

A fresh start for the regulation and inspection of substance misuse services

Working together to change how we regulate, inspect and monitor specialist substance misuse services



The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.

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Introduction from the Chief Inspector of Hospitals

We have started to put in place the changes in our strategy, *Raising standards, putting people first*, and our consultation, *A new start*. They will enable us to deliver our purpose – making sure that health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging services to improve.

In *A new start* we said that we will inspect and regulate different services in different ways, based on what has the most impact on the quality of people’s care. However, there are some general principles that guide our future ‘operating model’. They apply to:

- The way we register those that apply to CQC to provide health and care services.
- The standards that those services have to meet.
- How we use data, evidence and information to monitor services.
- How we work with and hear from people who use services, their carers and families in our work.
- The expert inspections we carry out.
- The information we provide to the public on our judgements about care quality, including a rating to help people compare services.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

These principles will guide our regulation and inspection of the mental health sector but the detail will be specific to the substance misuse sector. We will ask our five key questions of all services – are they safe, effective, caring, responsive to people’s needs and well-led? As Chief Inspector of Hospitals, and with the Deputy Chief Inspector of Mental Health, we will lead expert inspection teams. These teams will spend more time listening to people who use services, carers, advocates and staff. They will use professional judgement supported by objective measures to assess the quality and safety of care, to help improve the experiences of those who use regulated specialist substance misuse services.



Professor Sir Mike Richards
Chief Inspector of Hospitals



Developing our new approach for specialist substance misuse services

Monitoring, regulating and inspecting specialist substance misuse services

Our consultation, *A new start*, set out the principles that guide how CQC will inspect and regulate all care services. It described our future 'operating model' which includes:

- Registering those that apply to CQC to provide care services.
- Intelligent use of data, evidence and information to monitor services.
- Expert inspections.
- Information for the public on our judgements about care quality, including a rating to help people choose services.
- Publishing information about our ongoing monitoring of the Mental Health Act.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

FIGURE 1: OVERVIEW OF CQC'S OPERATING MODEL



These principles guide our regulation of the substance misuse sector, but the detail of how we will do this will be specific to the sector and to the services within it.

Substance misuse treatment services that CQC will be responsible for regulating

1. Hospital inpatient-based services

These services provide assessment and stabilisation, and assisted withdrawal, of the needs of people with substance misuse problems. Services are available 24 hours a day, and are provided by a multidisciplinary clinical team with specialist training in managing addiction and withdrawal symptoms. The clinical lead in these services is usually a consultant in addiction psychiatry, or another substance misuse medical specialist.

The team may also include psychologists, nurses, occupational therapists, pharmacists and social workers.

People whose use of alcohol or drugs needs to be supervised in a controlled medical environment may be admitted to an inpatient unit. Treatment may be provided on a specialist ward, or as part of their care on another ward.

2. Community-based services

These services provide care, treatment and support in the community for people with substance misuse problems. They may also help people who have a dual diagnosis or co-occurring disorders (COD), where the person is experiencing a mental health problem and also has a substance misuse problem.

People are primarily cared for by a doctor, nurse or social worker, but services are provided by a broad range of health and social care professionals, working in multidisciplinary teams. The teams are also supported by community pharmacists when providing controlled drugs. Treatment is likely to involve the use of medicines, usually opioid substitution therapy, alongside psychosocial interventions.

3. Residential rehabilitation services

These services provide structured drug and alcohol treatment where people have to be resident at the service in order to receive treatment. This includes abstinence-based recovery services, as well as medicine-assisted recovery programmes, such as detoxification or stabilisation services. Teams vary according to the service's treatment programme, but may include psychosocial project workers, social workers, doctors and nurses.

The Chief Inspector of Hospitals and the Deputy Chief Inspector of Mental Health will oversee the regulation of hospital-based, community-based and residential treatment services for people with substance misuse problems. Cross sector inspections will include a specialist substance misuse inspector where appropriate.

As part of our new approach, we will develop substance misuse 'modules' to support the inspections of services that our Chief Inspector of Primary Medical Services and Integrated Care is responsible for. This will include joint inspections with other inspectorates. For example, we will develop modules for regulated substance misuse services in prisons to support our joint inspection work with Her Majesty's Inspectorate of Prisons. We will also make sure that we have internal Intelligent Monitoring systems in place to share information across these sectors.

Developing our new model in partnership

We are committed to developing changes to how we monitor, inspect and regulate in partnership. We have been discussing our ideas for change with a range of stakeholders including people who use services, providers, voluntary sector organisations, our staff and other interested individuals and groups to help develop our thinking.

We have established an expert advisory group to work with us to develop our proposals. This group has given us a helpful steer on the overall model, the key themes and data sources we should consider for our Intelligent Monitoring model of substance misuse treatment services, and how inspection might work in this sector. They have also raised some useful challenges about how our approach will work for providers who are a part of a local integrated model, where some of those services are provided by other agencies. In addition, they have emphasised the importance of recognising the diversity and complexity of the sector.

We have engaged members of this group and other colleagues in more detailed discussions on quality in substance misuse. This includes how to involve people who use services in our new inspections, indicators for our Intelligent Monitoring system and ratings for substance misuse services.

Our next phase of partnership working to develop the new approach will involve working with small groups on time-limited projects. These groups will develop:

- The questions that will underpin our regulatory judgement about substance misuse treatment services.
- Definitions of 'what good looks like' in substance misuse services.
- The methods we will use when we inspect.
- The indicators that will trigger follow-up as part of our Intelligent Monitoring of substance misuse treatment services.

- The guidance we will share with providers about the new model.

People who use services are represented on our expert advisory group, as well as in the smaller group projects. However, we are also working with other, specific groups to discuss aspects of our new approach. These include local Healthwatch groups and representatives from local and national advocacy organisations.

We will build on the work we have already undertaken to involve people who use substance misuse treatment services, their families and carers, to advise us on what to look at during inspection, how to gather and use information, and what methods will work best to secure people's views. They will also continue to take part directly in inspections and advisory groups.

“ At the heart of our new approach is our commitment to tailor our inspections on the issues that matter ”

Focusing on the issues that matter

At the heart of our new approach is our commitment to tailor our inspections on the issues that matter in each sector, while setting it within our overall framework of whether services are safe, effective, caring, responsive and well-led.

Our new model for inspecting specialist substance misuse services will reflect national policy priorities for substance misuse. In particular, it will reflect a key aim of the Government's drug strategy to put people's recovery at the heart of their approach, as well as the broader public health agenda. This means making sure that people are able to quickly access high-quality services that assess the whole individual. It also means making sure that people's

needs and choices are at the centre of their treatment. In addition, services will need to be supported by high-quality staff and professionals, who strive to understand the circumstances of their clients, and provide targeted, seamless care.

“ Substance misuse treatment is a unique, diverse and multifaceted sector and people using these services often have complex and varied needs ”

Substance misuse treatment is a unique, diverse and multifaceted sector and people using these services often have complex and varied needs. Treatment may be short- or long-term, and people’s needs can be immediate or life-long. Outcomes for people who use substance misuse treatment services vary, and people often need help from a number of agencies. How we measure the effectiveness of treatment, and the importance of integrated partnerships in achieving successful outcomes, will be key to our approach.

The unique and often complex needs of this group of people mean that the breadth of treatment options available is enormous. As a result, we will need to make sure that our own knowledge is consistently up to date, and that we regularly and promptly share this information with our inspection teams. Inspectors will also be informed by guidelines from the National Institute for Health and Care Excellence (NICE) and other evidence-based guidance, as well as a wide range of clinical and theoretical standards. For example, the concept of risk, and the application of risk assessment and risk management.

Our human rights approach

As an organisation, we are committed to promoting equality, diversity and human rights in all areas of our work and practices. As a result, we are developing a human rights approach – which includes equality – to the way we regulate services. This will take each of the five key questions into account, and will be based on good practice in integrating human rights into health and social care.

In order to provide a safe and effective service, we recognise that people who use substance misuse services can expect to receive a service that is structured and may include restrictions, for example to daily routines, movement and personal relationships. Where these restrictions exist we will make sure that they are:

- Based on specialist need and risk and/or are required by a treatment programme.
- Agreed with people at the time of assessment.
- Reviewed as they progress through treatment.

The sector

The substance misuse sector varies greatly. There are a large number of providers, with significant differences in the size of organisations and the types of care provided. There is also a strong independent and voluntary sector. This means that we will need to consider carefully the type of information we use to trigger and guide inspections, and to make sure that our inspections are comprehensive, without imposing an unnecessary burden on small providers.

The need to make efficiency savings has led providers to create new and innovative ways of delivering services. In some instances, this means using volunteers and peer supporters and mentors. Some volunteers will come from professional backgrounds, while others are members of the public. The sector also embraces the knowledge and experience that people who have previously accessed services can bring. It is important that we recognise the value of these contributions, while making sure that people are properly trained and

supported to deliver appropriate and agreed interventions.

Lessons learned

We will also consider the lessons from other key reports and findings, including: Professor Jon Strang's report *Medications in recovery: Re-orientating drug dependence treatment* (2011)¹; Professor Lord Patel of Bradford OBE's report *Reducing drug-related crime and rehabilitating offenders* (2010)²; and Robert Francis' *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013).³

We will develop our new approach to take account of these issues as we inspect and rate services. We know that within the current climate there are significant challenges for providers of substance misuse treatment services, but we will keep a focus on the impact of care, identifying where improvement is needed. We recognise that some factors that contribute to poorer outcomes are outside a provider's control and we will take this into account where this is the case.

Key relationships for corroborating our judgements will include Public Health England (PHE), NICE, local authorities and other relevant professional bodies.

1. National Treatment Agency for Substance Misuse. *Medications in recovery: Re-orientating drug dependence in treatment*. 2012.

2. Department of Health. *The Patel Report: Reducing drug-related crime and rehabilitating offenders*. 2010.

3. Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationery Office, 2013.



How we are developing the new regulatory approach

People responding to our consultation, *A new start*, helped us to work out the most important changes we need to make to improve the way we regulate substance misuse services. We set out our early thinking on this below and would welcome comments on our proposals for change.

- **People's views and experiences of care**

- we will make greater use of information from people who use services, employing new methods to do so and learning from best practice. Information we receive about people's experiences will inform our judgements, particularly in regards to the effectiveness and responsiveness of substance misuse services. We will gather this information through a range of sources including:

- Increased involvement of Experts by Experience, who have experience of services, in our inspections.
- Using information from external organisations, for example, advocacy services, local Healthwatch and community groups, as well as providers' own reviews and national surveys.
- Greater focus on engaging with people who use community substance misuse services, including services for young people and for people with a dual diagnosis.
- Greater focus on gathering the views of families and carers.

- Social media, including Twitter, Facebook, and relevant discussion forums. We will use these platforms proactively to share information, interact and engage with individuals, user groups and organisations.
- Complaints made by people who use services will form a key source of information within our new model. Although we are not able to follow up on individual formal complaints, we will place more emphasis on the content and trends in complaints made. We will also consider how complaints are handled and responded to by providers.

We recognise the difficulties sometimes experienced in engaging with people who use services in this sector and would welcome views from stakeholders on how we can most effectively develop this. Through the pilot process we can test and evaluate these ideas.

- **Expert inspectors, with specialists and Experts by Experience as part of inspection teams.** We are moving our approach away from our inspectors being responsible for a wide range of providers, to a model where inspectors specialise in particular areas. This means that inspectors will have specialist knowledge and further training in substance misuse treatment services to inform their regulatory judgement.

We will also include professional experts in our inspection teams, drawing from the range of disciplines that work in this sector including nurses, social workers, doctors, psychologists, pharmacists and therapists. They will bring current practice knowledge and expertise to the inspection process. We will also include more Experts by Experience in our inspection teams, to make sure that the voices of people who use services are heard, and that they inform our assessments and judgements about services and practices in the sector.

- **Consistent focus on people who are in especially vulnerable circumstances or from specific population groups such as:**
 - Pregnant women (and their unborn children)
 - Young people
 - Lesbian, gay, bisexual, and transgender people
 - People with complex needs, for example a dual diagnosis
 - Homeless people
 - Older people
 - Victims of domestic abuse
 - Offenders returning to the community
 - Sex workers.

We will work with stakeholders, providers, people who use services and those who care for them to develop how we do this. By looking at services for these groups of people, we can make sure our inspections look at the outcomes of care provided for all people, including those who are particularly vulnerable.

- **Focus on transitions, care pathways and joint working**, including where people move between services and where care is provided in an integrated way. Transitions between services include, for example, moving between children and young people’s services and adult services. They also include transitions between providers, for example between secure offender services and community services, or between community or inpatient services and residential services.

For the providers we regulate, this will mean looking at the timeliness of responses and the way they work with other providers to achieve positive outcomes for people who use services. This includes integrated working to: address physical as well as mental health needs; promote recovery, health and wellbeing; prevent or respond appropriately to crisis; and to achieve a good quality of life, for example in relation to housing, employment and social participation.

- **Clarify how national standards and guidance relate to the five key questions we ask of services** – are they safe, effective, caring, responsive and well-led – with people’s experience of services at the core. In consultation with experts, including people who use services, we will describe standards based on ‘what good looks like’ for each service type. We will also develop lines of enquiry that reflect the key issues and priorities for the sector including:
 - Promoting recovery, and good mental and physical health.
 - Promoting positive relationships.
 - Building on recovery capital (supporting people to build and maintain their own recovery).
 - Ensuring that people have a positive experience of treatment and feel included and involved in their recovery plan.
 - Ensuring staff are appropriately trained and supported.
- **Ratings.** There was support in our consultation for a rating using the following principles:
 - Ratings will follow an inspection.
 - Ratings will be made on a four-point scale (outstanding, good, requires improvement and inadequate).
 - Ratings will be given at a level where it is most meaningful to the public (for example whether at corporate, location or service level).

- Ratings will also be given for each of the five key questions we will ask of all care providers.
- Ratings will benefit a wide audience, including people who use services and their families and carers, the public, providers, commissioners and other stakeholders.
- Providers can appeal against their ratings on the basis that CQC has not followed due process.

Our approach to rating healthcare providers needs to recognise the complexity of both the NHS and independent healthcare sectors, and the similarities and differences between services. We will be testing how best we can rate these complex providers of multiple services as we carry out these inspections. We will be engaging with providers and people who use services to help us with our approach during this period.

For NHS trusts that combine a diverse range of services, we will decide on a rating for a set of core services within each sector (such as mental health or community health). We will then use this information to help us make a judgement about what this means for the quality of service provision for a provider overall. Although not a core service, substance misuse services will be considered for inspection based on the Intelligent Monitoring information we hold on the trust. If we identify, for example, particular services, specialities or pathways of care where we have concerns, or we believe the quality of care could be outstanding, we will look at them in detail and report on them specifically.

Where substance misuse services are provided by an organisation that provides other regulated activities, we will inspect the substance misuse services as part of a single, comprehensive inspection.

- **Frequency of inspections based on ratings.** The frequency of our inspections will be based on our ratings of a service. However, we will be able to bring forward an inspection of a provider rated good or outstanding if we receive concerns from people who use the

services, staff or others, or if we are alerted to a potential decline in quality through our Intelligent Monitoring analysis.

- **Greater focus** on how services work with other organisations that are important in supporting recovery in substance misuse, such as housing and the criminal justice system.
- **Better use of data and intelligence** – including information from whistleblowers and the findings of others, such as Healthwatch, and national surveys. In our operating model, we refer to all of the key information we will bring together as Intelligent Monitoring. This will be continually updated and reviewed on an ongoing basis.

We are developing sets of indicators under each of the five key questions, and will be testing them with experts, including people who use services, to make sure that we are collecting information about aspects of services that matter most to people's experience of care. We recognise the importance of positive risk management in substance misuse when making assessments about safety and risk. Qualitative data will be a strong component in our regulatory model for substance misuse to ensure that appropriate weight is given to people's views and experiences.

The data we use to inform our lines of enquiry and judgements of service providers will include information and indicators based on national data sets, such as the National Drug and Alcohol Treatment Monitoring Sets, including those that capture information from secure estates and young people's services.

We will also do more work in the time leading up to inspections to gather information, particularly where there are identified gaps, to inform which services to inspect and the focus of our inspection. This will include gathering information about the safety culture, quality governance, the views and concerns of people who use services, their families, carers and representatives and staff, and the support provided to people who have complex needs.

What these changes will mean for people using services

We anticipate that the changes we are making to our regulation of substance misuse treatment services will mean:

- Making it easier for people who use services, their families, carers and advocates to share their experiences of care.
- A greater focus on the voices of people who use services in our new inspection process – particularly through better involvement of Experts by Experience in reviewing the information from people who use services, shaping the lines of enquiry, gathering feedback from people who use services and carers and providing a user-focused perspective throughout the inspection.
- Better engagement with organisations representing local groups of people who use services and the voluntary sector to share their perspectives on the quality of care.
- Improved assessments of specialist substance misuse services by inspection teams, focusing more on the issues that matter to people who use the service and how people's rights are protected.
- Greater clarity about how services compare, where possible, to inform choice among people who use services and carers.
- In the longer term, improved quality of service provision where problems are identified and improvement action required.



What will happen next?

We will engage with people who use services, families and carers, Experts by Experience, provider representative groups and other stakeholders. This engagement will help us develop the thinking and co-produce the content for our inspection framework for specialist substance misuse services.

To support that engagement:

- Continue to use our external substance misuse expert reference group to help us develop our thinking. The membership of that group includes: representatives of provider networks, professional bodies, academics, Experts by Experience, and some of our key partners in substance misuse.
- We will establish time-limited task groups to help us to develop particular aspects of work. These groups will include our own staff, Experts by Experience and other external stakeholders.
- We will also engage the public through focus groups, through local Healthwatch, and through our networks of groups representing people whose voices are seldom heard.
- We will keep people updated on what the engagement is telling us.

- We will begin to pilot our new inspection approach, where the sample was selected on the basis of known risks. This will include hospital inpatient, community-based and residential services.

Current proposed timeline for changes to the substance misuse sector

We want to make the improvements we have identified quickly, but without compromising the time available for co-production and quality. Our proposed timeline and activities are set out below.

June 2014 to December 2014

- Engagement with internal and external stakeholders on the five key question areas, the Intelligent Monitoring indicators and methods.
- Meetings and consultation with the external advisory group and other working groups.
- Development of pilot inspection methodology and draft provider guidance.
- Pilot inspections as part of the mental health pilot waves of inspection where a trust has been identified as providing substance misuse services.

January 2015 to March 2015

- Pilot inspections with ongoing evaluation of the new approach and methods.
- Draft guidance for providers of substance misuse treatment services published for consultation.

April 2015

- Final provider guidance published.
- New model rolled out to all providers, including the use of ratings.

Although this is not a consultation, we would like to hear your views on any of the proposals and changes that we have set out in this document. If you would like to get in touch, please contact us at **CQCSM@cqc.org.uk**.

Appendix: Substance misuse treatment settings

Setting	Definition
Community	Structured drug and alcohol treatment in a community setting where people do not have to be resident to use the service. This includes treatment in community drug and alcohol teams and day programmes (including rehabilitation programmes).
Inpatient unit	Assessment, stabilisation and/or assisted withdrawal in an inpatient setting. Services are available 24 hours a day, and are provided by a multidisciplinary clinical team with specialist training in managing addictive behaviours. The clinical lead in these services is a consultant in addiction psychiatry or another substance misuse medical specialist. The multidisciplinary team may include psychologists, nurses, occupational therapists, pharmacists and social workers. Inpatient units are for alcohol or drug users who require supervision in a controlled medical environment.
Primary care	Structured substance misuse treatment in a primary care setting, where a GP, often with a special interest in addiction treatment, has clinical responsibility for the person.
Prison	Structured drug and alcohol treatment that is delivered by a locally commissioned substance misuse team in prison. These services provide the full range of evidence-based drug and alcohol interventions, in line Professor Lord Patel of Bradford OBE's 2010 report: <i>Reducing drug-related crime and rehabilitating offenders</i> .
Residential	<p>Structured drug and alcohol treatment where a person has to be resident to receive treatment. Although such programmes are usually abstinence-based, prescribing to prevent a relapse or for medication-assisted recovery are also options. The programmes are often, but not exclusively, aimed at people who have had difficulty in overcoming their dependence in a community setting. In this setting, people receive multiple interventions and support in a coordinated and controlled environment. The interventions and support provided normally comprise both professionally delivered interventions and peer-based support, as well as work and leisure activities.</p> <p>Residential services may also deliver assisted withdrawal programmes. These should be sufficiently specialist to qualify as a 'medically-monitored' inpatient service, and they should meet the standards and criteria detailed in guidance from the Specialist Clinical Addictions Network. This level of support and monitoring of assisted withdrawal is most appropriate for individuals with lower levels of dependence and/or without a range of associated medical and psychiatric problems.</p>
Recovery house	A residential living environment that provides integrated peer support and/or integrated recovery support. Recovery house interventions are for residents who were previously, or are currently, engaged in treatment to overcome their drug and alcohol dependence. Recovery houses require fewer staff and the standard of care is less intensive than a fully residential rehabilitation service. The residences can also be referred to as dry-houses, third-stage accommodation or quasi-residential. Supported housing that does not provide integrated substance misuse support, or peer or recovery support as part of the residential placement is not considered a recovery house for this purpose. Recovery houses may be independent, or associated with a residential treatment provider or housing association. Some will require 'total abstinence' as a condition of residence, whereas others may accept people in medication-assisted recovery who are otherwise abstinent.

How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA



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