Change, Grow, Live

Newham Rise

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

The service provides specialist community treatment and support for adults and young people affected by substance misuse who live in Newham. This included community-based alcohol detoxification and an opiate substitute prescribing service. This was the first inspection of this service.

We rated it as good because:

- The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. Staff managed risks to clients well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- The service provided safe care. The premises where clients were seen were safe and clean, well maintained and fit for purpose. The service had appropriate COVID-19 measures in place. The service managed client safety incidents well. Managers investigated incidents and shared lessons learned with the whole team.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. They ensured that clients had access to physical healthcare and supported clients to live healthier lives.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients, including those with protected characteristics. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.
- Leaders had the skills, knowledge and experience to perform their roles, and were visible in the service and approachable for clients and staff.
- A restructuring of services was planned which would introduce a single point of entry to the service and bring down the higher number of cases some practitioners were managing.

However:

- At the time of inspection there was no clinical oversight of new referrals. The service had implemented a new system following our inspection.
- Managers could not give a timeframe as to when staff were due to complete their outstanding BLS training.
- The service was conducting local level audits, although they were behind with audits for assessments, case records and consent.
- Our findings from the other key questions demonstrated that governance processes could be made more robust in recording performance outcomes and improving some of the data systems.
- Staff did not have their own dedicated team meetings and internal governance team meetings were not minuted. This meant that the provider could not be assured that all information was shared with staff.
- The service's risk register did not reflect all the current concerns about the delivery of the service, and we could not see where the risk register was reviewed. This meant that provider could not be assured that service risks were appropriately mitigated.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good	

Summary of findings

Contents

Summary of this inspection

Background to Newham Rise

Change Grow Live – Newham rise is part of a national Change Grow Live provider who deliver a not-for-profit drug and alcohol treatment service. The service provides specialist community treatment and support for adults and young people affected by substance misuse who live in Newham. Services were delivered at three sites within the London borough of Newham.

GL Newham offered a range of services including initial advice; assessment and harm reduction services including needle exchange; prescribed medicines for alcohol and opiate detoxification and stabilisation; naloxone dispensing; group recovery programmes; one-to-one key working sessions, health and blood borne virus checks and hepatitis C testing. CGL Newham also provided an outreach service to engage certain groups, this included a homeless recovery team, a criminal justice team and a youth resilience team. The youth resilience team provided advice and support to clients aged 11-18 years old and their families impacted by substance misuse. This was the first inspection of CGL Newham rise. CGL have been running the integrated substance misuse service in the London Borough of Newham since the 1July 2014. During this time, they have established partnerships with health, social care, probation services, GPs and pharmacies to provide help and support to clients within the borough of Newham. The service received most of its funding from the local authority and the Office for Health Improvement and Disparities for specialist practitioner roles, such as the criminal justice team and the homelessness recovery team.

The service is registered for the following regulated activity:

- Treatment of disease, disorder or injury.

The service was registered on 5 February 2019. There was a registered manager at the service.

What people who use the service say

Clients told us that staff were kind, caring and genuinely interested in their wellbeing and recovery. Clients said staff were respectful, non-judgemental and provided care that met their needs. One client commented that the staff 'helped them turn their life around and build up their self-confidence', another said that 'staff had done an amazing job in helping them to recover from opiates.

The service adapted contact with clients during the restrictions of the Covid-19 pandemic to virtual and telephone contact, to ensure that clients still received therapeutic interventions. Clients told us that they felt supported during that pandemic and they could receive advice from the staff about their medicines.

How we carried out this inspection

This inspection was carried out by three inspectors, one inspector who specialised in inspecting the management of medicines and one specialist professional advisor with expertise and experience in substance misuse.

During this inspection, the inspection team:

- visited the service and observed the environment for three buildings (one virtually) and how staff were caring for clients

Summary of this inspection

- spoke with the registered manager
- spoke with 19 staff including the deputy service manager, quality and governance lead, consultant, team leaders, recovery practitioners, registered nurses, a non-medical prescriber, a clinical administrator, a building recovery in the community coordinator (BRIC) and a peer support worker
- spoke with nine clients
- reviewed nine clients' care and treatment records and six client medicine records
- observed a preparing for detoxification alcohol group and a multi-disciplinary meeting
- reviewed prescribing and the medicines prescription process
- reviewed other documents concerning the operation of the service.

You can find information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- Staff recognised groups of people who were marginalised and harder to reach in the community. Staff worked with the police to build trusting relationships with sex workers, the service had installed a shower for women to use, to engage them with the service.
- Staff developed links with a local GP practice to register clients who were homeless with no fixed abode.
- The service held 12-week psychotherapy sessions for male perpetrators of domestic violence to complete a behavioural change programme.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

The service should ensure that the new referral to assessment process is embedded and followed by staff.

- The service should ensure that all clinical staff complete mandatory basic life support training (BSL).
- The service should ensure that it captures its key performance outcomes including more accurate recording of data.
- The service should ensure that all scheduled audits are completed.
- The service should ensure that there are monthly staff team meetings and internal governance meetings are appropriately minuted.
- The service should ensure that the risk register is regularly reviewed and updated.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Substance misuse services

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

Are Substance misuse services safe?

Good

We rated it as good.

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The service had appropriate COVID-19 measures in place.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Environmental checks were completed as part of a six-monthly health and safety audit for each building; any identified improvements were flagged as an action for staff to complete. Each building had staff who were assigned first aiders and fire wardens. Each building had a fire evacuation plan in place and their fire alarms were tested weekly.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. All premises were cleaned daily and since the pandemic an extra cleaning rota was introduced for staff to clean surfaces three times a day. Group rooms were cleaned in between groups

All interview rooms had alarms and staff available to respond. Staff tested alarms on a monthly basis. All clinic rooms had the necessary equipment for clients to have thorough physical examinations. Staff made sure equipment was well maintained, clean and in working order.

Staff followed infection control guidelines, and handwashing signs were on display. Staff had completed a COVID-19 risk assessment for each building and made changes to the environment in line with COVID-19 guidance, such as introducing hand sanitizer stations, clear Perspex screens and socially distanced workspaces throughout the buildings. Staff screened clients and visitors for COVID-19 symptoms and offered face masks to all who entered the service. The service also used carbon dioxide monitors (CO2) in smaller rooms to help identify poorly ventilated areas, staff vacated the room once the monitor was over a certain measurement. Windows were kept open to enable good ventilation.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. Staff made sure equipment was well maintained, clean and in working order. Clinical and confidential waste was disposed of appropriately.

Good

Substance misuse services

Safe staffing

The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the opiate practitioners was high, however the service had a plan in place to address this.

The service had enough staff to keep clients safe. There were 68 staff working within the service with experience and qualifications of working within substance misuse services. The service had 13 vacancies at the time of our inspection and three of these vacancies were filled with long term agency workers.

The remaining vacancies were one assistant psychologist, one dual diagnosis practitioner, one senior homelessness practitioner, one hospital liaison practitioner, one senior practitioner, one outreach and engagement team leader, one complex needs senior worker and one mental health link worker. Managers were proactively recruiting to these roles.

Managers were also recruiting to new roles that they had received funding for such as, one criminal justice women's worker, two criminal justice workers, one women's outreach worker and one youth awareness transitional worker.

Managers supported staff who needed time off for ill health and sickness levels were low, with two staff on long term sickness. Managers covered long term staff sickness and absence through the use of long-standing agency staff who were familiar with the service.

Staff in the opiate team had caseloads between 76 and 83 clients. This was a higher caseload than other practitioners. Managers were planning to restructure the service, with the aim of reducing high caseloads, by providing a single point of access. Staff told us that they welcomed the service restructure (known as the entry into services model), as this would reduce the time that they spent on administration and assessments and could focus on reducing their caseloads by producing more longer-term interventions. Clients told us that they had regular interventions with their keyworker and could contact them when necessary. Staff told us that despite caseloads being high, they still felt able to manage their caseloads safely. Staff in the alcohol recovery service, non-opiate service and outreach teams had smaller caseloads. Managers recognised high caseloads as a risk to staff wellbeing, so had included this as part of the service quality improvement plan.

The service had enough medical staff. The service had one full-time consultant psychiatrist with a specialism in substance misuse, who was based at the service for half of the week and available remotely for the rest of the week due to their regional role within the service, managers had also recruited an additional full-time doctor to be based within the service. The service also had four full-time nurses and two non-medical prescribers to carry out nursing and medical reviews. Clients said that there was no issue in accessing medical staff when they needed to.

Staff had completed and kept up to date with most of their mandatory training. Staff had completed 90% of their mandatory training, except for data protection training (77%) and basic life support training (BLS) (66%). Managers were aware of this but could not give a timeframe as to when staff were due to complete their outstanding BLS training. Managers ensured that there was a person trained to deliver first aid in each building.

The mandatory training programme met the needs of clients and staff. The training included health and safety, equality and diversity, data protection, the Mental Capacity Act and safeguarding Adults and children. Clinical staff had additional basic life support training as part of their mandatory training. Managers had an overview of mandatory training that was completed and training that was expired or due to expire.

Good

Substance misuse services

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

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in a client's health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Staff followed good personal safety protocols.

Assessment of client risk

Clinical administrative staff triaged and prioritised referrals according to client risks. They were provided with a flow chart to determine which clients were a priority referral due to being more vulnerable, such as pregnant or homeless clients. The clinical team reviewed all new referrals and clients risks in the daily handover meetings as they recognised that administrative staff were not trained to make clinical judgements surrounding risks. Managers had planned to restructure the service from March 2022 to ensure that a clinical staff team reviewed and triaged all new referrals.

We reviewed nine client records. Staff reviewed initial risks for each client on referral and used a recognised tool to complete a detailed risk assessment after meeting with the client. Risk assessments included the risks of clients experiencing alcohol withdrawal seizures and delirium tremens and the risk of overdose for clients using opiates. Delirium tremens is the effect of suddenly withdrawing from alcohol which can be fatal.

Staff assessed clients' risks surrounding their substance misuse, physical and mental health plus any safeguarding concerns and social risks, such as housing and social networks. Staff followed structured assessments to determine the severity of clients' alcohol use, such as the alcohol use disorder identification test (AUDIT), the severity of alcohol dependence questionnaire (SADQ) and used the clinical opiate withdrawal scale (COWs) to assess opiate withdrawal levels for clients who were under medication assisted treatment.

Staff made clients aware of harm minimisation and the risks of continued substances misuse. This included verbal and written information about the risks to clients of drinking alcohol or taking drugs with their prescribed medicines. The service also had a Harm Reduction Coordinator. Recovery workers referred clients to the nurse when assessments indicated this was appropriate. Clients were offered tests for blood borne viruses such as hepatitis B and HIV.

Management of client risk

Staff responded to changing risks to clients, which were reviewed in daily handover meetings and at weekly multidisciplinary (MDT) meetings. Staff shared information and reviewed client risks, new incidents and safeguarding concerns. Staff decided at MDT meetings whether a client was suitable for community detoxification from alcohol or whether their needs or living arrangements meant it was safer to complete this in an inpatient setting. Staff described these meetings as excellent and very informative. Staff continually monitored clients on referral lists for changes in their level of risk and responded when risk increased.

Staff ensured that there were risk management plans and actions in place for clients who had been verbally aggressive, and they were assessed to be high risk. Staff ensured that risk management plans and actions were in place for clients who had shown verbal aggression at the service, such as giving clients a verbal and/or written warning about their inappropriate behaviour.

Good

Substance misuse services

Client records showed that staff ensured that clients were made aware of the risks of continued substance misuse, such as using substances on top of prescribed medicines. Staff gave advice regarding withdrawal from alcohol, and the risks of continued substance misuse. Risk assessments covered the potential risk to others, including children. Any safeguarding concerns were flagged on the records so that staff were immediately aware of them.

Staff offered clients advice and support to keep as safe as possible. Clients, who took certain medicines such as methadone were offered a safe storage box so that children and other people could not access it. Staff offered clients different sized boxes depending on their needs.

Clients received varying levels of medical supervision, depending on their pathway and assessed risks. Clients completing the community detoxification treatment for alcohol were expected to meet with a nurse for the first five days and would be prescribed medicines to stop withdrawal symptoms. Clients on the opiate substitute treatment programme attended a community pharmacy daily for a pharmacist to supervise their consumption of the medicine. Clients who were assessed as lower risk were able to collect their medicine weekly or fortnightly from the pharmacy.

During the height of the COVID-19 pandemic, there had been increased flexibility in the frequency with which clients were able to collect their prescribed medicines. For those clients assessed as being at higher risk, daily pickups were still available.

Staff followed a protocol for clients who unexpectedly exited the service. Staff recognised that there may be occasions when clients dis-engaged from the treatment programme. Client records showed that staff made repeated attempts to contact clients who missed appointments to help them re-engage with the service. Clients who had missed appointments were discussed in the daily handover meeting and weekly multidisciplinary meeting (MDT). Staff were asked to share 10 clients who had disengaged from the service in the MDT meeting and actions were set, such as assigning a volunteer to contact the clients to ensure that they were safe. Staff informed other services when they had a duty to do so, such as safeguarding or probation services. Staff shared information leaflets with clients on the risks of using substances after completing treatment

Staff followed clear personal safety protocols. When staff made home visits to clients they did so in pairs and ensured that their diaries were updated with their whereabouts. Staff were expected to phone when they had finished a home visit, managers followed an escalation process if this did not occur.

The service had 549 clients in medication assisted treatment when we visited the service. Medication assisted treatment involves the use of medicines, in combination with other treatments such as psychotherapy, counselling and group therapy. The service was expected to complete a medical review for each client under medication assisted treatment annually in line with national guidance. The service had 27 overdue medical reviews; managers told us that these were overdue due to client disengagement.

All overdue medical reviews were discussed in the daily morning handover meeting and actions set, such as rebooking the review and prioritising according to client risk. For example, staff had asked one client to pick up their prescription from the service instead of a pharmacy in order to engage them in a medical review. Managers had oversight of overdue medical reviews on a dashboard, including contact attempts staff had made. Managers had identified this as an area to be addressed within their quality improvement plan but had not included this in the service's risk register.

Staff responded promptly to any sudden deterioration in a client's health. We saw evidence in records that staff had considered and updated risks where necessary. Clients who were suspected of using on top of their medicines were asked to administer their medicines under supervision. The service had a protocol in place for staff to follow if clients were suspected of passing their medicines to third parties. Clients were expected to provide information about their next of kin and who to contact in an emergency.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. At the time of the inspection, 90% of staff had completed adults at risk safeguarding training and 95% had completed children and young people safeguarding training.

Staff were able to identify risks to and from clients and knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave examples of where they had to make a safeguarding referral, such as where a client had disclosed that they were subject to female genital mutilation (FGM). Staff could access weekly drop-in sessions with the safeguarding lead to receive advice and guidance for client safeguarding concerns.

Staff discussed safeguarding concerns in daily handover meetings and weekly multidisciplinary meetings. Clients' records showed comprehensive and detailed records around safeguarding concerns. Clients with a current safeguarding concern would have an 'S' placed next their name, historical safeguarding concerns were also listed. Managers had oversight of current safeguarding concerns and were able to export a list of current safeguarding issues to be reviewed at the morning handover meeting.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff attended multi-agency risk assessment conferences (MARAC) meetings fortnightly and multi-agency safeguarding hub (MASH) meetings. The service provided protected visiting hours for young people, so that they did not mix with other clients. The Young person's team leader had recently presented to the MASH team about the services the young people's team deliver. Staff signposted clients to a local organisation which helped clients experiencing domestic abuse, modern slavery and help exiting sex work.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff explained that any form of harassment or discrimination would not be tolerated.

The service had held a 12-week psychotherapy workshops for male perpetrators of domestic violence to complete a behavioural change programme.

Mangers completed a safeguarding audit for 40 service users to review if appropriate referrals were made to social services and that records were updated with the relevant information, such as family details and protection plans.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Good

Substance misuse services

Staff used electronic clients records to record and access information concerning clients. Staff kept comprehensive and detailed records of clients' care and treatment. We looked at nine records, they were clear, up-to-date and all staff could access them easily.

One record had wrong client information, this was highlighted and immediately rectified.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed systems and processes to store, prescribe and administer medicines safely. Medicines and controlled stationary were stored securely, and electronic records were kept of their use.

Clinical staff were responsible for producing and signing printed prescriptions. Prescriptions were either given directly to the client or posted to the pharmacy. All prescriptions were logged and recorded on the electronic client record system, which enabled staff to follow up if there were any issues of loss or theft. The service used a courier service to deliver prescriptions to pharmacies.

Clinical rooms were clean, spacious and equipped with handwashing facilities. Staff had access to emergency equipment, medicines and disposal facilities. The service had a contract with a waste management company who disposed of all their use sharps bins and clinical waste. However, we were told that the company had not collected one sharps bins due to a miscommunication, but this was resolved.

Staff monitored the temperatures of medicines storage areas. If temperatures went outside the recommended range, staff acted to safeguard the medicines. This included liaison with the pharmacy team. Staff completed monthly medicines and medical equipment audits.

Staff developed links with a local GP practice to enable clients to register if they did not have a doctor, such as clients with no fixed abode. Staff requested a GP summary for clients every six months in preparation for their medical reviews and to ensure that medicines records were up to date. Staff also wrote to GP practices to keep them informed of treatment provided to clients.

Staff reviewed each client's medicines regularly in multidisciplinary meetings and provided advice to clients and carers about their medicines. Staff provided training to opiate clients on how to use Naloxone, which is used in an emergency to reverse the effects of an opioid overdose. Staff were able offer clients Naloxone kits at each site, in addition to needle exchange kits. Clients using the opiate substitute prescribing service were given information leaflets, which included using methadone, buprenorphine, naltrexone and espranor and the risks of using on top of these medicines. Clients were also given leaflets on how to keep medicines safe with children at home and a safer injecting guide.

Staff followed current national practice to check clients had the correct medicines.

Staff obtained client's consent to share and receive information with their GPs. This enabled staff to access medical and drug histories prior to the prescribing of medicines and to limit the risk of double prescribing medicines. Staff requested

a GP summary for clients every six months in preparation for their medical reviews and to ensure that medicines records were up to date. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff limited client access to certain medicines if they suspected them of using on top of substances or passing their medicines to others, known as diversion.

The service had systems to ensure staff knew about safety alerts and incidents, so clients received their medicines safely. Medicines incidents were reported on an electronic system and investigated by the clinical lead. Incidents were reviewed in the internal governance team meeting. Learning was shared with staff as well as implemented changes.

Staff reviewed the effects of each client's medication on their physical health according to NICE guidance. Clients agreed to be subject to random Urine Drug Screening (UDS) to determine if clients had used any illegal substances on top of their medicines. Clients were offered blood borne virus tests prior to treatment (hepatitis B, hepatitis C, and HIV).

If a client tested positive for hepatitis B, nurses was able to administer the hepatitis B vaccine, as a Patient Group Direction (PGD) was in place. A PGD allows specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber. Clients receiving over 100mg of methadone per day had an annual electrocardiogram. This was to monitor clients for abnormal heart rhythms which are associated with high doses of methadone, which could be fatal.

Track record on safety

The service had a good track record on safety. Seventeen clients using the service had died within the previous 12 months. None of these deaths were related to the treatment provided by the service, however the prison ombudsman had identified, where some service improvements could be made. They had identified that there were gaps in some cases where contact was made with the clients, inconsistencies with the re-engagement protocol and a lack of contingency planning when staff were on sick leave.

Managers had introduced a service wide plan to make improvements by ensuring that continuity planning was in place for when staff were on sick leave by including a prompt as part of the daily handover meeting. Managers had improved the re-engagement protocol to ensure that contact was made with clients who had disengaged. These clients were discussed in the daily handover meeting, and actions agreed, such as assigning volunteers to contact them. The service had also introduced a 'prison release tracker' to be reviewed at the daily handover meetings to ensure that weekly contact was made with prisoners who had been released from prison. Quarterly workshops were introduced for the quality and governance lead to support and train staff around effective case management and the different tools they could use.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff understood their responsibilities to raise concerns and report incidents in line with the service's policy. Staff felt confident and supported when reporting and discussion incidents. The service had 87 reported incidents within the last 12 months. The highest reported incidents were verbal aggression incidents from clients, medical emergencies, deaths, medication, security and environmental issues. The service had no never events.

Good

Substance misuse services

Incidents were discussed in the daily handover meeting and reported on the electronic records system. Staff ensured clients, and where appropriate family members and other professionals, were updated. Staff also ensured care records were updated after an incident. Managers investigated incidents and shared lessons learned with the team in the monthly internal governance review meeting, such as improvements made from the internal deaths review.

There was evidence that changes had been made as a result of staff feedback. Managers recognised that there had been a high number of incidents of racial abuse towards staff and other clients and had introduced a 'Newham rise response to racial incidents' strategy. This included completing a staff survey, introducing a working group and creating a 'no excuse for abuse' poster in the service. The service's risk management protocol was reviewed to ensure that there was a collective approach in the service dealing with incidents of verbal abuse. Managers had noted a decrease in verbal abuse, since introducing these measures.

Managers ensured that staff were debriefed and supported after any serious incident. The psychosocial lead held de-brief sessions for staff within 24 hours after a client had passed away.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. Information posters were on display in the service detailing the duty of candour.

Are Substance misuse services effective?

Good

We rated effective as good.

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients when they accessed the service. They worked with clients to develop individual recovery plans and updated them as needed. Recovery plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

We looked at nine care and treatment records. Staff completed a comprehensive assessment of each client. Assessments covered drug and alcohol history, mental health and physical health needs, sexual health needs, safeguarding concerns and social needs. Records showed that staff met regularly with clients, whether in person or virtually.

Recovery plans were personalised, holistic, recovery-orientated and reflected the needs of each client, including mental health, social circumstances and physical health needs. Client views were present in the records. Clients told us that they were involved in developing their recovery plans and recovery coordinators helped clients develop treatment goals. Staff regularly reviewed and updated recovery plans with clients when their needs changed.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. Records showed that clients received a physical health assessment when they started with the service and that this was reviewed frequently. Staff followed clear pathways when assessing clients. Nurses and doctors assessed clients for community alcohol detoxification and doctors assessed clients and the opiate substitute treatment programme. Clients were expected to attend a face to face assessment with the doctor before being prescribed any medicines.

Good

Substance misuse services

Records showed that staff supported clients to safely reduce and stop their alcohol and drug use through the appropriate use of withdrawal tools and by following national guidance on detoxification. Staff ensured that all appropriate correspondence was recorded, such as assessments, GP summaries, blood test results, urine drug screen testing, ECGs and Liver function tests (LFTs).

Best practice in treatment and care

Staff provided a range of treatment and care for clients based on national guidance and best practice. They ensured that clients had good access to physical healthcare and supported them to live healthier lives. Staff had access to recognised rating scales to assess and record severity and outcomes. They also participated in clinical audits.

Staff provided a range of care and treatment suitable for the clients in the service. Staff delivered care and treatment in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence (NICE) and the Office for Health Improvement and Disparities guidance. This included motivational interviewing, one to one key working, substitute prescribing community alcohol detoxification, self-management guidance, activities, psycho-social therapy groups and work opportunities.

The service had a psycho-social therapy group timetable for clients such as alcohol pre-detox and detox groups, opiate change groups, recovery support groups, a non-opiate group and a family and carers group. Managers planned to increase the psychosocial groups for the opiate and non-opiate pathway to mirror those provided by the alcohol detox pathway.

The service offered groups both virtually and face to face as managers recognised that this benefitted different groups of clients, for example some clients expressed that they felt safer attending groups virtually. We observed a face to face group taking place. The focus of the group was recovery capital, the resources that clients could access to support and maintain their recovery. Clients participated actively in the discussion. One client said they enjoyed the groups and found them helpful, particularly sharing experiences with others

Staff were aware of NICE guidelines and used these to help clients access mental health services. For example, a worker used the NICE guidelines in respect of post-traumatic stress disorder to help a client access appropriate mental health support. Staff supported clients to access mutual aid groups such as Alcoholics Anonymous.

Staff made sure clients had support for their physical health needs. Clients with opiate dependence had a prescription for methadone or buprenorphine depending on their individual needs and circumstances and in line with national guidance. Clients' prescriptions were reviewed regularly, and clients had urine drug tests to monitor their use of illicit drugs. Clients were prescribed thiamine and Pabrinex in line with national guidance to minimise memory loss as a result of alcohol misuse. A client described a range of tests they received at the service in relation to their physical health, including blood tests.

Clients seeking treatment for alcohol misuse were assessed using the alcohol use disorder identification test (AUDIT) and the severity of alcohol dependence questionnaire (SADQ). Staff used the clinical opiate withdrawal scale (COWS) to monitor the severity of opioid withdrawal during opioid detoxification. Staff recorded assessment scores in client records and knew when to escalate results to a nurse or doctor.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. The service signposted clients them to health and wellbeing support in the community, such as smoking cessation services.

Staff took part in clinical audits and these included health and safety, safeguarding, infection, prevention and control, vaccine storage, prescriptions, case records, risk and recovery planning, assessments, supervision, consent, safeguarding, incidents, complaints, equality diversion and inclusion, information governance and service user involvement. Managers recognised that the service was behind with their audits for assessments, case records and consent and planned to complete these by March 2022.

Managers had completed some additional audits which were not included in the annual audit schedule to improve client care. These included a GP shared care audit, to review 62 client records under this agreement, such as ensuring that clients had a copy of their crisis plan and were offered naloxone and safe storage boxes. Records were reviewed in November 2020 with improvements and areas of good practice highlighted, records were then re-reviewed in July 2021. Managers planned to introduce this audit annually.

Staff used technology to support clients. Staff offered clients telephone and video call support and also sent reminder text messages to clients. Staff could access GP summaries on the client record system.

Monitoring and comparing treatment outcomes

Staff used recognised rating scales to assess and record severity and outcomes. Staff told us that they used treatment outcomes profile (TOPS) to assess clients' progress and outcomes before, during and at the end of treatment. The service contributed to the National Drug Treatment and Monitoring System.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each client. Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including agency staff. Staff included opiate, non-opiate and alcohol recovery practitioners, criminal justice practitioners, outreach practitioners including young people and homelessness workers, nurses, complex needs practitioners, doctors, peer support workers, social workers, volunteers and a clinical psychologist, a dual diagnosis worker and a building recovery in the community coordinator (BRIC).

Managers informed us that the current supervision rates were 67%, although supervision data was only provided for 45 staff but there were 68 staff working within the service. Despite this, all staff we spoke with told us that they received monthly clinical and managerial supervision. Managers supported staff through regular, constructive appraisals of their work. Managers had completed 81% of annual appraisals by December 2021. Staff received monthly reflective practice sessions facilitated by a psychologist. Staff said they were able to access support from senior staff whenever they needed to.

All staff received a comprehensive two-week induction before starting work. Managers made sure agency staff had a full induction and understood the service before starting their shift. Agency staff received a specific induction plan, which included the management team profiles, organisational staff structure, contact numbers and necessary policies and procedures, such as the medicines management policy.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, some staff told us they had completed training in motivational interviewing and suicide prevention. Staff had access to training provided by the local authority. Staff informed us that progression in their career development was encouraged, for example the building recovery in the community (BRIC) coordinator was previously a peer mentor within the service. Nurses told us that they were moved between the alcohol service, opiate and non-opiate services on a six-month rotation to ensure that they were not deskilled by only working within one service. Managers planned for staff to attend an e-learning training programme on the 'Best practice in Optimising Opioid Substitution Treatment' within 2022.

Managers made sure that staff attended multidisciplinary meetings and monthly internal team governance meetings (IGTM), however staff did not have their own dedicated team meeting to feedback about the service. Managers said that they planned to introduce meetings for staff only by March 2022. Managers created a set agenda and a presentation for the IGTM, although we could not see any other minutes for this meeting, such as detailing which staff were present at the meeting and any feedback or follow up actions.

Managers recruited, trained and supported volunteers to work with clients in the service. The service had four volunteers and one peer support worker within the service and planned to recruit more.

Multidisciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team had effective working relationships with other relevant teams and services outside the organisation.

Staff held weekly multidisciplinary meetings (MDT) to discuss clients' progress and improve their care. We observed an MDT meeting, staff had a good detailed knowledge of clients and there was strong team working amongst the clinical and non-clinical staff. Discussions included physical health and mental health, social circumstances, prescriptions, safeguarding concerns, risks and engagement with the service. Learning from incidents and overdue medical reviews were also discussed in the MDT. Staff also had space at the end of the MDT to discuss and learn from good practice that they had noted within the team.

Staff made sure they shared clear information about clients and any changes in their care including during daily handover meetings. Staff took minutes of the meeting and actions were noted for the next meeting. The service had a shared care agreement in place with a local GP to jointly manage the care and treatment of clients using the service. The service carried out a recent audit, which showed that this was working effectively.

Staff had effective working relationships with other teams in the organisation. Staff worked closely with other teams within the service located across the three buildings. In addition to the alcohol recovery pathway, non-opiate and opiate pathways, there was an outreach service. The outreach services included the criminal justice team, the homelessness recovery team and the young person's resilience team.

Staff had effective working relationships with external teams and organisations. Staff gave us examples of how they worked with a range of other agencies to help meet clients' holistic needs. These included probation services, police, local acute hospitals, local authority safeguarding teams, pharmacies, housing services and voluntary sector organisations. Staff told us that partnership working with mental health services could be improved. Some said mental health services were reluctant to engage with clients using substances. Managers were in the process of recruiting a new mental health dual diagnosis worker to address this.

Good

Substance misuse services

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the providers' policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for clients who might have impaired mental capacity.

Staff received training in the Mental Capacity Act and knew to seek support for the service managers if needed. Staff had completed 92% of their mental capacity act training.

Staff knew where to get accurate advice on Mental Capacity Act. Staff discussed clients' capacity in multidisciplinary meetings and if there was any doubt then the consultant would conduct a capacity assessment.

Staff gave clients all possible support to make specific decisions for themselves. Clients records showed consideration and assessments of clients' capacity was in line with underlying principles of the Mental Capacity Act. Staff gave examples of when a client's mental capacity to make decisions about their care could become temporarily impaired, such as when a client was intoxicated.

Staff ensured that clients consented to their care and treatment in the service and this was recorded in a client consent form, including sharing information with other professionals.

Are Substance misuse services caring?

Good

We rated caring as good.

Kindness, dignity, respect and support

Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.

We observed staff treating clients with compassion, respect and kindness. They spoke with understanding about clients and the problems they were facing. We spoke with nine clients, they said staff were respectful, non-judgemental and provided care that met their needs. One client commented that the staff 'helped them turn their life around and build up their self-confidence', another said that 'staff had done an amazing job in helping them to recover from opiates.'

Staff clearly understood and respected the individual needs of each client. Clients told us that they could always contact their keyworkers when needed, such as to receive advice or discuss medicines. Staff provided help, emotional support and advice when they needed it. The peer support worker contacted clients weekly during the restrictions of the pandemic to check on their wellbeing.

Staff supported clients to understand and manage their own care treatment or condition through one to one key working sessions and groups. We observed a preparation for alcohol detoxification group. Clients were informed of what they could expect when they started their detoxification journey, including a discussion of coping strategies and goals they wish to achieve.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. Staff has raised concerns about racial verbal abuse, managers had responded to this by reinforcing the service user agreement, reminding clients that they do not tolerate any kind of racial, sexual, homophobic or discriminatory abuse.

Staff directed clients to other services and supported them to access those services if they needed help, such as housing, finance and health and wellbeing support.

Staff followed a policy to keep client information confidential.

The involvement of people in the care they receive

Staff involved clients in recovery planning and risk assessment. They ensured that clients had easy access to additional support.

Involvement of clients

Clients told us that they were given clear information as to what they could expect from their care and treatment. Clients said that they were involved in creating their recovery plan with their keyworker and had a copy of this. Staff provided clients with written information in addition to verbal information, such as the effects of suddenly withdrawing from alcohol which can be fatal (known as delirium tremens). The service was in the process of updating their leaflets. Clients said staff were responsive to their needs. One client described how a recovery worker had attended a mutual aid group with them.

Staff involved clients in decisions about the service, when appropriate. Clients were informed of updates to the service and could give feedback through the monthly service user forum, chaired by the peer mentor, for example clients asked for a women's only group, which was due to be implemented in March 2022.

Clients felt confident to give feedback on the service and their care and treatment. Staff listened to client feedback and implemented changes for them to access non-medical prescribers for advice.

Staff made sure clients could access advocacy services. Advocacy information was on display for women who required support in exiting prostitution.

Involvement of families and carers

Staff gave families and carers client information and were invited to attend appointments, with the clients' consent. The service had a dedicated carers and families lead that gave advice, information and support to carers and families and signposted them to other agencies.

Staff gave interventions to families and carers who were directly or indirectly impacted by substance misuse. Carers and families were invited to attend a 'strengthening families together' group. This was a virtual psychosocial group which helped to educate and support parents and families, who were impacted by substance misuse or addictions.

Staff helped families to give feedback on the service. The service had a weekly carers and family group for staff to support carers and family with their needs and to obtain feedback about the service. One family member commented that 'thank you for being a supportive person towards my mum, they are now motivation to carry out tasks.'

Good

Substance misuse services

Are Substance misuse services responsive?

Good

We rated responsive as good.

Access and waiting times

The service was easy to access. Staff planned and managed discharge well. Staff followed up clients who missed appointments.

The service had clear criteria to describe which clients they would offer services to. Clients could access the service by self-referring or through referrals from third party agencies, which included GPs, housing teams, probation services and social services. The service aimed to offer a first assessment appointment within the two days of receiving the referral and eight days from the first assessment to prescribing, if appropriate. New referrals were assessed and allocated in the daily handover meeting; urgent referrals were seen within 48 hours. The service used a system to monitor referral waiting lists and the average time from referral to assessment was 1.37 days. Staff tried to contact clients who did not attend appointments to rebook them and offer support. Clients' records showed that delays were due to clients not being able to attend offered appointments. Clients' records showed persistent attempts to contact people that did not attend appointments, including signposting clients to other community services, contacting third party agencies and carrying out home visits if necessary.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support. The service had outreach workers, a homeless recovery team and a young person's team. The homeless recovery team provided drop-in services to local hostels.

Staff recognised groups of people who were marginalised and harder to reach in the community. Staff worked with the police to build trusting relationships with sex workers, the service had installed a shower for women to use, to engage them with the service. The Young person's service had engaged with young people within local schools and had also planned to deliver training to external agencies, such as foster carers and children impacted by substance misuse.

The service had developed a specific pathway for clients who were dependent drinkers and resistant to change, called the 'blue light pathway'. The service aimed to meet the needs of clients who struggled to engage with the service and regularly relapsed. This new approach involved a more in-depth assessment, including a home visit. Staff offered more coaching to clients and explored alternative approaches to supporting the clients and addressing their complex needs. Staff had received training in the 'blue light' approach, but not additional funding. The pathway was created as part of a national initiative to develop alternative approaches and care pathways for change resistant drinkers who presented to emergency services, such as frequent hospital attenders.

The service also had a complex needs team to work with clients who were assessed to be of high risk, such as those with a mental health illness or clients who were not stable with their medicine scripts. The team also worked with clients to identify appropriate inpatient detoxification and rehabilitation facilities. One staff member had excellent knowledge of the rehabilitation services available around the country, the type of client they catered to and were most successful with. They completed applications for funding for placements on behalf of clients. The complex needs worked kept in touch with the clients while they were in rehabilitation. Clients in rehabilitation and detoxification were reviewed every six weeks and staff were in contact when clients completed rehab programmes and returned to the area.

Clients had some flexibility and choice in the appointment times available. Staff tried to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible. Clients said that appointments were rarely cancelled. When clients did not attend planned appointments, records showed that staff made repeated attempts to contact them.

Staff supported clients when they were referred, transferred between services, or needed physical health care. When clients were ready to be discharged from the service, staff followed a clear discharge process. Staff sent clients and their GP a letter of discharge and signposted clients to other services in the community. Managers reviewed discharges weekly to ensure that they were appropriate.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Each premises had enough space for clients and staff to us, Interview rooms in the service had sound proofing to protect privacy and confidentiality. Clients had access to a service user kitchen where they could make hot drinks.

Staff had access to clinic rooms in each building with equipment suitable for the physical examination of clients. Each premises had a welcoming reception area for clients, including a water machine.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication support needs.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Staff explained that they adapted their communication method as much as possible to meet the needs of people with a learning disability or autism, for example one client found it helpful to have their treatment plan explained to them in diagrams.

Staff understood and respected the individual needs of each client, including the issues facing vulnerable groups, including lesbian, gay, bisexual and transgender, queer plus (LGBTQ+), homeless clients and clients subject to domestic abuse. The service had a dedicated LGBTQ+ champion and HIV champion who staff and clients could access for support, advice and feedback about the service. Information was on display to celebrate LGQBT+ history month.

The service provided information in a variety of accessible formats so the clients could understand more easily. Clients could access interpreters if they did not speak English and could specify the preferred gender of the interpreter.

The service was accessible for clients using wheelchairs and clients with other mobility needs. One building was based on the ground floor and had an accessible ramp to access the building, another building had a lift for clients to access each floor. The buildings also had accessible toilets for clients to use.

The service had worked in conjunction with the police to support women, by including women only visiting hours and a women's only group, the service was in the process of creating a therapeutic space for women and joint working with female police officers. The service had also introduced protected visiting hours for young people to only attend the service.

Staff made sure people could access information on treatment, local service, their rights and how to complain. Recovery coordinators provided a range of social support to clients including supporting them with benefits and housing. In a therapeutic group we observed staff provided information to clients on local community groups. Staff described how they went the extra mile for clients. For example, when a client did not have any food, a recovery worker accessed a local food bank and delivered the food to them at home.

The service had information leaflets available in their reception areas for clients, such as local Narcotic anonymous or alcohol anonymous groups. the mental health crisis line and information in different languages, such as polish and Greek. Staff provided leaflets to clients about different types of drugs and their side-effects and

Clients using the alcohol recovery service were provided with a 'my journey' folder, which included reflective tools for clients to use such as a drink diary and information that they could access to stay abstinent, such as websites with online resources.

The service had employed a building recovery in the community (BRIC) coordinator who was actively recruiting new volunteers and peer support mentors to the service and building relationships with services in the community, such as working with a local college to enable clients to access training courses. Peer mentors received training on safeguarding, health and safety and maintaining professional boundaries.

Clients could access a service called 'build on belief', which provided activities on the weekends at one of the premises, such as art workshops, table tennis, gardening, books and quizzes to help aid clients with their recovery.

The service worked in partnership with other agencies to meet the needs of clients. The service had formed a partnership with a legal organisation which offered clients free legal advice and representation on issues such as housing and debt. Staff also engaged clients in an employment support service, to provide advice and skills to clients in working towards employment.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

The service had received five complaints in the previous year. One complaint was partially upheld, two were upheld and three were not upheld.

Clients knew how to complain or raise concerns. Clients could feedback on the service through suggestion boxes located in the reception areas, complaint information was also on display. Clients we spoke with said they felt confident in raising concerns if they needed to. Recovery workers reminded clients how to raise concerns or complaints about the service at the beginning of a therapeutic group.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint. Clients received a letter detailing the investigation and the outcome within 28 days of making the complaint, unless there were unforeseen delays.

Managers investigated complaints and identified learning to improve the service. For example, the service had adapted its website to include information on complaints and compliments after a client had highlighted that this was missing. Complaints were reviewed as part of the quarterly management governance meeting, although we could not see where feedback from complaints was shared with staff.

Good

Substance misuse services

The service used compliments to learn, celebrate success and improve the quality of care. The service had received 12 compliments within the last 12 months, managers reminded staff to record the compliments they had received, including thank you cards. One client said, 'thank you to staff for helping me through my detox and aftercare, as they helped me to turn my life around.'

Are Substance misuse services well-led?

Good

We rated well-led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, and were visible in the service and approachable for clients and staff.

Staff felt supported and could approach the management team. Staff spoke highly of the service manager and deputy manager. The service manager was due to leave the service, the deputy manager was to act as the interim service manager with support from a neighbouring service manager, whilst their post was advertised.

Vision and values

Staff knew and understood the service's vision and values and how they were applied to the work of their team.

staff understood the vision and values, and these were displayed in the service. These were believing in people, being open, compassionate and bold. Clients said that they could approach the service managers if they needed to.

Culture

Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.

Staff wellbeing was a priority for the service's managers. It was included on the service's quality improvement plan. Staff told us that the provider encouraged them to take a well-being hour each week, within work time to do as they wished. Staff told us they appreciated this and found it valuable. Staff at two of the premises were able to maintain a herb and vegetable garden to promote their wellbeing. Staff also had access to an employee assistance programme. Staff expressed that they felt proud and passionate in working for the service.

Staff gave positive feedback about the planned restructure to the service, recognising the impact that it would have on each team within the service.

Staff reported that the service promoted equality and diversity in its day to day work and in providing opportunities to staff who had experience of misusing substances. Managers had recognised that there was a high number of incident concerning racial abuse towards staff and created a number of measures to deal with this, such as creating a working group, reviewing incidents in the daily handover meeting, asking staff to complete a survey and ensuring that staff knew how to immediately escalate incidents of abuse.

Good

Substance misuse services

Good governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively. Recording outcomes and data, audits, team meetings and the risk register could be further embedded and improved.

There was a governance structure to learn from incidents, deaths and complaints, discussed in the monthly governance meetings. There were robust referral processes, management of client risk, safeguarding procedures and a business continuity plan to keep clients safe, however not all areas of the service were subject to performance monitoring. The service had not consistently recorded outcomes in relation to their key performance indicators due to the COVID-19 pandemic, although managers had planned to introduce this from March 2022 as part of their quality improvement plan.

Managers had access to a dashboard of clients, including overdue medical reviews and treatment outcome profiles (TOPS). Managers also had oversight of annual appraisal rates and mandatory training rates. However, oversight of recording on some of the data systems could be improved, for example managers were unable to produce an up to date list of individual staff caseloads, as two staff caseloads were missing and supervision data was only provided for 45 staff but there were 68 staff working within the service.

The service completed an annual audit schedule which included health and safety, safeguarding, infection, prevention and control, vaccine storage, prescriptions, case records, risk and recovery planning, assessments, supervision, consent, safeguarding, incidents, complaints, equality diversion and inclusion, information governance and service user involvement. However, the service was behind their planned schedule due to the COVID-19 pandemic. Managers recognised this and planned to complete the audits for assessments, case records and consent by March 2022. Managers did not have oversight of all compliance percentage rates for audits on one dashboard, which could be difficult for managers benchmark compliance rates over a period of time.

The service had an internal governance team meeting for all staff with a set agenda and a presentation shared with staff, although this meeting was not minuted, which meant that there was no record of the discussions and actions to be followed up. Managers attended fortnightly business meetings, staff did not have their own dedicated team meetings, although managers planned to introduce these by March 2022. We also could not see where the risk register was reviewed, although service risks were listed on the quality improvement plan, which was reviewed in the quality governance meeting.

The service submitted data and appropriate notifications to the CQC when required.

Management of risk, issues and performance

The service had a quality improvement plan in place to identify and address risks, although this did not correspond with the service's risk register. Managers identified the top risks to service delivery as staff wellbeing, recruitment and high caseloads for staff.

The service's risk register did not reflect all the current concerns about the delivery of the service. The service did not have the overdue medical reviews or high caseloads listed on their risk register, although these were listed on the service's quality improvement plan, which was reviewed in the monthly quality governance meeting. We could not see where the risk register was reviewed or how this was shared with staff.

Service managers could not share the key performance outcomes, such as the number of psychosocial groups that had been completed during quarter three as this has been on hold during the COVID-19 pandemic. Managers informed us that they were due to start recording performance outcomes from March 2022.

The service had a business continuity plan in place for each of the buildings to address how to deal with emergencies. One of the buildings had suffered from a flood and had followed the business continuity plan, using other premises whilst this was resolved.

Information management

Staff ensured that incidents were recorded on the service's incident reporting system. Managers recognised that this could be improved, so the quality and governance lead planned to deliver workshops with staff.

Staff informed us that they had the technology and equipment to do their work and the telephone system worked well. Managers had purchased new telephone headsets for the restructure of the service with a single point of access. Clients told us that they did not face any problems in trying to phone staff when needed.

The service used an electronic confidential client record system. Staff ensured that clients understood how their information was stored and shared and asked them to sign a consent form, which was kept in their records.

Leadership, morale and staff engagement

Staff described good morale and were very positive about their colleagues. They felt respected, valued and supported by managers and colleagues. Staff were passionate about working together to help clients achieve their recovery goals. Clients told us that it was helpful to have a recovery worker who had lived experience of addiction issues, to encourage and empower their recovery.

Managers made sure that staff attended multidisciplinary meetings and monthly internal team governance meetings (IGTM), however staff did not have their own dedicated team meeting to feedback about the service. Managers said that they planned to introduce meetings for staff only by March 2022.

Staff said they could raise ideas for improvements. Staff had identified that the London borough of Newham had a high rate of fires in the home that were related to alcohol consumption. Staff had contacted the London Fire Brigade to ask them to share fire safety and prevention information with clients.

Commitment to quality improvement and innovation

Even though the service did not use a quality improvement model to improve the service, managers had identified improvements and developed the service.

Managers had created a new 'entry into services' model from March 2022 to provide a single point of access for clients. A dedicated clinical team provide assessments and intensive support before clients were transferred to the recovery practitioner for longer-term support. Managers also created this model to address the high caseloads of some practitioners, as staff were expected to assess clients in addition to managing their caseloads.

Good

Substance misuse services

The service worked closely with the local authority and the Office for Health Improvement and Disparities in recognising and responding to the needs of the local population, for example one service is located in an area of Newham which has a high population of sex workers and drug use. The service actively engaged and formed partnerships in the local community to ensure that clients with substance misuse problems received quality care to meet their needs, such as third-party organisations.