Change, Grow, Live

CGL Lewisham New Direction

Inspection report

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Date of inspection visit: 7 July 2022 and 14 July 2022
Date of publication: 16/09/2022

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location was good because:

- The service provided safe care. The premises where clients were seen were safe and clean. Staff managed risk well.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- Most clients that we spoke to were happy with the level of service they were receiving and felt well supported by staff.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes mostly ensured that its procedures ran smoothly.

However:

- The number of clients on the caseload of some key workers was high. Caseloads in the opiate team were over 80 for some key workers. Staff told us this sometimes prevented from giving each client the time they needed.
- The care and treatment records we reviewed contained all the necessary information, but the risk assessments were not always clear about what was a current or historic risk.
- Eight per cent of clients had not received a medical review or a non-medical prescriber review in the last 12 months, in line with the services policy and procedures.
- Some risks that we identified during the inspection, such as overdue medical reviews, were not recorded on the service's risk register although the provider was aware of this and taking steps to address the outstanding reviews.
- There was no clinical oversight of new self- referrals at the time of inspection. This meant that client risk may not be appropriately identified. The service had implemented a new system following our inspection.
- Psychosocial interventions offered by the service were still running at reduced capacity following the covid-19 pandemic.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to CGL Lewisham New Direction

CGL Lewisham New Direction is part of Change Grow Live, who deliver a not-for-profit drug and alcohol treatment services nationally. The service provides specialist community treatment and support for adults affected by substance misuse who live in Lewisham.

They offer a range of services including initial advice; assessment and harm reduction services including needle exchange; prescribed medicines for opiate detoxification and stabilisation; naloxone dispensing; group recovery programmes; one-to-one key working sessions; and doctor and nurse clinics, which includes health checks and blood borne virus and hepatitis C testing. At the time of the inspection, the service was seeing clients face to face and remotely.

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

At the time of inspection, around 500 clients were in active treatment at the service. The service had 18 recovery coordinators, two admin staff, four team leaders, six clinical staff, one deputy service manager and one service manager.

The service is registered for the following regulated activity: Treatment of disease, disorder or injury. The service was registered on 24 April 2019. There was a registered manager at the service.

This was the first time we have inspected CGL Lewisham New Direction

What people who use the service say

Most clients that we spoke to were extremely positive about the service they were receiving. Multiple clients told us that they felt the service had saved their life and they were incredibly appreciative of the help and support they had received.

Clients felt involved in their care and treatment. Clients told us that they felt listened to and particular treatments weren't forced on them by staff.

Most clients told us about issues with contacting the front desk at the service, but nearly all clients said that their key workers were easy to contact and responsive.

One client we spoke to was unhappy with the quality of the service, they told us that they had to repeat themselves to their keyworker on several occasions. They also told us that their key worker had changed multiple times in a short period of time.

How we carried out this inspection

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

During this inspection, the inspection team:

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 14 staff including the deputy service manager, consultant, team leaders, recovery practitioners, registered nurses, a non-medical prescriber and volunteers.
- spoke with ten clients
- reviewed ten clients' care and treatment records
- reviewed prescribing and the medicines prescription process
- reviewed other documents concerning the operation of the service
- attended morning handover meeting

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

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that risk assessments clearly identify current client risk and how those risks are managed.
- The service should continue their work to ensure that all clients receive a medical review or a non-medical prescriber review annually, in line with their policy and procedure.
- The service should ensure that work continues to address the high caseload numbers allocated to individual recovery coordinators to ensure that all clients are appropriately supported.
- The service should ensure service's risk register reflects all current concerns that meet the threshold for inclusion.
- The service should ensure that the new referral to assessment process is embedded and followed by staff.
- The service should consider how to continue to increase its psychosocial intervention offer to clients.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Community-based substance misuse services

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

Are Community-based substance misuse services safe?

Good

We rated it as good.

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff conducted regular health and safety audits. The service had completed a fire risk assessment in January 2022. The fire risk assessment had no actions required. The latest environmental risk assessment was completed in July 2022.

Not all interview rooms had wall alarms, however, staff collected personal alarms from the reception when having sessions with clients. During the inspection we observed staff collecting these alarms. Some staff told us that not all staff used the alarms. Managers were aware of this and reminded staff to take alarms during the morning meeting. The personal alarms were tested monthly as part of the monthly environmental checks.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. Staff made sure equipment was well maintained, clean and calibrated. All calibration records we reviewed were completed and up-to-date.

All areas were clean, well maintained, well-furnished and fit for purpose. The cleaning services were provided by an external provider. The service manager had access to an online portal that the service manager could check to monitor cleaning records.

Staff followed infection control guidelines, including handwashing. At the time of inspection, staff were not required to wear masks in communal areas. However, staff were required to wear masks when in close contact with clients. Hand sanitizer stations were located throughout the building.

The service had a contract with a waste management company who disposed of all their used sharps bins and clinical waste.

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 some key workers was high. Staff told us this affected the time they could spend with some clients.

The service had enough nursing and support staff to keep clients safe. At the time of the inspection, the service had 18 recovery coordinators, two admin staff, four team leaders, six clinical staff, one deputy service manager and one service manager. The service had a vacancy rate of 16%. At the time of the inspection, the criminal justice team had two vacancies, which were both out for advert. The service had also introduced seven new posts following an increase in funding; these posts were in the process of being recruited to. The service also employed two agency staff members at the time of the inspection, one nurse and one non-medical prescriber. The non-medical prescriber was employed to try and reduce the number of clients waiting for a medical review.

The service also had volunteers working within the service. Managers told us that the number of volunteers had reduced during the covid-19 pandemic. At the time of the inspection, the service was actively recruiting more volunteers to support the running of the service.

Caseload sizes had increased across the service during the pandemic. At the time of inspection there were 18 recovery workers at the service. The average caseload of clients per staff member in the opiate team was over 80 and the average caseload of clients per staff member in the alcohol team was over 40. Managers acknowledged that the caseloads were high and were working to reduce them. Key workers told us that the high caseloads were impacting their ability to discharge stable clients as their focus was on the higher risk client. Team leaders were conducting monthly caseload reviews with recovery workers to try and reduce the strain on recovery workers. The service was also in the process of recruiting three additional recovery coordinators to try and reduce the caseloads.

Managers made arrangements to cover staff sickness and absence through the use of agency staff. Managers requested staff familiar with the service and staff new to the service received an induction before starting work. Managers told us that during the pandemic the quality of agency staff had varied widely, but the service was now using a different agency and had since received more suitably experienced staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Both agency staff members had been at the service for a period of several months and knew the service well.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Agency staff members told us that they had received a detailed induction to the service.

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

Staff had completed and kept up-to-date with their mandatory training. At the time of inspection 98% of staff had completed their mandatory training.

The mandatory training programme was comprehensive and met the needs of clients and staff. The mandatory training included, data protection and information awareness, mental capacity act, safeguarding children and adults and basic life support.

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

Staff received training to support clients on the different pathways provided by the service. For example, staff in the criminal justice team received specific training about substance misuse in criminal justice services. Staff also provided training to local custody centres on drug use.

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

Staff 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, at the time of inspection self-referrals had no clinical oversight before assessment. Around 10% of clients in medication assisted treatment were overdue medical reviews but the provider was working to address this.

Assessment of client risk

The service had clear criteria to describe which clients they would offer services to and offered clients a place on waiting lists. The service used a complexity matrix which helped staff identify which service in the borough was best placed to accept clients.

We reviewed ten client care and treatment records. Staff completed risk assessments as each client was allocated onto a recovery workers caseload. The initial assessment covered potential risks including current and historic substance misuse, mental health and physical health. The records we reviewed contained all the necessary information however the risk assessments were not always clear about what was a current or historic risk. There was the potential for new staff to not fully understand each clients risk if current and historic risks were not clearly recorded. For example, a client had reported they had recently had several blackouts. Staff advised them to discuss this with their GP. The risk was identified on the risk assessment, but it was not clear how the risk was being managed. Following further follow up by the clinical team, staff told us that there was no evidence that the blackouts were related to the client's substance use. We were told the recovery worker should have amended this risk to previous, rather than leaving it as within the last three months.

Staff could carry out assessments face to face or remotely. If clients were identified as higher risk, they would be reviewed face to face.

Improvements were needed to ensure new self-referrals were safely and appropriately triaged. There was no clinical oversight of new self-referrals at the time of inspection. Self-referrals would be reviewed initially by a member of the admin team and would be booked for assessments. This meant that client risk may not be appropriately identified. A more thorough risk assessment would not happen until the client had been formally assessed. Following our inspection, the provider implemented a new system to ensure that risks were identified as soon as referrals were received. All new referrals would be reviewed at the morning meeting which was attended by the multi-disciplinary team. This process was already in place for referrals from other professionals such as GPs.

Good

Community-based substance misuse services

Clients receiving opiate substitution treatment, such as methadone, had varying levels of medicines supervision, based on assessed risks. Some clients attended a community pharmacy daily for a pharmacist to supervise them taking medicine. Other clients, with lower assessed risks, collected their medicine every week or two from the pharmacy. Clients were also provided with naloxone.

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

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

Staff responded promptly to any sudden deterioration in a client's health. We saw evidence in records that staff had considered and updated risks where necessary. Clients with mental health concerns would be assessed by the dual diagnosis worker at the service. The dual diagnosis worker regularly worked with the nearby mental health inpatient unit.

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

The service had 331 clients in medication assisted treatment when we visited the service. Medication assisted treatment involves the use of medicines, in combination with other treatments such as psychotherapy, counselling and group therapy. The service was expected to complete a medical review for each client under medication assisted treatment annually in line with national guidance. Around 10% of clients in medication assisted treatment were overdue medical reviews; managers told us that the majority of the reviews were overdue due to client disengagement. The service had recruited an agency non-medical prescriber to try and review clients who were overdue a medical review. It was not clear from discussions with the manager how this risk was being managed. Managers had oversight of overdue medical reviews on a dashboard that was reported to the wider organisation. Overdue medical reviews had not been included in the service's risk register.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. At the time of the inspection, 97% of staff had completed safeguarding children and young people training and 97% of staff had completed safeguarding adults at risk training.

Staff knew how to recognise adults and children at risk of or suffering harm and in most cases worked with other agencies to protect them when appropriate. Staff gave examples when they had raised a safeguarding concern, for example when children were present at the home when clients were under the influence of drugs or alcohol. However, we identified one case in which a safeguarding concern was not followed up in a timely manner. A client discussed with their recovery worker that they had been assaulted, however there was no evidence that this had been discussed with

the MDT or shared with any other agencies. The service manager told us that although the concern had not been followed up in a timely manner, there was appropriate support in place. The client had been in regular contact with the service following the disclosure and there were discussions with the client about creating a safety plan in relation to concerns they had regarding their property and people targeting them. This included being supported to make reports to the police and being given a phone with a camera so they could document incidents. The newly appointed designated safeguarding lead planned to complete monthly safeguarding surgeries to support staff and to give staff the opportunity to highlight particular areas of risk with clients.

Staff discussed safeguarding concerns in daily handover meetings and weekly multidisciplinary meetings. Most clients' records showed comprehensive and detailed records around safeguarding concerns. Clients with a current safeguarding concern had an 'S' placed next their name, historical safeguarding concerns were also listed.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw examples of Multi-Agency Safeguarding Hub (MASH) referral letters and could see communications sent by the service to the local mental health and acute trust to ensure information about the client was shared.

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

When clients took methadone home, they were provided with lock boxes to minimise the risk of children or others gaining access. Staff would check that drugs were stored safely during home visits.

Staff access to essential information

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

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

Client care and treatment records were audited as part of the audit programme. The most recent audit on care plan/risk assessment was completed in November 2021. Recovery workers would also routinely have their caseloads reviewed through caseload reviews with their manager. The caseload reviews consisted of reviewing care plans, supporting staff and identifying any training needs for the wider service. During our review of records, we identified inconsistencies with the quality of client care and treatment care records. Managers were aware of this and were in the process of improving the audit programme and the quality of care and treatment records. The service had recently completed refresher training for the whole service on care and risk plans. A quality lead role had recently been recruited to. The quality lead would be responsible for all auditing within the service.

Medicines management

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

Good

Community-based substance misuse services

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

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Staff discussed the progress of each client in multidisciplinary meetings. New staff were provided with training regarding naloxone. All staff actively encouraged clients to have access to naloxone. Clients were provided with information on how to use it.

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.

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

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

Staff learned from safety alerts and incidents to improve practice. Medicines incidents were reported on an electronic system and investigated by the senior 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 were working with community pharmacies to develop more training to minimise the incidents of errors.

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 a urine drug screen initially and during their time with the service. Clients were offered blood borne virus tests prior to treatment (hepatitis B, hepatitis C, and HIV). If a client tested positive for hepatitis B, nurses was able to administer the hepatitis B vaccine on site via a Patient Group Direction (PGD). A PGD allows specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber. 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, 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 Staff made notifications to the relevant external bodies as needed. Staff sent notifications in a timely manner to the Care Quality Commission.

Reporting incidents and learning from when things go wrong

Good

Community-based substance misuse services

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

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

Staff saw the reviewing of incidents as an opportunity for learning. We saw good evidence of learning and improvements following incidents. The service manager told us of an incident last year when a client assaulted a member of staff. Learning was put in place following this incident. Following the incident, a reminder was added to the morning briefing to remind staff to take a personal alarm before seeing clients. Staff had also recently had refresher training on de-escalating aggressive behaviour. The service manager told us that staff had been reminded to not accept verbal abuse.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. For example, staff would apologise to clients if there were issues with their prescription script.

Learning from incidents was discussed regularly at the integrated governance team meeting. At the meeting in May 2022, three incidents were discussed that related to pharmacy errors and prescription issues. Due to these incidents a community pharmacy training event was planned with specific detail on titration prescriptions and the staff induction was reviewed to ensure it clearly outlined the titration process for clients.

The service manager attended a monthly service managers meetings. The meeting was attended by all the CGL service managers in the area, and learning from serious incidents would be shared. The service manager would also attend quarterly death panel meetings with commissioners and other stakeholders. The service manager told us that the commissioners were supportive in this process.

Are Community-based substance misuse services effective?

Good

We rated it as good.

Assessment of needs and planning of care

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

We reviewed ten clients' care and treatment records. Staff completed a comprehensive mental health assessment of each client. Clients were referred to local community mental health teams as and when required.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. We saw examples where clients had more regular reviews due to physical health problems. Staff would also support clients to register with a GP. Staff worked with other services when clients had more complex physical health problems. For example, the local acute trust would routinely attend on site to carry out fibroscans. A fibroscan is a type of ultrasound which measures how much scarring there is in the liver due to liver disease.

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

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.

The service had multiple treatment pathways for clients. The service had an opiate, non-opiate and alcohol pathways. The service also offered a criminal justice pathway and had a rough sleeper team. The service also had links with the local hospital and had set up a pregnant women pathway. Staff worked with midwives at the hospital and could fast track clients into the service.

The criminal justice team worked in local prisons, custody suites and local magistrates courts. The criminal justice workers worked within prisons to assess people and carry out risk reviews. The team had recently appointed a group facilitator to work within local prisons.

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

Clients with opiate dependence had a prescription for methadone. For clients taking methadone, the dose was increased gradually in the initial titration. Clients' prescriptions were reviewed regularly, and clients had urine drug tests to monitor their use of illicit drugs. During the pandemic, the service focused on maintaining clients on a safe consistent dose of methadone. Clinical staff were now actively trying to increase the number of clients who were reducing their levels of methadone. The reduction in methadone would be supported by the increased psychosocial offer by the service.

Clients with alcohol dependence had treatment based on their assessments. The service only accepted clients that had a high level of alcohol intake as there was another service in the borough that supported clients with a lower level of alcohol intake

Staff made sure clients had support for their physical health needs. Clients who were on medically assisted treatment had a full physical health assessment before commencing treatment. This included vitals and blood tests where appropriate. Staff would support clients to access other services. Staff worked alongside other care professionals, for example staff attended joint meetings with a hospice for a client who was receiving palliative care.

The psychosocial offer to clients had been adversely affected by the pandemic. Managers told us that the service had been focused on keeping clients safe during the pandemic. Managers wanted to increase the number of groups offered by the service and all staff were keen to introduce more psychosocial interventions. The service had a psycho-social therapy group timetable for clients, but the number of groups was still not at pre-pandemic levels.

The service was routinely visited by a specialist tissue viability nurse. There was a plan to upskill all the nurses in the service and enable them to provide an enhanced service to the clients in this area.

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

Monitoring and comparing treatment outcomes

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff took part in clinical audits and there was an annual service audit plan. These audits were set by the provider. These audits looked at health and safety, safeguarding, infection, prevention and control and COVID-19 safe environments.

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

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of each client. Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. The service had recently created their own induction plan due to feedback from new starters. The induction process was four weeks long and included shadowing staff and completing mandatory training.

Managers supported staff through regular, constructive appraisals of their work. At the time of inspection, 89% of staff had an appraisal recorded in the last 12 months. Staff received monthly reflective practice sessions facilitated by a dual diagnosis worker. Staff also attended four managerial supervision sessions a year in line with the provider policy. Ninety-three per cent of staff had received at least four supervision sessions in the last 12 months. All staff told us that they felt well supported.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meetings covered the future working model and learning from incidents. All meetings were minuted and the minutes were saved in a shared drive which all staff could access.

Good

Community-based substance misuse services

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they were able to access specialist training. Staff had recently received training on managing challenging behaviour, trauma informed care, psychoactive substances, effects of stimulants and training around chemsex. The local safeguarding board also provided training to staff, they had recently attended a team meeting and delivered training on gang violence and violence against women and girls.

Volunteers also received sector specific training to develop their skills and knowledge. For example, one volunteer told us that they had recently attended schizophrenia and psychosis training.

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

Multidisciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss clients and improve their care. Staff held daily morning meetings to discuss the plan for the day and to discuss high risk clients.

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

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

Staff had effective working relationships with external teams and organisations. These included community mental health teams, pharmacies, local authority safeguarding teams and other service providers such as housing providers and probation services. Clients' records showed communications and updates on client support and care with other teams and organisations. The service worked closely with local GPs and would be in regular communication with them. For example, we saw communication with a local GP advising that they should no longer prescribe co-co-codamol and instead prescribe a non-opiate pain killer. However, the service did not follow up again to make sure the prescription of co-codamol had stopped. The service manager told us that staff would be reminded to make sure to follow up with the GP to ensure that the communication to GPs had been read and actioned.

Managers engaged actively other local service providers to ensure that people with substance misuse problems experienced good quality care. The service was transparent and collaborative with commissioners about performance. The service manager told us that they had a positive and supportive relationship with commissioners.

Good practice in applying the Mental Capacity Act

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

Good

Community-based substance misuse services

Staff received training in the Mental Capacity Act and knew to seek support from the service managers if needed. The Mental Capacity Act was included in mandatory training, and at the time of the inspection 97% of staff had completed the training. The service held joint training events with the local authority on mental capacity. Staff told us that they would speak to the consultant if they were concerned about a clients' capacity.

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

Are Community-based substance misuse services caring?

Good

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

As part of the inspection we spoke to 10 clients currently using the service. Most clients we spoke to were extremely positive about the service. They described staff as caring and supportive. One client told us that the service had saved his life.

During the inspection we observed interactions between staff and clients. Staff were discreet, respectful, and responsive when caring for clients.

Staff supported clients to understand and manage their own care treatment or condition. Clients told us that staff would take the time to explain the treatment options available and would allow clients to make decisions about their own care. For example, one client told us that they were initially reluctant to attend group work sessions but did not feel pressured by staff to attend them.

Staff directed clients to other services and supported them to access those services if they needed help. One client told us that staff had supported them to register for a GP and another told us that they had been provided food bank vouchers by the service.

Staff understood and respected the individual needs of each client. During the morning meeting we attended, staff showed that they knew about each clients' care and treatment and were aware of their personal relationships.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. All staff told us that they felt able to raise concerns with their manager or the senior leaders within their team.

Involvement in care

Good

Community-based substance misuse services

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.

The involvement of people in the care they receive

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

Staff actively engaged people using the service and their carers in providing feedback on their care and treatment. A suggestion box was in the reception area. The service manager wanted to re-introduce a service user forum to the service to improve client involvement in the development of the service. The service user forum had been stopped during the Covid-19 pandemic. The local authority had a service user involvement team. The service manager told us that they would encourage the local authority to contact their clients.

At the time of the inspection the service was increasing the number of service user representatives and peer mentors in the service. These positions had been affected due to the Covid-19 pandemic.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Most clients we spoke to told us that they did not want their families involved. When clients did provide consent family members were invited to attend meetings with their loved ones. For example, family members had recently attended a joint meeting with the service and a local hospice to discuss their loved one's care.

The service offered family and carers groups which occurred on a Saturday. The family and carers group was held to help carers understand addiction. Key workers told us that they would offer 1:1s with carers, where carers could be referred to other services to provide additional support. Staff told us that families and carers could provide feedback about the service verbally during the family and carers group.

Are Community-based substance misuse services responsive?

Good

We rated it as good.

Access and waiting times

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.

Good

Community-based substance misuse services

The service had clear criteria to describe which clients they would offer services to and offered clients a place on waiting lists. The service used a complexity matrix which helped staff identify which service in the borough was best placed to accept clients. The most common type of referral for the service were self-referrals. Clients could fill out an online referral form or phone the service. The service also received referrals from a range of agencies. These included GPs and community mental health teams.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. However, at the time of inspection there was no clinical oversight of new self-referrals which meant that some urgent referrals may not be appropriately identified. Staff told us that they could assess new urgent referrals on the same day or within a couple of days.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from substance misuse services. The service had a hostel pathway lead who provided outreach work in local hostels in the borough.

Staff followed a protocol for clients who unexpectedly exited the service. Staff recognised that there may be occasions when clients dis-engaged from the treatment programme. Staff tried to contact people who did not attend appointments and offer support. Clients' records showed staff made persistent attempts to contact people that did not attend appointments.

Clients had some flexibility and choice in the appointment times available. Clients told us that the service offered flexible appointments to fit in with their jobs, however a few clients told us that they had to leave work early to attend appointments.

Clients reported that their key workers were easy to contact. However, a lot of clients that we spoke to expressed their frustration at trying to contact the service through the main reception. Clients told us that they would have to phone up several times before getting through to someone.

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.

When clients were ready to be discharged from the service, staff followed a clear discharge process. Staff sent clients and their GP a letter of discharge and signposted clients to other services in the community.

The facilities promote comfort, dignity and privacy

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

The service had a full range of rooms and equipment to support treatment and care. The service had six individual rooms for 1:1s and two rooms for group activities. Furniture was in good condition. However, due to the Covid-19 pandemic furniture had been removed in the reception area to encourage social distancing. During the inspection the reception area was very busy with some clients standing when waiting for appointments due to lack of seating. The service manager told us that they were in the process of adding additional seating to the reception area.

Interview rooms in the service had sound proofing to protect privacy and confidentiality. However, there was a gap in the ceiling between the reception and staff office. Staff told us that they were mindful of discussing client confidential information. Team meetings were held in separate more private room to protect client confidentiality.

Good

Community-based substance misuse services

Meeting the needs of all people who use the service

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

The service acted as a women only service for one day a week. Staff from other organisations such as domestic violence charities would also attend the service on that day to meet and offer support to clients.

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. The service manager had also requested for a hearing loop to be installed to better support clients with a hearing impairment. A lesbian, gay, bisexual and transgender (LGBT) flag was displayed in the reception with stickers stating, 'everybody welcome'. The service had recently held an LGBTQ+ day where staff made cakes and handed out bags to clients which contained information about LGBTQ+ charities in the borough. Managers told us that the service was in the process of setting up a chemsex pathway, the lead nurse was visiting a service in Soho to receive specific training. Managers told us that the lead nurse would then be able to offer training to team members within the service.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. A large range of leaflets were available in the reception area. For example, there were leaflets about advocacy, homeless charities, housing advice and how to make a complaint.

The service had information leaflets available in languages spoken by the clients and local community. Although leaflets in different languages were not displayed, we were told that this could be arranged. Translators could be arranged to support the clients either over the phone or in person.

Listening to and learning from concerns and complaints

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

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

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint. The service manager told us that they would try and resolve most complaints informally. The service had received five compliant in the previous 12 months. The most common theme of complaint was struggling to get through on the office number. These concerns were also shared during client interviews during the inspection. The service was working on improving this. Text messages had recently been sent out to all clients with their key workers mobile number while a more long-term solution to the office telephone system was reviewed.

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

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

Managers investigated complaints and identified themes and also shared feedback from complaints with staff and learning was used to improve the service. The service had received five compliments and five complaints in the previous 12 months. Feedback from clients was shared during team meetings.

Good

Community-based substance misuse services

Are Community-based substance misuse services well-led?

Good

We rated it as good.

Leadership

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

The local senior leadership was in the service were motivated and enthusiastic about supporting the client group. Staff told us that they felt well supported by the senior leadership team and that they were approachable. There had been a lot of change of the senior leadership at the service in the previous 12 months. At the time of inspection there was a service manager and deputy service manager in place. Staff told us that whilst the service manager was away on maternity leave the service had gone through a difficult period as the service manager role was being covered by several other managers. Staff were very positive about the service manager returning to work. New positions had been created to support the senior leadership at the service. A quality lead and data lead had been recruited to and were awaiting start dates.

Vision and values

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

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

Culture

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

Staff felt supported and valued, and the team worked well together. It was evident that all colleagues wanted the best outcome for clients. Staff were committed to working for the service and were positive about the future. Staff told us that the management team were receptive to any concerns or issues that were raised and were working to support the team. Managers told us that they operated an open-door policy and would talk regularly to staff and volunteers if they had concerns or queries, without waiting for formal supervision. Staff also felt that managers valued and respected volunteers and lived experience workers input.

Good Governance

Good

Community-based substance misuse services

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

There was a comprehensive and detailed governance system supporting staff to provide safe and high-quality care and treatment. All areas of the service were subject to performance monitoring and audit. There was ongoing performance monitoring and auditing in areas such as health and safety, safeguarding, infection, prevention and control. However, at the time of inspection the governance system heavily relied upon the service manager. This meant that detailed care and treatment records audits were not completed consistently. The service manager told us that their workload was high. In response to this, two new roles had been created, a quality lead and data lead had been recruited to and were due to begin their roles shortly. The service manager was positive about the addition of these two new roles and felt this would allow more effective governance.

Team meetings followed a standard agenda. This ensured incidents, complaints, safeguarding referrals and learning from investigations were shared with staff. The minutes of the clinical and non-clinical meetings were stored on the staff intranet so that all staff could access and read them.

Staff had access to a range of policies and procedures which they could access through the services intranet.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect, although the risk register tool used by managers to monitor risks did not include all the risks that met the threshold for inclusion.

The service's risk register was not complete. It did not include all of the identified risks in the service that met the threshold for inclusion. Although 10% of medical reviews were overdue and mitigations were in place such as the recruitment of an agency non-medical prescriber, this was not present on the risk register or improvement plan. Most of the other current concerns about the delivery of the service were included that met the threshold for inclusion. For example, managers told us that two of the biggest risks for service delivery was high caseloads and staff wellbeing. These risks were found in the risk register with actions to mitigate them. For example, high caseloads was one of the key risks for the service. To mitigate this the service was in the process of increasing the psycho-social intervention offer to clients so more clients could move through treatment. Key workers were also using pods to try and reduce pressure on staff. Key workers told us that they would see clients in pods which would allow them to complete certain tasks.

Managers told us that lessons learned would be shared by other services within the organisations. Lesson learned from other services were shared during the monthly service managers meetings.

Managers had access to a performance dashboard. The performance dashboard displayed performance indicators for the service. For example, it showed which clients were overdue full risk reviews and service user care plan reviews.

The service had an action plan for improvements in place. The service improvement plan had recently been developed since the service manager had returned from maternity leave. The action plan was being reviewed review every week by the senior leadership team. Managers told us that the plan was still being embedded. The improvement plan included leadership development, improved governance and improved service user journey and staff experience.

Information management

Good

Community-based substance misuse services

Staff collected analysed data about outcomes and performance.

The provider routinely collected performance and training data. The service had systems in place that provided leaders with information about the running of the service. This enabled leaders to maintain clear oversight of the service and identify good practice and areas for improvement. An activity dashboard had recently been introduced to the service. This dashboard was highly detailed and allowed recovery workers and managers to have oversight of caseloads. For example, the dashboard recorded when clients had their medical reviews this allowed staff to identify clients who required medical reviews. At the time of inspection, this dashboard had not been shared with key workers, but there were plans to do this shortly. Managers were extremely positive about the introduction of the dashboard and told us that the dashboard would allow team leads to have better oversight of key workers caseload.

Leadership, morale and staff engagement

Most staff told us that morale in the team was improving. Staff told us that working during the pandemic was challenging. Staff were confident in the leadership in the service and were positive about the service going forward.

The service held a staff forum bi-monthly. The forum allowed staff to discuss challenges and concerns without the presence of the senior leaders. Representatives from the staff forum attended the senior leadership team meetings to share actions from the staff forum. The service also had a weekly wellbeing hour, which allowed staff to take a break from their work. Staff told us it was not always possible to utilise this wellbeing hour due to their workload.

Commitment to quality improvement and innovation

Even though the service did not use a quality improvement model to improve the service, managers had identified improvements and developed the service. For example, managers planned to improve the psychosocial interventions offered by the service and to add new treatment pathways to the service.