



**Report detailing the responses to CQC's consultation on how to regulate specialist substance misuse services**

**July 2015**



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## 1. Introduction

### About Quality Health

Quality Health is an independent healthcare consultancy, commissioned by the Care Quality Commission to support this consultation process. The consultation documents and the various processes for collecting feedback were designed and organised by the Care Quality Commission. Quality Health has reviewed, analysed and reported on the data collected from all aspects of the process. The conclusions reached in this report are therefore the conclusions of Quality Health based solely on the responses provided to the consultation; they do not necessarily represent our own views or the views of the Care Quality Commission.



## 2. Consultation contributors

46 people contributed to the consultation on the substance misuse draft provider handbook.

13 respondents replied to the consultation questions via the webform and 7 responded to the consultation questions via written responses. Respondents included:

- 10 stakeholders (consisting of those who identified themselves as “stakeholders” on the webform and the 7 respondents who submitted written responses).
- 5 healthcare professionals
- 3 provider of services
- 1 member of the public
- 1 commissioner of services

Feedback was obtained via two focus groups with 12 participants.

Feedback was obtained via workshops attended by 10 participants: 7 stakeholders and 3 CQC staff members.

Feedback was obtained from 4 participants: 3 stakeholders and a CQC staff member, via teleconference.



### 3. Online and written responses to consultation questions

#### **1. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors' judge how safe, effective, caring, responsive and well-led specialist substance misuse service providers are?**

18 respondents replied to this question.

13 answered "yes".

- 4 healthcare professionals
- 6 stakeholders
- 1 provider of services
- 1 member of the public

5 answered "no".

- 2 provider of services
- 1 stakeholder
- 1 healthcare professional
- 1 commissioner of services

1 stakeholder specified neither agreement nor disagreement but gave the following response:

- "We are pleased to see that LGB&T (Lesbian, Gay, Bi-sexual and Transgender) people are included in the list of local demographics to be considered under 'Other inspection methods/information gathering' in Section 8. However, the CQC (Care Quality Commission) must consider how inspectors will ensure that these communities are engaged. All stages of information gathering should include demographic monitoring which includes sexual orientation and gender identity, whether this be reviews of existing service data, interviews, focus groups etc. Inspectors should work with the local voluntary and community sector (VCS) to reach seldom heard communities and ensure representation of LGB&T people's views and inclusion of their needs. The National LGB&T Partnership has produced guidance on monitoring service user sexual orientation and gender identity (<http://nationallgbtpartnership.org/publications>). We are pleased to see that the needs of LGB&T people are specifically mentioned in the Key Lines of Enquiry (Appendix B). However, these should also consider how organisations gather views from stakeholders regarding who may know of experiences of those who do not access some services which may highlight



issues specific to some groups, clients and advocates regarding involvement in risk/needs assessments and support planning. We welcome the focus on transitions, care pathways and joint working as LGB&T people accessing substance misuse services are likely to also need to access mental health services and sexual health services, and improvements are needed in transition between these services”.

For those respondents who answered “yes”, the reasons given and extra comments included:

- “It should also include the views of relevant local third sector providers directly linked with the substance misuse treatment provider in question as they may be involved in a number of shared care treatment provisions. For example pharmacy dispensing, harm reduction services, probation services, etc.”
- “To a degree, but don’t rely just on the providers to give you evidence”.
- “The prompts take into consideration appropriate information to help inspectors judge how safe, effective, caring, responsive and well-led specialist substance misuse service providers are!”
- “Although substance-misuse specific information is missing from the KLOEs (Key Lines of enquiry) and prompts, I have been reassured by CQC's substance misuse lead that these elements will be captured in the internal tools”.
- “Yes, we feel that the prompts give structure and consistency to the inspections and support providers in knowing what to expect. The prompts are adequately specific to substance misuse services Safe - we suggest adding references to hidden harm, self-harm and child sexual exploitation to this section. Responsive - could there be specific reference to methods / regular collecting of and responding to Service User feedback? This should be periodic and services should use a variety of methods to collect feedback. There is mention to using information to improve care and responding to concerns/complaints but perhaps there could be a specific prompt about this. There seems to be more of this type of prompt under the 'well led' category”.
- “This is a model and process that is established and familiar”.
- “We are satisfied that the KLOEs, overall, are adequate to help CQC inspectors judge specialist substance misuse service providers on the five key questions of how safe, effective, responsive, caring and well-led they are. We would like to ensure that provision of training on overdose recognition and intervention plus the provision of take-home naloxone to service users and others for the reversal of opioid overdose is clear, and in line with current guidance published by Public Health England”.



- “Should be an effective tool in determining the quality of a service if applied appropriately by inspectors”.
- “The key lines of enquiry (KLOE) and the list of prompts overall seem appropriate. The KLOE are very much focused on processes and whilst specific issues are identified - for example race is mentioned on a number of occasions - important aspects of care in drug and alcohol services (for example drug related deaths), are not mentioned”.
- “We welcome this and believe that it will give a good overall idea of how the service functions within those broad categories. The questions are excellent prompts for a discussion on the service, but many of them are closed questions and could be opened out for further discussion as well as for discussing further the evidence produced and the mechanisms described. Ideally this would be done by a person skilled and experienced in the particular area so that the inspection panel could judge the relevance of the evidence. In terms of KLOEs:

#### SAFE:

- (KLOE S3). Are people protected from abuse and avoidable harm? This section covers safety of physical environment, risk assessment and obvious abuse of clients, but it does not refer to the staff use of treatments and interventions that may be harmful to the client or treatments that are untested in their effects on clients. This issue is countered by the use of evidence-based treatments and NICE (National Institute for Health and Care Excellence) -recommended interventions, but it is suggested that the services are asked what interventions are they using that are NOT NICE-approved. They might also be asked what percentage of non-NICE-approved interventions they do use in proportion to the NICE-approved ones.

#### EFFECTIVE:

- (KLOE E1). In terms of evidence-based treatments the KLOE questions ask how they are identified and used, but how is provision monitored and maintained. How is the quality of each particular Psychosocial Intervention monitored? Are ALL NICE interventions available - including, for example, BCT and CBT (Behavioural Couples Therapy and Cognitive Behavioural Therapy) for Common mental health problems? Who provides these interventions? What are their qualifications?
- (KLOE E2). What kind of outcome monitoring is provided, and is it provided for common mental health problems too?



- (KLOE E3) These are appropriate questions which need to be matched to evidence of qualifications in the staff group, and with those qualifications being appropriate to provide treatments that are NICE-approved. (I.e. staff might be qualified, but are they qualified in areas that allow them to practice NICE-approved, evidence-based interventions?) What kind of supervision is provided? What kind of qualifications do the supervisors have? Does supervision include a focus on PSI's (Psychological Interventions)? Does supervision include a competence assessment and element? Does supervision and training involve non NICE-approved and non-evidence-based interventions?
- (KLOE E4). What kind of clinical meetings are held and what is the staff-mix at these meetings? Are there multidisciplinary meetings where clients' care plans are discussed and reviewed? What evidence is there of joint working – both within the service and across other services such as IAPT (Improving Access to Behavioural Therapies) and social services?
- (KLOE E6). Are clients made aware of the interventions and treatments available and their efficacy, and their consent to receive such treatment? How is this done?

#### CARING:

- (KLOE C1). Are clients shown respect by informing them of the interventions and treatments available and their efficacy, and their consent to receive such treatment? How is this done?
- (KLOE C2). What PSI's involving partners are offered as part of the treatment?
- (KLOE C3). What knowledge do staff have of the (emotional) effects of certain PSI's on clients and their families? What knowledge do staff have of the PSI's that are used to treat the emotional symptoms that clients present within the treatment service? (I.e. CBT for common mental health (emotional) problems like anxiety and depression).

#### RESPONSIVE

- (KLOE R1). Are services planned around and informed by NICE and other professional guidelines and designed to provide evidence-based treatment in an effective and efficient manner? How much do treatment programmes rely on evidence-based interventions? How much are treatment programmes planned using non NICE-approved interventions?
- The KLOEs provide a comprehensive list of prompts and should be an effective tool in determining the quality of a service if applied appropriately by





inspectors. However, there are several further points we would like to highlight:

- When looking at whether lessons are learnt and improvements made when something goes wrong, it is important to involve family members in any investigations conducted. Families can often provide valuable insight professionals do not have: the Carer's Trust's 'Triangle of Care' guide (2013) found that in a number of inquiries into serious incidents, failure to communicate with and listen to carers was a significant contributory factor. For example, family members often have vital information, relevant to the safe and effective treatment of the service user, and are best placed to notice any changes in the behaviour of their relative – thus being more likely to pick up on risks of relapse. In the same way, families can make an important contribution to the assessment of risk and in monitoring and maintaining the safety of those in treatment. As such, it is important that a service provides a procedure whereby families and others with information pertaining to the client are able to report any concerns they may have, or discuss any issues they consider relevant to the client's treatment. The provision of such a mechanism should be included in the list of safety prompts. (Safety)
- With regards to the safe management of medicines (including prescribing, recording, handling, storage, safe administration and disposal), it is worth considering risks posed by take-home prescriptions, especially in relation to opioid substitution treatment (OST). Adfam has published a research paper, 'Medications in Drug Treatment: Tackling the Risks to Children,' which examined risks posed to children when their parents, guardians or other adult care-givers are prescribed OST; following a number of high profile reports of children dying or coming to serious harm after ingesting OST (Opioid Substitution Treatment) medication, usually prescribed to one or both parents. Amongst other things, the report found that parents and professionals were often insufficiently aware of the dangers of OST to children; and consequently, that necessary safety precautions, including safe storage of OST, were not adhered to. In addition, we found that despite guidance from National Institute for Health and Care Excellence (NICE) Technology Appraisal 114 and the Department of Health's 'Drug Misuse and Dependence: UK Guidelines on Clinical Management,' - which acknowledge the possible dangers to children and proscribe safety measures - prescribers were failing to adequately consider children's safeguarding as a primary factor, both when



deciding which drug to prescribe and whether to permit take-home doses. It is therefore advised that an additional prompt question be included to gather evidence of the service's policies and procedures with regards to OST and safeguarding. (Safety)

- The focus on providing a 'holistic' approach is welcomed. Holistic working requires an understanding of the complexity of the client's situation and issues, the environment in which they exist and the effects these have on the client in various aspects of their lives. We would therefore propose that family involvement and consultation are key components of holistic working, in terms of truly understanding the issues and situations facing the individual client and the repercussions, or possible repercussions, of these. In ensuring that a service is effective, it is important to highlight that individuals in treatment attain better outcomes when families are closely involved in their care. The 'Triangle of Care' (Carers Trust, 2013) promotes the inclusion and recognition of carers as 'partners in care,' given that successful long term outcomes are most likely when staff accept the benefits of carer involvement, and collectively promote the concept of a therapeutic triangle formed by themselves, the service user and carer. According to the Forgotten Carers report (UK Drug Policy Commission, 2012), there is considerable variation in the extent to which services involve family members in the treatment of their loved one, despite overwhelming evidence that family involvement contributes to effective outcomes for the user: helping to prevent relapse and aid long-term recovery. Research by Copello (2008) found that interventions that work with both the user and their family either match or improve outcomes when compared to interventions focused solely on the user. As is recognised in the list of prompts, the engagement and involvement of those who use the services and those close to them is further evidence that a service is well-led, delivering person-centred care. (Effective and Responsive)
- Whilst family involvement is undoubtedly beneficial for the client in treatment, it is also conducive to addressing the needs of the families themselves: 1.5million people are affected by a relative's drug use and their needs often go unmet and un-assessed (UK Drug Policy Commission, 2012). Families report negative impacts on their physical and mental health and wellbeing, financial circumstances and social relationships. They are more likely to be diagnosed with their own medical condition than other families, and often suffer stress-related physical and psychological symptoms, which can be severe and long



lasting, and are associated with high use of primary care services (Copello et.al., 2010). In addition, the care and support that families provide to relatives with a drug problem saves the state an estimated £747million a year (UKDPC, (UK Drug Policy Commission) 2012). When families are supported, family health, self-esteem and functioning improves. It further helps break down stigma and prejudice in local communities. As a result, the UKDPC noted, 'Increasing and improving the support available for families, both in their own right and to assist their contribution to their relative's recovery, is imperative both from a moral duty and from a simple economic standpoint.' It is recommended that the recognition of these benefits and the incorporation of such support within a service be taken into account during inspection and rating. (Caring)"

For those respondents who answered "no", the reasons given included:

- "I feel somewhat that pre inspection, gives the opportunity to change things that are not right prior to any inspection (regardless of any service this is) it should be given a date the inspection is going to happen-fair enough, but then no highlighting of what is going to be inspected. People and agencies fudge figures and information when they know what is going to be looked at".
- "Consideration must be given to the fact that new models of delivery may include sub-contracting arrangements, lead provider arrangements or a high level of integration which means that different organisations work alongside each other within the same buildings and often at the same time in respect of interventions for clients. It will be important to understand how the inspection would focus on these KLOEs in these circumstances".
- "There should be more of a focus on preventing drug-related deaths, and especially on the provision of take-home naloxone to prevent opiate overdose deaths. A substance misuse service should be regarded as unsafe and ineffective unless this simple and cost-effective intervention is in place".

Additional comments included:

- "I think all Substance misuse services should be regulated. Volunteer and statutory. Otherwise it is a system of double standards just because one is not established in legislation but both can do the same job".
- "Positive views about using the 5 key questions overall. You then need specific focus on what these mean for people with high end needs e.g. people in detox and stabilisation."



**2. We have provided examples of evidence we may collect to inspect substance misuse services. Do you agree that this is the right kind of evidence for us to look at?**

16 Respondents answered this question

The overwhelming majority of those who answered agree that the examples provided are the right kind of evidence.

15 answered “yes”:

- 6 stakeholders
- 5 healthcare professionals
- 3 providers of services
- 1 member of the public

1 answered “no”:

- 1 commissioner of services

Reasons for answering “yes” were as follows:

- “We believe that further evidence could be TOP (Treatment Outcome Protocol) and other evidence-based outcome measures that are used on-site”.
- “All stages of information gathering should include demographic monitoring which includes sexual orientation and gender identity, whether this be reviews of existing service data, interviews, focus groups etc.”
- “It would be interesting to look in more detail at certain data for example drug related deaths, needle exchange provision, blood borne virus data, LAPE (Local Alcohol Profiles for England) data, perhaps local prescribing data including naloxone, National Drug Treatment Monitoring System (NDTMS) data, and data from organisations such as Health Protection Agency on blood borne viruses; data held by the Hep C Trust”.
- “As noted above, all stages of information gathering should include demographic monitoring which includes sexual orientation and gender identity, whether this be reviews of existing service data, interviews, focus groups etc. Inspectors should work with the local VCS to reach minority communities and ensure representation of LGB&T people’s views and inclusion of their needs. We have produced guidance on monitoring service user sexual orientation and gender identity (<http://nationallgbtpartnership.org/publications>). The CQC should also



consider how organisations analyse the information and data gathered: do they use an intelligent approach to data analysis, such as exploring the intersection of protected characteristics or specific groups (e.g. LGB&T homeless people's experience of services)? Some VCS groups may hold such information".

The reason for answering "no" was as follows:

- "In addition we recommend:\*considering the links to mutual aid, and how this will be evidenced;\*looking at the range of psychosocial interventions and the quality of these as delivered (both groups and one-to-ones);\*the range of medical interventions(not only maintenance prescribing);\*the offer for families/concerned others in their own right, as opposed to solely in relation to the substance misuser\*the effective use of digital interventions, for which there is an increasing evidence base".

1 respondent, a stakeholder, neither agreed nor disagreed but commented as follows:

- "The consultation of those close to the person in treatment, including families, through the collection of ongoing local information, pre-inspection information and on-site inspection is extremely welcome. It is our view that family members are too infrequently consulted, despite their familiarity with treatment services. To illustrate this point; findings from our ongoing Outcomes Measurement project show that only 44% of family members agreed with the statement that they were aware of how their relative's treatment was progressing and only 36% felt involved in important decisions made around their relative's treatment, whilst 62% felt respected by treatment staff. Firstly, it would be useful to collect evidence such as this through questionnaires or interviews with family members of clients. Secondly, it seems reasonable to suggest that a possible indicator of a good treatment service is one which makes those with whom they come into contact, be it a client or their family, feel respected, communicated with and not excluded".

### **3. Are there any other sources of evidence you think we should look at?**

13 respondents answered this question.

11 answered "yes":

- 4 stakeholders
- 3 healthcare professionals
- 3 providers of services



- 1 commissioner of services

2 answered “no”:

- 2 healthcare professionals

Those that did think there were other sources of evidence to look at gave the following examples:

- “It would be useful to know if staff and organisations are aware of 'mainstreaming'. This is the principle that if a client has a substance use and mental health problem and is therefore subject to both the Care Programme Approach and Models of Care, both of which require a key worker to be appointed, it is the mental health key worker who would take the lead in co-ordinating care”.
- “We would recommend a detailed consideration and evidence of "Partnership Working" (e.g. Criminal Justice System including prisons, ETE relevant organisations, Troubled Families providers, Mental Health Services)”.
- “Design and location of services also have an impact on the effectiveness of service delivery. Link to mental health and general acute services especially in relation to the management co-occurring disorders, e.g. mental illness, diabetes, etc.”
- “Judge against best practice with the idea of innovation in mind”.
- “The provision of needle and syringe programmes in the local area”.
- “Possibly feedback from referral agencies and organisations which also form part of the support package to clients”.
- “It is important to consider people who do not use services but have problematic drug or alcohol use and ascertain why they do not access these”.
- “We would recommend providing examples based on staff qualifications, training, experience and any registration with professional bodies”.
- “The National LGB&T Partnership has produced guidance on monitoring service user sexual orientation and gender identity:”  
[\(<http://nationallgbtpartnership.org/publications>\)](http://nationallgbtpartnership.org/publications).
- “It would be interesting to look in more detail at certain data for example drug related deaths, needle exchange provision, blood borne virus data, LAPE data, perhaps local prescribing data including naloxone, National Drug Treatment Monitoring System (NDTMS) data, and data from organisations such as Health Protection Agency on blood borne viruses; data held by the Hep C Trust”.



#### **4. What are your views on how we should rate specialist substance misuse services?**

10 respondents replied to this question:

- 5 healthcare professionals
- 3 providers of services
- 1 member of the public
- 1 commissioner of services

The answers were as follows:

- “Something along the lines of a starring system”.
- “Rather than keep reforming and introducing new, but essentially recycled old standards to bench mark the range and quality of services being delivered, why not bring back the essence of the models of care and HimP, (Health Improvement Programme) albeit recycled within the new NHS improvement framework. They provided a far better rating measure on the design, delivery and integration of services, which reflected the comprehensive needs of the user”.
- “Rate against a quality service for the client and with best practice and flexibility in mind”.
- “This should be aligned to the ratings of other services rated by the CQC. The CQC should consider how organisations (as opposed to individual services) will be rated – will, for example, the national non-statutory provider organisations be given an aggregated organisational rating or will their services be rated by locality basis. Similarly, when services are provided through integrated partnerships how will this be addressed in the ratings process?”
- “It is right to have separate ratings in relation to the 5 key questions. It is better that ratings will be scaled and allow for positive appraisal rather than just level of concerns. It seems more comprehensive this way that the previous system”.
- “Substance use services often have multiple providers under one umbrella organisation and these should be separately rated rather than treated as a whole”.
- “The rating system used is appropriate. More information on the frequency of inspections and the follow-up procedures for services failing to attain ‘good’ or ‘outstanding’ ratings would be welcome”.
- “We believe that this is a very thorough range of questions to guide the inspectors and a good range from Inadequate to Outstanding. We believe that the inspector’s own experience of services and their ability to ‘see’ and recognise best practice as well as confirm that the service is aware of the recognised guidelines (and evidence-based treatments) and follows them consistently would enable them to translate the questions into an what incisive process would be. The Society regards this as particularly important regarding



the PSI's and talking therapies, as this is by far the major part of the treatment they receive".

- "We support the approach to rate services after a pilot phase. We support the approach that not every characteristic will have to be present for the corresponding rating to be given, particularly when dealing with extremes".

**5. What are your views on the characteristics outlined (in appendix B)? Are these what you would expect to see in a specialist substance misuse service that was outstanding, good, required improvement or was inadequate?**

14 respondents answered this question.

- 5 healthcare professionals
- 4 stakeholder
- 2 providers of services
- 1 member of the public
- 1 commissioner of services

Answers were as follows

- "Yes these seem to be appropriate".
- "Yes they are what I would expect to see".
- "Yes".
- "Overall, the characteristics are very clear and appropriate to the type of service. There are at times a fine line between good and outstanding, particularly in relation to Responsive".
- "In order to measure these standards I would have some in part a confidential questionnaire, that is e mailed out to staff and they can respond anonymously. Where you have concerns I would in negotiations with the commissioners hold a half/ or full day conference and work with those in recovery to get the service users there".
- "It may be helpful if some of the terms were better defined and explained e.g. Caring: People are truly respected and valued as individuals and are empowered as partners in their care. Some additions are required within the ratings in respect of, for example, partnership working, work with families and concerned others (in their own right), and links mutual aid."
- "Again, the provision of needle and syringe programmes and/or naloxone should be a criteria for any outstanding or good service".
- "It is difficult to see how a specialist service would rate as outstanding given the nature of the risks associated with the service user population and the abuses often perpetrated upon them at a societal level. This rating seems to





be derived from a systems perspective (i.e. does the organisation have policies and procedures in place) that does not acknowledge the wider social context. Specifically a service may be exceptional in the work it does with its service users in reducing harm and minimising risk, but the social and environmental context remains unchanged”.

- “This is a very broad, yet thorough coverage of the standards and characteristics expected. We believe that it would be helpful if the inspection team had members who were familiar with (and experts in) such services so that one could “translate” and match actual practice with the written characteristics”.
- “We believe that this is a very broad, yet thorough coverage of the standards and characteristics expected. We believe that it would be helpful if the inspection team had members who were familiar with (and experts in) such services so that one could “translate” and match actual practice with the written characteristics. The need to have experts in the PSI’s and in evidence-based psychological treatment as part of the interview group would be part of this process, particularly when establishing the difference between inadequate and adequate (competent), and between good and outstanding (NICE and professionally compliant)”.
- “We support the characteristics outlined. Our understanding is that it would be essential for services to monitor the characteristics of service users (including sexual orientation and gender identity) in order to be able to provide evidence to meet the criteria for a Good or Outstanding rating. This is an approach that we support. However, it should be made clearer in the document that monitoring will enable services to provide evidence of so that both services understand what is required of them and that inspectors understand the full extent of what they are inspecting”.

1 respondent commented in detail as follows:

- “It is encouraging to see that a service rated ‘outstanding’ in safety requires staff take a proactive approach in anticipating and managing risks to people, whilst involving users and their families in managing their own risks. However, the risks posed by take-home prescribed medication (in particular OST) is one we are keen to see gain recognition and be accorded appropriate prioritisation by treatment services. The number of cases where children have died after ingesting their parents’ medication, and the increasing regularity with which they arise, demands that this issue be tackled effectively. As such, it is considered that a service cannot be rated as ‘outstanding’ on safety indicators without robust policies and procedures in place, which recognise and prioritise these risks. Conversely, where insufficient procedures or policies are in place,



the service should be rated 'inadequate.' Furthermore, a service with 'outstanding' safety measures should have in place a mechanism whereby families or others close to the client are able to report concerns and other issues of which they believe the service should be informed. (Safety).

- We would support the view that a service should not be rated 'outstanding' unless it recognises the value of family involvement in treatment, with policies in place to facilitate such involvement. Treatment is most likely to be effective (that is, achieving long-term positive outcomes for both the user and those close to them) when they are closely involved in the care and support of the person in treatment. (Effective).
- Given the range and severity of negative impacts suffered by the families of drug and alcohol users – including to their physical and mental health and wellbeing, finances and social relationships - we would suggest that the provision of support services for families as well as the user is an indication of 'outstanding' service provision: ensuring a person-centred culture, that people are treated with compassion, kindness, dignity and respect and that services are responsive to local needs. When families receive support, they are better placed to be able to support the person in treatment and are a crucial source of recovery capital. The assertion that people's emotional and social needs are highly valued in a service – an indicator for 'outstanding' practice under the 'caring' heading – would be weakened without a level of engagement with those close to the individual in treatment. Where a service does not offer formal family support or mutual aid services, we believe that 'outstanding' services should sign-post families on to appropriate forms of support as a minimum offer. (Caring and Responsive)
- Similarly, a strategic drive, led by management, towards the recognition of the needs of families themselves and the benefits of family involvement in treatment should be expected of a service considered to be 'outstanding.' (Well-led)
- Whilst it is essential that families are consulted throughout the treatment stages – this being well-recognised in the list of prompts – it is suggested that a service worthy of 'outstanding' status goes one step further: involving and supporting families as 'partners in care', in service design and delivery. The extent to which services recognise and promote these principles and engage successfully with families is important in evaluating the overall effectiveness of a drug and alcohol treatment service, and is an indication that the service is providing strong, evidence-based, holistic care and support



## **6. What are your views on our equality and human rights duties impact analysis?**

11 respondents answered this question:

- 4 stakeholders
- 4 healthcare professionals
- 1 provider of services
- 1 member of the public
- 1 commissioner of services

The responses were as follows:

- “This appears to be comprehensive and well thought through”.
- “I like the fact it includes transgender community. it also appears to have their views and desires at the heart of treatment”.
- “As mentioned in your booklet, these should be undertaken in alignment with the MCA.
- “This is appropriate and proportionate”.
- “1. Patient choice will be limited and human rights are the right areas to look at. 2. Hep C Not many services are taking this seriously”.
- “Our views are that it provides a framework for analysis. However, in inspecting services, the local context should determine where the focus may lie. For example, for some areas there may be an increasing Eastern European population, or an extensive Somali/Yemeni population, where Khat has more relevance. Other issues which may present a human rights risk in respect of some of our clients include the levels of deprivation and health inequalities within the geographical area in which the services operate. With regard to the economic downturn and the fact that differing areas in England are coming out of this at different rates, some areas continue to feel the impact of this. In addition, there have been varying approaches to the cuts to council budgets, which will disproportionately affect the range and availability of other support services for clients e.g. hostel provision and homelessness services, accommodation based support services, changes to mental health commissioning etc.)”.
- “We support the approach to integrate human rights principles into the key lines of enquiry, ratings characteristics, intelligent monitoring, inspection methods, learning and development for inspection teams and policies around judgement making and enforcement. The ‘Equality and human rights duties impact analysis’ section on sexual orientation should include reference to research which shows that Lesbian, gay and bisexual people experience barriers to accessing substance misuse services. ‘Part of the Picture’ (University of Central Lancashire and The Lesbian & Gay Foundation, 2014) found that LGB people reported difficulties with the process of accessing drug and alcohol use services, even those with an overall positive experience. The experience of being an ‘outsider’ related to sexual orientation was common. Service structures and even ethos created barriers to access and completion



of treatment, as did a failure to address complex needs such as mental health issues (both diagnosed and undiagnosed) with substance dependency (see [www.lgf.org.uk/potp](http://www.lgf.org.uk/potp)). This section should also include biphobia where homophobia is mentioned in the final paragraph. There is some evidence that trans people are at greater use of substance misuse than the general population, so this evidence should be included in the section on gender identity (see Cochran and Cauce, 2006 and Rooney, 2012). We also suggest that the term 'trans' is used throughout these documents rather than 'transgender' as this is a more inclusive, umbrella term to describe those whose gender identity and/or expression differs from that assigned at birth.

- “This is a welcome addition to the scope of the inspections”.
- “It's is a good idea and we believe that it could support equality and diversity being integrated into all parts of the inspection process. The 'What we know' section (Section 3) is a very light touch approach to summarising what is known about substance misusers under each of the protected characteristics. The intention of the document is clear but section 3 does not link into the following sections of the document. Confusing”.
- “We believe that it is essential to have such an analysis as part of the assessment, and its adds an additional component when one considers that as part of “respect” for clients of the service it should be included that they have the right to receive the correct, evidence-based treatment from appropriately qualified staff, and conversely the right to refuse treatment from any service or staff member unable to provide the appropriate NICE-approved and evidence-based treatment”.
- “A system of regulation that places human rights and equality at its centre is commended. Drug and alcohol users and their families are often marginalised, stigmatised and discriminated against, whilst also facing a number of other challenges brought about by the substance use. Last year, we ran an anti-stigma campaign during which we sought families' views and experiences of stigma: this consultation (much like reports received from other projects and communication with family members) showed that experiences of stigma and discriminatory attitudes were plentiful, and that they were serious barriers to people accessing all forms of support. An awareness and knowledge of human rights and equality in services is therefore paramount. It is also essential that services are familiar with the information contained in the 'what we know' section of the impact analysis. In order for inspectors to be able to judge how safe, effective, caring, responsive and well-led specialist substance misuse service providers are, inspections must be highly conscious of human rights principles. It is essential to have such an analysis as part of the assessment. One further point on which to pick up would be:
  - Carers: It is suggested that this section (under the 'what we know' heading) include a reference to the Carers Act 2014, which expanded and concretised the rights of carers, including those of drug and alcohol users. Under the Carers Act 2014, any adult 'who provides, or intends to provide, care for another adult' is entitled to a needs assessment and access to support. Carers of individuals with a drug or



alcohol problem are thus entitled to the same assessment and support as, for example, carers for people with mental illness; regardless of their needs for support or their financial resources. Under this new legislation, carers are not discriminated against based on the needs of the person for whom they are providing care”.

**7. Are there any additional organisations that we should develop relationships with to understand people's experiences of care and identify examples of good practice in substance misuse organisations? If so, what organisations would you suggest?**

15 respondents replied to this question.

12 respondents said yes:

- 4 stakeholders
- 3 healthcare professionals
- 3 providers of services
- 1 member of the public
- 1 commissioner of services

3 respondents said no:

- 2 healthcare professionals
- 1 stakeholder

Respondents made the following comments regarding organisations to develop relationships with:

- “Older generations or third age drug users are inadequately served. NHS, Social Services and Third Sector old age organisation simply are unprepared to work with this client age group. CQC could make a start there by setting up guidelines and getting them involved. The statutory instruments for these organisations are already in place in terms of addressing the health needs of their old age population. CQC has to make sure addiction in old age is recognised and addressed”.
- “We often get information about issues in primary care based drug and alcohol services, and would be interested in developing relationships with the CQC to look at how this information might be shared. DrugScope is another organisation which may be worth approaching for this purpose. The National User Forum who may get information, and Release should also be approached, as well as for example the National Needle Exchange Forum”.
- “Other local organisations and groups that may interact with substance misuse service providers and people that use these services’ should include VCS organisations which provide complementary services (e.g. mental health and wellbeing, sexual health etc.) also accessed by those accessing



substance use services and that have a referral relationship with those services”.

Other answers included:

- CRC
- Prisons.
- CCG
- Acute trusts.
- MH
- Employment agencies.
- Troubled Families.
- Education providers.
- Social services.
- Homelessness services.
- Services for the elderly.
- Contact Haematology departments and ask to speak with the Hep C nurses or consultant.
- Police and Crime Commissioner.
- Social Care.
- Health Visitor
- The main pharmacy in the town or city.
- The recovery Centre.
- Probation8.
- Citizens Advise.
- Health and Wellbeing Boards.
- Students for a sensible drug policy.
- Local service user groups (e.g. LA level rather than SU groups specific to the organisation which may be less objective).
- Local and/or national drug user networks.
- Third sector and patient organisations, e.g., The Rehabilitation for Addicted Prisoners Trust (RAPt), The Correctional Services Accreditation and Advice Panel (CSAP) and Substance Dependence Treatment Programme (SDTP).
- Other social care organisations including housing and employment services.
- Outreach and street based agencies working with people who find it difficult to access structured services.
- Relationships with local community groups.

1 respondent commented in detail as follows:

- “Building relationships with local community groups is key. We would suggest that local family support services, in particular, are a valuable source of information and feedback. Families are, like most ‘experts by experience’, often very keen to share their experiences and opinions. As well as local family support services, national umbrella organisations would be able to provide valuable insight, having a wide network of



contacts in the sector, including local grassroots services. Through their networks, such organisations would be well placed to provide both national and local accounts of the state and standard of specialist treatment service delivery. The Substance Misuse Skills Consortium – a cross-sector initiative and alliance intended to maximise the skills and capacity of the treatment workforce and share good practice – could additionally provide valuable insight into the sector and guidance on good practice”.

**8. How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice in specialist substance misuse services? From 1 (very confident) to 5 (not very confident).**

13 respondents replied to this question.

1 respondent answered “1”:

- 1 healthcare professional

8 respondents answered “2”:

- 3 healthcare professionals
- 3 stakeholders
- 2 providers of services

2 respondents answered “3”:

- 1 healthcare professional
- 1 Commissioner of services

1 respondent answered “4”:

- 1 member of the public

1 respondent answered “5”

- 1 provider of services

2 respondents replied in more detail:

- “The sources listed provide sufficient scope to be able to identify risks and good practice in substance misuse services. Again, however, we would press the point that the collection of information from families and those close to the person in treatment is vital. In gathering information from patients and the public, it is advisable to heavily target family support services and family members themselves to gather their experiences of care and treatment. When collecting complaints submitted to the service, it



is also worth inquiring whether family members are afforded the ability to lodge complaints and, if so, these should also be indicators in the overall analysis of the service and the KLOEs”.

- “CQC should ensure that they work to gather views from those who do not access services and may not engage with official CQC channels (e.g. through working with the VCS). The indicators should client self-assessment of their outcomes rather than simply service provider assessment. Inspections should take account of compliments and suggestions as well as complaints (i.e. general feedback). It appears that the information about staff is only gathered from staff; views should be gathered from service users and their advocates too”.

### **What other indicators would you suggest?**

9 respondents replied to this question:

- 1 healthcare professional
- 1 commissioner of services
- 1 member of the public
- 1 providers of services
- 4 stakeholders

Responses were as follows:

- “Apologies for being pessimistic. Services have been designed in such a way that for people who don’t work in them all you can see is an entry and exit point. Everything else in the middle you can’t see and you have to rely on what you are told, even NDTMS is fed only what it requires”.
- “Some areas have a high number of vulnerable people with on-going health, personal care and other support needs. This context means that, in setting realistic outcomes for clients, these will vary, with a number focusing on harm reduction. It would seem appropriate that any inspection framework is able to consider this in the context of outcomes for clients - that for many this may be the reduction of harm, rather than achievement of abstinence. We suggest in depth scrutiny of psychosocial interventions and integration with mutual aid, peer mentors, recovery champions. In addition, scrutiny of the approach to families, carers and concerned others as clients in their own right. The process for review of clients (and its effectiveness) should be considered, and a look at how the whole system works, and the pathways within it”.
- “Views of local commissioners and PHE (Public Health England) centre teams”.





- “The provision and availability of take-home naloxone, and of needle and syringe programmes”.
- “Performance and local outcomes”.
- “It is important to consider who does not use services and why - substance users who are not in treatment do not have easy access to a 'voice'. They are less likely than the population to have access to, or skills to use, internet resources. They are less likely to complain to an organisation. They are often transient and homeless - difficult to contact. Will require creative approach to ascertain these views (and may require use of incentives). Good practice should include improved psychological and mental health, improved physical health, improved social and occupational functioning and improved family relationships. Post treatment reviews would be helpful - what do those who have completed or dropped out of treatment have to say”.
- “The collection of information from families and those close to the person in treatment is vital”.
- “We believe that the sources listed are a very good overall view of the quality of the service. The indicators give a good idea of how the service measures and manages risk. They seem a good way of determining adequate practice, but would not easily help decide if a service was good or outstanding. In determining a good to outstanding service, the Society recommends that one establishes the degree to which the service utilises NICE-approved and evidence-based PSI’s (good to outstanding service), and also to what degree the service might use non NICE-approved interventions, as the higher this proportion, the less adequate (effective) the service would be. It would need to be ensured that those actual sources are seen by the inspectors and the CQC in order to determine the quality of care”.

**9. Is there other information we should be asking for from providers about the specialist substance misuse services they deliver before an inspection?**

15 respondents answered this question.

14 answered “yes”:

- 6 healthcare professionals
- 3 stakeholders
- 3 providers of services
- 1 member of the public
- 1 commissioner of services



1 answered “no”:

- 1 stakeholder

Respondents who answered “yes” gave the following suggestions:

- “What specific evidence based treatment & interventions do they offer to people presenting with cannabis problems, particularly where this is identified as the primary drug problem, as this group is the fastest growing in terms of presentation to treatment”.
- “Care plans, risk plans reviews”.
- “Most of them have fragmented operational policies as drug services have been more disruptive than any other health service. CQC should ask about their SOPs”.
- “Intelligent Monitoring. As there are differing requirements of NHS and non-NHS organisations around reporting of patient safety incidents some clarification on this would be beneficial”.
- “Treatment retention and dropout rates. Range of interventions available and rate of take up. Complaints and compliments. Joint working protocols and policies. Accessibility of services - locations and opening hours. Quality (not quantity) of crisis and risk management plans. Follow up and after care availability - what happens after treatment?”
- “Possibly to identify other stakeholders such as referral agencies and other social care organisations that work alongside us to support our service users that would be useful to speak to. It would be good for inspectors to identify the different groups of clients at the start of the inspection or during the notice period. This would help us to plan the visit to ensure that inspectors are able to see a range of clients at various stages of recovery”.
- “NDTMS and commissioner views”.
- “Pathways between/relationships with other key services”.
- “When looking at medicine management, safety and a service’s effectiveness, it is important that inspectors gather evidence of the service’s policies and procedures around take-home medication, in particular OST, and the safeguarding policies in place to protect children or vulnerable adults who may be at risk. The extent to which services value holistic working and their modes of achieving this are also key indicators of the quality of a service; and evidence should be gathered to this end, including the level of involvement of families and carers in care planning and treatment”.
- “When gathering information from the provider, performance against the KLOEs should include assessment of the service’s monitoring data on service user characteristics, including sexual orientation and gender identity (where available). This will enable inspectors to fully assess whether the needs of



local communities (including LGB&T are being met. Under ‘Gathering information from people who use services and stakeholders’ we suggest adding promotion via the local VCS, in order to better reach seldom heard communities. We agree that third party services should not necessarily be inspected as part of the provider’s inspection (section 6) however, we recommend that the provider’s inspection should include assessment of performance data for that third party service, as part of assessing whether an inspection of that service is needed”.

- “Missing any reference to a critical aspect of looking after people with substance misuse issues – because there is no real provision for after-care in the services mention. After-care on a regular basis is essential, even if it is only something that is visited once a month. The maintenance of a regular check-point which the service user can use as a goal and interact with peers in the same situation is fundamental. A professional of some kind (key worker, nurse etc.) should facilitate this”.
- “Information on needle exchange, access to and liaison with mutual aid, blood borne virus testing, provision of naloxone, brief interventions regarding alcohol, together with any local data they may feel is useful. Inspectors will also hopefully have a range of information from NDTMS”.
- CQC should look specifically at whether people’s transitions are effective – particularly for young people and the safety of transitions.
- “Supervision, training, qualifications and experience of staff.
  - How well-trained are front-line staff (key and recovery workers, volunteers, professional staff, etc.?)
  - What staff-mix do you have – nurses, occupational therapists, psychologists, doctors, etc.?
  - How does this contribute to the multidisciplinary team necessary to provide adequate and appropriate treatment interventions to the complex clients presenting to substance misuse services.
  - How well trained are the senior staff – management and team leaders – in providing leadership through supervision (both clinical and managerial).
  - What knowledge do the senior management have of the requirements of the NICE and other guidance that informs the quality of interventions – particularly psychosocial”.
- “It is recommended that the CQC inspection framework examines how providers relate to each other within a system, and the level of integration of policy and procedures e.g. where there are sub-contracting arrangements, or a lead provider, especially in relation to integrated data sharing, common



sharing assessment framework, how the community service links into the Tier 4 provision”.

- “What are your current priorities?
  - Do you report all drug related deaths to your commissioners?
  - Are there any lessons being learnt from DRDs in the last 2 years.
  - Are you facing any unintended consequences due to policy change both at a national and local level?”

**10. We recognise the difficulties sometimes experienced in engaging with people who use specialist substance misuse services. Have we proposed appropriate methods to ensure that we are able to gather the views of people who use different types of substance misuse services before and during inspections? Please explain.**

15 respondents replied to this question

11 respondents said “yes”:

- 4 healthcare professionals
- 3 providers of services
- 4 stakeholder

3 respondents said “no”:

- 1 healthcare professional
- 1 stakeholder
- 1 commissioner of services

1 respondent replied neither yes nor no but gave a detailed response:

- 1 stakeholder

Reasons given for answering “yes” were as follows:

- “The methods suggested for gathering views of service users seem comprehensive”.
- “The inclusion of an ‘expert by experience’ in the inspection team is an excellent measure in seeking to gather the views of people using the service, given that we know people often feel more comfortable in confiding and sharing opinions when they share similar experiences. In our experience, families are eager to share their opinions and offer feedback and also have a valuable insight into the safety, effectiveness, responsiveness, compassion and management of a service - from a unique perspective. In order to capture the experiences and opinions of families, the same methods can be used:



drop-in sessions or discussion groups, speaking to families individually, using comment cards, posters, questionnaires and online forms designed for families”.

- “The proposed methods are appropriate. In addition, we recommend engaging with the local VCS to better reach seldom heard communities. This includes LGB&T communities who are more likely to misuse substances and also experience significant barriers in accessing substance misuse services. Where possible, we recommend that these methods include demographic monitoring (including sexual orientation and gender identity) in order to ensure representations of all parts of the community”.
- “Flexibility is key. You need to go to where people are and engage with them when they can cope with it. CQC also needs to be able to talk to people at different times of the day/different days when they are more able to communicate. This needs to be done over an extended time period. Providers increasingly offer service users access to computers. It would be worth trying an online survey that providers could encourage people to complete before/during an inspection”.

Reasons for answering “no” were as follows:

- “We recommend the utilisation of on-line approaches and the use of contingency management. There needs to be little disruption to the daily remit of, for example, peer mentors in response to delivery of services. Peer mentors may be employed within the system and will have a remit which is integrated into daily delivery”.
- “Offer as much flexibility as possible, consider contacting via other services/local networks - e.g. for protected groups consider maternity care, sexual health, local advocacy groups and support services”.
- “Will require concerted effort and time to ascertain views of this population. Working with related services (homelessness, sexual health etc.) to gain access. Consider use of incentives (vouchers for food/clothes) to increase participation”.

1 stakeholder gave a detailed response regarding engaging with service users:

- “The first 8-10 days when people are in detox can be a particularly difficult time to engage them about their care. In the 5 weeks after this there are much better opportunities. However after this period, people can leave services and then it is difficult to gather their feedback. Is there any methodology from the hospital inspections that could be used in substance misuse services inspections – to help reach people once they have left services?”



- Positive views on the use of experts by experience programme. A key point to note is that people who become experts by experience have a relatively short 'shelf life' in this sector – as they quickly become rather like members of staff/volunteers in the service and lose the perspective of being a new user.
- Flexibility is key. You need to go to where people are and engage with them when they can cope with it. CQC also needs to be able to talk to people at different times of the day/different days when they are more able to communicate. This needs to be done over an extended time period.
- CQC should look at services for groups of people with particular complex needs e.g. Dual diagnosis, people with a learning disability, people who have come through the prison system, the street homeless.
- Service users often don't know which services are regulated and which ones aren't. CQC will need to check which services they are talking about.
- Pilot work on inspections has found that it works better to engage with people without giving them too much warning – working flexibly and asking people who are around at drop-ins etc. to come for a chat.
- Providers increasingly offer service users access to computers. It would be worth trying an online survey that providers could encourage people to complete before/during an inspection.
- Social media is increasingly used by some service users – it is also worth testing these.
- Text messaging and promoting CQC via text and social media should be part of the methodology
- CQC could spend time in user group sessions in providers with their permission”

**11. Would different methods be needed to engage with people who have complex needs or who are in vulnerable circumstances before and during inspections? If so, what methods would you suggest?**

12 respondents replied to this question.

10 answered “yes”:

- 4 healthcare professionals
- 2 stakeholders
- 1 provider of services
- 1 commissioner of services
- 1 member of the public

2 answered “no”:

- 1 healthcare professional



- 1 provider of services

Respondents gave the following reasons for answering “yes”:

- “Could be accompanied by carer or significant other”.
- “Speech language needs need to be taken into account. e.g. Dyslexia, abilities, hearing, sight, Asperger’s, autism”.
- “Interviewing and making contact within a buy pharmacy would be worth consideration and away from the treatment service”.
- “Work in conjunction with hostels, outreach services, mental health services and the CRC and employ contingency management techniques i.e. rewarding clients for their involvement/attendance/feedback through, for example, voucher programmes. Identify individuals in recovery who would previously would have met the criteria for complex needs and understand their journey and pathways”.
- “Integrated model of care just like in Toronto CAMH (Centre for Addiction and Mental Health)”.
- “Offer as much flexibility as possible, consider contacting via other services/local networks”.
- “The majority of adults who use our services receive treatment at our premises so most of these methods are appropriate. However, vulnerable people and those with complex needs would require more support to engage. We would also suggest that telephone interviews, utilising peer mentors and attending a group session may be beneficial”.
- “Location of service user needs to be considered - e.g. work with mental health to ascertain views of people with a dual diagnosis. Establish 'events' in safe and accessible locations to ascertain views. People will need support (practical and or financial) to attend”.
- “Clients with a Dual Diagnosis or complex presentation, often with another associated mental health problem and/or trauma, as well as clients with cognitive deficits (learning disabled and cognitive deficit as a consequence of substance misuse) would need to be engaged in a more sensitive and appropriate manner to enable them to give an accurate opinion on services. We believe that this could be achieved by using interviewers familiar with this population group as well as using feedback methods appropriate to this group”.
- “Inspectors should make sure that the engagement methods used are accessible to people who have complex needs”.

## **12. How should we best seek to gather the views of people who use community-based substance misuse services?**

11 respondents replied to this question:

- 4 healthcare professionals
- 3 stakeholders
- 2 providers of services



- 1 member of the public
- 1 commissioner of services

Respondents suggested a variety of approaches should be used, including:

- Focus groups.
- Advertising in pharmacies.
- Local recovery communities.
- Big group surgeries.
- Websites.
- Service user workers/mentors.
- On line survey.
- Service feedback (look at what has already been done to seek feedback).
- Feedback from other people involved (families/carers/professionals).
- Ensure flexibility of approach and be prepared to attend service user group meetings which are already in place (obviously with service user/membership agreement). These may be in the evenings or at weekends.
- Utilise contingency management/reward systems.
- Individual interviews/ case stories.
- Looking at substance misuse provisions in CAMHS for a start.
- Drop-in sessions, snowball outreach techniques, and community forums.
- Utilise skills of the client's key worker with whom they have a rapport for support to give their view.
- Accompanying a member of staff on an outreach visit or seeing people in the community.
- Attending a core group meeting or multidisciplinary meeting with mental health/safeguarding teams.
- Consider service user/carer groups independent of services as well as internal groups. Offer phone interviews as well as feedback on the day of inspection, publicise opportunities to feedback via social media within local services.
- The proposed methods would work equally well in community-based services.
- Engage with the local VCS to better reach seldom heard communities including LGB&T communities who are more likely to misuse substances and also experience significant barriers in accessing substance misuse services.
- Include demographic monitoring (including sexual orientation and gender identity) in order to ensure representations of all parts of the community.
- The CQC must consider how it will gather the views of those who do not access services as well; these views can add salient information about barriers to accessing those services.





### **13. How should we best seek to gather the views of young people who use specialist substance misuse services?**

#### **11 Respondents replied to this question.**

- 5 healthcare professionals
- 2 providers of services
- 2 stakeholders
- 1 member of the public
- 1 commissioner of services

In many cases respondents suggested similar methods for gathering views of young people as for gathering the views of people who use community based substance misuse services:

- On-line or using social media.
- Publicise opportunities to feedback via social media within local services.
- Webyouth services.
- Work with the YOT (Youth Offending Team), schools/colleges, 5-19 services etc.
- Talk to them.
- Refer to 'You're Welcome' standards (DH, (Department of Health) 2011)
- Offer phone interviews as well as feedback on the day of inspection.
- Drop-in sessions.
- Snowball outreach techniques.
- Community forums.
- Involve local peer support groups.
- Ask providers to inform all service users of the visit and encourage people to get involved.
- Engage with the local VCS to better reach seldom heard communities e.g., LGB&T.

Other comments included:

- “CQC have to be proactive and be avant-garde. At present it is too set, institutionalised and not creative enough - as far as seeking the views of young people are concerned”.
- “Most of the young people who access our services are treated in the community and not at our premises. For our internal quality checks we use the following methods of engagement:- transporting a young person to our premises for a discussion- telephone interviews with young people and their parent carers - these often take place at the end of the day or out of hours to minimise disruption to education/training or work- interviews via text”.
- “Route of information provision through other young people's services (not only specialist substance use) e.g. education, community groups. Online - young people are often most media savvy. Make it interesting to look at - designed by YP for YP, seek YP views and guidance as to how best to



access - convene their assistance in establishing means of consultation and promoting this”.

- “We think that the proposed methods would work well in services for young people. As noted above, we recommend engaging with the local VCS to better reach seldom heard communities. This includes LGB& young people who are more likely to misuse substances and also experience significant barriers in accessing substance misuse services. Where possible, we recommend that these methods include demographic monitoring (including sexual orientation and gender identity) in order to ensure representations of all parts of the community”.
- “The CQC must consider how it will gather the views of those who do not access services as well; these views can add salient information about barriers to accessing those services. The VCS may be able to help with qualitative and quantitative collection of experiences, especially in relation to those who share protected characteristics (such as LGB&T people). The VCS may also be able to help with gathering views from service users about services in a confidential, safe space for some communities, where they may feel nervous about being so open within services”.

#### **14. How do you think we should seek the views of families, carers or people close to people who use specialist substance misuse services to help inform our inspections and assessments?**

16 respondents replied to this question:

- 7 stakeholders
- 5 healthcare professionals
- 2 providers of services
- 1 member of the public
- 1 commissioner of services

Respondents gave the following answers:

- “Perhaps try contacting those who have successfully completed treatment to seek their permission. It is important to speak to those families and carers of those who have not been successful in either accessing treatment or completing it, but contacting these people is clearly more difficult and likely to require significant effort and possibly innovation, a research project?”
- “Invite them to meet”.
- “Contact the local family/career organisations”.
- “Use a variety of approaches-on line surveys-focus groups-service feedback (look at what has already been done to seek feedback)-feedback from other people involved (families/carers/professionals)-ensure flexibility of approach and be prepared to attend service user group meetings which are already in place (obviously with service user/membership agreement). These may be in the evenings or at weekends.-utilise contingency management/reward systems-individual interviews/case stories”.



- “Diverse approaches combining both traditional and innovative ways to seek their views”.
- “Ideally, the services should be able to tell you who these are. But the service users should as well”.
- “Consider service user/carer groups independent of services as well as internal groups. Be as flexible as possible, offer phone interviews as well as feedback on the day of inspection, publicise opportunities to feedback via social media within local services”.
- “Drop-in sessions, snowball outreach techniques, and community forums”.
- “We would suggest that when engaging with opiate addicted former prisoners, a person with a similar background should be present to better gauge their opinion”.
- “Linking in with carers' networks, arranging specific drop-ins and meeting with people in the community, as often, carers do not like to attend treatment services. Also using online and remote methods such as surveys and telephone interviews”.
- “Approach local support groups. Use national forums such as Adfam to seek guidance as to how best to access - convene their assistance in establishing means of consultation and promoting this”.
- “Our beliefs as regards to seeking the views of families, carers and those close to people engaging with specialist substance misuse specialists have been expressed throughout.. Seeking the views of families, friends, carers and other close to the person in treatment is highly advisable. However, as well as consulting the views of families and those close to current clients, consultation with independent local family support services would be of additional value; since it would also provide a window into the experiences of families, carers and people close to those who aren't presently in treatment, and further broadens the evidence base. Families and others who are members of these groups are both familiar and in contact with local treatment services: they are a valuable and independent voice on families' and carers' experiences of the whole local treatment environment”.
- “Many areas have peer led groups that support the parents/ carers of drug and alcohol users. Many areas have a post that is responsible for supporting family/ carers of people with drug and alcohol problems and where this post does not exist, there may be a generic post that supports carers/ families in general”.
- “Families and carers are usually very happy to get involved and give their views if they are invited to the service and offered refreshments. CQC could ask providers to do this as part of the inspection process”.
- “The proposed methods would work equally well to engage with families, carers or people close to people who use specialist substance misuse services”.
- “The common view was that families and carers are usually very happy to get involved and give their views if they are invited to the service and offered



refreshments. CQC could ask providers to do this as part of the inspection process”.

### **15. What are your views on the methods we propose to use for gathering evidence during inspections of specialist substance misuse services?**

12 respondents replied to this question:

- 6 stakeholders
- 2 healthcare professionals
- 2 providers of services
- 1 member of the public
- 1 commissioner of services

7 of these expressed support of the methods proposed, saying they were fair, wide-ranging and inclusive.

5 commented as follows:

- “These seem wide ranging & inclusive. You will need to interview see notes and more importantly cross reference with the data systems”.
- “The framework still seems very much geared around the traditional “NHS” □ approach and in many cases local authorities that are leading on commissioning drug and alcohol services do not necessarily have commissioning frameworks that are aligned to this approach which ultimately shapes the model of delivery”.
- “How will samples be selected (identified specific characteristics or a random sample or both)?”
- “We believe that these are adequate and reasonable. An additional aspect that would confirm the quality-control would be to have experts as part of the inspection team, as well as have those experts interview the experts in the organisation. The number and range of expert professionals within the organisation will also be an indicator of the quality of that service and its commitment to evidence-based and NICE-approved treatments. Therefore, the general efficacy of the service and its potential to fulfil CQC-requirements of an adequate service”.
- “We are pleased to see that LGB&T people are included in the list of local demographics to be considered. However, the CQC must consider how inspectors will ensure that these communities are engaged. All stages of information gathering should include demographic monitoring which includes sexual orientation and gender identity, whether this be reviews of existing service data, interviews, focus groups etc. Inspectors should work with the VCS to reach seldom heard communities and ensure representation of LGB&T people’s views and inclusion of their needs. Guidance has been produced on monitoring service user sexual orientation and gender identity (<http://nationallgbtpartnership.org/publications>)”.



**16. What are your views on our proposed approach to reviewing the cases of individual people who use specialist substance misuse services?**

10 respondents replied to this question:

- 4 stakeholders
- 3 healthcare professionals
- 2 providers of services
- 1 commissioner of services

7 were in support of the proposed approach, 1 with the following additional comment:

- “We support this approach, with the proviso that consent is sought from the individual concerned. The CQC should also consider opportunities to involve a service user’s advocate, if the individual requests it”.

3 commented as follows:

- “It may be difficult to identify and review cases of individuals who identify as belonging to one of the protected groups/other groups listed. The handbook could be more explicit as to how this could be addressed - perhaps working in advance with providers to maximise opportunities for people from these groups to share their experiences”.
- “Location of reviews may impact on what people feel able to say (staff and service users)”.
- “There is a need for a structure that includes a regular multi-disciplinary team meeting with skilled staff in attendance that reviews cases on a regular basis in line with agreed professional practice, NICE and other professional guidelines”.

**17. What are your views on our proposed approach to reviewing the use of restrictions by specialist substance misuse service providers?**

9 respondents replied to this question:

- 3 healthcare professionals
- 2 stakeholders
- 2 providers of services
- 1 commissioner of services
- 1 member of the public

6 of these expressed support of the proposed approach.

3 commented as follows:

- “Safeguarding must be the priority and as such we are unsure of the role of CQC in reviewing restrictions”.
- “Should be judged on guidance internally and externally. Also on a case by case basis and on resilience of the team!”



- “I am not clear about the methodology. Need to consider if there are also clear policies and protocols in place regarding restriction and if these are consistently followed”.

**18. What are your views on the proposal that we will rate independent standalone substance misuse services at key question and location levels?**

11 respondents replied to this question:

- 4 healthcare professionals
- 4 stakeholders
- 1 provider of services
- 1 commissioner of services
- 1 member of the public

5 of these expressed support of the proposal, one with the following additional comment:

- “We support this approach. However, there should be opportunities to celebrate good practice and encourage this to be rolled out elsewhere”.

6 commented as follows:

- “It would not apply to our locality as we provide an integrated model of delivery. This requires all services to operate within one system, under one name, and using one data system. In addition, there are sub-contracting arrangements in place within the system”.
- “I simply do not agree on the myth of stand-alone services for addictions. It's ineffective and should be discouraged”.
- “Fine, more guidance needed on services that are not independent and standalone”.
- “The provider handbook needs a little elaboration on how this will work, particularly in relation to services delivered in partnership to ensure a consistent approach by inspectors and clear understanding for providers”.
- “Familiar model and method is beneficial”.
- “There is support for the principle that all substance misuse services and providers are accountable to the same set of standards and are rated under that system”.



#### 4. Focus Group Responses

2 Focus Groups were held with a total of 12 participants.

##### **Q1: How do you think CQC should seek the views of people who use substance misuse services to help inform inspections?**

- CQC should speak to ex-users (like myself) before they do the inspections. We've used these services so know what they're like. They should be talking to people who use services like NACRO and CEDAT (that's where users go to get their script); and they should be talking to people on residential detox programmes and with homeless people who go to drop in centres like the one at (name removed) Church.
- For the last 20 years I've been in and out of many different treatment programmes and centres - but never once heard of CQC. I didn't know that services were regulated and inspected. CQC should publicise their role more. I would like to give feedback but no one's ever asked my views. The public doesn't know CQC exists!
- I agree, I've been in community and residential settings but no one has ever asked my views about any of the services I've used. I've been asked to complete all sorts of forms – they want to know everything about your personal life - some of which is impersonal and irritating but I've never been asked to give feedback about the service. Any feedback form has to be simple, for example, a one sided, stamped post card that's easy to complete with the postal address on the other side.
- CQC should be interacting with service users outside the service setting. They should be telling service users what level of care they should expect and publishing standards of care. The service user cannot measure what's good care if they don't know what the standards are. This information should be included in the patient's treatment pack. CQC should be doing more to raise awareness of care standards.
- Have a CQC What Standards to Expect leaflet for treatment centres etc.
- I agree there's so much disparity between services within the same Borough and between different Boroughs. What's acceptable in one area is not acceptable in another. For example, when I did my detox - I was on a section wing on a psychiatric ward. All I had was the TV and video and was left on my own to get on with it – no support at all! I felt like a piece of meat. In another location I went through a 6 month treatment programme – the care and service I received was very different. Some places treat you very badly. If you try and complain they shut you down. The inspectors should go to where service users are.
- My care manager told I about the residential treatment in here and that's why I came down here almost 6 years ago but I've never once been told about the complaints procedure – how can CQC change this culture?



## **Q2: Do you think CQC needs to use different methods to seek people's views?**

- Yes, CQC needs to use different methods. Not everyone is able to talk openly in groups especially if you've been in prison; a lot of people can't read or write so it's no use expecting them to complete questionnaires or feedback forms. Many don't have access to the internet. They don't have a roof over their head; and have to wait for the soup kitchen to open up to get a meal – so the internet would be the last thing on their mind. For many ex-offenders 'officialdom' is scary – you can't come across as 'authoritarian' – you need to get to their level. Use simple English; speak respectfully. Go and meet people on their patch where they feel 'safe'. Most addicts spend the morning going for their script; the afternoon drinking – they are not used to time keeping. You've got to be flexible!
- Yes, you need to use different methods. How you approach someone detained in a mental health institution going through a detox - would be different to someone getting treatment in a community setting. You should engage with Advocacy services as they tend to work with people in residential settings.
- You can't have 'a one size fits all' approach. Giving incentives to involve people is a good thing – people will come forward. I came today because I knew I would be getting an incentive – people can't give their time up for free. It's also important that people get feedback – they feel valued.
- The general public and some professionals are very judgemental about drug addicts. No one wants to know them – if you want to speak to them you have to meet them in drop in centres, soup kitchens, or on the street (many are homeless) – you have to go through their care workers to access them. They won't turn up to a focus group their lives are too chaotic.
- After care (which means going to dry houses) is a good place to speak to service users who are in the community. People are around in the morning then we have to be our actively seeking paid work, volunteer work or education.

## **Q3: What do you think about speaking to families and carers of people who use substance misuse services as part of CQC's inspections? How should CQC do this?**

- Families (and carers) have a big role to play and should be involved from the outset. They're greatly impacted. The problem is that because of data protection services only want to speak to the client. Yet the family's caring for that person but there's no help for them unless there are children involved - but the family gets worried in case Social Services remove them. The system's not joined up. CQC needs to advertise that they are an accessible organisation and speak to families and carers before they start inspecting the service.





- Yes, CQC should be speaking to families and carers – this should be on a one to one basis and in small focus group settings.
- It's important to speak to carers and families but sometimes they are the cause of the addiction. I'm in my 30's and as far back as I can remember my mother was ill. Her illness affected me so much that I needed help and referred myself to Social Services. Instead of helping me they pushed me from pillar to post. The service was completely disjointed with no communication between the organisations. I felt like a ping pong ball.
- I agree they're (organisations) so busy competing with each other for funding and resources they forget about the client. At times I felt 'at risk' because of the internal rivalry. They're so busy tied up with paper work they forget about the caring aspect of their job.
- If you turn a pyramid upside down – that's the situation of the patient. He's at the bottom. I relapsed after 10 years and the quality of care was poor! The professionals are too busy ticking boxes; chasing up paperwork; preparing statistics; writing reports. I felt I was on a conveyor belt. I felt forgotten. This is not care. The services are not linked up. The Police, Health and Social Care services are all working to their own agendas - the poor patient is at their whim and mercy!"
- Follow my patient pathway – it's complicated.
- My mother shares special guardianship with my daughter and because she's ill my daughter looks after her. She's become her carer. I've been trying to reverse the special guardianship but Social Services are objecting to it. I'm so frustrated because I've been clean for seven years and just want my daughter back.
- Language is very important. It labels you straight away. The word 'substance misuse' implies you're making a rational choice to misuse. Yet no one wants to harm themselves by taking something that might kill them. The reality is that drug and alcohol addiction is a disease and needs to be treated as a disease.
- I agree, my daughter came home from school one day and was very upset. The school had been running a drug awareness session and using language which she found offensive because it portrayed me – her mother - as a drug addict!
- My other point is about Social Services. In the past 3 years we've had five different Social Workers. There's no continuity. We settle down with one and then they leave – the gap between the next one is too long – it's too much change too frequently! The whole family has to start all over again with the new Social Worker which is very disruptive. It takes time to build trust.
- We used to have a really good family therapy programme but they finished the funding and put us onto a family treatment programme – but in the last year we've only had one, one-hour session. There is no continuity of care!



**Q4: What are the key issues CQC should look at in inspections to understand whether a service is safe, effective, caring, responsive and well-led?**

Safe:

- Is it in an accessible location and run at an appropriate time; do the staff treat vulnerable people with care and patience.
- In a residential treatment centre the safety of the residents is paramount – especially from other residents who might relapse. For example, someone who decides to use heroin can within a few hours cause serious havoc in the Centre – it's a domino effect! I've seen a lot of people who are in the Centre because of a court order or family pressure and really don't want to be there and they usually relapse. This can cause friction and tension - leading to various problems including safety of other residents. When you go into a treatment centre you're putting your trust in other people and expecting the best care. The environment has to be safe. Questions that Inspectors can ask are: 'How many times have you asked people to leave the treatment centre and why? What support has been put in place?'

Effective:

- Is the service consistent for example, do they have the same key worker; is the package structured in a way that suits the user.
- Is the treatment making a difference? Is it helping you?
- I had the chance to come to [location] but had to demonstrate for one year that I was committed before I got the treatment. The state funded it but I had to demonstrate that I was worth this investment. I know it's helped me – I'm changing my life round

Responsive:

- Is it flexible to suit my needs; do they listen to what I have to say and are interested in my ideas.
- I would like to see a flexible service. I would like to stay in here but the city doesn't want addicts so the aftercare policy drives you out
- A care package tailored around my needs.

Well-led:

- Is there a good support system which is tailored around my needs?
- Expertise of staff, some staff operate text book style and whilst others are hands on – with real life experiences so they treat you differently. Staff are role models and should create culture of inclusion.

Caring:

- Am I able to talk to someone when I need to; can I trust them. Do they go out of their way to help me.
- Aftercare. I would like to stay in here but the aftercare is better in [location] **London**. In [location] I'll receive support 3 days a week which is what I need – whereas in here I'll only receive one hour a week and that's optional. I need structure and support so moving to [location] is better for me even though I would prefer to stay here. Going back to old haunts and friends is not always a good idea.



- To qualify here you need to demonstrate you've had a 'local connection' for a period of 6 months. However, they do not consider 6 months in treatment and 3 months in a dry house as a 'local connection'. So the aftercare varies considerably which can be a disadvantage.
- You should feel that staff care about you – being able to get hold of your key worker is important.
- Having counsellors in the treatment centre who have experienced similar addictions is very important – they can empathise, can be role models and understand.
- On the other hand ex users can be the worst counsellors.
- I would want to tell someone if I was being treated with respect – or not.
- Most people who are clean are very isolated – they don't want to mix with their 'old group of friends' and along the way have lost most of their family – the pressure and stress has been too much for family. They need a caring, responsive service.

**Q5: What do you think of the methods CQC has suggested for gathering evidence in inspections?**

- The new approach is good. CQC should talk to service users and their families and carers so that they don't get a sugar coated view from professionals. You need more sessions like this so that we can get involved. Giving them a rating is a good idea but all of them should be rated. For example, the GP's the first port of call for nearly everyone and if he/ she's not sympathetic then you've had it. For me my GP was the one person who knew more than my mum and dad - I trusted him but he didn't help me and I went into a downward spiral I had no one to go to! That's why I feel you should inspect and rate all services not just independent standalone ones from this year.
- My experience is that you get better care in the independent sector. I was in a faith based service and found them to be more flexible even though they had high standards of care. They were strict but tailored the services around my needs – they had a better ethos.
- I agree. NHS services are not very flexible. They tend to use the 12 step programme and are not really concerned whether they are suitable for the client or not; but this shouldn't be the only model for recovery.
- I agree, you get a better level of care in the independent sector. They've got the flexibility to design things around your needs.
- The independent sector feels more human. There's respect for the client whereas the NHS employs a tick box conveyor belt approach.
- There are different ways that work for different people – needs to be flexible.



## 5. Stakeholder workshop on substance misuse draft provider handbook

This section gives a summary of feedback from a workshop held with stakeholders, about the draft provider handbook for specialist substance misuse services.

### 1. How independent standalone substance misuse services should be rated:

- For independent services, a location rating is more appropriate than a provider level rating and it may be difficult to rate at provider level.
- The existence of consortiums reinforces the need for a location level rating.
- All five questions are important, though 'caring' may be of particular interest to service users.
- The purposes of ratings are driving change, highlighting good practice and encouraging patient choice.

### 2. Equality and human rights duties impact analysis:

- There are overlaps between groups, such as young carers. Are there any statistics available on how many young people are affected by parents' substance misuse?
- Alcohol use amongst older people is increasing.
- In relation to data, one person may be counted twice if using separate drug and alcohol services.
- Access to services can be difficult for some groups, such as some offenders returning to the community.
- Certain ethnic groups may have a tendency to use particular drugs (e.g. khat amongst certain communities).
- 'Legal highs' and novel psychoactive substances also have a certain demographic (i.e. young people) – does recorded data capture people using these?
- It is important that substance misuse services are visible to overcome barriers to access.
- The workforce needs to be diverse and properly trained, mirroring local demographics. For example, staff should have training on religious needs.
- The group also commented on issues relevant to specific groups:



#### Gender including pregnancy and maternity

- A person may not know they are pregnant and be attributing symptoms down to substance use rather than just avoiding the service.

#### Sexual orientation

- The pattern of substance use is often radically different.
- Services should be able to support this group of people.
- Commissioning can have an impact on service delivery.

#### Gender identity

- The group agreed with points.
- It was also noted that accommodation for transgender service users' needs to be handled appropriately.

#### Carers

- Need to add consent and confidentiality to the issue identified - support and involvement with patient.
- Ensure carers have support even if they are not directly involved with care.
- Include child carers who care for their parents who misuse substances.
- These children are a high risk group and need as much support as can be given.

### 3. Engaging service users:

- Focus groups are essential. But, the questions asked will be important to ensure that feedback reflects current experiences.
- Some people may be reluctant to discuss services in groups so feedback should also be gathered on a one-to-one basis.
- Questions should capture who residential care worked for and whom it did not work for.
- The difficulty of written feedback was raised.
- It is very difficult to get people to complete comment cards. More meaningful feedback might be given if a service user has an opportunity to sit down with a key worker.
- A service user representative could engage with the CQC in feeding back comments from service users (perhaps this could be done on a six-monthly basis). Service user representatives could also assist with gaining feedback on written/online questionnaires.



- In a prison setting, the person has to have someone with them when giving feedback. Prisons need at least 48 hours' notice from an inspector so they can be allocated to a focus group.
  - It was suggested that CQC engage with existing service user groups.
  - It was suggested that there is a need to set out some guidelines for inspectors/service users when inspecting services to ensure that there is enough space and time allocated. Inspectors should also be sensitive in their engagement with service users.
  - Experts by Experience should be included in focus groups, with permission from the group, for a better outcome, rather than inspectors.
  - Use Experts by Experience to talk to people who use the services.
  - Use different methods for different service types. In a residential service, CQC need to be very aware that it is a therapeutic environment and inspectors should be sensitive to the possibility that they may appear to be intruding. Rather than using therapy groups, specific times for CQC feedback should be arranged and Experts by Experience should be used much more.
  - It was also noted that some service users may not want to give feedback.
4. Engagement with vulnerable people:
- Homeless people were considered to have particular challenges around engaging them for feedback about services. Providers needed to identify vulnerable groups and what specific support their particular/local demographic needs.
  - Telephone interviews or texting were suggested for engaging with housebound patients.
  - Vulnerable people can be afraid of saying something negative about a service in case it impacts negatively on their treatment.
  - A pictorial questionnaire was suggested for communicating with people with complex needs.
  - Service users for whom English is not their first language sometimes do not have access to the services due to the language barrier. A question could be included in Provider Information Returns about whether the service has a large population for whom English is their second language.
5. Engagement with people who use community services:
- Incentivise people to encourage engagement – e.g. vouchers.
  - Tie in engagement with activities that already happen, (such as clinics or appointments), as people may not attend just for an engagement activity.



- It was suggested that CQC engage with user local groups, and that a service user forum (focused and planned in advance) could be held. There would be scope within those of having an inspector attend.
- It was suggested that inspectors speak to peer mentors, who can comment on their own experience and those of people they work with.

6. Engagement with young people:

- Care needs to be taken when engaging with young people. A suggestion was that perhaps a trusted adult at a youth group could engage with the young people in need on a one on one basis.
- Incentives: Offering incentives such as vouchers/sport/music may help engagement with service users.
- CQC could work with Public Health England to tap into existing networks and access hard to reach groups.
- There should be a peer mentor at service user forum groups: a young person who has accessed services themselves in the past and who is now living life to the full within the community.
- Respond to feedback from service users.
- Social media will be the best way to engage with young people.

7. Engagement with families and carers:

- Family and carers often want to be involved in a service user's care. Involve family/carers by asking what they think of the service.
- After care groups could be used as a way of engaging (what were services like, what worked well, what could be improved).
- Interpreters may be needed for people for whom English is not their first language.
- Family visits are important if someone is detained in a prison service.
- Feedback from carers who care for people with complex needs may not be the most appropriate option. As the carers fluctuate, the feedback may not be consistent.
- Many local areas have family and carers support groups CQC could access, though caution should be exercised about the information as not all of the family/carers speak directly with the service.

8. The use of restrictions in services:

- There may need to be some restrictions, but these should be explained to the service user prior to engaging with the service/treatment.
- Issues regarding how services review use of restrictions for service users include:



- whether reviews occur, how and when
  - service user involvement in the review
  - whether there is scope for a service user to go back on restrictions if appropriate
  - how a restriction relates to an individual's risk assessment and recovery plan
  - whether restrictions are individualised
  - what evidence is sought and support in place for a person coming off restrictions?
- It is important to talk to staff and service users, along with looking at care plans/recovery plans/discharge plans.
  - There is variation in use of restrictions between service types. Specific restrictions that may be used in different types of substance misuse services – particularly community, residential rehabilitation and inpatient services – were discussed.

#### 9. Regulatory Impact analysis.

- Providers will incur costs associated with establishing new auditing methods.
- Provider Information Return (PIR) – short term costs higher but reduce over time. It is difficult to judge how time intensive it will be to complete PIRs, but could streamline overall.
- There will be costs associated with preparing for an inspection.
- There is potential for hidden costs.
- Site visit will be more intensive. Bigger inspection teams will affect service delivery (e.g. by impacting staff time).
- Will cost time.
  - More information needed for pre-inspection will cost staff time.
- PIRs may highlight things that are going wrong and providers will try and fix them before CQC come to inspect:
  - Group felt that that was the whole point – they want providers to improve no matter what.
- More staff costs.
- PIR needs to be sent to nominated individual in head office to fill out and have that accountability.
- More inspectors on visits will impact on service delivery.
- New methodology is more rigorous, therefore providers have to be more rigorous too.





- There is a benefit of learning between and across organisations e.g. where good practice could be learned from in relation to key questions. The visibility of reports will also drive learning.
- In reports, it would be useful to see examples and how inspectors have gained evidence.
- Rating would be a driver to improve.
- There was agreement with the benefits of specialist advisors being involved in inspections.
- There will be more demand in what is expected from providers, such as the expectation to identify stakeholders.
- There was discussion about the implications of ratings – particularly if a service was rated as inadequate but a re-inspection doesn't occur for some time, but there is a requirement to display a rating in the interim.



## 6. Teleconference contribution

Engaging with service users:

- The first 8-10 days when people are in detox can be a particularly difficult time to engage them about their care. In the 5 weeks after this there are much better opportunities. However after this period, people can leave services and then it is difficult to gather their feedback. Is there any methodology from the hospital inspections that could be used in substance misuse services inspections – to help reach people once they have left services?
- Positive views on the use of experts by experience programme. A key point to note is that people who become experts by experience have a relatively short 'shelf life' in this sector – as they quickly become rather like members of staff/volunteers in the service and lose the perspective of being a new user.
- Flexibility is key. You need to go to where people are and engage with them when they can cope with it. CQ also needs to be able to talk to people at different times of the day/different days when they are more able to communicate. This needs to be done over an extended time period.
- CQC should look at services for groups of people with particular complex needs e.g. Dual diagnosis, people with a learning disability, people who have come through the prison system, the street homeless
- Service users often don't know which services are regulated and which ones aren't. CQC will need to check which services they are talking about.
- Pilot work on inspections has found that it works better to engage with people without giving them too much warning – working flexibly and asking people who are around at drop-ins etc. to come for a chat
- Providers increasingly offer service users access to computers. It would be worth trying an online survey that providers could encourage people to complete before/during an inspection
- Social media is increasingly used by some service users – it is also worth testing these.
- Text messaging and promoting CQC via text and social media should be part of the methodology
- CQC could spend time in user group sessions in providers with their permission