

Change, Grow, Live

CGL Cambridgeshire

Inspection report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

Change Grow Live Cambridgeshire Alcohol and Drug Behavioural Change Service is part of a national Change Grow Live provider who provide a not-for-profit drug and alcohol treatment service. The Cambridgeshire services are across three bases in Cambridge, Huntingdon and Wisbech. Satellite sites in Ely, St Neots, St Ives, Ramsey, March, Chatteris and Whittlesey ensure accessibility for clients. The service is open access to anyone with a drug or alcohol issue over the age of 18 years.

We rated this service as good because:

- The premises where clients were seen were well-maintained and clean.
- Staff assessed and managed risk well.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff regularly reviewed the effects of medicines on each client's mental and physical health.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- The service provided a range of treatments suitable to meet the needs of the clients and in line with national guidance and best practice.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training and regular appraisal. Staff worked well together as a multidisciplinary team.
- 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, and clients were seen in a timely manner.

However:

- Governance structures were not embedded across all three hubs in order to ensure all staff had access to essential information.
- Managers did not ensure that staff received regular supervision.
- Managers did not ensure that staff induction records were signed off once completed.
- The service had a high number of vacancies.

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

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Summary of this inspection

Background to CGL Cambridgeshire

Change Grow Live Cambridgeshire Alcohol and Drug Behavioural Change Service is part of a national Change Grow Live provider who provide a not-for-profit drug and alcohol treatment service. The provider took over this service in October 2018 from the previous provider.

Change Grow Live Cambridgeshire operates a hub and spoke model. The Cambridgeshire services are across three bases in Cambridge, Huntingdon and Wisbech. Satellite sites in Ely, St Neots, St Ives, Ramsey, March, Chatteris and Whittlesey ensure accessibility for clients. The service is open access to anyone with a drug or alcohol issue over the age of 18 years.

The service delivers a range of interventions such as advice and guidance, brief and extended interventions, Foundations of Recovery group work, psycho-social support, medical assessments and treatment. The service provides alcohol screening, advice and brief interventions, blood-borne virus screening and vaccination, access to Hepatitis C treatment, a drug interventions programme, criminal justice services, drug rehabilitation requirements and alcohol treatment requirements services. The service can accommodate those with physical disabilities. Each hub has a number of specialist teams and recovery workers: the opiate team, alcohol team, homeless team and criminal justice team and families safeguarding team. Change Grow Live Cambridgeshire is registered with the Care Quality Commission to provide treatment of disease disorder or injury as a regulated activity. The service had a registered manager in post at the time of our inspection.

What people who use the service say

We spoke with ten clients. Clients told us:

They feel safe using the service for face-to-face appointments, group meetings and telephone appointments.

The service is accommodating to their needs and provides good telephone support, this included the use of text messaging.

The service manages medication and supports recovery well.

The service provides useful information on other services as well as help with finances (including benefits), housing, bereavement counselling, psychological support and social support.

Group meetings were helpful; the gardening group and the acupuncture sessions were particularly helpful.

The service arranges appointments at suitable dates/times and appointments usually run on time. The appointment reminders were very helpful.

The staff are very welcoming.

Staff are easy to talk to and non-judgemental. They are very interested in the person's well-being.

They feel listened to and have built trusting relationships.

Summary of this inspection

They are offered refreshments which is greatly appreciated.

The service responds to voicemails, text messages and e-mails in a timely manner.

There are regular progress reviews and the service is responsive to individual needs.

They appreciate the consistency in staff however two clients were concerned about low staffing levels in Cambridge.

Clients are offered training to become peer support workers for the organisation and they can be employed when they have completed the training.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited all three hubs and toured the buildings;
- spoke with the registered manager;
- spoke with the service quality and performance lead;
- spoke with the service data lead;
- spoke with 27 staff including; team leaders, recovery co-ordinators, specialist doctor, prescribing doctor, outreach workers, nurses, pharmacy liaison lead, safeguarding lead, clinical administrators, non-medical prescriber, psychosocial intervention worker, psychologists; cluster lead nurse and deputy service manager;
- spoke with 10 clients;
- spoke with a volunteer;
- reviewed a total of 17 client care records;
- attended a flash meeting;
- attended a multidisciplinary meeting;
- attended an alcohol focus group;
- reviewed policies and procedures, data and documents.

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

Areas for improvement

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

Action the service **MUST** take to improve:

- The service must ensure that governance frameworks are fully embedded to ensure all staff have access to essential information. (Regulation 17)

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

- Managers should ensure that induction records are fully completed.

Summary of this inspection

- The service should ensure that all staff receive regular supervision.
- The service should review their strategies to improve staffing numbers and reduce vacancies.

1.






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	Requires Improvement	Good
Overall	Good	Good	Good	Good	Requires Improvement	Good

Community-based substance misuse services

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

Are Community-based substance misuse services safe?

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. The service had health and safety systems in place to manage the safety of the environment in all three hubs we visited. This included monthly premises checks, annual infection control audits and six-monthly fire assessments.

The provider had closed circuit television in all three hubs to monitor public areas and access to the building where appropriate. Closed circuit television screens were observed throughout the day. Alarms were situated in all rooms where clients were seen.

The service had a range of suitable rooms at all hubs accessible to clients. This included one to one interview rooms, group rooms, clinic rooms for medical reviews, testing rooms and needle exchange rooms. All areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. All hubs we visited had dedicated cleaning schedules and audits in place.

Staff followed infection control guidelines, including handwashing. We saw antibacterial hand sanitisers were made available in corridors and bathrooms.

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service had high vacancy rates. However, staff, knew the clients and received basic training to keep them safe from avoidable harm.

The service ensured that staff kept clients safe.

Community-based substance misuse services

The provider employed a total of 82 substantive staff at the time of inspection. This included a range of health care professionals, for example; specialist doctors, non-medical prescribers, nurses, recovery co-ordinators, psychologists, social workers and clinical and data administrative staff.

However, at the time of inspection there were 14 vacancies of which 10 of these posts were for recovery co-ordinators. This meant that a total of 22% of recovery co-ordinator posts were vacant. Managers told us a number of these vacancies were for new posts to increase the staffing team above the numbers in the original staffing model.

Managers told us that recruitment for recovery co-ordinators was an ongoing process and could be challenging, within the Cambridge location. A rolling advert campaign was in place. Two vacant recovery co-ordinator posts were in the process of being filled and there were staff checks underway for those staff offered a post.

In the six months prior to the inspection, nine staff had left the service. Of the nine leavers this included eight recovery co-ordinators. Staff turnover rate was reported at 1.35% for the most recent complete month, July 2022. We were informed staff had the opportunity to complete exit questionnaires which were managed through CGL's central human resource department.

The service did not routinely use bank and agency nurses and limited their use of other agency staff with staff familiar with the service. At the time of inspection, agency staff included a specialty doctor and a recovery co-ordinator.

Managers made arrangements to cover staff sickness and absence and supported staff who needed time off for ill health.

Sickness levels were low. At the time of inspection, short term sickness was 2.4% and long-term sickness was 2.3%. The Provider did not have a target for sickness rate.

Staff records were not held at the hubs but centrally with CGL's central human resource department. Managers reviewed monthly human resources audits of compliance rates with DBS checks, at the time of inspection this was at 97%.

Medical staff

The service had enough medical staff.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

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

The service had a vacancy for a Consultant Psychiatrist. However, this was being covered by an agency Specialist Doctor. Additional support was also provided by the Regional Consultant Psychiatrist. A full time permanent Consultant Psychiatrist had been recruited and was due to start in October 2022.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. At the time of inspection, 84% of staff and volunteers had completed their mandatory training.

Community-based substance misuse services

The mandatory training programme was comprehensive and met the needs of clients and staff. Mandatory training courses included for example, Safeguarding Adults and Children, Data Protection and Information Security Awareness, Introduction to Equality, Diversity and Inclusion, Introduction to Health and Safety and Introduction to Mental Capacity Act.

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

Assessing and managing risk to clients and staff

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

Assessment of client risk

Staff completed risk assessments for each client on arrival, using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed 17 client records and found all records had an initial risk assessment, a risk management plan in place and the most recent risk assessment was up to date.

All 17 records documented unexpected treatment plans. However, the quality of these was variable within the Cambridge and Huntingdon hubs. Of the 17 records we reviewed, nine had unexpected treatment plans in place but were of lesser quality. Managers were aware of the quality issue and were working with the quality lead and line management supervision and staff meetings to improve the quality.

Management of client risk

Staff followed clear personal safety protocols, including for lone working. Staff we spoke with were aware of the lone working policy.

Caseloads were high in some teams. At the time of inspection caseload numbers per team were as follows:

Average caseload numbers, per staff member, ranged from between 17 and 93, average 55

(Wisbech); between 32 and 78 (Huntingdon) and between 23 and 80 (Cambridge).

Managers were aware that caseloads were high and put mitigation in place. Managers routinely monitored recovery co-ordinators' caseloads. The provider did not use a formal caseload management tool. However, managers told us caseloads were regularly reviewed and discussed in supervision, daily flash meetings and weekly multidisciplinary team meetings. We reviewed minutes of these meetings and saw evidence that caseloads were being managed, discussed and minuted. Managers ensured that higher caseloads included lower risk clients and the most experienced staff managed caseloads of higher complexity.

The service provided detailed and informative harm minimisation advice across all three hubs to clients making them aware of the risks of continued substance misuse.

Recovery co-ordinators promoted harm reduction and offered support and advice throughout the hubs.

Community-based substance misuse services

Staff held daily flash meetings across the three service hubs. We observed a flash meeting during the inspection and saw that all staff engaged in detailed discussion of client risks. Where appropriate, these risks were shared with relevant stakeholders such as the local authority, health services, criminal justice partners and probation services.

Managers reviewed and monitored weekly case management information and identified where action needed to be taken to ensure compliance with service policy timeframes. The report included key indicators such as date since last Full Risk Review (FRR), medical review date and face to face contact.

Managers monitored the rate of full risk reviews that were due at 12 weeks to ensure their completion in accordance with the service's policy of within a six months period. Of 1516 clients, 674 (44%) had not had a full risk review within 12 weeks and 161 clients had not had a full risk review in line with the service policy of six months (10%). All clients had a date booked in for a full risk review. We saw examples within client records of staff following up clients who failed to attend appointments.

Managers monitored clients' last medical contact within the previous six months, this was within the service policy which stated that all clients had a medical contact within twelve months. However, 105 out of 814 clients (13%) had not had a medical review within 6 months. One client was overdue a medical review by more than twelve months.

Managers reviewed most recent face to face contact information. The most recent weekly report showed that 456 clients out of 1516 (30%) had not had a face to face contact in the previous 12 weeks. This is broken down by hubs as follows: Cambridge 33%, Huntingdon 27%, Wisbech 26%. However, out of these 456 clients, two (0.4%) had not had any contact, either face to face contact or remote contact, within a 12-week period.

We saw from client records that staff made every attempt to follow up on missed appointments and we saw that missed contacts was a standing agenda item at weekly multidisciplinary meetings.

All clients we spoke with told us they felt safe using the service for face-to-face appointments, group meetings and telephone appointments.

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.

The service had a dedicated family safeguarding team.

Staff received training on how to recognise and report abuse, appropriate for their role. Of eligible staff and volunteers, 78% had completed mandatory safeguarding adults e-learning, and 80% had completed mandatory children's e-learning.

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 knew how to make a safeguarding referral and who to inform if they had concerns.

Community-based substance misuse services

Safeguarding adults and children were a standing agenda item at the weekly multidisciplinary teams meeting.

Staff we spoke with were able to describe the process for making a referral to raise a safeguarding concern. Each hub had an identified safeguarding lead.

Managers took part in serious case reviews and made changes based on the outcomes.

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.

The provider used an electronic recording system for client records. The system was easy to use.

Client notes were comprehensive and all staff could access them easily.

Recovery co-ordinators updated the system regularly after appointments and interventions. The relevant staff had prompt and appropriate access to care records for clients.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely.

Clinical rooms were clean, spacious and equipped with handwashing facilities. Staff had access to emergency medicines, equipment, and medicines disposal facilities.

The service had a dedicated staff member at each site to process repeat and instalment prescriptions. Prescribers authorised changes to medicines and signed all prescriptions generated.

All staff were trained to administer naloxone in case of an emergency. Staff gave clients naloxone and trained them on how to administer it to reduce the risk of overdose from opioid use.

Clients were offered Blood Borne Virus testing (hepatitis B, hepatitis C, and HIV) at treatment commencement and during their treatment episode. Hepatitis vaccinations were routinely offered at the point of assessment and at review appointments to all service users administered via a PGD. (A PGD allows specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber).

The regional lead consultant had oversight of prescribing at the service. All prescribers met regularly to discuss prescribing best practice and provide peer support.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines information leaflets were available for staff to print or send electronically to clients.

Community-based substance misuse services

We saw evidence that staff wrote to General Practitioners (GPs) to keep them informed of the treatment being provided by the service. They also advised GPs not to prescribe certain medicines that could interact with the treatment the person was receiving.

Staff completed medicines records accurately and kept them up to date. Staff used an electronic system to document medicines prescribed.

When they reviewed clients' medicines, they requested an up-to-date list of medicines from their GP.

Staff stored and managed all medicines and prescribing documents safely. Medicines and prescription forms were kept securely. Their use was monitored in line with national guidance. Prescriptions were posted to pharmacies where clients collected their medicines from.

The service monitored the temperatures of medicines storage areas. If temperatures fell outside the recommended ranges, staff knew what actions to take.

Clients were given lockable boxes for safer storage of medicines at home.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff obtained clients' consent before requesting and sharing information with their registered GPs.

If clients moved to a different service out of area, staff ensured they provided details on their medicines and any other relevant information to the new service.

Staff learned from safety alerts and incidents to improve practice. Medicines incidents were reported electronically and investigated appropriately. Learning was shared in multidisciplinary team meetings. Improvements to systems and processes were made as a result of incidents reported.

The provider had a system in place for receiving and actioning safety alerts.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Prescribers liaised with GPs to review clients' medicines and reduce the risk of over sedation from treatment they were receiving.

Staff reviewed the effects of each patient's medicines on their physical health according to The National Institute for Health and Care Excellence (NICE) guidance.

Staff discussed side effects of medicines with clients during medical reviews.

Electrocardiograms (ECGs) were conducted by nursing staff to monitor people on high doses of methadone. If the ECG result was abnormal, staff completed the necessary referral for more investigations.

Records indicated that staff encouraged clients to attend appointments related to their physical health.

Community-based substance misuse services

Track record on safety

The service had a good track record on safety.

In the previous twelve months there had been a total of 41 deaths and five incidents involving the police. These had been reported to the Care Quality Commission. The service offered staff the opportunity to de-brief on the day of a death notification and share feelings around the death. A monthly 'loss of life forum' is also in place to review and discuss practice, efficacy of process, reports, learning and recommendations and to start the process of learning from the client death as appropriate.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff told us that the system had recently changed from Datix to CRIIS, the in-house electronic records system.

Staff raised concerns and reported incidents in line with the service's policy.

Managers understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff received feedback from investigation of incidents.

Managers investigated incidents thoroughly. The service had an incident tracker. This was available to all staff on the electronic records system (CRIIS). The tracker included deaths and police incidents and the investigating officer and recorded when the investigation was completed. However, the tracker did not include actions or learning. This was recorded within the individual incident report stored within the service's electronic records system.

Staff met to discuss the feedback from incidents and look at improvements to client care. Incidents were discussed in daily flash meetings and through reflective practice.

Staff gave examples of incidents and learning including an incident of verbal aggression by a client during a therapy group and a further client disclosing past traumatic experiences. Both incidents were reported, discussed and actions taken to improve client care. However, not all staff at Huntingdon we asked were able to give examples of learning from incidents or how learning was shared.

Are Community-based substance misuse services effective?

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.

Community-based substance misuse services

We reviewed 17 care and treatment records and found staff completed an initial assessment for clients in a timely manner. Care records were comprehensive and included clear client goals and recovery plans. All 17 records we reviewed showed there was a recovery plan in place and the client had been given a copy. Recovery plans were personalised, holistic, strength-based and goals oriented and recorded the person's views. The most recent quarterly commissioners key performance indicator (KPI) report showed that 100% of clients had a recovery plan.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. The most recent quarterly commissioners KPI report showed that 100% of clients had a care plan in place within 21 days.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems.

All but one record showed clients had a physical health assessment and all but one record showed there was ongoing physical health monitoring (the one record was marked as psychosocial intervention only).

The most recent quarterly commissioners KPI report showed that 99.8% of services users had a healthcare assessment.

Staff regularly reviewed and updated care plans when clients' needs changed.

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 interventions suitable for the clients in the service. The interventions included those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE) for medicines and psychosocial interventions.

Clients had access to psychological therapies and support. The psychology team provided one to one therapy, group interventions (including Cognitive Behaviour Therapy (CBT) and seeking safety group) and there were plans to run a managing emotions group. The service recently piloted a series of five CBT psychoeducation workshops on Anxiety, Low Mood, Anger, Sleep, Trauma. The pilot was evaluated through client feedback which was collected, collated and analysed and there were plans to roll this out as part of a timetable of activities. Staff were supported to provide trauma-informed care to clients through internal training sessions reflective practice and with ongoing consultation and support from psychology staff.

Staff supported clients to minimise risks associated with substance misuse. For example, all hubs in the service had a needle exchange service as recommended by the Department of Health and Drug misuse guidelines. The service offered safe storage for the return of needles to the needle exchange and offered safe storage boxes for medication to clients who had children at home.

Blood borne virus testing was routinely offered and the service organised events in the community to increase testing of blood borne viruses.

The provider supported clients with ambulatory (outpatient) detoxification where appropriate. Clients who were in stable accommodation and wanted detoxification from substances were supported through this service.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE).

Community-based substance misuse services

Staff made sure clients had support for their physical health needs, either from their GP or community services.

Nurses ran flu vaccination clinics during the flu season. They were trained annually and a patient group direction was in place for this.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. Examples included; arts crafts and gardening groups; yoga; tai-chi and acupuncture.

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

The service used recognised recovery tools such as the Severity of Alcohol Dependence Questionnaire, Alcohol Audit and the Treatment Outcomes Profile. Also, the International Trauma Scale; Substance Misuse Recover Evaluation Tool; Self-attacking and Reassuring Scale and CORE10 to measure outcomes.

Staff completed regular internal audits including daily, weekly and monthly checks such as temperature monitoring, stock management and clinical areas and equipment.

They also participated in service evaluation. For example, a recent evaluation of staff training and an evaluation of the seeking safety pilot had taken place. Recommendations were made and changes implemented.

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.

The service had access to a full range of specialists to meet the needs of each client.

Staff included doctors, nurses, recovery co-ordinators, psychologists, clinical and data administrative staff, receptionists,

The service had a vacant Social Worker role based across Cambridge and Fenland. This vacancy was open and managers told us it had been for a long time. Managers told us this was being managed by an experienced recovery co-ordinator. Both Cambridge and Huntingdon hubs had social workers in post.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

The provider had a centralised human resources department that had responsibility for recruitment checks and storage of staff records.

Managers gave each new member of staff a full induction to the service before they started work.

The service had an induction policy. The service provided all staff including direct employees, sessional staff and volunteers with a comprehensive induction plan over a minimum three month period. This included mandatory training, information about the service and its structure. Staff needed to complete key tasks related to their role during this period, such as Naloxone training, Disposal of Medication, Ambulatory Alcohol pathway and immunisations for infection diseases. Managers told us staff were expected to complete competency-based assessments.

Community-based substance misuse services

However, some staff at the Huntingdon hub told us that the induction check lists were not always signed off at the end of the induction period. Senior managers had identified this as an area for improvement. This meant managers were not assured that all staff had fully completed their induction training.

Managers supported staff through regular, constructive appraisals of their work.

At the time of inspection the staff appraisal rate was 92%.

Managers supported staff through regular, constructive clinical supervision of their work.

The service's policy was a minimum of four supervision (one to one) session within a 12-month period. However, staff told us they could access supervision more frequently if needed

At the time of inspection, the staff supervision rate was 69%.

Managers made sure staff attended regular team meetings and gave information to those who could not attend.

Meetings were documented so that staff could access information if they were unable to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers told us they identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge through supervision. Staff told us there were learning opportunities available within the organisation. These could be accessed online and staff were also able to request training opportunities and attend training courses and the organisation would make every effort to accommodate this to support learning and development within teams.

Managers made sure staff received any specialist training for their role.

All nurses had recently undertaken phlebotomy training. The provider was in the process of establishing a service to enable nurses to take blood samples on site. This would be undertaken for high-risk clients to avoid delays in initiating treatment.

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

Managers recruited, trained and supported volunteers and peer workers to work with clients in the service. For example, an ex-client had been recruited as a recovery co-ordinator.

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 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.

Community-based substance misuse services

Weekly multidisciplinary meetings were held at each hub. These were attended by the whole team including nursing, recovery co-ordinators, psychology, managers.

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

Multidisciplinary meetings had a standing agenda across the three hubs. Staff discussed clinical case management daily at morning flash meetings. We attended a flash meeting and saw that staff shared information about clients and discussed any concerns or changes in their needs.

Staff had effective working relationships with other teams in the organisation. Staff also had effective working relationships with external teams and organisations.

A pharmacy liaison lead was newly appointed to maintain good working relationships with local pharmacies and deal with any issues raised.

The service worked closely with the hepatology team from Addenbrooke's Hospital to coordinate the running of hepatitis C clinics on the service premises.

The service supported the police locally with the established initiative for officers to carry and administer nasal naloxone in emergencies.

The clinical consultant psychologist held the strategic lead role with the local mental health service providers. They are undertaking a survey of clients' experiences of trying to access mental health care.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

Of 96 eligible staff and volunteers, 84% had completed their mandatory training.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Not all staff were able to describe the policy or knew where to get advice should they have concerns about a client's capacity.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a client needed to make an important decision.

Community-based substance misuse services

We reviewed 17 client records. All records included a mental capacity assessment that had taken place and evidence of consent to treatment.

Are Community-based substance misuse services caring?

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.

Staff were discreet, respectful, and responsive when caring for clients. Clients told us staff were easy to talk to and non-judgemental. They were interested in the person's well-being.

Staff gave clients help, emotional support and advice when they needed it. Clients felt listened to and told us they had built trusting relationships with staff.

Staff supported clients to understand and manage their own care treatment or condition.

Staff directed clients to other services and supported them to access those services if they needed help.

Clients said staff treated them well and behaved kindly. They told us staff were very welcoming.

Staff understood and respected the individual needs of each client. Some clients told us they chose not to attend the centre in-person and the service is accommodating to their needs and provided good telephone support, this included the use of text messaging.

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

Staff followed policy to keep client information confidential. We reviewed 17 records and all included evidence of confidentiality agreements.

Involvement in care

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

Involvement of clients

Staff involved clients and gave them access to their care plans. Of the 17 client records we reviewed, all clients had been given a copy of their recovery plan and recovery plans were personalised and reflected the client's views.

Staff involved clients in decisions about the service, when appropriate.

Clients could give feedback on the service and their treatment and staff supported them to do this.

Community-based substance misuse services

Staff encouraged clients to give feedback on their care and treatment and tell their story via an online platform called Care Opinion. Feedback was positive.

Staff had collected, collated and analysed feedback via a survey asking clients how best new finances could be spent. These resulted in recommendations for service improvements.

Staff made sure clients could access advocacy services.

Staff informed and involved families and carers appropriately.

Ex clients, peers and volunteers were trained by CGL to support the service. We found one example in that a full-time recovery coordinator was in post who used to be ex-client of the service. Clients reported that the service was effective for managing medication and supporting recovery.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Staff told us they sought consent from the client.

Staff helped families to give feedback on the service. Families could give feedback through an online platform called Care Opinion.

Staff gave carers information on how to find the carer's assessment.

Family members and carers had access to a weekly support group.

Are Community-based substance misuse services responsive?

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.

There were a variety of ways in which clients could be referred into the service. The most common was self-referral. Clients could attend a walk-in appointment and receive a triage and personalised assessment on the same day. The usual waiting time for a nurse alcohol assessment was five to ten working days.

The service did not have waiting lists. The service delivered an open-door policy and accepted walk-in self-referrals and those referred, were offered a time and date to be assessed in a timely manner.

Staff saw urgent referrals quickly. The service had not set a target for time from referral to initial assessment. However, data showed that no one waited more than four days for an assessment.

The service had clear criteria to describe which clients they would offer services to.

Community-based substance misuse services

Staff tried to engage with people who found it difficult, to seek support from services. The service had a dedicated homeless outreach team; a criminal justice team and migrant outreach work.

Staff told us they tried to contact people who did not attend appointments and offer support. We saw that missed contacts were discussed in multi-disciplinary team meetings and were a standard agenda item across all three hubs. Actions were agreed and recorded in the minutes.

Managers reviewed contact information through weekly data reports.

Clients had some flexibility and choice in the appointment times available. Clients told us they were able to arrange appointments at a date or time that suited them.

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.

Appointments ran on time and staff informed clients when they did not.

Clients told us that appointments usually ran on time and could be rearranged if required. Clients said the service arranged appointments at dates and times suitable for them.

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 to support treatment and care.

All three hubs had a welcoming environment that were clean and comfortable.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. However, the Cambridge hub was situated in an older building with narrow corridors and stairwell making it difficult for wheelchair users. Accessible meeting rooms were available on the ground floor.

The service provided information in a variety of accessible formats so the clients could understand more easily.

The service had information leaflets available in languages spoken by the clients and local community.

Managers made sure staff and clients could get hold of interpreters or signers when needed.

Staff could access translation services for people who did not speak English as a first language.

There was a dedicated team in place working with homeless clients to provide them with support and access to treatment.

Community-based substance misuse services

There was a dedicated criminal justice team in place.

Clients told us the service provided useful information on other services as well as help with finances (including benefits), housing, bereavement counselling, psychological support and social support.

Clients told us they found group meetings helpful; the gardening group and the acupuncture sessions were particularly helpful.

Clients told us the service responded to voicemails, text messages and e-mails in a timely manner.

There were regular progress reviews and the service was responsive to individual needs.

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.

We saw complaints posters displayed in client areas across all three hubs.

Complaints and feedback were a standing agenda item at the integrated governance team meeting.

The number of formal complaints was low. In the previous twelve months the service had received two formal complaints. These had been fully investigated and one upheld and one partially upheld.

Most staff knew how to handle complaints and feedback received from clients. However, some staff in the Huntingdon office told us they were not clear the complaints process or complaints was shared.

Both complaints and informal feedback were recorded directly onto the service's electronic record system. Managers used this information to identify themes from both positive and negative feedback and shared feedback with staff.

Are Community-based substance misuse services well-led?

Requires Improvement 

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 registered manager of the service had strategic oversight of all three hubs. Locality managers and team leaders at the hubs felt the manager was visible in the service and accessible to clients and staff. The staff we spoke with confirmed this.

The leaders at the service had the skills, knowledge and experience to perform their roles, and provided leadership to their staff. The organisation had a clear definition of recovery and this was understood by all staff.

Community-based substance misuse services

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care and were open and transparent in sharing areas which needed to improve.

Some staff told us there was a lack of leadership training available. However, they were aware of some modules that were planned within the months following our inspection.

Vision and strategy

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

The service's mission was to help people change the direction of their lives, grow as individuals, and live life to its full potential. Staff knew and understood the vision and values of the team and organisation and what their role was in achieving that.

Culture

Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work. They felt able to raise concerns without fear of retribution. Staff worked well as a team and spoke passionately about their work with clients.

All staff we spoke with reported feeling valued by their line managers. They said they were supported through regular one to ones and were able to ask for support outside of scheduled meetings.

However, some staff reported feeling overwhelmed with high caseload numbers alongside the administrative tasks associated with their roles. One client we spoke with told us they found staff were stretched.

Managers ensured clients were kept safe through regular review of team and individual staff's caseloads; one to one support for staff; and daily discussion of workload through morning flash meetings. Staff worked as a team to ensure clients' needs were met.

The service had implemented a staff wellbeing hour. This meant staff could take one hour each week from work time to improve their own wellbeing. Examples included, going to the hairdresser, taking a walk or finishing the working day early. Managers used the daily flash meetings to ensure there was adequate staff cover at these times.

Staff were very passionate about their work with clients.

Staff spoke positively about the support that they have offered to clients during the pandemic.

Clients were offered training to become peer support workers for the organisation and they could be employed when they had completed the training.

The service had a whistleblowing policy in place. Staff we spoke with were aware of this and were confident they would use this if required.

Governance

Governance systems did not always operate effectively and were not fully embedded across the hubs.

Community-based substance misuse services

The provider did not have a fully effective structure to support the overarching governance framework. We reviewed three months of integrated governance meeting minutes held across all three hubs. There was not a consistent clear framework and agenda of what must be covered, to ensure that essential information, such as learning from incidents and complaints, were shared and discussed with staff. However, whilst clinical meetings provided a clear and thorough forum to discuss client safety matters, staff meetings were variable across the three hubs. This was evidenced by not all staff at Huntingdon reporting they felt fully engaged in governance processes, or were given the opportunity by managers to be made fully aware of processes used to improve quality such as lessons learnt in incidents and complaints. Some staff at the Huntingdon hub told us that induction check lists were not always signed off at the end of the induction period. Senior managers had identified this as an area for improvement. This meant managers were not assured that all staff had fully completed their induction training.

The service had high vacancy rates for recovery co-ordinators. The Registered Manager told us this was a particular challenge for the Cambridge hub. Managers confirmed that more staff were being recruited to address the high vacancy rate. At the time of inspection there were 10 recovery co-ordinator vacancies, of which one was being covered by an agency worker. Therefore, we were not fully assured by the measures put in place to improve staffing levels and reduce the workload pressure felt by staff whilst recruitment was underway.

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. Performance and risk were managed and monitored well.

There were clear quality assurance management and performance frameworks in place.

Managers had clear oversight of client-based information and proactively reviewed and monitored key indicators on a weekly basis.

Managers told us caseloads were regularly reviewed and discussed in supervision, daily flash meetings and weekly multidisciplinary team meetings. However at the time of inspection, the staff supervision rate was 69%.

The service had a risk register. The register described the issue, rated the risk and detailed mitigations put in place.

The service routinely reported quarterly key performance indicators to commissioners. The reports show that managers collected, collated and analysed data against a number of outcome, performance and activity measures.

Information management

Staff collected analysed data about outcomes and performance.

The service used systems to collect data and managers received weekly reports including client level data and information.

The service had a data team in place including a data lead and clinical and data administration team.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care.

Managers ensured staff had access to the equipment and information technology needed to do their work.

Community-based substance misuse services

Information governance systems-maintained confidentiality of clients' records.

The service reported on a number of performance and quality indicators such as successful completions, number and source of referrals and referral to assessment times, care plans, recovery plans and health assessments.

Engagement

Staff, clients and carers had access to up-to-date information about the work of the provider and the services they used for example, through the provider's website.

Senior leaders engaged with external stakeholders including commissioners through quarterly contract monitoring meetings and monthly quality review meeting.

Staff reported barriers to making referrals to mental health services for clients experiencing substance misuse and mental health problems. The service employed a clinical consultant psychologist who worked with system partners to improve access to local mental health services.

Some staff told us that GPs could be difficult to contact.

However, joint working with other partners such as homeless charities, criminal justice system and the police worked well.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The service did not ensure that governance frameworks were fully embedded to ensure all staff have access to essential information.</p>