Change, Grow, Live

CGL Waltham Forest Adults Substance Misuse Service

Inspection report

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Date of inspection visit: 19 January 2022
Date of publication: 15/03/2022

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 affected by substance misuse who live in Waltham Forest.

Our rating of this location was good because:

- The service provided safe care. The premises where clients were seen were safe and clean. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received 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. They actively involved clients in decisions and care planning.
- Most clients that we spoke to were happy with the level of service they were receiving and felt well supported by staff.
- 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 was well led, and the governance processes mostly ensured that its procedures ran smoothly.

However:

- Not all clinical staff had completed basic life support training.
- The service's risk register did not reflect all of the leadership team's current concerns about the delivery of the service.
- At the time of inspection there was no clinical oversight of new referrals. The service had implemented a new system following our inspection.
- There were significant vacancies in the alcohol and non-opiate team. At the inspection three out of four vacancies were covered by agency staff. This meant that there was a risk that clients could receive inconsistent care and treatment.
- Client's consent to treatment was not always recorded.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	

Summary of findings

Contents

Summary of this inspection

Background to CGL Waltham Forest Adults Substance Misuse Service

Change Grow Live- Waltham Forest 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 affected by substance misuse who live in Waltham Forest.

They offer 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 and doctor and nurse clinics which includes health checks and blood borne virus and hepatitis C testing.

The service works in partnership across Waltham Forest with other agencies, including NHS services, social services, probation services, GPs and pharmacies.

The service is registered for the following regulated activity: Treatment of disease, disorder or injury. The service was registered on 7 November 2018. There was a registered manager at the service.

This was the first time we have inspected Change Grow Live- Waltham Forest.

What people who use the service say

Most clients we spoke to were extremely complimentary about the service they were receiving. Clients told us that their treatment had been clearly explained and that they had received clear advice throughout their treatment.

Most clients felt involved in their treatment and stated that they were encouraged to take responsibility for their own recovery. Clients told us that there were no problems with communication and everyone stressed how supported they felt whatever their needs.

One client was disappointed with the service since restarting treatment with them during the COVID-19 pandemic. They felt that staff were distant and they were frustrated they were not invited to the group therapy. This was fedback to the service who have since been in contact with the client and provided invites to group therapy.

How we carried out this inspection

This inspection was carried out by two inspectors, one inspector who specialised in inspecting the management of medicines and two specialist professional advisors with expertise and experience in substance misuse. This inspection involved a one-day site visit.

During this inspection, the inspection team:

- visited the service and observed the environment and how staff were caring for clients
- spoke with the registered manager
- spoke with eight staff including the deputy service manager, consultant, team leaders, recovery co-ordinators and registered nurses
- spoke with 10 clients

Summary of this inspection

- reviewed seven clients' care and treatment records
- observed a service MDT meeting and a service team meeting
- attended a peer steering group
- reviewed prescribing and the medicines prescription process
- looked at policies, procedures and other documents relating to the running 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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 they continue to recruit into the team vacancies, especially in the alcohol/non opiate team.
- The service should ensure that the new referral to assessment process is embedded and followed by staff.
- The service should ensure that CQC is notified about all notifiable incidents.
- The service should ensure that they record clients consent to treatment.
- The service should ensure service's risk register reflects all the current concerns about the delivery of the service.
- The service should ensure all clinical staff complete basic life support training.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community-based substance misuse services

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

Are Community-based 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.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff conducted regular health and safety audits. Fire safety checks were completed on a weekly basis. Staff also completed regular COVID-19 risk assessments; this was last updated in November 2021.

All interview rooms had alarms and staff were available to respond. Staff wore personal alarms and there were wall alarms in all client interview rooms, these alarms were tested monthly as part of monthly environmental checks.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff maintained specific changes designed to minimise COVID-19 transmission. Cleaning requirements had increased since the pandemic. Staff disinfected rooms after every staff and client use, wiping down all furniture and frequently touched surfaces such as door handles. During the inspection staff were observed disinfecting door handles throughout the day. Chairs and desks in the service were set apart and there were now clear floor markings in all rooms throughout the service to promote social distancing. Perspex screens had also been introduced to help separate desk space.

Staff made sure cleaning records were up-to-date and the premises were clean. Contracted cleaning staff visited daily to clean and signed daily cleaning schedules, these schedules were fully completed at the time of inspection. A cleaning supervisor attended the service quarterly to complete a cleaning audit.

Staff followed infection control guidelines, including handwashing. At the time of inspection all staff were observed to be wearing appropriate personal protective equipment (PPE). PPE was readily available in the reception area for clients and staff to access. Hand sanitizer stations were located throughout the building.

Staff made sure equipment was well maintained, clean and in working order. Staff completed monthly medical equipment audits.

Safe staffing

There was a high number of vacancies in the service. Most of these vacancies were covered by agency staff. The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.

The service had enough nursing and support staff to keep clients safe. The service had a vacancy rate of 31%. This totalled 10 vacancies across the service. The team with the most vacancies was the alcohol and non-opiate team. The alcohol and non-opiate team had four vacancies at the time of the inspection. All of these vacancies were covered by agency workers. Managers told us that these vacancies were due to staff leaving for promotions or secondments. Managers were aware of the increased pressure on permanent staff due to the high vacancy rate. Managers were actively recruiting to fill the vacancies within the service. Managers attended local universities to advertise roles and were providing placements for social work students. Staff told us that staffing before Christmas felt strained and this had caused an increase in their caseloads. By the time of the inspection most of the vacancies were covered by agency staff.

The provider estimated staffing numbers by taking into consideration the average caseload sizes per recovery worker.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers had recently increased the number of supervision sessions for agency staff, this was to ensure the quality of care was maintained.

Caseload sizes had increased across the service during the pandemic. At the time of inspection there were 12 recovery workers at the service. The average caseload of tier three clients per staff member was 55. Tier three clients comprise of clients with planned interventions including substitute prescribing, psychodynamic interventions and recovery support. Staff reported to us that their caseloads felt manageable.

Managers told us that staff sickness rates had been low throughout the COVID-19 pandemic and that there were currently no staff members on long term sick.

Managers made arrangements to cover staff sickness and absence through the use of agency staff. Managers requested staff familiar with the service and staff new to the service received an induction before starting work. Due to longstanding vacancies some agency staff had been in post for several months and they knew the service well. Managers told us that they had previously recruited agency staff into permanent roles.

The service had enough medical staff. The service could get support from a psychiatrist quickly when they needed to. Clients said they were able to see the consultant when needed.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training. At the time of inspection 88% of staff had attended mandatory training overall. Clinical staff had additional basic life support training (BLS) as part of their mandatory training. The service had set up online BLS training due to difficulties with procuring face to face training.

However, at the time of inspection only one member of clinical staff was up to date with their BLS e-learning. The service manager was aware of this and had told us that the other two members of clinical staff would begin the e-learning shortly. Following the inspection we were informed that a further member of clinical staff had completed basic life support training and there were plans for the third member to complete training shortly.

The mandatory training programme was comprehensive and met the needs of clients and staff. The training included, health and safety, equality and diversity, data protection, children and adult safeguarding and the Mental Capacity Act.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff monitored training compliance through the training portal. Managers would discuss staff training compliance during managerial supervision.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.

Assessment of client risk

We reviewed seven client care and treatment records. Staff completed risk assessments as each client was allocated onto a recovery workers caseload. The initial assessment covered potential risks including current and historic substance misuse, forensic history, caring responsibilities and physical health. The client care and treatment records we reviewed were of a high quality, the records included detailed risk management plans and comprehensive progress notes.

However, improvements were needed to ensure new referrals were safely and appropriately triaged. Referrals would be reviewed initially by a member of the clinical admin team. The service manager told us that new referrals would be booked for assessments by the clinical admin team. There was no clinical oversight of new referrals at the time of inspection. This meant that patient risk may not be appropriately identified. A more thorough risk assessment would not happen until the client had been formally assessed. Following our inspection, the provider implemented a new system to ensure that risks were identified as soon as referrals were received. The duty worker now reviewed new referrals at the end of the day alongside the admin team to ensure that risks were escalated appropriately.

Management of client risk

Clients receiving opiate substitution treatment, such as methadone, had varying levels of medicines supervision, based on assessed risks. Some clients attended a community pharmacy daily for a pharmacist to supervise them taking medicine. Other clients, with lower assessed risks, collected their medicine every week or two from the pharmacy. When clients took methadone home they were provided with lock boxes to minimise the risk of children or others gaining access. At the start of the COVID-19 pandemic, the provider advised all services that clients taking their medicine under the supervision of a pharmacist should have their prescription changed so that they could collect it once a week or fortnight. Operational and clinical leaders in the service identified some clients where the risks of overdose or diversion of their prescribed medicines would be too high if this happened. Those clients continued to be supervised by pharmacists taking their daily medicines. If staff were concerned about a client they would ask the client to collect their prescription from the team base, this allowed staff to monitor some clients more closely.

Clients receiving over 100mg of methadone per day had an annual electrocardiogram (ECG). This was to monitor clients for abnormal heart rhythms which are associated with high doses of methadone. Such abnormal rhythms can be fatal and this monitoring followed best practice guidance (Drug misuse and dependence: guidelines on clinical management, Department of Health, 2017). At the time of inspection only one client who was receiving 100mg of methadone per day had not had an annual ECG. The client was booked in for their ECG the following week.

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

Staff worked with clients to develop and use crisis plans according to their needs. All records showed plans for unexpected treatment exit and all records showed involvement with other agencies where needed. Unexpected treatment exit plans included information to assist staff to support clients to re-engage with the service. If clients did not attend an appointment, staff contacted the client to help them re-engage with the service. Client records showed when clients missed appointments, they initially received several calls and messages from staff within a few days.

Staff followed clear personal safety protocols, including for lone working. Staff told us that they would only do home visits with another professional and following a thorough risk assessment. For example, the criminal justice worker carried out joint visits alongside the police.

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, 91% of staff had completed safeguarding children and young people training and 91% of staff had completed safeguarding adults at risk training.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of suffering harm and worked with other agencies to protect them**.** During our review of a clients' care and treatment records we saw Multi-Agency Safeguarding Hub (MASH) referral letters and could see communications sent by the service to the local mental health and acute trust to ensure information about the client was shared. Multi-Agency Safeguarding Hubs are a team made up of social workers, police officers and health and education staff who aim to protect vulnerable children and young people. The senior practitioner would attend daily MASH meetings. Staff would also Multi-Agency risk assessment conferences (MARAC). A multi-agency risk assessment conference is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local organisations such as the police and healthcare staff. Staff from the local authority would also provide safeguarding workshops for staff.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they would discuss safeguarding concerns with their manager or would discuss it during the morning flash meeting.

Managers took part in serious case reviews and made changes based on the outcomes. Managers held safeguarding drop ins for staff to discuss cases with safeguarding concerns. Managers also regularly carried out safeguarding audits. Learning from the audits would be discussed as part of the safeguarding workshops.

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.

Staff used an electronic records system. Staff kept comprehensive and detailed records of clients' care and treatment. Staff used this system to record and access each client's progress notes, care plan, risk assessments and other information relating to care and treatment. Staff had their own laptops which allowed them to work from home and access information when visiting clients.

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 prescribe and administer medicines safely. Medicines and controlled stationary were stored securely. Records were kept of their use. Staff (support workers and the prescriber) had to complete and sign a 'prescription change form' before clinical administrators generated prescriptions. Once the prescription was generated, it was signed by the prescriber (usually a doctor). Prescriptions were either given directly to the client or posted to the pharmacy. All prescriptions were logged which enabled staff to follow up if there were any issues of loss or theft.

Access to medicines storage areas was appropriately restricted. Clinical rooms were clean, spacious and equipped with handwashing facilities. Staff had access to emergency medicines, equipment, and medicines disposal facilities. The service had a contract with a waste management company who disposed of all their used sharps bins and clinical waste. Controlled drugs (CD) were not stored at the service. Temperatures of medicines storage areas were monitored by staff. If temperatures fell outside the recommended range, staff acted to safeguard the medicines. This included liaising with the pharmacy team. The lead nurse took the lead for ensuring that non-clinical staff received relevant training. They also worked with local GPs, pharmacies and CCG medicines optimisation teams to provide training on topics relevant to substance misuse services.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Staff discussed the progress of each client in multidisciplinary meetings. New staff were provided with training regarding naloxone. Naloxone is used for the emergency treatment of known or suspected opioid overdose. All staff actively encouraged clients to have access to naloxone. Clients were provided with information on how to use it. At the time of inspection 88% of all opiate clients had their own naloxone kit.

Staff completed medicines records accurately and kept them up-to-date. When prescriptions were generated by the service, they were automatically added to the client's medical record.

Good

Community-based substance misuse services

Staff stored and managed all medicines and prescribing documents safely. Staff used an electronic system to document medicines prescribed. Staff could access all policy documents via the intranet. We saw evidence that staff wrote to GP practices to keep them informed of the treatment being provided by the service. In one example, a GP was asked not to prescribe opiates or sedative medicines as they would interact with the medicines being prescribed.

Staff followed national practice to check clients had the correct medicines when they were admitted or they moved between services. Staff obtained client's consent to access and share information with their own GPs. This enabled staff to access medical and drug histories prior to the prescribing of medicines.

Staff learned from safety alerts and incidents to improve practice. Medicines incidents were reported on an electronic system and investigated by the clinical lead. Incidents were reviewed at a governance meeting. Any learning was shared with staff as well as any changes that required implementation.

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance. Clients were offered a urine drug screen initially and during their time with the service. 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 on site via a Patient Group Direction (PGD). A PGD allows specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber. Electrocardiograms (ECGs) were conducted by staff in the service where appropriate, for example, clients who were taking high doses of methadone.

Track record on safety

The service reported seven notifiable incidents to CQC between January 2021 and January 2022.

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.

All staff we spoke with were aware of what incidents to report and how to report them. Staff told us that there was a positive culture around reporting incidents. They understood that they would not be blamed if things went wrong.

Staff saw the reviewing of incidents as an opportunity for learning. We saw good evidence of learning and improvements following incidents. All referrals received from the alcohol team at the local hospital were automatically flagged as high risk. This process was put in place to ensure that all high-risk clients from the alcohol team were flagged as soon as possible. This was in response to incidents of when client risks were not escalated appropriately at referral or discharge from hospital. In addition, all hospital discharges were discussed weekly in the MDT meeting to ensure discharge plans were followed up. Following the death of a client, monthly meetings were now held with local mental health trust managers to escalate concerns on dual diagnosis pathway and to discuss complex cases.

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.

Good

Community-based substance misuse services

Managers debriefed and supported staff after any serious incident. An employee counselling service was available to staff. Staff had access to regular reflective practice. A peer support group also ran once a month without managers to allow staff to discuss concerns with their colleagues. Feedback from this meeting was shared at the monthly managers meeting.

Are Community-based substance misuse services effective?

Good

We rated it as Good.

Assessment of needs and planning of care

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

We reviewed seven clients' care and treatment records. Staff would carry out assessments in person or on the telephone. Telephone assessments had been introduced during the COVID-19 pandemic. If staff were concerned about a client they would try and assess them in person.

Staff completed a comprehensive mental health assessment of each client. Clients were referred to local community mental health teams as and when required. One of the findings following a recent death of a client was that a recent suicide attempt was not further explored. This meant that a referral was not made to the community mental health team. Following this incident, additional mental health and professional curiosity training had been rolled out for staff.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. We saw examples where clients had more regular reviews due to physical health problems. Staff would also support patients to register with a GP. Staff worked with other services with complex physical health problems. For one client, the service had linked in with palliative care services and set up appointments with a local hospice.

Care plans were personalised, holistic and recovery-orientated. Recovery co-ordinators supported clients to identify appropriate treatment goals based on their needs. Most clients we spoke to felt involved in their treatment and stated that they were encouraged to take responsibility for their own recovery.

In line with national guidance, clients seeking treatment for alcohol misuse were assessed using the alcohol use disorder identification test and the severity of alcohol dependence questionnaire. Experienced nurses and doctors assessed these clients for community alcohol detoxification with a focus on risk factors associated with community alcohol detoxification. When clients needed a prescription for opiate substitution treatment they were assessed in person by a doctor. Correspondence from clients' GPs, blood test results and urine drug screen tests were part of clients' assessment.

Best practice in treatment and care

Good

Community-based substance misuse services

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

Staff provided a range of care and treatment suitable for the clients in the service.

Clients with opiate dependence had a prescription for methadone. For clients taking methadone, the dose was increased gradually. Clients' prescriptions were reviewed regularly, and clients had urine drug tests to monitor their use of illicit drugs.

Clients with alcohol dependence had treatment based on their assessment and AUDIT and SADQ results. Clients with less severe dependence had psychosocial treatment to support them with reducing their alcohol intake.

In accordance with best practice guidance, clients were prescribed thiamine and, where indicated, pabrinex. These medicines were prescribed to minimise memory loss as a result of alcohol misuse.

Psychosocial interventions for clients were evidence-based and followed best practice guidance. Clients could access therapeutic groups immediately after their assessment. They did not need to wait for a further appointment. Groups had been taking place virtually due to the COVID-19 pandemic.

Blood borne virus (BBV) testing was routinely offered to clients at the point of assessment. Eighty two percent of clients who were current or previous injectors had been tested for hepatitis C. The team had recently begun offering a voucher as an incentive for patients attending the hepatitis C clinic.

Staff took part in clinical audits and there was an annual service audit plan. These audits were set by the provider. These audits looked at health and safety, safeguarding, infection, prevention and control and COVID-19 safe environments. Patient care and treatment records would be audited as part of the audit programme. Recovery workers would routinely have their caseloads audited. Team leads would score different aspects of patient care and treatment records. Team leads would then feed back learning to the individual and would share themes during workshops. If an individual was performing less well then the level of auditing and supervision could be increased.

Staff used technology to support clients. Staff provided text, telephone and video call support which clients found particularly helpful. Clients could now access appointments and groups online. Managers in the service were keen to continue a hybrid service in the future with virtual and face to face appointments available.

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 bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Managers used an induction checklist for new starters. The induction checklist covered things such as important policies and procedures and mandatory training.

Managers supported staff through regular, constructive appraisals of their work. At the time of inspection 96% of staff had an appraisal recorded in the last 12 months.

Managers supported staff through regular, constructive clinical supervision of their work. Staff that we spoke to told us that they received regular supervision. Managers told us that they would use the activity report dashboard to inform parts of the supervision discussion. The activity dashboard was available to all staff and it contained key performance indicators for the service. For example, it would show when clients last had a medical review and displayed when the last positive contact was with the client. Managers told us that the dashboard helped quickly identify if a member of staff was struggling with their workload.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. As part of the inspection we attended a staff team meeting. The team meeting covered recent staff survey results, the future working model and audit findings. This meeting was minuted. The minutes were saved in a shared drive which all staff could access.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they were able to access specialist training Staff had recently received training on naloxone, dual diagnosis and managing challenging behaviour.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency 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 within the organisation and with relevant services outside the organisation.

As part of the inspection we attended a multi-disciplinary team (MDT) meeting. The MDT meeting was held weekly, staff attended this meeting in person and virtually. This meeting covered staff wellbeing, followed up actions from previous meetings, covered high risk clients and clients who were in hospital were discussed. All of the MDT were involved in conversations about client risk and planning complex clients care and treatment.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation. The registered manager regularly attended the East London and South East managers meeting and the Regional Leadership Team meeting. These meetings were with colleagues and peers from other CGLs in the regions. During these meetings learning from other services would be shared.

Staff had effective working relationships with external teams and organisations. These included pharmacies, local authority safeguarding teams, community mental health teams, and other service providers such as housing providers

and probation services. Clients' records showed communications and updates on client support and care with other teams and organisations. For example, one client had recently been referred for a learning disability assessment. The service worked closely with local GPs and would be in regular communication with them. For example, we saw communications with a local GP advising that they should no longer prescribe sedatives to a client.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff received training in the Mental Capacity Act and knew to seek support from the service managers if needed. The Mental Capacity Act was included in mandatory training. There was a policy on the Mental Capacity Act, which staff knew how to access. The service held joint training events with the local authority on mental capacity. Staff told us that they would speak to the consultant if they were concerned about a clients' capacity.

Staff did not always ensure clients consent to care and treatment was recorded in their records. Staff told us that consent to treatment would be discussed verbally. We saw evidence of discussion around consent in two of the seven client records we reviewed. Client consent was monitored by the service. At the time of the inspection 19% of clients had no recorded consent to care and treatment.

Are Community-based substance misuse services caring?

Good

We rated it as Good.

Kindness, privacy, dignity, respect, compassion 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.

As part of the inspection we spoke to 10 clients. Clients described staff as lovely people and supportive. Most clients told us that they had a key worker and felt fully supported by them. Two clients we spoke to felt staff felt more distant since the COVID-19 pandemic.

Staff gave clients help, emotional support and advice when they needed it. Clients told us that staff were available when needed.

Staff supported clients to understand and manage their own care treatment or condition. Clients felt involved in their treatment and stated that they were encouraged to take responsibility for their own recovery. Most clients we spoke with said they missed face to face groups but understood why these had stopped due to the COVID-19 pandemic.

Good

Community-based substance misuse services

Staff directed clients to other services and supported them to access those services if they needed help. For example, a solicitor would frequently attend the service to support clients with any legal issues. One client told us that the legal support had helped them find temporary accommodation and were incredibly grateful for the service.

Staff understood and respected the individual needs of each client. Staff clearly knew their clients and spoke very positively about them, challenging stereotypes. Staff were passionate about their work.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Involvement of clients

Staff communicated with clients so they understood their care and treatment. Clients reported that they felt informed and involved within their treatment decisions and care planning. Nearly all clients reported that they had seen their care plan and were happy with it. Clients told us that they received advice from the staff about medications and that their care was reviewed regularly.

The service empowered and supported access to appropriate advocacy for clients. Clients facilitated groups where they could discuss any issues in relation to the service. The service had advocacy programmes along with peer mentors. Peer mentors ran a number of groups including mutual aid groups.

Staff actively engaged people using the service and their carers in planning their care and treatment. An online patient survey had recently been completed to gather feedback about the preferred format of groups in the future.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Most clients we spoke to told us that they did not want their families involved. One relative was very positive about the support they had received in caring for their partner. The relative told us they had been taught coping mechanisms by a member of staff and were offered counselling. Staff would contact relatives via text message and email where appropriate. Clients family members were also invited to medical reviews.

Are Community-based substance misuse services responsive?

Good

We rated it as Good.

Access and waiting times

Good

Community-based substance misuse services

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

The service had clear criteria to describe which clients they would offer services to and offered clients a place on waiting lists. The most common type of referral for the service were self-referrals. Clients could fill out an online referral form or phone the service. The service also received referrals from a range of agencies. These included GPs, community mental health teams and the hospital alcohol team.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. However, at the time of inspection there was no clinical oversight of new referrals which meant that some urgent referrals may not be appropriately identified. Staff told us that they could assess new urgent referrals within a couple of days. Each recovery worker had three assessment slots available each week.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Clients' records showed persistent attempts to contact people that did not attend appointments. This included discussing safety measures and signposting people to alternative community services and home visits where necessary.

People could also access treatment regardless of their housing or social circumstances. As a response to the COVID-19 pandemic clients could access groups via video and telephone calls. Most clients told us that these online groups were working well. One client expressed frustration that they had not received invites for the virtual groups even after several requests sent to their key worker.

At the time of our inspection, the offer for psychosocial interventions (PSI) was mainly online and the variety of interventions was limited. This was in response to the COVID-19 pandemic and to ensure effective infection prevention and control was maintained. However, the provider had clear plans in place to increase the PSI offer and gradually introduce more groups back to face to face but with limited numbers.

Clients had some flexibility and choice in the appointment times available. For example, one client told us that the service provided appointments during lunch as they were currently working.

When clients were ready to be discharged from the service, staff ensured that other agencies had relevant information to support clients. Managers actively promoted discharging clients when safe to do so. The number of discharges were monitored on the activity tracker and staff were congratulated when clients were discharged successfully.

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. The environment was welcoming, and COVID-19 measures were in place to protect clients visiting the service. Clients told us that there was a lack of space in the service and this meant that client group sizes were significantly reduced to ensure social distancing guidelines were followed. Staff also told us that the premises were too small for the size of the team. Staff would come work on-site on rotation as the service was not large enough to accommodate the entire team safely.

At the time of the inspection some of the consultation rooms were not sound proofed. Due to the low footfall in the service patient confidentiality was maintained.

Good

Community-based substance misuse services

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 was accessible for clients using wheelchairs and clients with other mobility needs. A suitable toilet was located on the ground floor. Interpreters were available for clients who did not speak English. Leaflets and information in other languages and easy read versions could be downloaded by staff to provide to clients. Managers made sure staff and clients could get hold of interpreters or signers when needed. The service had recently created promotional videos with local mosques to promote the service to the local Muslim community.

Staff within the service had good understanding of the local needs of the communities they worked in. They worked in partnership with local community groups.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. Information was on display throughout the service, for example there was information about how to complain, HIV support services, IAPT talking therapies and the local carers hub. Staff told us that digital copies of this information was available to send clients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Clients, relatives and carers knew how to complain or raise concerns. All clients told us that they knew how to complain and would feel able to do so.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint. The service manager told us that they would try and resolve most complaints informally. The service had been receiving less complaints since the COVID-19 pandemic. The manger felt this was due to less clients attending on site.

Staff protected clients who raised concerns or complaints from discrimination and harassment.

Clients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, one client submitted a complaint that their prescription pick up had changed from weekly to twice weekly without their knowledge or agreement. Learning was discussed at the next governance meeting. Staff were reminded that they need to ensure that they have offered appointments to clients and given them opportunity to engage prior to changing the collection regime.

The service used compliments to learn, celebrate success and improve the quality of care. Thank you cards from clients were displayed in the service and feedback from compliments was shared in team meetings.

Good

Community-based substance misuse services

Are Community-based substance misuse services well-led?

Good

We rated it as Good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.

The local leadership was strong and had worked for the provider for many years in a variety of roles. The leaders in the service were motivated and enthusiastic about supporting the client group. They strove to deliver and motivate staff to succeed. The team had an in-depth knowledge of the client group. The service had a clear definition of recovery that was shared and understood by the staff group. They adapted services and encouraged new and innovative ways of working to meet client needs. The service had adapted during the COVID-19 pandemic.

Staff told us that managers in the service were approachable and that they operated an open door policy.

Vision and strategy

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

Leaders and staff clearly understood the providers' vision and values of making a difference in people's lives and giving everyone an opportunity. Leaders clearly demonstrated the values in practice and ensured staff understood how they applied to the work of the team. Clients told us that staff treated them with kindness and that they trusted the service to help them if needed.

Staff were currently involved in deciding how the service would function in the future. Staff and clients were asked to complete a survey on how they wanted the service to look once the COVID-19 pandemic had ended.

Culture

Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff stated that they felt able to raise concerns. Staff were aware of the whistleblowing process.

The provider endeavoured to ensure they communicated with staff. A peer support group had been introduced to support staff during the pandemic. Feedback from this group would be shared during the managers meeting. Reflective practice sessions were also available to staff. Managers would also hold wellbeing check-ins at the end of each day.

Staff that we spoke to felt respected, supported and valued. Staff told us they were happy working within the service. The service ran an employee of the month award, the monthly winner would receive a voucher and an extra days annual leave.

Managers monitored morale and job satisfaction of staff through regular managerial supervision. Managers would check-in with staff on a daily basis and staff wellbeing was a standing agenda item for the team meetings.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively and that performance and risk were mostly managed well.

There was a comprehensive and detailed governance system supporting staff to provide safe and high quality care and treatment. All areas of the service were subject to performance monitoring and audit. There was a clear structure to the governance system, learning from incidents and complaints, and robust safeguarding procedures. There was an annual audit plan and a business continuity plan. There were several risks identified by the management team that was not included on the risk register and quality improvement plan. Managers told us how these risks had been mitigated however they were not recorded on the local risk register.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service's risk register did not include all current concerns about the delivery of the service. For example, managers told us that two of the biggest risks for service delivery was having less face to face interactions with clients due to the COVID-19 pandemic and staffing vacancies. These risks were not included on the risk register or quality improvement plan. Staff told us the measures that were in place to mitigate the risks however it was not clear how this was reported to the provider's senior leaders. For example, the high staffing vacancies in the alcohol and non-opiate team was not included on the risk register. Managers told us that the risk was mitigated by the deployment of four agency workers with an increased level of case-load reviews and supervision.

Information management

Staff collected analysed data about outcomes and performance.

The provider routinely collected performance and training data. The service had systems in place that provided leaders with information about the running of the service. This enabled leaders to maintain clear oversight of the service and identify good practice and areas for improvement. Managers spoke highly of the data analyst in the service who had helped create an activity dashboard. All staff had access to the activity dashboard. This dashboard was highly detailed and allowed recovery workers and managers to have oversight of caseloads. For example, the dashboard recorded when clients had their medical reviews this allowed staff to identify clients who required medical reviews. This service had no overdue medical reviews at the time of inspection.

All information needed to deliver care was stored securely and available to staff, in an accessible format when they needed it.

Staff made notifications to external bodies as needed. The service notified the Care Quality Commission of most notifiable incidents. During the inspection it was identified that the Care Quality Commission had not been notified of a client death. The notification was submitted following the inspection.

Engagement

Managers actively engaged with local health providers and community organisations to ensure they met the needs of the local population. For example, the service had seen an increase in clients identifying as LGBQT+ during the pandemic. In response to this the service had been engaging with local charities to look at how the service could better support LGBQT+ clients.

As part of the inspection we attended the fortnightly Public Health England steering group. The purpose of the group is for peer mentors and volunteers to come up with initiatives, social enterprises or activities for service users following an increase in funding. So far the group had planned to buy electronic equipment, such as cameras and laptops to conduct a short documentary series. The group were also looking at engaging the local college so that they could receive training on how to print t-shirts and enquire about hiring a soundproof studio to record podcasts in relation to recovery.

Senior leaders held regular lunchtime sessions that all staff could dial into. These sessions would be held by different directors and would cover different themes, such as recruitment and equality and diversity.

Learning, continuous improvement and innovation

The management team were clearly committed to continuous improvement of the service. There had been a focus on promoting the values within the teams. The deputy service manager had recently been on secondment to help develop the organisational values. Managers felt that staff displayed the providers values and were all committed to making a positive difference to client's lives.