clients where the risks of overdose or diversion of their prescribed medicines would be too high if this happened. Those clients continued to be supervised by pharmacists taking their daily medicines. During COVID-19, no clients had died as a result of treatment-related decisions.

Clients receiving over 100mg of methadone per day had an annual electrocardiogram (ECG). This was to monitor clients for abnormal heart rhythms which are associated with high doses of methadone. Such abnormal rhythyms can be fatal and this monitoring followed best practice guidance (Drug misuse and dependence: guidelines on clinical management, Department of Health, 2017).

Staff gave clients information on harm minimisation to minimise risks to them. This included information to prevent clients getting blood borne viruses and about the risks to clients of drinking alcohol or taking drugs with their prescribed medicines.

Staff responded quickly and effectively when there were changes to clients' risks. For example, when a client had been admitted to hospital and started medically assisted alcohol withdrawal, staff ensured that treatment continued when the client was discharged. Clients' continued use of illicit drugs prompted reviews of their dose of prescribed medicines. Staff prioritised clients with higher risks for appointments to commence treatment.

Clients had early exit plans detailing the risks related to them leaving treatment early. These plans included information to assist staff to support clients to re-engage with the service. If clients did not attend an appointment, staff contacted the client to help them re-engage with the service. Leaders had changed the frequency of staff calls to clients who were disengaging. This meant that when clients missed appointments they initially received several calls from staff within a few days. The new guidance developed by the service was being shared and used by the provider's other services in London.

Safeguarding

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 knew how to apply it.

Staff were able to identify risks to and from clients. They understood how to make a safeguarding referral and could get further advice from the designated safeguarding lead. They held a drop-in meeting every week for staff to discuss clients and safeguarding matters. Staff also had debriefs regarding the impact that safeguarding matters had on them.

Good

Substance misuse services

All staff undertook safeguarding adults and safeguarding children training. Staff had also received additional training from an external agency. This training concerned domestic violence and how staff could assess this risk and make safety plans with clients remotely during COVID-19.

All safeguarding matters concerning clients were monitored by the designated safeguarding lead. They also attended the multi-agency risk assessment conferences (MARAC). The hidden harm worker for the service was based in the multiagency safeguarding hub and worked with clients' families to identify children at risk of neglect or abuse. They also provided education sessions to children in local schools.

Information concerning clients, their families and safeguarding risks was recorded on clients' electronic records. Information recorded was comprehensive and very detailed and was accompanied by a clear prompt for staff to consider confidentiality when information sharing. Safeguarding matters were only closed by the designated safeguarding lead following a full risk review and, where appropriate, confirmation that information had been handed over to other professionals.

Staff access to essential information

Staff used electronic clients records to record and access information concerning clients. All staff, including agency staff, had access to the system.

Medicines management

Staff followed good practice in medicines management.

Prescriptions for clients' medicines were carefully controlled and a system was in place to record changes to prescriptions and to track each prescription. This included tracking the delivery of each prescription to community pharmacies.

Emergency medicines were stored in the service. These were checked regularly and were part of the emergency equipment, which included an automated external defibrillator (AED). Emergency equipment was calibrated and maintained.

Staff actively encouraged clients to have ready access to naloxone and provided them with information on how to use it. If a client no longer had a naloxone supply on a subsequent visit, they were provided with a further supply. During the COVID-19 pandemic, staff in the service had also trained and provided a supply of naloxone to staff in homeless hostels, pharmacies, the police, street wardens and outreach teams.

Temperatures of medicines storage areas were monitored by staff. When these temperatures fell outside the recommended range, staff acted to safeguard the medicines. This included liaising with the chief pharmacist of the service.

The service had a stock of medicines safes (lock boxes). These were always available for clients to take home to ensure their prescribed medicines were stored out of reach of children or vulnerable adults.

Good

Substance misuse services

A Patient Group Direction (PGD) was in place. When clients had not been vaccinated against hepatitis B, the PGD authorised health professionals to administer the hepatitis B vaccine. PGDs were also in place for influenza vaccines and pabrinex. The PGD documentation met legal requirements. Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

Track record on safety

There had been two serious incidents in the service recently. Both of these related to alleged boundary breaches by staff regarding clients.

Ten clients of the service died in the previous year. None of these deaths were related to the treatment being provided by the service.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team.

Staff knew what incidents to report and how to report them. A range of incidents were reported and these were discussed at team meetings and 'flash' meetings. Staff were involved in feedback from incidents and had the opportunity to discuss incidents. Staff also had debriefs following serious incidents.

Staff in the service learnt from incidents. For example, there was a clear recording and tracking process which documented which prescriptions had been delivered to specific pharmacies. This prevented any incidents of pharmacists reporting lost prescriptions and staff not knowing where the prescription was. Treatment care reviews were held to review the care and treatment of clients who had died and involved a team leader and three other staff. A theme from these reviews was that staff often under-recorded the time they spent with clients. Feedback to staff in various meetings had led to an improvement in accuracy.

Staff and managers in the service understood that when mistakes had been made they should be open and honest with clients. However they could not describe the precise requirements of the duty of candour, such as apologising in writing to clients. Immediately after the inspection, managers developed a presentation on the duty of candour requirements to rectify this. They planned to discuss this at the next integrated governance team meeting.

Are Substance misuse services effective?

Requires Improvement

Assessment of needs and planning of care

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.

Good

Substance misuse services

We reviewed 13 clients' care and treatment records. Staff in the assessment team carried out assessments in person or on the telephone. Telephone assessments had been introduced during the COVID-19 pandemic.

Assessments included clients' physical and mental health, social circumstances, housing and legal matters. A detailed description of the client's substance misuse history was documented.

Clients seeking treatment for alcohol misuse were assessed using the alcohol use disorder identification test (AUDIT) and the severity of alcohol dependence questionnaire (SADQ). Use of these assessment tools followed best practice guidance (Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, National Institute for Health and Care Excellence, 2011). Experienced nurses and doctors assessed these clients for community alcohol detoxification with a particular focus on risk factors associated with community alcohol detoxification.

When clients needed a prescription for opiate substitution treatment they were assessed in person by a doctor. Correspondence from clients' GPs, blood test results and urine drug screen tests were part of clients' assessment.

Recovery co-ordinators supported clients to identify appropriate treatment goals based on their needs. Clients' care plans were detailed and personalised and focused on client recovery. Care plans covered all identified areas of clients' needs. Clients' care plans were reviewed with clients and updated when appropriate.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group. All of these care and treatment interventions followed best practice guidance, except for community alcohol detoxification treatment.

Clients with opiate dependence had a prescription for methadone or buprenorphine. For clients taking methadone, the dose was increased gradually. This followed best practice guidance (Department of Health, 2017). Clients' prescriptions were reviewed regularly and clients had urine drug tests to monitor their use of illicit drugs.

The service had also commenced a low dose detoxification programme. Clients could access this programme if they were not using illicit drugs following a detailed assessment, including completion of a readiness to change questionnaire. During this eight week programme clients were seen at a separate building where a room was hired. This was designed to move clients away from substance misuse services. To maximise clients' confidence in remaining abstinent they attended a weekly psychological therapy group. Clients were also expected to self report withdrawal symptoms. The programme was designed to empower clients and move away from the 'medical model' of treatment. Consistent with this, staff did not use withdrawal scales to assess clients' withdrawal symptoms and did not request samples for urine drug testing.

Clients with alcohol dependence had treatment based on their assessment and AUDIT and SADQ results. Clients with less severe dependence had psychosocial treatment to support them with reducing their alcohol intake. This followed best practice guidance (NICE, 2011).

For community alcohol detoxification treatment, clinical staff had observed that clients often became focused or fixated on medicines to prevent withdrawal symptoms. This had the effect of distracting clients from the psychosocial interventions delivered by staff when clients commenced detoxification treatment. To empower clients to take control of their treatment and risks clients were given a prescription the Friday before their alcohol detoxification treatment was due to start. On the Saturday they could collect four days' worth of medicines. The service was not open at the

weekend. On the Monday clients would attend the service with their medicines to meet with staff. The client would then receive a call from a nurse or recovery worker every day. On the fourth day of detoxification treatment, the client would attend again and collect a prescription for a further four days of treatment. The CIWA-Ar scale was used by staff and clients, and clients were usually expected to have a 'sober companion' with them throughout detoxification treatment.

All of the clients receiving community alcohol detoxification treatment had been reviewed by the lead consultant and the risks of treatment had been carefully assessed. Nevertheless, treatment was delivered in a way best practice guidance specifically cautions against. The National Institute for Health and Care Excellence recommends clients having alcohol detoxification treatment in the community are not given more than two days worth of medicines. This is to avoid overdose or diversion of the medicines (NICE, 2011). There had been no serious incidents involving clients having alcohol detoxification treatment in this way, however, the provider's method of treatment delivery was not part of a research project, or otherwise subject to external scrutiny such as ethics approval.

In accordance with best practice guidance, clients were prescribed thiamine and, where indicated, pabrinex. These medicines were prescribed to minimise memory loss as a result of alcohol misuse. Clients were also prescribed acamprosate to assist with relapse prevention, following best practice guidance (NICE, 2011).

Psychosocial interventions for clients were evidence-based and followed best practice guidance (NICE, 2011; Department of Health, 2017). Clients could access therapeutic groups immediately after their assessment. They did not need to wait for a further appointment.

Groups had been taking place virtually due to the COVID-19 pandemic and covered areas such as relapse prevention and managing difficult emotions. Clients described some groups as very successful with over 20 participants. However, they noted that the number of groups was significantly less than those provided pre-pandemic. In addition, some clients could not access these groups due to a lack of private space or confidentiality, or because they did not have good internet access. One of the buildings used by the service for groups had structural problems and could not be used. In the meantime, managers had identified other buildings where they could hire rooms and planned to recommence face to face groups. These had been delayed because the venues had not been open during COVID-19 lockdowns.

Individual psychological therapy for some clients had also been affected by the lack of rooms in the service. The psychology team had maintained regular check-in calls to clients and had sourced rooms outside of the service. They were planning to recommence individual therapy for clients shortly after the inspection. The psychology team also had plans to put self-help materials in the waiting room for clients to use as they wished. The assistant psychologist was planning to start individual low intensity cognitive behaviour therapy in the rough sleepers' service. They were also planning to provide workshops in hostels.

Clients were supported by peer mentors who were provided by an independent third-party organisation. Peer mentors received full training, support and supervision. Clients benefitted from the support of someone who had experienced addiction problems and recovery. Peer mentors provided individual support to clients and facilitated groups.

The service had celebrated national recovery month in September 2021. A recovery walk for clients and staff had been held in Hyde Park.

Clients' physical health was assessed and monitored in the service. In partnership with local NHS hospitals, clients had blood borne virus testing and treatment, fibroscans, contraceptive implants, tuberculosis scans and general physical health treatment, such as treatment for leg ulcers.

Managers and staff made effective use of technology. The service had a licence for online groups so that anyone, regardless of access to modern technology, could call into the group. The service also accessed electronic GP summaries which provided staff with quick access to information when assessing clients and making decisions regarding their treatment.

Staff in the service undertook a range of clinical audits and there was an audit plan. These included audits concerning consent, safeguarding, infection control, risk and recovery planning, vaccine storage and prescriptions.

The service contributed to the National Drug Treatment and Monitoring System (NDTMS). The number of clients successfully completing treatment in the service had been affected by the COVID-19 pandemic. At the time of the inspection, the percentage of clients successfully completing alcohol treatment was above the provider average and Public Health England (PHE) average. Completion rates for clients on opiate substitution treatment were above the provider average and due to be at the PHE average the month after the inspection. Non opiate and non opiate and alcohol completed treatment were also improving. The percentage of completed treatment for some client groups was above pre-covid levels. Staff in the service also used the treatment outcomes profile (TOP) to assess clients' progress and outcomes before, during and at the end of treatment.

Outcomes for the low dose detoxification programme were measured by numbers of clients successfully treatment. During the pilot programme, all four clients successfully completed treatment.

The hidden harm worker used the hidden harm outcome profile (HHOP) to measure the effectiveness of interventions with children.

Skilled staff to deliver care

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. An induction programme for new staff and agency staff was provided.

All staff told us they received regular clinical and managerial supervision at least monthly. The assistant psychologist received supervision every week from the consultant clinical psychologist. The clinical psychologist facilitated regular reflective practice meetings for all staff and supervised the psychosocial interventions programme.

Staff in the rough sleepers' team accessed a 12-module national training course. This covered topics such as the use of naloxone, blood borne viruses, motivational interviewing and best practice in optimising opioid substitution treatment (BOOST).

Peer mentors had a personal training budget, which enabled them to buy books and course materials as well as attend courses. Peer mentors received supervision for their work with clients as well as personal life coaching.

The hidden harm worker was part of a network of hidden harm workers working across the provider's services in England. This provided important support and learning. They received clinical supervision from the clinical psychologist in the service.

Multidisciplinary and inter-agency team work

Good

Substance misuse services

Managers and staff held effective multidisciplinary team meetings. The team had effective working relationships with services outside the organisation.

There were a number of multidisciplinary meetings held in the service. A team meeting was held twice per month to discuss operational changes to the service. A monthly governance meeting, attended by all staff, focused on a specific area, such as incidents, performance or client deaths. The weekly managers' meetings focused on service-wide matters, such as business continuity, performance, staffing and operational risk management.

A weekly multi-disciplinary team meeting focused on clients' treatment and, specifically, clients with complex needs or increased risks. A weekly safeguarding drop-in meeting was held by the designated safeguarding lead for staff to discuss clients and safeguarding matters. Daily 'flash' meetings were also held. These were used for staff to share updated information regarding clients and to ensure that staff sickness or absence did not affect clients' appointments or treatment.

Managers and staff in the service developed and maintained effective links and joint working with a wide range of organisations. In addition to health professionals from NHS hospitals working in the service to deliver general health, liver and sexual health treatment, staff in the service also worked closely with the alcohol liaison team of the local NHS hospital. This ensured they were kept informed about clients who had been admitted to hospital and had then started medically assisted alcohol detoxification. When safe to do so, staff in the service continued the client's detoxification when they were discharged from hospital. Doctors in the service had also attended the NHS hospital to prescribe injectable diamorphine for a client for their drug misuse. This was necessary as few doctors hold a licence to prescribe diamorphine for this purpose. The hospital did not have any doctors with the licence, but the service did.

Managers had developed a working protocol with the local NHS mental health trust. This meant referral pathways between mental health services and the provider's service were simpler and clearer for clients and staff. Training for staff of both organisations had also taken place and a monthly meeting was held between both organisations. There had been demonstrable improvements in joint working.

The COVID-19 pandemic had affected how the service worked with GP services. Due to the existing good working relationships between staff and GPs, staff in the service were involved in plans to redesign GP shared care.

Managers and staff also worked with a range of other partners. These included the organisation commissioned to manage the peer mentor and service user work, local authority safeguarding teams, hostels and the local housing department. Staff worked with an older people's charity to develop substance misuse questions for their own referral form and had been working with the police to identify how the service could undertake early interventions in custody suites. Work was also undertaken with other charities, and managers had been arranging services from sports venues and a local barber, to promote clients' recovery without impacting their financial circumstances. The service also sent regular partnership newsletters to a range of partners including GPs, the recovery support service and community pharmacies.

Good practice in applying the MCA

Staff supported clients to make decisions on their care for themselves. Staff 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. Staff discussed clients' capacity in team meetings and if there was any doubt then the consultant would conduct a capacity assessment. Staff received training in the Mental Capacity Act.

Good

Substance misuse services

Are Substance misuse services caring?

Good

Kindness, dignity, respect and support

We observed staff in the reception and waiting room treating clients with compassion and kindness. If appointments were running late the receptionist kept clients informed. We observed in one instance when a recovery coordinator was absent at short notice, another staff member stepped in to see the client.

Three clients described staff as thoughtful, committed, caring, and willing to go the extra mile. One client was very positive about the service describing the huge difference it had made to their life.

Staff frequently advocated for their clients with other agencies to ensure their wider psychosocial needs were met. Staff clearly knew their clients and spoke very positively about them, challenging stereotypes. Staff were passionate about their work.

Staff received feedback about how community pharmacies treated clients, including occasional discriminatory behaviour. Staff also experienced discriminatory attitudes from some pharmacies on occasion. Managers had developed a system whereby pharmacies were given a warning if they treated clients or staff in a disrespectful manner. In some cases, the service no longer sent prescriptions to specific pharmacies because of the way they had treated clients or staff.

Staff went to significant lengths to ensure clients continued to receive treatment during COVID-19 lockdowns. One staff member's family member, who was not working, provided transport for staff to deliver prescriptions and naloxone to clients. This continued for 18 months. Another staff member drove from London to Bournemouth to deliver a prescription to a client when the particular pharmacy in Bournemouth had closed.

On a few occasions, the service offered treatment at its own expense to clients it was not commissioned to treat. If clients and their partners lived in separate boroughs and both wanted to treatment, the service treated both of them. This was to support both people and maximise the chance of successful treatment. Following a period when the clients were stable in treatment, the service started the transition of moving one of the clients to treatment in their own borough.

Staff protected the confidentiality of clients. Whenever service user representatives or peer mentors attended meetings, such as the governance meeting, the chair reminded staff that they were present to protect the confidentiality of clients.

The involvement of people in the care they receive

Clients were involved in their own care and treatment plans. Staff involved clients in their risk management and care plans. Clients set their own goals for treatment. Staff communicated information about clients' treatment in a way they could understand, using information published in other languages or easy read versions as required.

A service user representative raised concerns that not all clients had internet access and had had difficulty participating in the service during the pandemic. They felt there had been a lack of communication regarding which parts of the

service were open and when. The service had sent text messages to clients concerning building closures and naloxone. Staff were unable to send clients letters as clients' consent forms were not always up-to-date and staff were aware of the increased risk of domestic violence during lockdowns. Letters could have exacerbated the situation for a few individuals. Staff obtained clients' consent during remote assessments and meetings and obtained written consent when clients attended the service.

The service involved clients and service user representatives in a number of ways. Clients were part of a recruitment panel and sat in on the competency stage of interviews for staff. Service user representatives attended the service governance meeting and a group of clients and service user representatives had recently met with staff to discuss improving the waiting room. The aim was for the reception area to be a trauma-informed environment, more relaxed and less sterile.

A different organisation was commissioned to manage and provide peer mentors and client feedback. However, clients could also feedback directly to the service by completing feedback forms, providing feedback during groups or meetings and using email and social media. For example, a building was not being used due to a major flood. When the building was ready to be used again, there was a plan to remodel the shower room as a result of client feedback.

Managers and team leaders were always available to listen to feedback from clients. Compliments, concerns and informal complaints were systematically recorded so that themes and trends in feedback could be identified.

The service had a families and carers worker who worked with clients' friends and relatives. The families and carers worker used evidence-based family interventions to support friends and relatives, which could also have an effect on clients' wellbeing.

Are Substance misuse services responsive?

Good

Access and discharge

The service was easy to access. Staff planned and managed discharge well.

People who contacted, or were referred to, the service for treatment were assessed within 48 hours. Staff gave people harm reduction advice when they initially contacted the service. After clients were assessed, they started treatment within five working days. This meant they had been allocated, and met, a named recovery co-ordinator within this time. Clients requiring opiate substitution treatment were seen by a doctor within this period and started prescribed medicines.

People who were rough sleepers, or were high risk and vulnerable, and people released from prison or discharged from hospital, were assessed by staff within 24 hours. In most cases people were assessed by staff the same day. Staff from homeless organisations could bring rough sleepers wanting treatment to the service. The service doctors always created time to assess these clients. The doctors also had specific appointments slots on Fridays available for them. Staff in the service requested and received electronic GP summaries detailing clients' medical history. Once clients were assessed, with relevant additional information received, clients' treatment could start, usually on the same day.

Good

Substance misuse services

The service had outreach workers and a rough sleepers team working in homeless hostels and communities. Staff raised awareness with marginalised and hard to reach people and other agencies so that they were aware of the service. People could also access treatment regardless of their housing or social circumstances.

When clients did not attend appointments, staff contacted them. The system for staff contacting and re-engaging clients had recently changed. Previously, staff attempted to contact the client at specific intervals. This had changed so that staff attempted to contact clients more frequently during the initial period. This change was to increase the success rate for re-engaging clients.

When clients were ready to be discharged from the service, staff ensured that other agencies had relevant information to support clients. Any safeguarding concerns were also communicated to other relevant agencies before a discharge took place.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a number of rooms to support treatment, including rooms for therapeutic groups. However, the building with group rooms had had recent structural issues and could not be used. Managers had sourced group rooms in the community until this building could be used again. This was also the building which met some clients' basic needs and had a shower and microwave oven for clients to use.

The main building where most clients were seen had a reception area where chairs could be spaced out for social distancing. The reception are was clinical and there were plans to redesign this space so that it was a trauma-informed environment. There were five consultation rooms which were soundproofed. There was also a clinic room with equipment suitable for the physical examination of clients. The main building also had a number of toilets for clients to use to produce urine drug screen samples.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication support needs. During COVID-19, the service provided basic mobile phones to clients who did not have them.

The service was accessible for clients using wheelchairs and clients with other mobility needs. Interpreters were available for clients who did not speak English. Leaflets and information in other languages and easy read versions could be downloaded by staff to provide to clients.

Rapid access to treatment was available for high risk clients, including those who were homeless. A group operated specifically for clients receiving a pension and there was a separate group for clients who misused over-the-counter medicines.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. The service had received 10 complaints in the previous year. Four complaints were not upheld, three were partially upheld and one was upheld. Two complaints were under investigation at the time of the inspection.

Good

Substance misuse services

Clients were informed about how to make a complaint when they started treatment at the service. Complaints leaflets were available, including easy read versions and in languages other than English. Clients could inform staff they wanted to make a complaint or could make a complaint by email or by completing a form on the service website. Clients could also speak with any member of the leadership team on duty.

When a client complained they received acknowledgement of the complaint within five working days. After the complaint was investigated, a manager met with the client to inform them of the outcome. The outcome was also provided to the client in a letter. The outcome letter described the different areas of complaint and how the complaint was investigated. However, the outcome letter did not clearly record which elements of the complaint had been upheld or not upheld. Clients usually received the outcome letter within 28 days of making the complaint unless there were unforeseen delays.

If a client was unhappy with the outcome of their complaint, or the way it had been investigated, there was an appeals procedure. We reviewed one complaint which demonstrated that the appeals procedure was effective and the outcome or learning from a complaint could be changed.

Managers ensured that there was learning from concerns and complaints. For example, the shower room in the separate building was being remodelled due to concerns voiced by clients.

Are Substance misuse services well-led?

Good

Vision and values

Leaders and staff clearly understood the providers' vision and values of making a difference in people's lives and giving everyone an opportunity. Leaders clearly demonstrated the values in practice and ensured staff understood how they applied to the work of the team.

Good governance

There was a comprehensive and detailed governance system supporting staff to provide safe and high quality care and treatment. All areas of the service were subject to performance monitoring and audit. Activity in the service was used to forecast reliable predictions and there was a constant attention to detail in all aspects of the service. There was a clear structure to the governance system, learning from incidents and complaints, and robust safeguarding procedures. There was an annual audit plan, a service risk register and a business continuity plan. Systems and tools, such as staffing levels and the business continuity plan, were reviewed and tested to ensure they continued to reflect the service.

Staff in the service understood how to work with other organisations and leaders attended multi-agency meetings.

Leadership, morale and staff engagement

Good

Substance misuse services

Leaders had the knowledge, skills and experience for their roles. They had a clear understanding of the service and could explain how the service provided care and treatment for clients. Leaders were visible in the service for both staff and clients. They identified staff members' skills and experience and worked with them to progress their careers. All of the staff we spoke with were very positive concerning leaders in the service.

There was a positive staff culture in the service. Staff of different professions and seniority worked well together and collaborated to meet clients' needs. Staff supported each other and were passionate about the work they undertook. They had regular supervision and appraisal and felt valued and positive working for the provider. Staff felt able to raise concerns without fear of negative consequences.

The chief executive of the provider had a weekly virtual meeting which staff could attend to ask any questions.

Commitment to quality improvement and innovation

The service did not use any structured quality improvement model to improve and develop the service. However, leaders were clearly committed to improving the service and responded to feedback from clients and staff. There was also innovative practice. For example, a recovery worker had suggested that clients on low doses of methadone could have a fixed timescale community detoxification. Clinical and operational leaders developed a system where this could safely take place.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not do all that was reasonably practicable to mitigate risks to clients receiving community alcohol detoxification treatment. Regulation 12(2)(b)