

Change, Grow, Live

# Croydon Adult and YP SMS

## 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?

Requires Improvement



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 for adults and young people affected by substance and alcohol misuse who live in Croydon. This was our first comprehensive inspection of this service.

We rated it as good because:

- We rated the service as good for effective, caring, responsive and well-led.
- Staff assessed and managed most risks well and followed good practice with respect to safeguarding. The premises where clients were seen were safe and clean. Young people were kept separate from adult clients.
- 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 team included or had access to a range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood their individual needs. 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 was well led, and the governance processes mostly ensured that its procedures ran smoothly.

However:

- We rated the service as requires improvement for safe.
- Clients receiving community detoxification for alcohol misuse did not receive face-to-face contact from clinical staff for the first three days of their detoxification as per the provider's policy. Furthermore, staff did not regularly use the alcohol withdrawal scale tool or always record the contact details of clients' named person.
- The number of clients on the caseload of some recovery workers was high. Caseloads in the opiate and alcohol teams were over 75 for some recovery workers. Some staff told us this felt high and they could not provide all clients with holistic care.
- Emergency medicines and equipment were not always managed appropriately. Staff did not complete a record to show which emergency medicines and equipment were present, and that they had been checked.
- Meeting minutes did not always contain details of discussions. This meant absent staff could not update themselves on current trends, issues and learning.
- Staff did not always receive supervision in line with the provider's policy, although staff did feel well-supported.
- Staff did not always update the referral tracker they used to monitor their contact with clients between referral and allocation.
- The service did not have a clear schedule of local and provider-level audits and some actions from audits had not been completed.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	See summary above.



# Summary of findings

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# Summary of this inspection

## Background to Croydon Adult and YP SMS

Croydon Adult and YP (Young Person) SMS (substance misuse service) is provided by Change Grow Live, who deliver a not-for-profit drug and alcohol treatment service nationally. The service provides specialist community treatment and recovery support for adults and young people who live in Croydon. The service mainly provides treatment and support from Lantern Hall, but the young person team is co-located with other services at a separate community site.

Croydon Adult and YP SMS offers a range of services including initial advice; assessment and harm reduction services including needle exchange; prescribed medicines for opiate detoxification and stabilisation; community alcohol detoxification; referrals to inpatient detoxification; naloxone dispensing; group recovery programmes; brief interventions for young people; one-to-one key recovery worker sessions; and doctor and nurse clinics.

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

At the time of the inspection, the service was supporting and/or treating just over 1200 clients. There were approximately 40 staff.

The service is registered for the following regulated activity: Treatment of disease, disorder and injury. The service was registered on 15 October 2021 having taken over from a different provider. There was a registered manager at the service.

This was the first time we have inspected Croydon Adult and YP SMS.

### What people who use the service say

Most people were very positive about the service they were receiving and about the support offered by staff. Care and groups were non-judgemental and met clients' individual needs. They said staff were friendly, respectful and compassionate.

The service offered clients the opportunity to complete a feedback survey in July 2022 and 37 clients responded. Clients raised some concerns about their experiences in the reception area including waiting times, the environment and décor, and having clearer information on display. At the time of our inspection, some changes had already been made and some were ongoing. One client we spoke with said their experience had improved since they complained about waiting times.

## How we carried out this inspection

This inspection was carried out by 2 inspectors, a medicines inspector and a specialist professional advisor with expertise and experience in substance misuse. An expert by experience conducted phone calls with clients.

This inspection involved a 2-day site visit and was followed up by video-call interviews with staff.

During this inspection, the inspection team:

# Summary of this inspection

- visited the service and observed the environment and how staff were caring for clients
- spoke with the registered manager
- spoke with 20 staff from across the different teams. These included recovery workers, team leaders, nurses (1 of these external to the service), a specialist doctor, a psychiatrist, the deputy service manager, the senior data analyst, the counselling coordinator and a building recovery in the community (BRIC) worker
- spoke with 6 clients
- reviewed 16 clients' care and treatment records
- observed 6 meetings including the all staff morning briefing, separate team meetings, and a meeting between CGL staff and external agencies.
- reviewed 2 recent supervision records
- reviewed 3 complaints and a selection of compliments
- 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>.

## 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 **MUST** take to improve:

- The service must ensure that clients receiving community detoxification for alcohol have contact from staff and that withdrawal tools are used in line with the provider's policy. (Regulation 12)

### Action the service **SHOULD** take to improve:

- The service should ensure that care and treatment records for clients receiving community detoxification for alcohol contain contact details for the client's named person (Supportive Other) as per the provider's policy.
- The service should ensure that work continues to address high caseload numbers allocated to recovery workers to ensure all clients are appropriately supported.
- The service should ensure it completes medical reviews for clients on medication assisted treatment within the target timeframe.
- The service should ensure it that completes and records checks of emergency medicines and equipment.

## Summary of this inspection

- The service should ensure meeting minutes are completed in full to reflect discussions and share information with staff unable to attend.
- The service should ensure staff receive supervision and appraisals in line with the provider's policy to enable them to carry out their duties and develop their skills.
- The service should ensure the referral tracker is kept up to date to ensure clients receive appropriate levels of contact based on their risks between being referred and being allocated to a member of staff.
- The service should ensure there is a clear schedule of local and provider-level audits and that actions are promptly followed up on.

# Our findings






## Overview of ratings

Our ratings for this location are:

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



# Community-based substance misuse services

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

## Are Community-based substance misuse services safe?

Requires Improvement 

### 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. Ninety-four per cent of staff had completed their mandatory health and safety training. Health and safety audits were completed every month. There was an additional health and safety audit every 6 months. This was overdue having last been completed in January 2022, but it was scheduled for completion shortly after the inspection. High ligature points in the toilets had been removed following a ligature risk assessment in September 2022.

The service had weekly fire alarm tests, monthly emergency lighting tests, and fire drills every 6 months. Fire extinguishers were serviced and in date. Fire wardens were named in the daily morning meeting. Staff and visitors were asked to sign in and out at reception.

First aid boxes were well stocked and in date. Four staff were trained as first aiders and there were plans to train additional staff to these roles. Clients told us they felt safe when they visited the site.

All consultation rooms had alarms and staff available to respond. Staff could either trigger the alarm so it alerted reception, or they could call police directly. Signs were displayed to inform visitors CCTV was in use.

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. Clinical equipment was calibrated and safe to use. The reception area had recently been redecorated. Clients were invited to choose the paint colour. Refurbishments were ongoing and new chairs for reception were about to be delivered.

Staff made sure cleaning records were up-to-date and the premises was clean. Clinical waste was collected every week and hazardous cleaning materials were locked away. Staff cleaned high-touch surfaces.

# Community-based substance misuse services

Staff followed infection control guidelines, including handwashing. The last infection prevention and control assessment, which included a Covid-19 risk assessment, was completed in September 2022. Hand sanitiser and PPE was readily available, and lateral flow tests were available on site.

Staff made sure equipment was well maintained, clean and in working order. Safety checks were completed on electrical equipment.

## Safe staffing

**The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. However, the number of clients on the caseloads of some recovery workers was high which sometimes impacted how much time they could spend with clients.**

The service had enough staff and support staff to keep clients safe, although it had a high vacancy rate of 34%, which meant that some members of staff had high caseloads. The manager informed us the average caseloads over a 6-month period were no higher than 56 clients. Some members of staff told us they had caseloads of up to almost 80. Some staff described the pressures they felt from high caseloads, although noted their caseloads had reduced. Managers had taken some steps to relieve pressures, for example, by altering recruitment to allocate an extra recovery worker to the opiate team, and some team leaders had caseloads to relieve pressures from their staff.

Managers continued to recruit new staff and used agency and sessional staff to cover most of the vacant posts. Agency staff, which included some of the clinical staff, were familiar with the service and clients. All staff said there were enough clinical staff who clients could access easily. External funding had been provided for the service to recruit 4 new recovery workers and 3 outreach workers.

The service could get support from a psychiatrist quickly when they needed to. The regional consultant psychiatrist was available on site 2 days a week and via phone on other weekdays.

Other professionals were available to support the service. For example, 2 external nurses from local hospitals attended the site 1 day a week to carry out testing and vaccinations for blood borne viruses (BBV), liver health tests, and dry blood spot testing. These nurses could link clients straight into other services for help with long-term conditions connected with their substance misuse which reduced delays.

The service had 6 volunteer counsellors who offered clients 6 - 12 sessions each. The counselling coordinator could also provide short Cognitive Behavioural Therapy (CBT) input. Clients with complex mental health needs were referred to specialist services such as therapy for bereavement trauma or rape. The counsellors planned to start a mindfulness group for the service. They told us they used to do 2 therapeutic groups for the service but had not since April due a high workload.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. There was an induction template for agency workers that managers used. Volunteers were usually inducted by one of the managers on sickness leave, so the service had paused the start dates for their service user representatives.

Managers made arrangements to cover staff sickness and absence. Sickness levels were reducing. At the time of our inspection, 1 recovery worker and 2 of the 8 team leaders were on long-term sickness leave. The service was recruiting to a 6-month secondment to cover a team leader role. The manager met with HR every 2 weeks to monitor sickness and absences.

# Community-based substance misuse services

Staff maintained contact with most clients, but some clients had not been reviewed for over 6 months. The service aimed for reviews at least every 6 months, or more regularly if a client was high risk. Staff had reviewed most of the 998 clients on structured support in the last 6 months, although they had not reviewed 52 clients. Staff had recorded meaningful contact with 76% of clients in the last 30 days, and 94% within the last 90 days.

## Mandatory training

Most staff had completed and kept up to date with their mandatory training, and most of the completion rates were in line with the provider targets with a compliance rate of 90% or above. The mandatory training programme was comprehensive and met the needs of clients and staff. For example, safeguarding children and adults, the Mental Capacity Act, equality and diversity, and health and safety. Registered clinical professionals, such as doctors and nurses, were required to complete basic life support (BLS) training. All the service's clinical staff had completed their BLS training. However, only 79% of staff had completed their data protection and information security mandatory training. The service reported 6 data breach incidents in the past 12 months.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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

**Staff mostly 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. However, staff did not follow robust systems to manage risks potentially faced by clients receiving community alcohol detoxification.**

### Assessment of client risk

Staff completed initial risk assessments for each client on arrival using a recognised tool and reviewed this regularly, including after any incident or where the risk levels changed. We reviewed 16 client care and treatment records. On most of the records we reviewed, risks related to physical and mental health were assessed, in addition to specific risks regarding substance and/or alcohol misuse, safeguarding information, and social factors such as support networks and housing. Clients using opiates were asked about their injecting history as part of their risk assessment. Recognised risk assessment tools related to the pattern and severity of alcohol use and the severity of dependence were used to help staff decide on appropriate treatment plans. Clients who wanted to be detoxed from alcohol and opioids had detailed assessments by the clinical team and their suitability for treatment was discussed during multidisciplinary team (MDTs) meetings. Staff from the criminal justice team could complete assessments while based in the court and obtained release plans to inform these. Managers often encouraged staff to update risk information when necessary. The number of risk reviews completed within the 6-month target had increased from 74% in April 2022 to 93% in November 2022. Records showed staff liaised with other professionals involved with the client where necessary, for example, with social services, probation services, and clients' GPs.

Staff encouraged clients to undertake BBV screening for infections such as Hepatitis B, Hepatitis C, and HIV. Nurses employed by 2 local hospitals worked from the service once a week to carry out BBV testing among other health checks. Clients could receive immediate treatment through these nurses if they tested positive. One of the nurses attended the sexual health clinic at the local hospital twice a month and assisted HIV positive clients to attend these. GPs were kept informed.

# Community-based substance misuse services

The service had formal processes to re-engage clients who unexpectedly exited treatment or disengaged from the service. For example, staff discussed clients who had not attended appointments and contacted them to reschedule. If newly referred clients had not attended their scheduled appointments, staff informed the referrer. If clients had not been seen and could not be contacted by phone, we saw examples of other teams, such as the outreach team, going out to look for people to gain contact that way. Updates were shared between all the teams during the morning briefing meeting. The records we reviewed often contained contact details for family members and GPs who could support clients if they began to disengage from the service. However, they did not always clearly document individualised plans to keep clients engaged with the service.

## Management of client risk

Staff were aware of the risks and safeguarding concerns for their clients which informed their support. Staff liaised closely with GPs when clients had complex healthcare needs, updated them on treatment plans, and contacted social services where required. Staff discussed and reviewed high-risk clients and high-risk referrals as part of the all staff morning briefing meetings and during MDT meetings. Staff said they could speak to managers at any time if they had concerns about clients.

Clients receiving opiate substitute treatment had varying levels of medicines supervision based on their assessed risks. Some clients attended a community pharmacy every day to be supervised taking their medication. Other clients with lower assessed risks could collect their medication once or twice a week. Staff reported good relationships with local pharmacies and GPs. They liaised with pharmacies to check clients were collecting their prescriptions. Safety measures such as safe storage boxes for medicines were also discussed. Prescribing staff told clients about the risks of overdose and of mixing prescribed drugs with illicit drugs. Naloxone, a medicine used to reverse an opioid overdose, was repeatedly offered to clients. Managers regularly reminded staff to offer naloxone to clients and the service trained clients and professionals on its use. Most records showed evidence of harm reduction advice given to clients which was continuously discussed and reviewed.

The service monitored clients receiving medication assisted treatment (MAT), although some clients were overdue for medical reviews. At the time of the inspection, the service had 340 clients in MAT. This treatment involves the use of medicines, in combination with other psychosocial interventions such as counselling and group therapy, to treat opioid use. Seventeen clients (5%) on MAT were overdue their medical reviews. The service monitored all clients receiving MAT and data was available via a service dashboard to inform staff of upcoming and overdue medical reviews. These were discussed in team meetings. The service's director received performance reports which included data on overdue medical reviews.

Staff responded promptly to any sudden deterioration in a client's health. For example, a recovery worker suspected a client had jaundice based on their appearance during a visit to the service. They requested a nurse assessment and as a result the client was told to go to A&E immediately where they were admitted for treatment. Staff had requested ambulances where necessary and provided handovers. Staff discussed clients in hospital during their daily morning briefing so they had oversight of when clients were discharged so support could resume.

Staff followed clear personal safety protocols, including for lone working. Home visits were always conducted in pairs and staff phoned managers before entering and after exiting client's homes. Staff were sometimes allocated to clients based on risk factors. For example, a male criminal justice worker was allocated a client until more details of their sexual offence was obtained. During the morning briefing meeting, staff were allocated to first responder roles in case a safety incident occurred. Staff and clients told us they felt safe. However, staff did not wear personal safety alarms.

# Community-based substance misuse services

The service considered the risks associated with keeping adults clients separate from clients using the young person service. The young person service was for people up to 24-years old. Staff told us no one under 18-years-old came to the main site. They said it was rare for 18 to 23-year-olds to attend the site but if they did then a member of staff met them in the car park and escorted them in and out through a different entrance. Most interventions by the young person service took place within the community.

Clients who wanted to complete an alcohol detoxification within the community were assessed by staff for suitability. Staff and GPs shared relevant information before detoxification started and throughout.

Staff did not follow a robust system when treating clients having community detoxification for alcohol misuse. Nursing staff did not complete daily in-person checks for the first 72 hours and did not complete the alcohol withdrawal scale tool every day.

Nurses did not review clients daily and in-person for the first 72 hours of their community detoxification for alcohol misuse. The service had recently updated their policies, but both versions recognised the greatest risks of seizures and withdrawals were within the first 48 to 72 hours. The old version stated clients should ideally be reviewed for a minimum of 3 consecutive days. The most recent version stated 2 contacts per day were required, at least 1 of these being in-person by a nurse, for the first 3 days. We reviewed 4 records of clients who had completed or were completing community alcohol detoxification. None of these records showed daily contact from a nurse in the first 72 hours. One showed the nurse assessments happened on the second and fourth days of the detoxification, and another client did not have a nurse assessment until day 4 of their detoxification. These daily reviews were important because nurses could assess withdrawal symptoms, conduct physical health checks, and note their clinical observations. Following the inspection, the lead nurse emailed the nurses to say they must have face-to-face contact with clients for the first 3 mornings of detoxification and make phone calls in the afternoon. The level of contact on days 4 and 5 would be determined by individual need.

Nurses also did not complete the alcohol withdrawal scale tool every day. This tool scores severity of withdrawal symptoms including tremors, auditory, tactile and visual disturbances, and anxiety. Particular scores prompt considerations around additional medications or emergency transfer to hospital. The nurse assessments showed they considered the presence or absence of some of these withdrawal symptoms, but the approach was not consistent, scored, or completed daily. This could mean that if a client needed additional help to manage withdrawal symptoms, this may not always be recognised. The service manager said their expectation was for this to be completed daily for the first 5 days of community detoxification. This expectation was also outlined within the lead nurse's email following our inspection. Furthermore, a tracker to monitor daily contact was added to the alcohol team's daily meeting agenda.

Clients who were abstinent following detox were offered continued support through relapse prevention groups and contact with their recovery workers.

## 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. Most staff kept up to date with their safeguarding training. At the time of the inspection, 94% of staff had completed safeguarding adults at risk training

# Community-based substance misuse services

and safeguarding children training. Staff had also received additional training, for example, domestic violence awareness from a local external provider. Staff on the young person team were due to receive Level 3 safeguarding training through the local council. This would make them trained to the same level as the service's designated safeguarding leads (DSLs) and nurses.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They discussed safeguarding concerns and actions during team meetings and MDT meetings. The service had 3 DSLs. Staff knew who they were and felt able to go to them for advice. The DSLs met weekly to review safeguarding cases, share good practice, advice and information. We were told examples of good practice, learning and policy updates were passed down to staff. The DSLs were able to escalate risks or seek advice if required.

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 or suffering harm and worked with other agencies to protect them. Staff reported good relationships with the local authority safeguarding team. Managers attended forums with external agencies such as domestic violence perpetrators meetings, vulnerable women group, and multi-agency risk assessment conferences. The service also attended weekly clinics at the local hospital where professionals reviewed and discussed pregnant clients. There were extra safety measures for clients using illicit substances with children. For example, recovery workers conducted home assessments and gave clients safe boxes to safely store their medication. Risks were usually identified during initial assessments, but staff could ask GPs or contact the local authority if they felt uncertain.

Information concerning clients, their families and safeguarding risks were recorded on clients' electronic records. The system flagged clients with safeguarding concerns and alerted staff to review safeguarding matters. Managers discussed the number of overdue safeguarding reviews during their meetings. Managers were awaiting dates for safeguarding review training. The service planned to introduce a senior leadership meeting shortly after our inspection. One purpose of this new meeting would be to highlight outstanding safeguarding reviews. Any overdue reviews would be shared with staff for completion.

A corporate provider safeguarding audit was completed in June 2022 and actions were outlined. For example, to create joint working protocols with children and adult social care teams. However, these actions had not been followed up due to capacity issues. The service manager said they planned to conduct a local safeguarding audit in December 2022 and would incorporate the outstanding actions into this.

## 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.**

Records were stored securely. Staff used electronic records to record and access information about clients. Client notes were mostly comprehensive and up to date, and all staff could access them easily.

When clients transferred to a new team, there were no delays in staff accessing their records.

Meeting minutes were stored on a shared drive so staff could access them if they had not been able to attend. However, the quality of details contained within these minutes varied.

# Community-based substance misuse services

The service manager had completed a local audit of full risk reviews (FRRs) and case notes in February 2022 having recognised staff needed to complete more FRRs. The outcome of the audit informed the training given to staff in May 2022. The training was recorded and has since been used as part of the induction for new staff. The manager planned to complete another audit of clients' records by the end of the year. Team leaders we spoke with said they audited the quality of their team's record keeping but it was unclear if these audits were formally recorded.

## Medicines management

**The service used systems and processes to safely prescribe and administer medicines. Staff regularly reviewed the effects of medicines on each client's physical health. However, emergency medicines and equipment were not managed appropriately.**

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff discussed the progress of clients in multidisciplinary meetings. Clients' physical and mental health was assessed at the start of treatment and reviewed periodically as per the provider's policy. Staff encouraged clients to have access to naloxone and provided information on how to use it. Clinical staff we spoke with said they used information from pharmacies and clients to decide if clients could self-administer medication. If they had any concerns, clients were returned to supervised consumption.

Staff followed national practice to check clients had the correct medicines when they started with the service or they moved between services. Staff obtained clients' consent to access and share information with their GPs. They were able to access medical and drug histories using summary care records prior to the prescribing of medicines.

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance. Clients were offered urine drug screens initially and during their time with the service. Clients were offered BBV tests. Electrocardiograms (ECGs) were conducted by staff in the service where appropriate, for example, with clients who were taking high doses of methadone.

Staff learned from safety alerts and incidents to improve practice. The service had 45 medication incidents in the past 12 months. In response to these, a review of medication incidents was completed in August 2022. Themes identified included pharmacies not receiving prescriptions, unsigned prescriptions, and prescriptions issued with the wrong dosage. Actions taken included sharing learning with staff, the introduction of monthly medication incidents meetings for some staff, and a new checklist to guide staff when giving out prescriptions. The service had requested a medicines management audit from the provider's central pharmacy team which was due to take place shortly after our inspection.

Staff did not store and manage all emergency medicines, equipment and prescribing documents appropriately. Staff did not complete a record to show which emergency medicines and equipment were present, and that they had been checked. They did not always complete a weekly stock check of controlled drugs as per the provider's policy.

The service stored NHS prescription stationery securely in a locked area, but managers did not keep a record of when it updated key codes for accessing this area.

## Track record on safety

**The service mostly had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately.**



# Community-based substance misuse services

The service mostly had a good track record on safety. Staff sent notifications in a timely manner to the Care Quality Commission. Between November 2021 and October 2022, 20 notifications were received. Nine of these were in relation to deaths of clients. Managers had investigated the circumstances around each death and changes had been made. For example, a client had died on 24 July 2022 and the local pharmacy informed the service on 27 July 2022 the client had failed to collect their prescription. The pharmacy then contacted the service on 6 September 2022 to notify them the client had died. Managers identified a missed opportunity to contact the client following the missed collection of medication. Actions taken in response included identifying clients on the opiate caseload who had not had contact for a month. The service's senior data analyst reviewed this information and had monthly data meetings with staff. We observed staff discuss contact with clients and pharmacies during their team meetings.

The service knew about a bad batch of heroin and regularly offered naloxone. Staff shared information about drug alerts with clients, staff and external agencies. The service's outreach team had increased their visibility within the community in response to the alert. Managers had created a learning tracker related to client deaths and reviewed these during managers meetings.

## Reporting incidents and learning from when things go wrong

**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. However, meeting minutes did not always contain details about learning from incidents.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. They felt confident and supported when reporting and discussing incidents. The service used an electronic system for recording incidents.

Managers investigated incidents and shared trends with staff. These included incidents concerning medical emergencies, data breaches, safeguarding, medication, deaths and acts or threats of violence or aggression.

Staff understood the duty of candour. They were open and transparent and gave clients, professionals and families a full explanation if and when things went wrong. Staff gave examples of times they had apologised following issues with clients' prescriptions.

Managers debriefed and supported staff after any serious incident. For example, there had been several incidents involving an aggressive client on the alcohol treatment pathway. Through debriefs, the team discussed the client's triggers and came up with solutions for how to work with them.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers and clinicians attended regional meetings where learning from incidents was shared. Staff said they met to discuss the feedback and look at improvements to client care. However, meeting minutes did not always contain details of learning from incidents.

There was evidence that changes had been made as a result of feedback. For example, the probation worker based at the court said it was difficult to work effectively with a part-time CGL worker. As a result, and within 2 weeks of the feedback, the service increased their presence at the court from 3 to 5 days a week. The probation worker had reported an improvement in flexibility and responsiveness as a result.



# Community-based substance misuse services

## Are Community-based substance misuse services effective?

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.**

Staff completed a comprehensive assessment of each client. Recovery plans reflected the assessed needs and were personalised. Care and treatment records showed evidence of recovery-focused psychosocial activities and groups were discussed. Records showed when clients had been invited to these groups, and when they had attended them or failed to attend them. Clients we spoke with said groups they attended, such as groups to support clients before and after abstinence, were very beneficial. Clients were offered copies of their recovery plans, although of the records we saw, most clients declined this offer.

Staff made sure that most adult clients had a full physical health assessment and knew about any physical health problems. These were completed on admission to the service and ongoing physical care was completed by the clinical team or in collaboration with clients' GPs. Staff supported patients to register with GPs if they did not already have one. Staff knew which clients were currently in local hospitals and discussed updates on their wellbeing during daily morning meetings. Staff reported having good relationships with staff from the local hospitals. Most clients on the opiate or alcohol support pathways received full physical health assessments through the service or in collaboration with their GP. However, at the time of our inspection 5% of clients receiving MAT were overdue their medical review.

Staff developed a comprehensive recovery plan for most clients that met their mental and physical health needs. Most recovery plans considered clients mental and physical health needs as well as their social circumstances. For example, 1 client's record included goals around their housing situation and the recovery worker had assisted by liaising with housing officers. However, another care plan we reviewed did not contain recovery goals and only focused on the medication aspect of the treatment.

Staff regularly reviewed and updated recovery plans when clients' needs changed. The service manager told us he regularly reminded staff to update service user plans whenever risk levels changed. Most of the records we looked at supported this.

Most care plans were personalised, holistic and recovery-orientated. Staff considered the wishes of patients regarding medication and altered prescriptions if they felt it was safe to do so. Clients had input on their goals and staff helped them to achieve these. One client had been supported by staff to enter an inpatient detoxification. Staff had worked with the client to create a weekly aftercare plan so support was in place immediately after discharge. The aftercare plan included time dedicated to addiction recovery groups, to personal care such as shopping and washing, and social time with family and at their local temple.

In line with national guidance, clients seeking treatment for alcohol misuse were assessed using the alcohol use disorder identification test (AUDIT). If the score indicated dependent levels of use, staff completed the severity of alcohol dependence questionnaire (SADQ) to help decide the most appropriate treatment pathway. Treatment could range from advice through to a referral for inpatient detoxification. Experienced clinical staff assessed clients for community

# Community-based substance misuse services

alcohol detoxification and discussed clients' suitability for the treatment during MDT meetings. Staff focused on risk factors and we saw evidence where a community alcohol detoxification was postponed until staff were satisfied the client's cognitive and mental health assessments were completed. This was arranged between staff and the client's social worker. Clients who needed a prescription for MAT were assessed in person by a doctor or non-medical prescriber (NMP). Correspondence from clients' GPs and urine or saliva drug screen tests were part of initial and ongoing assessments.

## Best practice in treatment and care

**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. Staff delivered care in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence (NICE). These included self-management and recovery training groups, motivational interviewing, and counselling. The service recently started a recovery group on a Saturday, in addition to a Thursday group, so clients with weekday commitments or responsibilities could still attend. Other interventions offered to clients included needle exchange, outreach and assertive engagement for hard to reach clients, and assistance with other needs such as finances and accessing education or training. Most clients we spoke with felt happy with the interventions and support offered. Two clients told us the relaxed approach of the recovery groups made it a positive experience for them. There was no clinical psychologist at the time of our inspection.

Clients accessing the young person service mainly received brief interventions and resilience work, although MAT was available. Young people could be booked to have an assessment with the alcohol nurse if they reached certain scoring thresholds on the AUDIT and SADQ. At the time of our inspection there were no clients under 24-years-old receiving medical interventions. Brief interventions took place in the community hub the young person team was based from, or in schools and colleges. Young people transitioned to the adult service when they turned 24-years-old. This process was started 6 months before the young person turned 24-years-old and staff from both teams would meet to discuss the transition with the client.

Staff made sure clients had support for their physical health needs, either from their GP or community services. Two nurses from local hospitals came to the service every week to conduct physical health checks. Clients with opiate dependence had a prescription for methadone or buprenorphine which followed the national guidance. Clients' prescriptions were reviewed regularly, and clients had urine and saliva tests to monitor their use of illicit drugs. Where possible, staff would obtain GP summaries prior to prescribing opioid substitution medication. If clients did not have a GP, staff discussed this during team meetings and helped them register with one. Clients with alcohol dependence had treatment based on their AUDIT and SADQ results. Clients with less severe dependence were offered psychosocial treatment to support them reduce their alcohol intake, which followed NICE guidance. Clients had access to dependent or non-dependent recovery workers from the alcohol team depending on their needs.

All clients considered for community alcohol detoxification treatment were reviewed and discussed during MDT meetings. Staff in attendance included the recovery worker, nurses and a doctor. At the time of our inspection the service did not have a lead consultant psychiatrist. The service had onsite access to the regional lead consultant 2 days a week and had 2 agency speciality doctors. Clients completing community alcohol detoxification were invited to attend recovery preparation groups prior to commencing, and relapse prevention groups straight after their initial detoxification. Groups were for 5 to 8 people and topics discussed included the cycle of change, coping with cravings,

# Community-based substance misuse services

managing risky situations, wellbeing, moving on and celebrating their success. Medication and vitamins offered during community alcohol detoxification treatment were in line with NICE guidance. These were used to reduce and stop withdrawal symptoms as well as preventing nerve damage in the body and brain. Staff sent detailed letters to GPs after completion of detoxification.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. All the care and treatment records we checked showed clients were offered BBV testing. However, staff were informed during a recent integrated governance team meeting that the service's testing levels were low and reminded staff to offer BBV tests to all clients. Some of the records we reviewed showed clients had been offered but had refused. One client said her recovery worker had talked to her about jogging, mindfulness and badminton which improved her social life. Clients, volunteers, managers and staff had recently participated in a national football tournament involving Change Grow Live services from across the country.

Staff used recognised rating scales to assess and record severity and outcomes. Staff measured the treatment and recovery outcomes of each client using the treatment outcomes profile (TOPs) tool. Staff working with opiate clients knew of the clinical opiate withdrawal scale (COWS) and were using it. Rating scales were integrated within the service's electronic record keeping system.

Staff used technology to support clients. Clients received text messages and phone calls to remind them about when they were due in for medication or reviews. Staff in the young person service had recently started 2 social media pages with the aim of reaching more young people. They also signposted young people to apps that could guide them through self-help such as affirmations, gratitude and staying calm.

Staff took part in clinical audits such as checking room and fridge temperatures every day and monthly medication and prescription stock management checks. However, stock checks for controlled drugs were not always completed weekly as outlined in the provider's policy. Some audits were set by the provider, for example, health and safety, infection prevention and control, safeguarding and vaccine storage. Some audits were decided locally according to need. For example, when the service manager first started their role, they conducted an audit of full risk reviews and case notes. The outcomes of this audit determined the content of the training which was then given to staff. The service planned to complete other local audits before the end of the year. These included medicines management, non-opiate and alcohol caseloads with a focus on pathways and performance, and safeguarding. Managers used results from audits to make improvements, although there were not always clear plans in place to address outstanding actions.

## Skilled staff to deliver care

**The team included or had access to the full range of most 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 opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, some staff had not received managerial supervision as frequently as outlined in the provider's policy.**

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. The service had access to a full range of specialists to meet the needs of each client. The nursing staff had backgrounds and specialist training in substance misuse services. However, the service did not have a clinical psychologist.

# Community-based substance misuse services

Managers gave each new member of staff a full induction to the service before they started work. This was a 2-week programme which involved completion of mandatory training, reading policies and shadowing other staff. Managers used an induction template for agency workers. Staff were positive about the induction they received.

Managers made sure staff attended regular team meetings such as business meetings, MDT meetings and leadership meetings. However, the quality of detail in meeting minutes varied.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, staff had recently had trauma informed training and the young person team had county lines training. Clinical staff received training on anaphylaxis and flu vaccinations. The provider had a 'women in leadership' training group and opportunities to be mentored.

Managers made sure staff received any specialist training for their role such as BBV awareness and best practice in optimising opioid substitution treatment (BOOST) training. BOOST training was not mandatory, but all staff had been assigned to complete it via their e-learning platform.

Managers recognised poor performance, could identify the reasons and dealt with these. The manager had regular meetings with the HR team.

Managers recruited, trained and supported volunteers to work with clients in the service. However, the manager responsible for progressing interest from 9 new service user representatives was on long-term sickness leave and therefore this was delayed.

Managers supported staff through regular, constructive conversations about their work, although some staff had not received managerial supervision in line with the provider's policy. Staff were very positive about the level of support they received from managers. Staff received monthly group supervision from an external supervisor. Those with professional registrations were supported to maintain these through clinical supervision.

Some staff had not received managerial supervision in line with the provider's policy, which stated that staff should receive at least 4 formal one-to-one managerial supervision sessions every 12 months. At the time of the inspection, 74% of staff were on track to complete 4 one-to-one supervision sessions over a 12-month period. This meant that staff did not always have access to formal written records of conversations, goals and actions. Most staff were positive about the level of support they received from managers, but some told us they would like more supervision or that their informal conversations were not recorded.

Not all staff had received their annual appraisal, but the service had a plan in place to ensure staff received an appraisal. At the time of our inspection the appraisal rate was 50%. The service manager said appraisal figures were due to managers having requested training on the process. Training was due to take place shortly after the inspection and all staff with overdue appraisals had been booked to have these before the end of the year. Leaders planned to monitor ongoing compliance rates in the new senior leadership meetings.

## 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 teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

# Community-based substance misuse services

Staff held regular multidisciplinary team meetings to discuss clients and improve their care. MDT meetings happened weekly and were separated into an MDT for the alcohol team and an MDT for the opiate and non-opiate teams. The rough sleeper and criminal justice teams attended the MDTs relevant to their client's primary substance needs. Doctors, nurses and NMPs also attended these meetings. MDT meetings gave staff the opportunity to discuss clients' treatment plans, share and manage risk, agree prescribing, discuss and agree on detoxification arrangements and monitor those in detoxification, and discuss safeguarding concerns. We observed strong communication and team working. Staff were knowledgeable and caring when speaking about clients.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. The service had good links with the local hospital and staff were able to provide daily hospital updates ahead of clients being discharged back into the community.

Staff had effective working relationships with other teams in the organisation. Staff attended a wide range of meetings both within the service and with staff based at other locations. For example, all staff attended the daily morning briefing and then broke off into their specialist teams for their own morning briefings. Staff discussed a range of topics including high-risk clients and referrals, clients no longer taking their prescription as planned, and clients in hospital. Managers attended forums with other leaders around the country in order to access support, share information and resources, and provide updates on service changes.

Staff had effective working relationships with external teams and organisations. These included pharmacies, local authority safeguarding teams and community mental health teams for young people and adults. Most of the records we looked at showed at least 1 other service or professional involved with the client. Recovery workers and other professionals, such as safeguarding midwives and social workers, had arranged joint visits to pregnant clients.

Staff attended a range of meetings with external stakeholders. The outreach team had a weekly meeting with professionals from the local NHS mental health trust, a prison link worker, a nurse specialist and representatives from a housing charity. They discussed complex patients with the aim of providing joined up care. The young person team had regular meetings with external agencies such as the council and the local Children and Adolescent Mental Health Service (CAMHS).

On the day of our inspection, the service was involved in an event at the nearby community centre in partnership with NHS England. The rough sleepers team had a stall and there was food and entertainment available for attendees.

## Good practice in applying the MCA

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

Staff received and kept up to date with 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, and at the time of the inspection 92% of staff had completed it.

As part of the assessment process, clients completed a consent form. The consent form contained questions to assist staff to assess capacity.

# Community-based substance misuse services

Staff gave clients all possible support to make specific decisions for themselves. Electronic care records showed consideration and assessments of clients' capacity was in line with the underlying principles of the Mental Capacity Act.

Staff understood Gillick competence which was relevant if they worked with children under 16-years-old. Gillick competence assesses whether a child has enough understanding to decide on the benefits and risks of treatment. If a child is not Gillick competent then someone with parental responsibility must make the decision on their behalf. Staff told us it was extremely rare for children to have treatment through the service, instead receiving brief interventions such as information and advice around cannabis use. Young people aged 16-years and over are assessed under the Mental Capacity Act and can consent or refuse treatment if they are deemed to be competent. Staff on the young person team said Gillick competence and capacity was addressed in confidentiality forms and assessment tools.

## Are Community-based substance misuse services caring?

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.**

As part of the inspection we spoke to 6 clients currently using the service. Most clients we spoke with were very positive about the service and said staff treated them well and behaved kindly. One client told us the service had saved her life. Another client had needed to complain about waiting times in the reception area but said this was quickly resolved and had improved since.

Staff were discreet, respectful, and responsive when caring for clients. We observed staff discussing clients in a kind and respectful manner during meetings. Staff knew clients well and celebrated their successes. Clients felt the staffing team were friendly, connected with each other and compassionate. One client said staff dealt well with aggressive and intoxicated clients.

Staff gave clients help, emotional support and advice when they needed it. One client said a member of staff had gone out their way to write to their solicitor. Another member of staff had repeatedly contacted the client when her phone broke to check she was ok. All clients felt staff were responsive and that they could contact them if they needed anything.

Staff supported clients to understand and manage their own care treatment or condition. Staff understood and respected the individual needs of each client.

Staff directed clients to other services and supported them to access those services if they needed help. For example, a staff member had accompanied a client to an appointment to get support for their mental health after they had failed to attend other appointments. Other staff had travelled with clients to the location of their inpatient detoxification if they could not get there alone. The service had a car they used for outreach and escorting clients to appointments.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. They felt positive about the levels of support within the team.

# Community-based substance misuse services

Staff followed policy to keep client information confidential. They completed client records in secure systems. Staff involved carers and family members if the client consented. Records showed strong evidence consent was discussed. However, 1 client told us they did not want their personal details shouted in the reception area for others to hear.

## The involvement of people in the care they receive

**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.**

Staff involved clients and gave them access to their care plans. Clients and staff worked together to create and record goals.

Staff made sure clients understood their care and treatment and found ways to communicate with clients who had communication difficulties. Clients found it helpful there were separate groups for clients still using substances and others who were abstinent. Clients were extremely positive about the benefits of the recovery meetings. They said these meetings were relaxed and non-judgemental.

Staff involved clients in decisions about the service, when appropriate. Clients could give feedback on the service and their treatment and staff supported them to do this. There were options to give handwritten, verbal or digital feedback. Nine clients had expressed an interest in becoming service user representatives. Leaders planned to invite service user representatives to monthly integrated governance team meetings. Unfortunately, due to staff sickness, there was a delay with this. Prospective service user representatives were kept engaged by the recovery motivator worker. They were also invited to informal feedback meetings where refreshments, puzzles and games were provided. Clients had been involved with making decisions about the service's environment. For example, feedback led to some areas being painted and the service had purchased new flooring and chairs for the reception.

Staff made sure clients could access advocacy services.

## Involvement of families and carers

**Staff informed and involved families and carers appropriately.**

Staff informed and involved families and carers appropriately. If clients provided consent, family members and carers were invited to attend meetings and be involved in their care. The service had recently started recovery meetings one evening a week to support families and carers. The young person team planned to start a group in partnership with the local child and adolescent mental health service (CAMHS) for cannabis use and mental health support. This would be run alongside a family and carers group so they could also receive support with these issues.

The provider's policy stated clients starting community-based alcohol detoxification must have a named person to support them for the first 3 days due to the risks involved. We looked at 4 community detoxification records and they all contained evidence of carers being involved with meetings prior to community detoxification, although staff had only recorded the contact details for one of the named persons.

Staff helped families to give feedback on the service.

Staff gave carers information on the support available to them.



# Community-based substance misuse services

## Are Community-based substance misuse services responsive?

Good 

### Access and discharge

**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. However, the referral tracker staff used to monitor contacts before clients started treatment was not always kept up to date.**

The service had clear criteria to describe which clients they would offer services to. Their website provided information about the services on offer including the dedicated young person team. Clients could self-refer or be referred by a family member or professional.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. Referrals received, how many had been processed, and those still outstanding were discussed during the daily morning meeting. Referrals for young people and rough sleepers went directly to those teams to speed up access. The service had sessional staff who completed triages and assessments over the weekend. Staff saw urgent referrals quickly and offered drop-in sessions where clients could often be seen the same day.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support. During team meetings, staff discussed clients who had not attended appointments and tried to contact people to offer support. The service had an outreach team who proactively visited areas they knew hard to reach clients may be. Staff conducted home visits where necessary. Many records contained family and carer contact details should a client unexpectedly exit treatment. However, records did not always state personalised ways to keep clients engaged.

Clients could access treatment regardless of their housing or social circumstances and had some flexibility and choice in the appointment times available. Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible.

Staff could refer clients to other services if their needs could not be met. For example, a client referred for heavy smoking was referred onto a suitable service.

Staff supported clients when they were referred, transferred between services, or needed physical health care. We saw evidence of effective handovers when a client was transferred from another borough. When clients were ready to be discharged from the service, either due to successful completion of treatment or not engaging, staff followed clear discharge processes. Staff updated client's GPs and said they operated an open-door policy should clients need further support after discharge.

However, systems used by the service to help them monitor waiting lists and support clients were not always effective. The service had devised a tracker of clients who had been referred and were awaiting their first appointments following allocation. The purpose of the tracker was to prompt staff to call clients within certain timeframes and to increase contacts to clients considered high risk. However, the tracker was not always kept up to date and managers did not have regular oversight to check if clients were being contacted appropriately. For example, the tracker showed a high-risk client had not been contacted by the service for over a month. However, we checked the electronic records system which showed multiple attempts at contact and the client was subsequently discharged due to lack of engagement.



# Community-based substance misuse services

This was in line with the provider's processes. Therefore, it was not always clear if clients had received appropriate levels of contact. The staff member responsible for updating the tracker was on long-term sickness so other staff had been asked to help. To try and mitigate future issues, managers had advertised a role for someone to oversee the tracker. High-risk clients were also discussed during team meetings.

## The facilities promote recovery, comfort, dignity and confidentiality

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

The young person service was based in a different building. On the rare occasion a young person needed to attend the adult site to meet with a clinician, staff met them in the carpark and escorted them through a separate entrance. Staff said young people were always kept separate from adult clients due to their vulnerabilities.

The service had a full range of rooms and equipment to support treatment and care, but some staff said they sometimes struggled to find a free room to see clients in.

Consultation rooms in the service did not have sound proofing. However, details of conversations could not be heard.

## Meeting the needs of all people using 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. The service was accessible for clients and staff with mobility impairments. There was an accessible toilet with an alarm pull cord. There was a hearing loop available so clients with hearing aids could pick up speech sounds more clearly. The reception area was in the process of being refurbished. There was a daily drop-in clinic so clients could access the service at a convenient time for them, and staff were sometimes able to assess them immediately.

Young people were generally seen in the community, but staff ensured they did not mix with adult clients on the rare occasion they needed to visit the main site.

Staff went out of their way to help clients with additional needs access treatment. For example, staff had transported a client to their inpatient detoxification site due to their physical health concerns. Staff completed an aftercare plan with the client before they had completed the detoxification so immediate support was in place. The aftercare plan was holistic and set aside time for the client's religious needs to be met. Another client told us they had been helped with matters related to their disability.

Staff made sure clients could access information on treatment, local services, their rights and how to complain. The service had information leaflets available in languages spoken by the clients and local community. Although leaflets displayed were only in English, we were told they were available in other languages if needed. Leaflets available included the different groups and services available, how to make a complaint, information on different substances, and naloxone use. One client told us they wanted more leaflets about activities in the local area rather than leaflets focused on recovery. The service manager told us some clients gave feedback that there were too many posters close together and with small text which caused confusion for some people. In response, the manager had ordered a digital screen for the reception area so information could be clearer and updated.

# Community-based substance misuse services

The service provided information in a variety of accessible formats so the clients could understand more easily. Managers made sure staff and clients could get hold of interpreters or signers when needed. Staff said some languages were more challenging to get interpreters for, so they'd use internet translation sites in the interim. Some staff told us they had written down information for a deaf client if they had been unable to immediately access signers. Another staff member had used pictures to assist a person with dyslexia.

## 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 the wider service.**

Clients, relatives and professionals knew how to complain or raise concerns. Most clients told us they had not needed to complain but knew how to and would feel able to do so. One client who had complained said it was dealt with immediately and they had since noticed improvements.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. The service had received 5 complaints in the last 12 months. Of these complaints, 3 related to an overall need for improvement in contact and response times throughout a client's time with the service.

Clients received feedback from managers after the investigation into their complaint, although the service was trying to improve the time it took to respond to complaints. Two of the complainants received a response within the 28-day target timeframe. Managers recognised the complaints process needed to be timelier and more effective, so this was added to the risk register. In response, staff received training on the process, managers discussed complaints in weekly meetings, and feedback options were added to the website.

Clients were also able to give informal feedback which was collated and acted upon. For example, some clients told staff they were not acknowledged when entering the building and waited unattended in reception for long periods. In response, staff were reminded of their duties when working on reception and added an extra staff member to ensure sufficient cover. Furthermore, the national service user involvement lead conducted a 'mystery shopper' exercise. This involved 14 random calls to staff and an unannounced visit to assess quality of responses and client care. The feedback from this exercise was very positive and managers had started to act on recommendations. Clients spoke highly of staff and of how they were treated.

Staff protected clients who raised concerns or complaints from discrimination and harassment. They told us complaints were always taken seriously and felt passionately about the clients' rights.

Managers shared feedback from complaints with staff and learning was used to improve the service. However, meeting minutes did not always contain records of these discussions. This meant staff who were unable to attend may not always have been aware of recent learning or improvements.

The service used compliments to learn, celebrate success and improve the quality of care. We saw evidence the service had received lots of compliments.

## Are Community-based substance misuse services well-led?

# Community-based substance misuse services

## 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. However, leaders did not always ensure actions from audits were completed in a timely way or ensure staff followed the provider's policies.**

The local leaders in the service were motivated and enthusiastic about supporting the client group. The service manager had started in January 2022, 3 months after the provider changed, and had previously worked for the current provider in a variety of roles. They had started to implement new ways of working to benefit clients and staff. Many team leaders had transferred from the previous provider and were familiar with the clients. All staff spoke positively about local service managers and felt comfortable approaching them for advice if they needed to.

The service manager spoke highly of the senior data analyst and quality lead who supported them to identify and implement service improvements.

Leaders attended regular internal and external meetings with the aim of seeking advice, and sharing information, learning and good practice.

However, there were some areas managers could have increased their oversight, such as ensuring all audits were completed on time and actions followed up.

## Visions and values

**Staff knew and understood the provider's vision and values and how they were applied in the work of their team.**

Staff clearly shared the provider's vision and values of being open, compassionate and bold, making a difference in people's lives, and giving everyone an opportunity. Managers, team leaders and staff role modelled the values in practice. Some staff told us the vision and values had been covered as part of their induction.

The service aimed to be flexible and adjust their approach to individual needs to give them the best chance of success. The service had a daily drop-in clinic so clients could attend with more flexibility. The feedback from most clients about staff attitudes suggested they were aligned to the provider's vision and values.

## 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.**

# Community-based substance misuse services

Staff we spoke with told us they were well supported by managers and colleagues. It was evident that staff valued each other's expertise, worked well together, and wanted the best outcome for clients. Managers told us they operated an open-door policy and regularly spoke to staff if they had concerns or queries without waiting for formal supervision. Staff were aware of whistle blowing processes and the policy was available via the service's intranet.

The daily morning meeting had an agenda item for celebrations where compliments about staff were shared and successful treatment outcomes for clients discussed.

Some clients had trained to become volunteers within the service. They were also in the process of recruiting 9 service user representatives. Their start date had been paused due to staff sickness, but the service kept them engaged through informal client feedback sessions.

The service did not have an equality and diversity (E&D) lead or any on site groups for LGBTQ+ clients to access. However, the staffing team was diverse, and we were told the service met diverse needs of staff and clients. For example, the service had offered one-to-one pre-detox sessions if they identified individual clients who would not benefit in group settings. There was a women's group. Staff had spoken about Black History Month during their morning meeting. The referral form asked gender identity questions to ensure the service met individual needs.

## Good governance

**Our findings from the other key questions demonstrated that governance processes mostly operated effectively at team level and that performance and risk were managed well. However, some actions were not completed quickly.**

There was a comprehensive governance system supporting staff to provide safe and high-quality care and treatment. There was ongoing performance monitoring and auditing in a range of areas such as caseload data analysis, health and safety, and infection, prevention and control. Staff discussed upcoming weekly and monthly audits during their morning meetings to ensure they were completed. The 6-month health and safety audit was overdue and the service manager said he was not prompted of this by the system.

There was a service risk register, a business continuity plan and a service quality improvement plan (SQIP). The service had struggled with staffing capacity and actions from some audits and discussed during meetings had not been completed.

The service manager had a senior data analyst and a quality lead who helped share governance responsibilities. The senior data analyst regularly provided data for contract monitoring purposes and to assist staff prioritise tasks. The service manager told us they planned to further improve performance by introducing an additional data oversight meeting which involved clinical staff. This would also include safeguarding reviews of which we found many were overdue.

Staff attended lots of regular meetings where they discussed clients, performance and risk. These included internal meetings such as the daily morning briefing, MDT meetings and managers meetings, as well as meetings with colleagues based in other CGL services and external agencies. Minutes from meetings were stored on a shared drive so staff could access and read them at any time. However, as mentioned elsewhere in this report, the quality of these minutes varied.

## Management of risk, issues and performance

# Community-based substance misuse services

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service had a risk register, but it did not include all risks.**

The service's local risk register, co-produced by staff and managers, included 10 current concerns about the delivery of the service. Managers were familiar with most of the key risks to service delivery and their associated factors. These included timely access to treatment, effective case management, quality of recording, supporting staff, responses to incidents and complaints, and reducing the risk of overdose in the community. Mitigations had been considered, with some already actioned and some ongoing. However, some issues were not specifically identified, for example, that the twice-daily checks to clients having community detoxification for alcohol were not being completed. The service manager told us the risk register was a work in progress and they planned to review risks in future management meetings. Development of the risk register featured on the SQIP.

Staff had access to a performance dashboard which displayed performance indicators for the service. For example, staff could use the dashboard to see any upcoming or overdue deadlines for clients. This meant managers had oversight of staff caseloads to guide their support and monitor any actions needed if someone went on leave or was sick. The service's senior data analyst offered staff individual and group support to review performance for their caseload. Staff were asked to use data to plan their workload and were encouraged to identify any support needs to do so.

Staff and managers were able to escalate risks within their teams and higher within the organisation. The service manager reported good visibility from the provider's senior leaders. Staff could also email the risk and assurance team if needed. Staff discussed risks, issues and performance in a wide range of meetings such as weekly MDTs and daily morning briefings. For example, all staff were aware of a current drug alert after a bad batch of heroin caused increased overdoses within the community. There was an agenda item within the daily morning briefing where staff were reminded to offer naloxone to clients.

The service held monthly integrated governance team meetings, although the minutes from these did not fully record what was discussed. We saw some actions rolled over for several months, for example, the creation of grab bags containing emergency equipment. There was a dedicated space for lessons learnt and examples of excellent practice, but the minutes did not capture these. However, we saw separate accompanying notes about learning from medication incidents and learning after deaths. Addressing learning of incidents at integrated governance team meetings was an action on the risk register to mitigate issues with incident reporting and repeated incidents.

## Information management

**Staff collected and analysed data about outcomes and performance.**

The service had systems in place that provided leaders with information about the running of the service. This enabled them to maintain clear oversight of the service and identify good practice and areas for improvement. The service had a senior data analyst who could help staff interpret the data via an activity dashboard. The service manager intended to provide training on the data management system so the whole leadership team could become more familiar with it. Detailed updates were shared with the commissioner every 3 months

Leaders used data to improve the service. For example, the new service manager recognised staff needed to increase completions of full risk reviews and service user plans. An audit was conducted shortly after they started their role and the results of this informed the training subsequently provided. Since this action, the number of overdue reviews had decreased. Managers planned to complete a follow-up audit in December 2022.

# Community-based substance misuse services

The senior data analyst met with staff members and their managers monthly to review their caseload and note actions required. This meant each staff member had access to information about their performance and any clients with outstanding actions, for example, overdue medical reviews. The data analyst offered additional one-to-one support sessions to staff if needed. The service was due to start new monthly meetings involving the managers and clinical leads to widen the data reviewed. Additional data reviewed would include overdue medical reviews, full risk reviews, and last meaningful contact between clients and staff.

## Leadership, morale and staff engagement

Most staff reported improved morale since the provider changed to Change, Grow, Live. Staff felt included in conversations about changes to the service.

All staff were positive about their teams and how they worked together with other teams, both internally and externally. Staff felt comfortable approaching the service's managers for advice when needed and felt well supported. Leaders responded to issues raised by staff. For example, staff on 1 team informed the manager their caseloads were too high. In response, the manager altered the planned recruitment, so the team received an additional staff member to try and balance caseload numbers.

The service had a weekly wellbeing hour which enabled staff to take a break from their work. Staff could request times and days of their choice for this during morning meetings. We were told agency and sessional staff had been brought in to assist staff with workloads.

## Commitment to quality improvement and innovation

The service had an improvement plan which detailed areas for improvement, completed and outstanding actions, and who was responsible for these. At the time of our inspection, there were 13 items on the plan. These included the development of the risk register, improvements to staff support, improvements to the referral pathway, case management and case recording.

The service manager had regular meetings with other regional service managers, and they shared learning and examples of good practice. For example, a manager from another borough provided advice on how they had implemented hostel workers, a role the Croydon service had requested through the commissioner. The service manager planned to shape the interview questions and scope of the role based on this discussion. Another team leader had contacted a member of staff based up north because they had been involved with writing content for criminal justice client groups. Staff attended a 2-day course and as a result were able to deliver this weekly intervention with clients. A peer advocate was also trained to co-facilitate.

Data showed the service's BBV testing was low. To encourage more clients to be offered testing, the service awarded monthly vouchers to staff with the highest testing rates.

The service was not involved with any research at the time of our inspection. However, there were some examples of innovative practice. For example, the young person team was about to partner with the local CAMHS team to start a support group for young people with mental health issues and cannabis use. The young person team co-produced the materials and the group was due to start in January 2023. They also recommended wellbeing Apps to young people and had social media pages in the hope these formats would engage young clients.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment  The service must ensure that clients receiving community detoxification for alcohol have contact from staff and that withdrawal tools are used in line with the provider's policy.