Change, Grow, Live

Camden Community Drug Treatment Service

Inspection report

210 Kilburn High Road
London
NW6 4JH
Tel: 02073283470
www.changegrowlive.org

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

Ratings

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

Summary of findings

Overall summary

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 team, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding. Staff were up to date with their mandatory training including safeguarding and basic life support.
- 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 audits to evaluate the quality of care they provided.
- The team included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. New staff were given a comprehensive induction. Staff worked well together as a multidisciplinary team and with 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.
- 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 ensured that its procedures ran smoothly. Clients could provide feedback on the service.

However:

- The Camden site was small and not always fit for purpose. The clinic room at the Camden site could not accommodate a clinical bed, and some rooms for groups were in the basement which was only accessible via a spiral staircase.
- Fire alarms were not always tested weekly across both sites as scheduled by the provider.
- There was only one health and safety lead within the service at the time of our inspection and audit outcomes and actions were not always recorded in a central location. This meant there was not a robust system in place in terms of health and safety oversight when the lead was absent from work. The provider was aware and planned to train a second person.
- Records did not always document when clients attended group sessions which meant it was not always clear if they were accessing the psychosocial aspects of the service.
- Records of controlled drugs did not differentiate between individual client's medicines and stock medicines for the service. Staff did not consistently monitor and electronically record temperatures of areas where medicines were stored.
- Records did not always document if consent had been reviewed regularly and gained from clients, and some clients told us they had not been asked about consent.
- Clients were not always given copies of their care plans. None of the clients we spoke to said they had crisis plans.

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

Contents

Summary of this inspection

Background to Camden Community Drug Treatment Service

The Camden Community Drug Treatment Service is delivered by Change Grow Live, a nation-wide provider who deliver not-for-profit drug and alcohol treatment services. The service provides community drug treatment and support from two fixed sites: one in Camden (open Monday to Friday) and one in Kilburn (open Monday, Wednesday and Friday). They also run group programmes and peer-led activities from larger hired community venues.

The community alcohol service has been commissioned separately from the drug service since 2015. The Camden Community Drug Treatment Service offers psychosocial interventions to adults affected by alcohol use, but the clinical elements are subcontracted to a third-party organisation; this was outside the scope of this inspection. These clinical elements include psychiatry, community detoxification and nursing interventions. All community alcohol services were provided from the same building.

The Camden Community Drug Treatment Service offers a range of services including psychosocial interventions, recovery coordination and medically assisted treatment for opiate detoxification. They have been commissioned to administer Buvidal, a prolonged-release injection to treat opioid dependence, and also offer prescribing services, a hostel in-reach service, and blood borne virus testing.

There are approximately 300 clients accessing the service. Staff regularly interact with each other but are based within different teams such as criminal justice, clinical, and treatment and recovery teams. Appointments are offered face-to-face and remotely. Clients can access group sessions or individual appointments.

The service works in partnership across Camden with other agencies including social services, GPs, pharmacies and those within the criminal justice system.

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

This was the first time we have inspected the Camden Community Drug Treatment Service.

What people who use the service say

Most clients we spoke with were very satisfied with the care and treatment they received from the service. We spoke with 17 clients. Most of these clients were accessing the drug service, but five were family members, friends and carers accessing the support services.

Most clients said staff were kind, respectful and supportive. People accessing the service felt involved in their care, treatment and goals. Families and friends accessing the support service felt involved by staff if their family member had given consent. Everyone accessing the service felt the buildings were clean, but most people said they were too small. No-one we spoke with knew what their crisis plan was. Some people said staff had not discussed their rights such as confidentiality, consent and sharing information with them. Some people did not have access to an advocate or know how to access one if required, and some people did not know the complaints process or feel involved in giving feedback on the service.

Summary of this inspection

How we carried out this inspection

This inspection was carried out by two inspectors, a medicines inspector and a specialist professional advisor with expertise and experience in substance misuse.

This inspection involved a two-day site visit and was followed up by interviews with clients carried out remotely.

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 12 staff including the quality lead, team leaders, the designated safeguarding lead, senior practitioner, recovery coordinators, the assessment and engagement coordinator, clinical administrator, non-medical prescribers, hostel in-reach coordinator, lead nurse, and a student nurse
- spoke with 17 clients
- reviewed seven clients' care and treatment records
- reviewed five medicine administration records
- observed a morning briefing meeting and a managers meeting
- observed two appointments between staff and clients
- reviewed prescribing and the medicines prescription process. Checked the medicines storage area and temperature monitoring records
- reviewed three supervision records and three appraisal records
- reviewed other documents concerning the operation of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service had created feedback pods. These meetings enabled clients to give direct feedback to staff and managers about an issue that had impacted them within the service. The client and staff members involved reflected on what had happened and learning was noted within the meeting and shared with the wider staff team. The concept of the feedback pods had been shared as examples of good practice with other managers across Change Grow Live.

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 fire alarms are tested weekly at both sites.

Summary of this inspection

- The service should ensure records contain details of how staff can keep clients engaged in their treatment plans and what advice they have been given if they find themselves in crisis.
- The service should consider ways of recording when clients attend group sessions so they can monitor engagement with the psychosocial aspects of the service.
- The service should ensure its records clearly reflect when individual client's medicines are received into the controlled drugs cabinet.
- The service should ensure clients are offered copies of their care plans and document when this has or has not happened.
- The service should ensure clients consent to treatment and to share information with other professionals is regularly reviewed and documented.
- The service should ensure managers can always access results from audits.

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

Safe and clean environment

Some 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. There was a fire safety risk assessment and emergency plan for each service location, with fire equipment serviced regularly, and there were named fire wardens for each site. Fire drills were completed every six months at both sites as required. However, fire alarms were not always tested weekly as scheduled and staff did not always consistently record the details of the environmental checks centrally. This meant that when the service's only health and safety lead was not at work, staff may not be aware of environmental issues.

All staff carried personal alarms and were available to respond. Clients and visitors signed in and out at reception. Keyworkers met clients in reception and supported them when in the building. Areas only accessible by staff had keypads fitted to the doors. There was an alarm at the reception desk which connected to the police and an alarm in the clinic room.

Both clinic rooms had most of the necessary equipment for clients to have thorough physical examinations. The clinic room at the Camden site was too small to accommodate a clinical bed.

Most areas were clean, well maintained, and well-furnished. Staff ensured the premises were clean and had a morning and afternoon cleaning rota. The service was also deep cleaned by contracted cleaning staff every day. The small meeting rooms at the Camden site were not soundproofed, but white noise machines were available. There were air purifiers to assist ventilation of the rooms. All clients told us the premises were clean, but most staff and clients said the rooms at the Camden site were too small and not fit for purpose. Some rooms were in the basement and only accessible via a spiral staircase. We observed the garden at the Camden site, accessible via a kitchen used by clients, was cluttered and contained items such as a broken mirror, dead plants and a broken chair. Management were aware of this and had arranged for it to be cleared.

Staff followed infection control guidelines, including handwashing. Staff disinfected rooms after each use and wiped down all furniture and frequently touched surfaces. Stickers were clearly displayed indicating when the room, furniture and touch points were last cleaned. Signage was in place indicating maximum room occupancy. Staff said the team worked together to ensure face-to-face appointment bookings were coordinated to ensure low numbers of clients attended the service at any one time. Disposable single-use gloves and aprons were available in covered wall mounted containers and we saw staff wearing these. Staff discussed Covid-19 updates and expectations around PPE during team meetings. The last infection control audit was in February 2022 and overall compliance for both sites was 98.4%.

Staff made sure equipment was well maintained, clean and in working order. We observed stickers on electrical equipment showing they had been tested in March 2022.

Safe staffing

The service had enough staff who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the 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 recruited several new staff over the pandemic and had supported them to gain skills.

The service had enough staff to keep clients safe. Staffing levels were based on their commissioning contract. There were four vacancies at the time of our inspection, two of which were for newly created posts for criminal justice workers. Both of their non-medical prescriber (NMP) positions were filled by agency staff, but these professionals had previously worked there so were familiar with the service. The service could access support from staff in other boroughs if necessary.

Staff knew the clients and received basic training to keep them safe from avoidable harm. Managers and team leaders supported new staff to develop their skills and competencies. Staff said caseloads felt manageable. Team leaders were working with staff to review caseloads.

Managers made arrangements to cover staff sickness and absence. We observed staff offering to cover for colleagues during their daily morning meeting. Some staff we spoke with said this impacted other areas of their work at times. One NMP was covering someone on long-term sickness leave.

The service ensured it had safe recruitment procedures. For example, the service's safeguarding lead attended safeguarding panels and explored applications from people with a Disclosure and Barring Service (DBS) flag. The service welcomed staff and volunteers with lived experience, but recognised the importance of safety.

Managers made sure all staff new to the service had a full induction and understood the service before starting work. A more comprehensive two-week induction had been introduced following feedback from staff that the process needed to be improved. Some clients told us staff needed more support to develop skills. The service had recognised this and had started coaching sessions and regular one-to-ones for less experienced staff. They had also introduced a competencies document, covering caseload management, clinical competencies, safeguarding and governance, which managers reviewed and signed off with new staff. The structure of multidisciplinary team meetings and team meetings had been reviewed so improvements to client care and interventions were discussed and implemented.

The service could get support from a psychiatrist quickly when they needed to.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. At the time of our inspection, training compliance across the seven mandatory courses was between 99% and 100%. The training included data protection, equality and diversity, the Mental Capacity Act, basic life support, and safeguarding adults and children.

The mandatory training programme was comprehensive and met the needs of clients and staff. All recovery coordinators had started or completed their Best practice in Optimising Opioid Substitution Treatment (BOOST) training. This programme, recommended by Public Health England, includes six sessions related to opioid substitute treatment.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers reviewed the service's training data at least once a month during their meetings. Staff said training was easy to access and they received prompts in advance of when training was due.

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

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in 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

During the triage process, the assessment and engagement coordinator gathered basic details from each person and completed the Alcohol Use Disorders Identification Test (AUDIT). This 10-question screening tool was completed with all new clients even if they reported low levels of drinking alcohol. Leaders had oversight of referrals and could prioritise them if the risks were increased, for example, if someone was pregnant. Staff stated clients with high risk concerns had their referrals fast tracked. They were assessed, reviewed and contacted within 24 hours.

Staff completed risk assessments for each client on arrival using a recognised tool and reviewed this regularly, including after any incident. We reviewed seven client care and treatment records. Staff completed initial assessments which covered a range of risks such as current and historic substance misuse, risks to themselves and others, and mental and physical health. Staff had access to colleagues in the service if they needed additional support, for example around managing clinical risks. Records showed risks were regularly reviewed once clients were allocated to recovery coordinators and any changes were well documented. At the time of our inspection the service was 80% compliant with their risk reviews.

Staff encouraged clients to undertake blood borne virus screening (hepatitis B, hepatitis C, and HIV). If the result was positive clients were informed by the nursing team, a letter was sent to their GP, and they were offered peer support. Treatment options were then discussed with clients.

Staff said they worked with clients to develop unexpected treatment exit plans which included information to assist staff to support clients to re-engage with the service. If clients did not attend an appointment, staff stated they contacted them to help them re-engage with the service. Some records we looked at documented contingency plans and ways to keep the clients engaged, but this was not always clear.

However, staff did not develop crisis plans with clients. None of the 12 clients we spoke with accessing the service for drug use said they had a crisis plan.

Good

Community-based substance misuse services

Management of client risk

Staff were aware of the risks and safeguarding concerns for their clients and provided examples of actions that were being taken to support them. Staff discussed and reviewed risks to clients in a range of forums, such as multidisciplinary clinical meetings, team business meetings, integrated governance meetings, managers meetings, and service lead meetings. Staff had access to clinical group supervision and one to one supervision.

Staff assessed risks and varied the level of supervision for clients receiving opiate substitute treatment, such as methadone. Some clients collected their prescriptions from a community pharmacy each day, and other clients could take their medication home and store them in locked boxes. The services planned to begin inviting most clients to their team bases so they could monitor their health more closely. Everyone using the drug treatment service was offered Naloxone each year which was replaced when necessary. Naloxone is a medication used to quickly reverse the effects of an opioid overdose. We observed staff telling clients about the risks of Naloxone and the importance of safe medication storage. Risk assessments were conducted when someone changed from having supervised medication, and home visits were conducted if clients lived with vulnerable people or children.

Clients on medically assisted treatment for opiate use should have prescribing reviews within six months of starting treatment, repeated every six months after based on need. The client care and treatment records we looked at showed evidence of these where relevant including discussions with the NMP and updates on dosages. Evidence of prescribing rationales were usually documented and shared with GPs.

Staff made clients aware of harm minimisation and the risks of continued substance misuse. This included discussion of safer ways of using substances such as smoking rather than injecting, needle exchange services and not sharing paraphernalia. Staff also shared information to prevent clients becoming infected with blood borne viruses and about the risks to clients of drinking alcohol or taking drugs with their prescribed medicines. However, two clients told us they wanted more focus on recovery rather than having their medication increased or being offered clean needles.

Staff responded promptly to any sudden deterioration in a client's health. Risk information was shared and discussed as part of the morning briefing meetings and discussed at wider multidisciplinary team (MDT) meetings. For example, in one MDT meeting staff worked with external professionals to support a client who had developed back pain and could no longer care for her basic needs. Briefing meetings were held each morning and staff discussed the clients and activities of the day. This included significant updates and changes in risk and safety for clients, appointments, referrals, discharges, incidents, and actions and tasks for the day. They also discussed cover for assessments booked that day and follow-up actions where clients had not attended scheduled appointments. Home visits could be arranged if clients were unable to attend the service or pharmacy.

Staff felt positive about plans to return to mostly face-to-face contact following restrictions from Covid-19. Some staff said they had felt concerned about how they would manage risk remotely over the pandemic. The service's risk register recognised the risks that came with remote working, for example, not being able to notice changes to physical health or appearance. They aimed to consult clients about meeting in person at least once a month. During the pandemic, the service had conducted a full caseload review to identify clients deemed clinically vulnerable so enhanced support could be offered.

Managers told us there were about 300 clients accessing the service. Of these, 20 had not received meaningful contact in the 28 days prior to our inspection. Two of these clients had gone without meaningful contact for over two months. Managers were aware and regularly reviewed this data.

Staff followed clear personal safety protocols, including for lone working. All staff wore personal safety alarms whilst working within the buildings. Home visits were always conducted in pairs and details of home visits were displayed on notice boards in the staff office. Staff phoned colleagues when entering and exiting client's homes. Staff were allocated to be first responders in case a safety incident occurred. There were 19 incidents recorded by the service in the past 12 months. Of these, four related to verbal aggression including threats and two to security. Most staff and clients told us they felt safe.

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 were up-to-date with their safeguarding training. At the time of our inspection, 99% of staff had completed their safeguarding adults training and 100% of staff had completed their safeguarding children training. Additional learning was provided through mentoring, coaching, and delivering training during the integrated governance team meeting. The designated safeguarding lead (DSL) attended safeguarding forums at least four times a year and was able to attend a weekly national CGL safeguarding surgery with other DSLs.

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 gave examples of working with partner agencies such as the community safety team, social services, the local authority adult safeguarding team and housing providers to support individuals experiencing and at risk of cuckooing. Cuckooing is a practice where people take over a person's home and use the property for illegal activities such as drug dealing. Staff discussed safeguarding concerns in meetings such as the daily briefing meeting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew who the service's DSL was and felt able to access them for support and advice. The DSL told us they were easily able to contact directors of the service if significantly concerned about a safeguarding matter.

The last annual safeguarding audit was completed in November 2021. The DSL told us additional safeguarding audits were completed every four to six weeks and additional training was delivered where necessary. For example, the DSL identified staff were raising issues as safeguarding matters when they did not meet the threshold. Training and coaching were provided to staff to increase their confidence at identifying safeguarding matters versus risk. The service lead told us of plans to have social services review their learning and actions from the next audit to see if any additional measures were needed.

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. However, records did not always document client attendance at group sessions.

Client notes were comprehensive and all staff could access them easily. Records were stored securely. Staff used electronic records to record and access each client's progress notes, risk assessments and other information relating to their care and treatment. The last case record annual audit was completed in November 2021 and followed up in January 2022 to get a larger sample size. During audits the service found that information on physical health was held

mainly in clients' medical reviews. Staff were asked to include this information into service user plans and risk reviews to encourage a more holistic approach they hoped would better meet client needs. NMPs and recovery coordinators started having joint meetings with clients to better capture this information. Managers were expected to oversee case management of their teams to assess quality. The service lead acknowledged this was an area for development due to an increase in team leaders' workloads.

Some new staff were unable to access their calendars for months after starting in their roles. This meant they could not book appointments themselves and had to ask other colleagues for assistance. Requests were made to the central IT team but there were often delays.

Records did not always reflect when clients had attended group sessions. Five of the seven records we looked at did not record examples of group attendance. Some showed contact from the service inviting them to groups, but it was unclear if they had attended. This meant staff could not always see if clients were engaging in the psychosocial aspects of the service. Managers recognised this as something they wanted to improve.

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 physical health. However, there had been a number of medicines incidents and managers were taking action to mitigate these.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Medicines and controlled stationary were stored securely. There were paper and electronic records used to show administration and prescriptions issued. The service had a clinical administrator whose role it was to oversee the correct issuing and completion of prescriptions. Once a prescription was generated this would be signed by an independent prescriber or doctor. Prescriptions could be given directly to the client or posted to their supplying pharmacy. Each prescription issued was logged when sent and a copy put into the client's record. Access to medicine storage areas were appropriately restricted. Staff had access to emergency medicines, diagnostic equipment and clinical waste disposal facilities. Controlled drugs were stored at the service.

The record keeping of controlled drugs did not differentiate between client's medicines and stock for the service, which meant we were unable to see a complete record of when a specific person's medicine had been received into stock.

Temperatures of the medicine storage areas were monitored by staff and recorded electronically. Records reviewed showed this did not always consistently take place. Staff were aware of what to do if a medicine went outside of the recommended range.

The service had experienced some medicine related incidents. Managers reviewed these by themes and found most were due to administration and supply errors. Actions were taken to try and mitigate errors, for example, by training additional staff to support the clinical administrator when they were absent.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Every patient who was due a clinical review had these completed at the time of the inspection. Staff discussed the progress of clients during daily morning meetings and multidisciplinary meetings. New staff were provided with training regarding naloxone. All staff actively encouraged clients to have access to naloxone. Clients, their families/friends, and professionals were provided with information on how to use it.

Good

Community-based substance misuse services

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. If a prescription was voided (not issued and destroyed) the service kept a record of this on the client's records.

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.

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 GPs. They were able to access medical and drug histories using summary care records prior to the prescribing of medicines. Staff wrote to GP practices to keep them informed of the treatment being provided by the service. Where people were unwilling to share information, staff were aware of the importance of continuing to try and explain the importance and benefits it brings when working alongside other healthcare professionals.

Staff learned from safety alerts and incidents to improve practice, and medicines audits were completed. Medicines incidents were reported on an electronic system and investigated by the leadership team. They were also discussed at governance meetings and learning was shared with staff. The provider had a system for managing patient safety alerts and ensuring that information was disseminated, however formal records were not kept of this.

Staff reviewed the effects of each client's medicines on their physical health according to National Institute of Health and Care Excellence (NICE) guidance. Clients were offered urine drug screens initially and during their time with the service. Clients were offered blood borne virus tests prior to treatment. If a client tested positive for hepatitis B, nurses were 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. PGDs were in date and had been signed by the nurses using them. Electrocardiograms (ECGs) were conducted by staff in the service where appropriate, for example, for clients who were taking high doses of methadone. If the ECG result was abnormal, staff completed the necessary referrals for more investigations.

Track record on safety

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

The service reported four notifiable incidents to CQC between July 2021 and June 2022. Two of these concerned police incidents and two were safeguarding notifications. None of these notifications raised concerns regarding the care and treatment of the client by the service. There were no whistleblowing alerts or complaints about the service.

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.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns and report incidents and did so in line with the service's policy. Staff felt confident and supported when reporting and discussing incidents.

Good

Community-based substance misuse services

Managers and team leaders investigated incidents and shared lessons learned with the team. Staff in the service learnt from incidents. For example, an incident occurred where several prescriptions were delayed in getting to the relevant pharmacies. On review managers found prescriptions had been left in the service rather than being delivered to the pharmacy. Checking for all prescriptions due for delivery was added as a standing item to the morning briefing meeting as a result, and additional staff were trained to support the clinical administrator. The service had also included medication incidents on their risk register and service improvement plan so it could be reviewed and monitored. There were plans to invite most clients back to their buildings to collect prescriptions rather than from the pharmacy. Staff said all incidents were discussed in the morning briefing.

Managers debriefed and supported staff after any serious incident. Staff ensured clients and, where appropriate, family members and other professionals were updated. Staff also ensured care records were updated. Incidents were reported on their electronic records system.

Staff understood the duty of candour. However, they were not always open and transparent and did not always give clients and families a full explanation if and when things went wrong. For example, we looked at a complaint from the mother of a client who was unhappy at the lack of communication from the service. The complaint went unseen for two months due to a setting on the system and the service acknowledged the lack of contact. We did not see evidence of duty of candour on the complaint record. However, we saw another example where an apology had been given.

There was evidence that changes had been made as a result of feedback. As a result of one complaint, the service lead had written a letter to all clients reminding them of their complaints policy and managers openness to receiving feedback. The service had also implemented a 'feedback pod' where staff and clients involved in an incident or complaint could meet to discuss the concerns. The feedback pod gave clients the opportunity to tell staff how a specific situation made them feel and what could have been done differently. Following one feedback pod, all staff were booked onto Trauma Informed Practice training.

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.

We reviewed seven clients' care and treatment records. Staff completed a comprehensive mental health assessment of each client.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. Staff reported that clients received an initial physical health assessment when they first attended the service. A further comprehensive physical health assessment was conducted with clients who reported or showed any physical health concerns. Nurses conducted a comprehensive physical health assessment for all clients starting on a community detox treatment programme. Staff also supported clients to register with GPs. We saw examples of staff advocating client's rights to be able to access GP services in their area.

Good

Community-based substance misuse services

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. Most clients we spoke with told us they were aware of their care plan and had been involved with their treatment and setting goals. The service had introduced a system where recovery coordinators attended medical reviews alongside non-medical prescribers (NMP). This was introduced following a review of a client's death where they found discrepancies in the recording of urine sample results by a recovery coordinator and a NMP. This has resulted in more joint up ways of working and has enabled recovery coordinators to immediately note any risks on the records system.

Staff regularly reviewed and updated care plans when clients' needs changed. We saw evidence that care plans initially tended to focus on drug use, physical health and mental health. Three out of seven care plans we reviewed later added goals around employment or family relationships. Clients were not always given copies of their care plans. Care and treatment records did not contain a section to document whether they had been offered and provided or not.

Care plans were personalised, holistic and recovery-orientated. We observed a face-to-face assessment for a new client and saw they were offered a good choice of treatment options. Staff shared examples of personalised recovery planning with each other. For example, during a team meeting staff discussed how they had identified one client had an interest in boxing so had a meeting with other professionals and found a boxing opportunity. The client reported they had not used drugs for two weeks since beginning these sessions. Managers had introduced coaching and workshops on different ways of delivering person-centred care to upskill staff.

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 NICE). This included motivational interviewing, one to one key working, substitute prescribing community substance detoxification, self-management guidance, activities, and psychosocial therapy groups. Prescriptions were reviewed and clients had urine drug tests to monitor their use of illicit drugs. Most care records we looked at had clear evidence of prescribing rationales which were in letters to GPs.

All clients were asked about their alcohol use during the initial assessment. Clients with less severe alcohol dependence could access the service's psychosocial treatment options, or clients could access the integrated Camden alcohol service, which is provided by CGL, if they required more complex interventions.

The service employed an in-reach hostel worker. The worker was able to re-design the job to provide a better service to clients and people who would benefit from accessing the service. The staff member was able to move away from providing standard in-reach sessions to a more open and individually led interests approach. This allowed staff to build a rapport around interests and activities in order to increase these while supporting individuals preparing to start recovery. This also built on participation with clients and potential clients suggesting activities. For example, several people in hostels who might have benefited from the service indicated an interest in football. The in-reach hostel worker contacted the local premiership football club and arranged a free tour of the stadium. The in-reach worker also worked closely with partner agencies such as a local NHS adult pathway team and GP surgeries.

Good

Community-based substance misuse services

Staff made sure clients had support for their physical health needs, either from their GP or community services. The service was able to conduct electrocardiograms (ECGs) on clients and sent the data to an external agency who interpreted the results. GP medical summaries were requested for each client. One staff member told us relationships between the service, GPs and pharmacies had become stronger over the pandemic.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. Some clients told us their keyworker discussed healthy eating, exercise groups and nutrition with them. The service provided naloxone training to clients, and their friends or relatives. They also provided sessions in hostels and for pharmacy staff. Clients were offered testing for blood borne viruses (BBV) and the service increased testing between 2021 and 2022. They held an event during European Testing week and 50 clients had BBV tests.

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 used the TOPS tool to measure change and progress in key areas of clients' lives such as substance use, mood, crime, social life and physical health.

Managers participated in clinical audits and benchmarking. There was an annual service audit plan set by the provider which included vaccine storage audits, prescription and controlled drug stationary audits, and infection, prevention and control audits. There were also additional local audits such as medicine incidents and dip sampling care records to assess quality. Managers and team leaders used results from audits to make improvements and shared outcomes with staff.

Staff used technology to support clients. Staff provided support through telephone, text messaging and video calls as well as in person. Text messages were sent to remind clients of upcoming appointments and group sessions. The service accessed electronic GP summaries which provided staff with quick access to information when assessing clients and making decisions regarding their treatment.

Skilled staff to deliver care

The team 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 a full range of specialists to meet the needs of each client. They could access a local consultant psychiatrist when required. 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.

Staff met each morning to discuss cover for staff on leave, changes to groups provided, current assessments, concerns about clients not attending and follow-up contact required, any updated provider guidance, and any issues with the working environment.

Managers gave each new member of staff a full induction to the service before they started work. The recently developed staff induction process included a checklist to ensure a wide range of areas were covered. Staff who had gone through this new induction process said it was comprehensive and they felt supported.

Managers supported staff through regular supervision and annual appraisals of their work. The provider's policy states that all staff should have an annual appraisal and at least four one-to-one supervision sessions a year. At the time of our

inspection, 86% of staff had received their appraisal and 81% had received their one-to-one sessions. These figures included staff who were on long term sickness leave, staff new to the service who were not yet eligible, and three appraisals that had been completed but were awaiting sign off. Actions had been taken to improve appraisal compliance to 95% by September 2022, and all staff had one-to-ones scheduled. Staff said they received regular supervision. Managers told us they used data from the service activity report dashboard to support supervision, which contained key performance indicators for the service and individuals. Supervision records showed that staff discussed wellbeing, case load reviews, support planning, risk management and training and development. The service also held regular group clinical reflection sessions. Staff stated their appraisals helped support their role and their development. Appraisals covered areas such as goals and continuous development, values and organisational fit.

Managers made sure staff attended regular team meetings such as business meetings, multidisciplinary meetings and leadership meetings. Learning and training sessions were embedded into some team meetings to continuously develop staff. Managers ensured meeting minutes were accessible to staff who could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. New recovery coordinators were expected to complete a core competencies document with support from their managers. Managers made sure staff received any specialist training for their role. Specialist training needs were identified through one-to-ones, appraisals, supervision and audits, as well as though emerging themes about client needs. In the months prior to our inspection, staff had completed specialist training such as child sexual abuse, complex trauma and trauma informed care, and the impact of Covid-19 on domestic abuse. Managers were completing a six-month training programme to grow and develop their leadership skills.

Managers recognised poor performance, could identify the reasons and dealt with these. Team leaders also used supervision to support staff to improve performance in areas such as harm reduction and responding to risk. Managers had, for example, supported staff to develop their skills in how to discuss sexual health with a client if they disclosed they had engaged in unprotected sex.

Managers recruited, trained and supported volunteers to work with clients in the service.

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.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. We observed strong communication and team working during the service's morning briefing meeting. There was also a multidisciplinary team (MDT) meeting every two weeks. The minutes from the most recent MDT meeting showed someone from an external agency attended to inform staff about referring clients to a women's domestic abuse organisation. Meeting minutes from the integrated governance team meeting showed short learning sessions on different topics to help improve client care. For example, one staff member provided information on dyslexia and the team discussed how they could better support dyslexic clients. Staff said they valued the meetings they attended, felt they supported learning across their teams, and encouraged holistic care.

Staff made sure they shared clear information about clients and any changes in their care during meetings. The service had good links with the local hospital. At the time of our inspection a client had been admitted to hospital and hospital updates were shared with the team ahead of the client being discharged back into the community.

Good

Community-based substance misuse services

Staff had effective working relationships with other teams in the organisation. For example, during one team meeting the criminal justice team shared information about their work with staff on other teams. Staff were able to ask their colleagues questions to gain further clarification.

Staff had effective working relationships with external teams and organisations. These included pharmacies, local authority safeguarding teams, community safety teams, community mental health teams, and other service providers such as housing providers. Most of the care records we looked at showed at least one other service or professional involved. Clients told us the service had provided them with useful information on other services.

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. At the time of our inspection, 99% of staff had completed their basic Mental Capacity Act mandatory training. A refresher training video was shown to staff during a meeting. They discussed fluctuating capacity and what actions were appropriate to take if a client arrived presenting under the influence of substances. They discussed case studies and multi-agency working.

Staff knew where to get accurate advice on the Mental Capacity Act and could seek support from the service manager. Staff knew how to access the provider's policy on the Mental Capacity Act.

Staff recorded capacity to consent clearly each time a client needed to make an important decision. The records we looked at showed mental capacity was well documented. Capacity was documented in all assessments and was considered at most contacts with clients. It was a standard question for clients on Buvidal.

Staff knew the importance of gaining client consent to treatment and sharing of information with other professionals. However, we did not always find consent was documented in records. We were told the organisation's expectation was for consent to be reviewed every 12 weeks. Of the seven records we looked at, two did not contain evidence that consent was discussed. Five clients we spoke with said they had not been asked for consent. The last annual audit about consent was completed in December 2021 and showed 50% compliance. Staff had not been able to easily find consent recorded on three random cases they looked at and this was escalated to the quality team. The risk register acknowledged there was no prompt on their electronic records system to remind staff about the need for regular reviews and updates on consent. An action was added to the service improvement plan for the team to reinstate written consent agreements. We saw evidence of consent and capacity discussed during multidisciplinary team meetings.

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.

Good

Community-based substance misuse services

We observed staff interacting with clients in a kind and respectful manner in meetings, on the phone, and face-to-face.

Most clients, carers and family members we spoke with were very positive about the staff. They said staff were friendly, compassionate, and treated them in a non-judgemental and dignified way.

However, of the 12 clients accessing the drug and alcohol services, four said staff had not spoken to them about their rights, such as confidentiality, consent and sharing information with others.

Three clients told us communication from staff could be improved. For example, two people we spoke with said they had not been informed about staff changes. One family member also told us this was an area for improvement after their family member had not been informed. Another told us there needed to be more verbal communication rather than just displaying notices on a board.

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.

Clients we spoke with accessing the drug and alcohol services felt involved in their care and treatment. They said they were clear on their treatment goals and had been involved with coming up with them. Most clients told us they were involved in regular reviews about their treatment and goals. Clients received advice about their medication. However, two clients told us they wanted the provider to focus more on recovery. One person told us they had been advised to increase their dosage of medication when they wanted to reduce it, and another said reduced medication should be the focus rather than supporting active use through access to clean needles.

Most people told us they had been given information on how to complain but five people said they had not. Most people told us they had not needed to complain but would feel comfortable to if they did. Most people who had complained told us their complaints had been resolved. However, one person told us they felt fearful to complain in case it impacted on their care and treatment.

Seven of the 12 clients accessing the drug service told us they had the opportunity to give feedback on the service or be involved in decisions about it. There was a service user representative who passed client's feedback to the volunteer coordinator. The feedback was then discussed by managers in a team meeting. Clients said positive outcomes had happened from feedback. For example, the service funded art events because clients wanted activities that did not just focus on addiction. One client told us they were invited to feedback meetings, and another said they had been invited to attend interview panels and helped decide on the successful candidate.

Most people we spoke with were aware of the group sessions available. Some groups were led by staff members and some were peer-led, for example, gardening, film making and a breakfast club. The service had facilitated day trips to local public gardens, canal trips, and visits to the zoo.

Clients were given additional support and referred to other services if they needed more assistance. For example, clients had been signposted to counselling, mental health helplines, and services to help with housing and benefits. One person told us their keyworker was helping them access accommodation and a rehabilitation facility.

Good

Community-based substance misuse services

Clients told us they were able to contact professionals when needed. However, all those we spoke with accessing drug and alcohol services said they did not have a crisis plan. One person said they had a number to contact out of hours. We saw evidence of posters which advertised advocates at both sites, but six clients told us they did not know how to access one.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, not all families and carers had been told how to complain or provided with the opportunity to be involved with service developments.

If clients provided consent, families and carers were appropriately involved in care planning and reviews. People told us they had been involved with their family member's treatment goals, reviews, updates on progress, and medication changes.

Families and carers were given help to understand addiction. Two out of five people we spoke with accessed the family and friends support service, Some Space, which they found very helpful. They had been able to quickly access a supportive and knowledgeable counsellor.

Two family members and carers told us they had been given the opportunity to get involved in service developments and consultations. This was through working groups regarding decisions about the service and through answering questions about the quality of the service. However, two people told us they had not been given the opportunity to be involved with service developments and one person was unsure.

Three of the five family members and carers we spoke with said they had not been told how to complain. Two people told us they had. No-one told us they had felt the need to complain but would feel comfortable doing so if they needed to. Change Grow Live's website contained a form where feedback or complaints could be submitted.

Some people told us they had been referred to other services or provided with additional support if they needed more assistance. For example, one person who accessed the service remotely said staff were good at signposting them to helplines for family support and group sessions and emailed this information. However, some people said they had not been helped or referred to other services by staff if needed.

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.

The service had clear criteria to describe which clients they would offer services to. Their website provided information on what the service could help with and people were able to ask questions to a trained professional via an online chat service.

Good

Community-based substance misuse services

The service received 42 referrals June and 46 referrals in July. Referrals could be made by clients or professionals via phone or email. There were no target timescales due to the service being small, and that clients were usually seen within seven days of being allocated to a recovery coordinator following the initial assessment. People could be referred to the subcontracted alcohol service if needed, for example, if they required detoxification for their alcohol use.

Staff saw urgent referrals quickly. Managers had oversight of referrals and could prioritise them if they felt there was an increased risk. We were told such clients were contacted within 24 hours.

Staff tried to contact people who did not attend appointments and offer support. Staff said they were persistent in attempts to contact clients who did not attend appointments. During team meetings, staff discussed clients who had not attended appointments and plans to engage them. Clients were repeatedly discussed in meetings if staff were unable to contact them. Staff had conducted home visits where necessary. There was a timetable of groups available to clients. However, although some care records we looked at documented ways to keep clients engaged, it was not always clear what staff should do if clients unexpectedly exited treatment.

Clients had some flexibility and choice in the appointment times available. The service was looking to relaunch their Saturday opening times so people unable to access it during the week could get support from staff and attend groups.

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. Some clients told us they could reschedule new appointments very quickly. However, two people told us this was not the case and had previously had to wait between two and four weeks which had negatively impacted their recovery.

The service used systems to help them support clients. The service's activity report dashboard monitored data such as the number of referrals into the service and the number of clients discharged along with the reason why. It also displayed any overdue assessments and reviews, and monitored clients who had not had recent face-to-face contact. In July 2022, six clients had been discharged after dropping out of the service. We were told if clients were discharged but wanted to subsequently reengage this was possible. The service's project manager reviewed all clients suggested for discharge and could either approve these or suggest additional measures or treatment options where required.

Staff supported clients when they were referred, transferred between services, or needed physical health care. When clients moved out of the borough staff contacted the equivalent service in their new area and liaised with the pharmacies. For example, one staff member told us about a client they supported to move to a new area. The staff member assisted the client to find a pharmacy near to their new house and facilitated a call between the client and the pharmacy to ensure everything was in place prior to the transfer.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of treatment rooms did not always support clients' treatment, privacy and dignity.

The service had a range of rooms and equipment to support treatment and care. The Kilburn site had a number of large consultation rooms and a well-equipped clinic room. Both sites had water machines in reception for staff and clients to use. Staff supported clients with hot and cold drinks. There were plans to re-open the Recovery Café at the Camden site which had previously been a popular space for clients. Staff stated they worked together to ensure appointments were

booked effectively so clients did not have to wait long in the reception area. However, the clinic room at the Camden site was very small and did not have a clinical bed in it. Interview rooms at the Camden site did not have soundproofing, but white noise machines were available to protect privacy and confidentiality. Staff and clients we spoke with said the Camden site was small and not always suitable.

The group rooms did not always allow space for social distancing, so the service had hired additional larger spaces in local community buildings.

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. Staff understood and respected the individual needs of each client. The service was accessible for clients using wheelchairs and clients with other mobility needs. Staff were also able to conduct home visits if clients were unable to travel to the service. There was a hostel in-reach worker who linked people into physical healthcare interventions and explored individual interests as a method of recovery.

Clients told us the service had helped them in times of need, for example, by accessing grants for household furniture and providing food bank vouchers. The Saturday service was due to reopen so more clients could access the service. Considerations around the benefits of specific medications were made. For example, one client we spoke with told us their monthly Buvidal injection allowed them to continue working. Staff told us it had also been positive for clients from cultures where there was a stigma around substance misuse.

Staff said they provided clients with information on treatment, local service, their rights and how to complain. Clients had access to housing, debt and legal advice clinics. They were also signposted to local alcoholics, narcotics, cocaine, and gambling anonymous groups. One client told us their recovery coordinator helped them with their physical needs and supported them to attend appointments.

The service provided information in a variety of accessible formats so the clients could understand more easily. Information was available about family support, domestic abuse, employment, feminism for change, drug related deaths, and needle exchange. Clients were able to speak to staff in person or over the telephone based on their risks. Automatic text messages were also sent to remind clients of appointments. The service purchased disposable phones for clients over the pandemic so they could access information and support.

The service had information leaflets available in languages spoken by the clients and local community. We saw some leaflets in reception that were in different languages. The service lead told us staff could print leaflets from their intranet in a variety of languages including Polish and Farsi. Easy read versions could also 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 provided dedicated clinics for female clients, including evening sessions with support from a local charity that sex workers could easily access. Staff discussed local support systems that clients could be supported to access. For example, managers were informed about a women's employment charity during a meeting and a link was shared with

staff. Staff supported clients with gym memberships and access to a range of groups including acupuncture, mutual aid, criminal justice groups, and counselling. Staff said that due to a request from clients there were plans to start a lesbian, gay, bisexual, transgender and queer plus (LGBTQ+) forum for clients. There had previously been a support group for LGBTQ+ clients but this stopped when the staff member running it left.

However, two clients we spoke with told us they had been told to make new appointments if they arrived late or when there had been prescription errors. These appointments were sometimes two to four weeks later. One client told us the delay with their appointments had caused them to relapse and another had experienced withdrawal symptoms.

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. However, some client, families and carers did not know how to complain.

Staff understood the policy on complaints and knew how to handle them. Managers and staff said clients were encouraged to complain and to provide feedback. Information about how to make complaints and a feedback box were available in the reception areas.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint. All formal complaints were logged on the service's data system. Improvement suggestions and complaints were also logged.

Managers investigated complaints and identified themes. In the past 12 months the service had received seven complaints. These ranged in themes and included effectiveness/quality of service provision, communication and prescriptions.

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. Feedback pods were developed from client feedback. They allowed the whole team including the nurse medical prescriber, the recovery coordinator, the service user lead, the team leader and the service manager to hear directly how processes and actions impacted on that individual. Staff said this space worked well for hearing client experience and lead to focused work on improvement areas such as power imbalance, and the use of language and tone. Staff discussed client feedback and complaints in team meetings and individual supervision.

The service used compliments to learn, celebrate success and improve the quality of care. In the past 12 months the service had received 24 compliments. The service lead said managers emailed the compliments to named staff.

However, not all clients, families and carers knew how to complain or raise concerns. Of the 17 clients, families and carers we spoke with, eight said they had not been given information about how to complain.

Are Community-based substance misuse services well-led?

Good

Community-based substance misuse services

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 the skills and knowledge to perform their roles. The registered manager had been at the service since its launch. Managers were involved with service improvement and improving knowledge of subjects related to substance misuse. During our inspection, one of the team leaders delivered Naloxone training to hostel staff.

Staff were very complimentary about the leadership and support provided by the managers. They felt the managers cared about the people accessing the service and the staff. Staff said managers encouraged clients to complain and provide feedback on the service. Most clients also spoke positively about managers. Managers attended client feedback meetings.

Staff felt the local leadership were visible and approachable. For example, the service lead had attended a client-led film making event when another colleague was on sick leave. Local leaders felt able to access support and guidance from senior CGL leaders. However, staff did not always feel the senior CGL leaders were visible within the service.

Visions and values

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

The organisation's vision is to develop, deliver and share a whole person approach that changes society. The organisation's values are to be open, compassionate, bold and to make a difference.

Staff understood the organisation's vision and their values aligned with the values of the organisation. Appraisal records reflected this, by having space to discuss if the person fitted with the values.

Some clients and carers we spoke with told us they had been offered training to become peer support workers which could possibly lead to employment. The feedback from most clients about staff attitudes suggested they were aligned to the organisation's vision and values.

Culture

Staff felt respected, supported and valued. They reported that the provider 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 felt supported and valued, and teamwork was highly effective. Staff felt that the positive, caring and supportive teamwork was one of the service's best assets. It was clear that staff supported each other to get the best outcomes for clients.

Staff said managers were receptive to any concerns or issues that were raised and were working to support the team. For example, when staff raised concerns about the relative inexperience of the team and the poor induction process, new practices such as the core competency framework and a comprehensive two-week induction were implemented.

The service endeavoured to promote equality and diversity. For example, a challenging racism forum was introduced to support staff and facilitate open discussions. The service had access to an external clinical supervisor who could refer staff to more specialist support if needed. The service hoped to get funding for an LGBTQ+ worker in the future.

The service had introduced initiatives to support disadvantaged staff and clients. For example, during the pandemic staff delivered food parcels, paracetamol and provided phones. Staff were also able to take an hour out of their working day each week to focus on their wellbeing. Health and wellbeing offers from the wider organisation were promoted during supervision and to-one-to conversations.

The service made efforts to make staff and leaders more representative of the community it served. For example, interview panels always included someone from a black, Asian or minority ethnic group. Volunteers and clients were sometimes asked to be on interview panels too. One member of staff started as a volunteer and developed through various roles before becoming part of the leadership team. The service lead told us she coached female staff who wanted to develop into management roles.

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.

At the time of our inspection, the service had recently refreshed their governance systems which were almost embedded. There were arrangements in place to discuss strengths and mitigate risks within the organisation, and there was a good flow of information. The service had developed a range of regular meetings to ensure oversight and communication within the service. These included multidisciplinary meetings, team business meetings, integrated governance meetings, managers meetings, and service lead meetings. They held quarterly meetings with the commissioners and provided contract monitoring reports. Managers and staff told us about the value of client involvement and there were monthly client feedback meetings.

The service had oversight arrangements for risk and performance. For example, managers had access to an activity report dashboard which displayed data about the service as a whole as well as for individual staff members. There was also a risk register which listed risks and mitigations, and managers were aware of their biggest risks. Work was ongoing to ensure the main risks were reflected on the service improvement plan.

There was a business continuity plan and an annual audit plan which fed into the service's quality improvement plan. For example, a local audit of medicines incidents prompted managers to add a section to their improvement plan about the need to improve their prescribing and administration processes to reduce the number of errors. This was in progress at the time of our inspection.

During our inspection we found audits were not always readily accessible to the service manager because they were not always recorded on a central system. For example, environmental and fire safety issues picked up in an audit, although the manager was aware of the issues that needed to be addressed. There was one health and safety lead across the service's sites so if they were absent from work, there was not a robust system in place to stay abreast of any

outstanding audits, actions or issues. We informed the service lead of our concerns at the time of the inspection and they noted it was a development area for the service. The risk register and service improvement plan acknowledged the issues of having one health and safety lead across two sites and they planned to train a second person. Managers planned to discuss outcomes of premises audits every quarter during the integrated governance team meeting.

Policies, procedures, meeting minutes and other guidance documents were accessible to staff.

Management of risk, issues and performance

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

The risk register had recently been moved to a different electronic system. Staff had been involved in conversations about what should be included on the risk register and had received training so they could add incidents to the system themselves. Work on the risk register was ongoing at the time of our inspection but we saw it reflected the main concerns. Risks could be escalated to director level if required.

Performance dashboards were available to leaders and reviewed regularly. Leaders planned to make these dashboards accessible to staff so they could monitor their own performance.

However, as detailed in our findings for other key areas, there was only one health and safety lead across the sites. The service's risk register acknowledged this caused an issue in focusing on their monthly premesis checks and bi-annual health and safety audits when the lead was absent. The health and safety audits were not always recorded centrally and therefore the outcomes or outstanding actions were not readily available to managers and staff. There were plans in place to address this matter.

Information management

Staff collected and analysed data about outcomes and performance.

The service collected performance and training data which could be viewed by staff and managers and were discussed in meetings. A data dashboard was updated by the regional data lead and presented to managers in a monthly meeting. The dashboard contained a range of information about the service such as referral and discharge rates, the number of clients being provided services, staff performance, and caseloads for different teams and services. It also showed data on key activities provided by the service, such as how many Naloxone kits had been offered and issued, and how many clients had been offered blood borne virus interventions which they had refused or accepted. The dashboard allowed staff to have clear oversight of clients on their caseloads and identify when reviews were overdue. It also named to top 10 high and low risk clients below optimal doses of medication.

Staff we spoke with told us they had the technology and equipment to do their work and the telephone system worked well. Information needed to deliver care was stored securely and was available to staff when they needed it. However, some staff said the electronic care and treatment records could be improved, for example, through the addition of codes they could enter to show clients' group attendance.

Leadership, morale and staff engagement

Staff we spoke with felt confident in the service's leaders. They felt supported and said leaders were always available to help them if needed. One person told us their flexible hours helped them manage their childcare needs. All staff spoke passionately about their desire to help and care for clients.

Morale appeared high amongst staff despite most staff acknowledging the challenges of the pandemic, covering for colleagues when absent, and a relatively inexperienced team. Some managers had high workloads, so the new project manager was starting in post earlier than planned to support them. The service's risk register recognised the strains on staff and negative impacts on health and service delivery due to an increase in unplanned absences. Managers had considered a number of opportunities to address this such as seeing how other services were managing increased sickness and promoting wellbeing offers. This was ongoing at the time of our inspection, but staff felt they were in a happy team.

Staff felt involved in conversations about the strategy and direction of the service. They had recently been asked to input on conversations around what should be on the service's risk register.

Staff were encouraged to look after their wellbeing. Policies and peer groups supported this, for example, the provider had introduced a new menopause policy and there were online groups to support staff.

Commitment to quality improvement and innovation

The leadership team were clearly committed to continuous improvement of the service. We were given examples related to service improvements for clients as well as improvements for new and existing staff based on feedback.

Managers and staff told us about the importance they placed on client involvement and this was evident during our inspection. There was a client forum every month. The volunteer coordinator updated managers, and minutes from the meetings were shared with the wider team. We saw evidence that clients had been invited to attend the integrated governance team meetings. For example, during one of these meetings a client was invited to speak to staff about their lived experience of the service. Managers invited a national client involvement coordinator to another meeting who spoke about the importance and renewed focus of client involvement.

Staff reflected on their work so they could improve the quality of service. For example, there was a review process known as service user journeys. In these review meeting, managers and recovery coordinators looked at the treatment journey of clients and reflected on the challenges, successes and any learning. The meetings were recorded and a summary report was uploaded to a shared folder for other staff to access.

Staff told us the organisation was supportive of development and encouraged training. Staff had accessed a range of specialist training courses.

The service was involved with research. For example, some clients receiving medically assisted treatment for opioids had been referred to an NHS study. A representative from the study had provided updates to staff and the outcomes were due to be shared with the team in autumn 2022. A client who had taken part in the study was invited to the morning briefing to tell staff about their experience.

Staff received recognition for their work and were told about compliments they had received.

Good

Community-based substance misuse services

The service demonstrated innovative practice through the introduction of feedback pods. This concept was in addition to the processes followed through the organisation's complaints policy. Clients were supported by the volunteer coordinator to tell staff and managers how a particular situation had impacted them and what they felt could be improved. Learning was then shared with the wider team. The concept had been presented to other managers across the organisation as a way of sharing good practice.