Midlands and North Regional Office

Quality Report

Midlands and North Regional Office
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We do not currently rate independent standalone substance misuse services.

We inspected Midlands and North Regional Office on 2 and 3 August 2017. This was an unannounced, focused inspection to find out whether the service had made the required improvements since our last inspection on the 31 October 2016.

We found the following issues that the service provider needs to improve:

- Clinical waste was not managed safely at Hull and Mansfield. Equipment at Manchester was not safe to use. Medicines were not stored safely or securely. The clinical hand washbasins at Mansfield and Hull were not compliant with the Department of Health guidance on infection control in the clinical environment. Staff had not completed a risk assessment to identify the risk of the spread of infection nor had actions been identified to mitigate the potential risks. Staff were not appropriately recording risks to clients.
- Staff could not be certain that they were meeting all clients' needs and achieving their preferences.
- Some clients did not know how to complain.
- Monitoring systems in place were not effective in ensuring the safe storage of prescribed dressings. Monitoring systems in place were not effective in ensuring that the registered managers and the service managers had complete oversight of mandatory training, appraisals and disclosure and barring checks.
- Although some improvements had been made to issues identified at the last inspection, these improvements had not been made at all sites.
- Audit findings were not always acted upon.

However, we also found the following areas of good practice:

- Since our last inspection in October 2016, staff at Blackburn had reviewed and improved the management of clinical waste. At Manchester, the clinical hand washbasin had been replaced and met the required standards.
- Staff were knowledgeable about identifying safeguarding concerns and knew who to contact for advice within the organisation. We found evidence that staff made appropriate safeguarding referrals when needed.
- Staff knew how to handle complaints and records showed that overall complaints were processed in line with the provider's policy. Since our last inspection, the recording of complaints had improved.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		See overall summary

Summary of findings

Contents

Summary of this inspection

Background to Midlands and North Regional Office

Change, Grow, Live is a substance misuse provider that delivers substance misuse services across the country. Midlands and North Regional Office delivers community substance misuse services and provides opiate substitute medication, community detox and psychosocial treatment to clients.

Midlands and North Regional Office was registered with the Care Quality Commission on 6 August 2014 for the treatment of disease, disorder or injury and diagnostic and screening procedures. There were two registered managers for this location.

Midlands and North Regional Office had 47 sites that provided services under one registered location across the midlands and the north of England.

The sites that we visited were:

Manchester Integrated Drug and Alcohol Services (Carnarvon Street)

New Directions Nottinghamshire (Sherwood Street, Mansfield)

Inspire Blackburn

ReNew: Criminal Justice Hull

St Helens Integrated Recovery Service

We have inspected Midlands and North Regional Office on two separate occasions. We inspected two services in July 2015 following concerns raised by a whistleblower. We issued two requirement notices, which at the inspection in October 2016; we found the provider had taken the necessary actions to improve the delivery of care and treatment. The services inspected in July 2015 were taken over by another provider soon after our inspection.

The last comprehensive inspection took place in October 2016. We issued two requirement notices in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Our inspection team

The team that inspected the service comprised CQC inspector Zena Rostron (inspection lead), eight other CQC inspectors, one inspection manager, one specialist advisor with experience in delivering substance misuse treatment and one expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

We carried out this inspection to find out whether Midlands and North Regional Office had made improvements to the service since our last focused inspection in October 2016.

We last inspected Midlands and North Regional Office in October 2016. We found two breaches of regulation:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

As a result, we issued two requirement notices and told the provider that they must take the following actions to improve their services:

- The provider must ensure that equipment used for delivering care and treatment is safe to use.
- The provider must ensure that clinical waste is managed safely and stored securely.
- The provider must ensure that medicines are stored safely.

Summary of this inspection

- The provider must ensure that staff identify and mitigate the risks of the spread of infection.
- The provider must ensure that staff keep a complete and contemporaneous care record for each client.

We also told the provider that they should take the following actions to improve their services:

- The provider should ensure that staff follow the provider's policy for dealing with complaints and keep a record of actions taken at all stages of the complaints process.
- The provider should ensure that all staff are up to date with mandatory training and receive an appraisal.
- The provider should ensure that staff disclosure and barring checks are completed in line with the provider's policy.

The provider sent us an action plan detailing the steps they were taking to meet the legal requirements of the regulations. During our focused unannounced inspection in August 2017, we checked for evidence against this action plan and found that the provider had addressed the concerns relating to care records. Whilst some actions had been taken in relation to regulation 12, we found that some concerns had not been fully addressed since our last inspection.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location.

During the unannounced inspection visit, the inspection team:

- visited five sites at this location and looked at the quality of the physical environment
- spoke with 21 clients
- spoke with one registered manager
- spoke with 33 other staff members employed by the service provider, including team managers, recovery co-ordinators, key workers, nurses, safeguarding leads and volunteers.
- looked at 38 care and treatment records for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 21 clients during our inspection. Clients at Mansfield did not wish to share their experiences with us. Overall, clients we spoke to were positive about the care and treatment they received. Clients told us that staff were polite and respectful and were interested in their wellbeing. Clients told us that they felt supported and safe. Generally, clients felt involved in decisions about their treatment and knew how to make a complaint. However, at Hull and St Helens we also received some negative feedback from clients. At Hull, one client told us they were unhappy with the treatment they were receiving and one client told us that the reception staff were not "client friendly". Four clients told us that there was no flexibility in appointment times, two of these clients told us their appointments often ran late. Four clients told us that they were not involved in care decisions and five clients told us they did not know how to make a complaint. At St Helens, one client did not feel involved in their treatment and told us that they avoided a group because of the staff member's attitude. Clients also told us that speaking to staff with lived experience of substance misuse was inspiring.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Clinical waste was not managed safely at Hull and Mansfield. This meant there was a risk of needle-stick injury and infection to clients, staff and visitors.
- Equipment at Manchester was not safe to use. We found two bodily fluids kits that included items that were out of date and one kit that was not dated. We also found three boxes of needles that were out of date.
- Medicines were not stored safely or securely. Staff did not follow the provider's policy on the storage of emergency medication. At St Helens, we found prescribed dressings in a cupboard with no record of when they were received or had been used. At St Helens, there was no medicines bin on site. At Mansfield, St Helens and Manchester, we found omissions to fridge and room temperature checks.
- The clinical hand washbasins at Mansfield and Hull were not compliant with the Department of Health guidance on infection control in the clinical environment. Staff had not completed a risk assessment to identify the risk of the spread of infection nor had actions been identified to mitigate the potential risks.
- Staff were not appropriately recording risks to clients. Out of 38 records, 15 did not include a risk management plan and seven risk management plans had not been updated since 2016. This meant that there was a potential risk of harm to clients.
- Although training figures showed that not all staff were up to date with mandatory training, we found staff were knowledgeable. Not all staff had received an appraisal.
- Staff were not following the provider's policy for pre-employment checks. Not all staff had a valid disclosure and barring service check or risk assessment in place where there was no disclosure and barring service check.

However, we also found the following areas of good practice:

- Since our last inspection in October 2016, staff at Blackburn had reviewed and improved the management of clinical waste.
- Staff were knowledgeable about identifying safeguarding concerns and made referrals when needed.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Staff could not be certain that they were meeting all clients' needs and achieving their preferences. 16 recovery plans were not holistic and did not reflect all of the client's needs, 20 did not include client views and 21 were not recovery orientated.

Are services caring?

Since our last inspection, we have received no information that would cause us to re-inspect this key question.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff knew how to handle complaints and records showed that complaints were processed in line with the provider's policy. Since our last inspection, the recording of complaints had been improved.

However, we also found the following issues that the service provider needs to improve:

- Some clients did not know how to complain.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Monitoring systems in place were not effective in ensuring that the registered managers and the service managers had complete oversight of mandatory training, appraisals and disclosure and barring checks.
- Although some improvements had been made to issues identified at the last inspection, these improvements had not been made at all sites.
- Audit findings were not always acted upon.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the use of the Mental Capacity Act at this inspection.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

At all services, there were arrangements in place for the collection and disposal of clinical waste. We found that clinical waste was managed safely at all services apart from Hull and Mansfield. At Hull, there were two sharps bins that were full and closed but not clearly labelled with a date to indicate when the sharps bins had been opened, nor when closed or disposed of. At Mansfield, the large clinical waste bin stored in the car park was not secured to the wall. This meant there was a risk of needle-stick injuries and infection to clients, visitors and staff at Hull and Mansfield, as the clinical waste was not managed safely. At Blackburn, staff had moved the large clinical waste bin, which was stored in the accessible toilet at our inspection in October 2016, to a secure yard outside of the building and secured the locked bin to the wall.

At St Helens, there were no medicines waste bins on site. This had been identified in the clinical site audits for May 2017, June 2017 and July 2017, however there was no evidence that staff had acted on the results of the audit. This meant that medicines could not be disposed of safely.

At Manchester, there were two kits that were used to clean up bodily fluids that included items that were out of date and one kit that was not dated. We also found three boxes of needles in the stock cupboard that were out of date, two boxes were dated December 2016 and one box was dated May 2017. Staff regularly completed clinical site audits, however the audits had failed to identify the out of date equipment. This meant that staff could not be certain that equipment was safe to use and the audit was ineffective.

All services stocked emergency medicines. At Mansfield, St Helens, Hull and Blackburn staff were not following the provider's policy on the storage of emergency medicines. The provider's policy on the storage of emergency medicines stated "Emergency medication should be stored in a sealed, tamper-evident clear bag with the contents, expiry date and batch number clearly recorded on the outside." At Mansfield and St Helens, Naloxone was stored in the emergency 'grab bag'. At Hull and Blackburn, Naloxone was stored in the reception area. At Manchester, Naloxone was stored in a clear tamper evident bag, which was hung on the wall in the clinic room. This medication was used to treat an opioid overdose in an emergency. Services also stocked Naloxone to issue to clients to take home for use in an emergency. At Manchester, we found a discrepancy between the number of Naloxone kits present and the number recorded as present. There were 13 Naloxone kits present and 14 recorded. Staff told us that they would ask other staff members if they had issued a Naloxone kit, however initial actions by staff did not include completing an incident form to report the missing medication.

At St Helens, we found prescribed dressings locked in a cupboard. Staff told us that some clients brought in their own dressings and some dressings were delivered by pharmacy. There was no system to record when the dressings were received and when they were used. The dressings were not included in the monthly clinical site audit. This meant that staff could not be certain that the dressings were safe to use and they were not stored safely.

Staff carried out temperature checks of fridges that were used to store medication. At Mansfield, we found one occasion in July 2017 when the fridge temperature had not been recorded. At St Helens, there was one occasion in June 2017 when the fridge temperature had not been recorded. Staff also carried out room temperature checks. At Mansfield, there were nine occasions between May 2017 and July 2017 when the room temperature had not been recorded. At Manchester, there were two occasions in June 2017 and four occasions in July 2017 when the room

temperature had not been recorded. This meant that staff could not be certain that medicines were stored safely. At Blackburn and Hull, we saw good practice in relation to the transportation of vaccines to ensure that they were stored according to the manufacturer's recommended temperature range.

Staff adhered to infection control principles and there were hand-washing posters displayed and hand sanitiser available at all of the services we visited. At Hull and Mansfield, the clinical wash hand basins were not compliant with the Health Building Note 00-09: infection control in the built environment. At Hull, three out of four clinical hand washbasins did not have non-touch taps. Staff told us that the main clinic room they used had a sink that met the required standards; however, staff also told us that the other clinic rooms were used for health care assessments and were occasionally used for blood screenings. At Mansfield, the clinical hand washbasin in the clinic room had an overflow, a plug and did not have non-touch taps. Staff had not completed a risk assessment to identify the risk of the spread of infection nor had actions been identified to mitigate the potential risks. At Manchester, a new sink had been installed that met the required standards, following our inspection in October 2016.

Safe staffing

Staff were not up to date with mandatory training. During our inspection visit, the registered manager was unable to explain levels of mandatory training. Data we received following our inspection visit detailed the compliance rate as of August 2017 for the five services that we visited.

Data protection and information security awareness (e-learning) ranged from 58% to 100%

Introduction to equality and diversity (e-learning) ranged from 4% to 68%

Introduction to equality and diversity (video) ranged from 4% to 70%

Introduction to health and safety (e-learning) ranged from 42% to 75%

Staff induction workshop ranged from 38% to 74%

Assessment and planning ranged from 5% to 82%

Mental capacity act – module 1 ranged from 24% to 89%

Mental capacity act – module 2 ranged from 24% to 89%

Motivational interviewing ranged from 21% to 53%

Safeguarding adults (classroom) ranged from 48% to 71%

Safeguarding adults (e-learning) ranged from 57% to 91%

Safeguarding children (classroom) ranged from 43% to 76%

Safeguarding children (e-learning) ranged from 65% to 91%

At Blackburn, seven of the 13 mandatory training courses were above 75% compliance. At Hull, only three of the 13 mandatory training courses were above 75% compliance. At Manchester, only one of the 13 mandatory training courses was above 75% compliance. At Mansfield, only two of the 13 mandatory training courses were above 75% compliance. At St Helens, only three of the 13 mandatory training courses were above 75% compliance.

In April 2017, the provider had completed a learning needs analysis, which identified the training needs of staff and the number of training courses required to meet those needs. Following our inspection in August 2017, the provider had carried out a further update to mandatory training progress, which detailed revised training requirements.

We were advised that all managers of services had reviewed their understanding of the electronic system and had completed an online refresher to allow them to make regular checks of mandatory training compliance. During our inspection visits, we requested to see mandatory training compliance rates on site. At Mansfield, St Helens and Blackburn we were unable to view records of mandatory training and staff told us that this information would have to be requested centrally. At Hull and Manchester, managers were able to provide an overview of mandatory training compliance.

Staff were aware of the provider's policy on disclosure and barring service checks. Service managers used a tracker to check when renewals were required and recorded the disclosure and barring check number. The registered manager provided data on the day of our inspection relating to disclosure and barring service checks. Out of 984 staff, excluding volunteers, 12 staff did not have a valid check in place and 39 staff had applied for a renewal. The registered manager was not certain about the plans in place relating to the tasks that the staff without a valid check could and could not carryout. The registered manager told us that the plan would be individual for each

paid member of staff dependent on the risk; however, volunteers would not commence work until the check was completed. We requested further information relating to disclosure and barring checks, which we received after our inspection visit. Data showed that 21 members of staff did not have a valid check; six of these checks had expired between 2012 and 2015. There were 13 staff who had applied for a renewal. Data showed that 23 volunteers had applied for a disclosure and barring service check and three volunteers required a renewal.

The data we received indicated that there were 29 risk assessments for staff and volunteers who did not have a valid check in place. We asked for a copy of these risk assessments following our inspection, we only received 12 risk assessments for staff without a valid check. Of the risk assessments that we received, nine had been completed after our inspection visit, between 9 August 2017 and 15 August 2017. This meant that at the time of our site visit out of 21 staff without a valid check, there were only three members of staff that had a risk assessment completed. The provider could not be assured that all staff working within services were suitable to do so.

Assessing and managing risk to clients and staff

Since February 2017, we received 83 statutory notifications to inform us of the death of a client. Since February 2017, we have reviewed 20 death investigation reports, of these reports 15 identified issues relating to risk assessment and management. Some of the issues included no risk management plan, staff not following the suicide toolkit and risk not clearly documented. As a result of this, we reviewed the assessment and management of risk during our inspection visit.

We reviewed 38 care records during our inspection. Out of 38 records, seven had no risk assessment document within the electronic care record, eight risk assessments had not been updated since August 2016 and one risk assessment had not been updated since 2015. Out of 38 records, 15 did not include a risk management plan and seven risk management plans had not been updated since 2016. Staff were not using a standardised document to assess and manage risks. In some records, risk was recorded on the basic client detail page which was a tick box list with no further detail, other records contained an uploaded document which was blank and other records included a risk review tool which detailed the risk however did not detail how the risks were being managed. This meant that there was a potential risk of harm to clients, as staff were not recording risks appropriately.

We requested the risk assessment and management policy as part of our inspection. The provider advised us that the policy that incorporated risk assessment and risk management, was still in development. However, we were provided with the draft policy and a copy of the quality standards used for risk and recovery planning. The draft policy set out the principles of risk assessment and management and the responsibilities of staff. Some information relating to the procedure of risk assessment and management was included, however the policy had not been finalised.

Staff received training in safeguarding adults and safeguarding children. The average training rate for safeguarding adults ranged between 53% and 77% and ranged between 57% and 75% for safeguarding children. During the registered manager interview, they told us that level three safeguarding training was required for all team managers; however, this was difficult to access from the local authority. After our inspection visit, we were advised that the provider's safeguarding mandatory training course was aligned to level three of the national occupation standards. Staff were knowledgeable about identifying safeguarding concerns and knew who to contact for advice within the organisation. At each service, a safeguarding lead was available to discuss any safeguarding concerns with staff. We found good communication with local authorities and GPs in relation to safeguarding. Records showed that staff made appropriate safeguarding referrals when needed.

Are substance misuse services effective? (for example, treatment is effective)

Assessment of needs and planning of care

We reviewed 38 care records during our inspection. Of these records, 28 included a recovery plan, three of which had not been updated since 2016. Records showed that 16 recovery plans were not holistic and did not reflect all of the client's needs, 20 did not include client views and 21 were not recovery orientated. Of the 21 clients, we spoke to, four clients at Hull and one at St Helens told us they were not involved in decisions about their treatment. This

meant that staff could not be certain that they were meeting all clients' needs and achieving clients' preferences. The Department of Health guidelines: Drug misuse and dependence (2017) states "Patients should be fully involved in the development of their plans for treatment, care and recovery, in setting appropriate goals and reviewing their progress."

All information needed to deliver care was stored securely and available to staff when needed. Since our inspection in October 2016, the provider had taken action to ensure that clients' care records were complete and contemporaneous. Care records were electronic and there were no separate paper records, apart from at St Helens. The reason that St Helens held paper records in addition to an electronic record was because this service was working through their implementation plan as a new service that the provider had taken over in February 2016.

Skilled staff to deliver care

Not all staff had received an appraisal. The percentage of non-medical staff that had received an appraisal in the last twelve months (August 2016 to August 2017) was 20% for Midlands and North Regional Office. For the sites that we visited as part of our inspection the appraisal rate was:

Blackburn 14%

Hull 8%

Manchester 11%

Mansfield 21%

St Helens 33%

The registered manager told us that appraisals were not fully captured on the electronic system used to record appraisals and as a result, the data provided was under-reported. We were advised that a new appraisal system would be implemented from October 2017.

Are substance misuse services caring?

Since our last inspection, we have received no information that would cause us to re-inspect this key question.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Listening to and learning from concerns and complaints

Data provided to us after our inspection visit indicated the number of formal complaints and compliments received by the provider in the past 12 months as of August 2017.

Midlands and North Regional Office

Total number of compliments received in the last 12 months 316

Total number of complaints received in the last 12 months 174

Total number of complaints upheld 76

Blackburn

Total number of compliments received in the last 12 months 6

Total number of complaints received in the last 12 months 4

Total number of complaints upheld 1

Hull

Total number of compliments received in the last 12 months 19

Total number of complaints received in the last 12 months 11

Total number of complaints upheld 5

Manchester

Total number of compliments received in the last 12 months 12

Total number of complaints received in the last 12 months 8

Total number of complaints upheld 3

Mansfield

Total number of compliments received in the last 12 months 14

Total number of complaints received in the last 12 months 13

Substance misuse services

Total number of complaints upheld 7

St Helens

Total number of compliments received in the last 12 months 6

Total number of complaints received in the last 12 months 19

Total number of complaints upheld 9

There were no complaints that had been referred to the independent ombudsman.

Overall, clients told us that they knew how to complain but had no reason to make a complaint. However, at Hull five out of seven clients we spoke with told us they did not know how to make a complaint. At all services, staff knew how to handle complaints appropriately. Staff were aware of the complaints process and how to record a complaint once received. Staff told us that they received feedback from the outcome of investigations of complaints during team meetings and supervision. We reviewed the last three months team meeting minutes for each service we visited. We found that staff discussed complaints and lessons learned at team meetings at all services apart from St Helens and Hull. At these services, complaints were not a standard agenda item.

Since our inspection in October 2016, the recording of complaints had been reviewed and all complaints were recorded electronically. At some services, alerts were sent when each stage of the complaint was approaching or was overdue, including acknowledgement, investigation and outcome. At other services, this remained the responsibility of staff to ensure each stage was completed in line with the provider's policy. Overall, we found that complaints were handled appropriately.

Are substance misuse services well-led?

Good governance

Monitoring systems in place were not effective in ensuring that the registered managers and the service managers had complete oversight of mandatory training, appraisals and disclosure and barring checks. The registered manager told us that they gathered this information from service managers during supervision and asked for reports. The registered manager was unable to ascertain the level of compliance for mandatory training and appraisals and was unable provide data on the day of our inspection. The electronic system used to record mandatory training and appraisals only allowed access to data for staff that were supervised by the staff member accessing the system. This meant that service managers and the registered managers had to request the information from supervisors within services as the system did not provide local or central oversight. The registered manager told us that the system had capacity to provide information on the status of training, appraisals and disclosure and barring checks. However, the registered managers were not receiving this information routinely and there was no formal process in place to monitor compliance.

We reviewed the regional quality improvement plans for this location. We found that themes were identified from death investigation reports, however we found differing approaches and the plans did not address all of the identified themes. For example, for addressing missed appointments the north west services plan had a different strategy to the north east services plan. It was also unclear in the north west how information was escalated to ensure that the registered manager had good oversight. Records showed that the registered manager had good oversight of the north east regional quality improvement plan that detailed staff involvement and oversight of local service quality improvement plans.

We requested service quality improvement audits for the services that we visited. These audits reviewed quality standards for assessment, risk and recovery planning, case records, safeguarding governance and supervision. St Helens had not completed the audits as the service was focusing on the implementation plan and audits would commence after six months. At Hull, 16 out of 35 audits were completed. Not all audits were completed as planned due to the transfer of a new service. At Mansfield/ Nottinghamshire 76 out of 119 audits were completed. Not all audits were completed as the service was a pilot site for a new care records system and the audit did not mirror the pilot.

There were a number of quality standards for each audit completed. Some of the quality standards for risk and recovery planning included each client had a recovery plan; the plan had been reviewed in the last month and included client strengths, needs and risks. Case records standards included a clear record, details of adults and

children at risk, details of client wishes and records of missed appointments. Safeguarding standards included staff and volunteers completed a disclosure and barring service check before conducting one to one work with clients, staff completed safeguarding e-learning training within four weeks of commencing their role and evidence of discussion of safeguarding concerns and actions taken.

At Hull, there was 25% compliance with case records quality standards. At Mansfield, compliance rates were 84% for assessment, 68% for risk and recovery planning, 87% for case records and 59% for supervision. At Blackburn, compliance rates were 88% for assessment, 72% for risk and recovery planning, 72% for case records, 95% for safeguarding and 96% for supervision. At Manchester, compliance rates were 75% for assessment, 57% for risk and recovery planning, 68% for safeguarding and 51% for supervision. Areas for improvement were identified and were fed into each service quality improvement plan.

We reviewed actions the provider had taken with regard to the requirement notices issued at the inspection in October 2016. For regulation 17 good governance, the provider detailed two dates to meet the requirements of the regulation, July 2017 and December 2017. The registered manager was aware that we did not agree an extension to the action plan. The action plan detailed that all documents had been uploaded onto the electronic care records system by July 2017. Further work was being carried out in relation to risk management plans and recovery plans on the electronic records system, which had a completion date of December 2017. For regulation 12 safe care and treatment, the initial actions were to address the issues identified and cascade to all service managers. We asked the provider to describe the assurance process that they used to ensure the requirement notices issued at the last inspection had been met. The registered manager told us that they believed regulation 12 had been met by 10 February 2017. We reviewed minutes of regional management team meetings and found that there were no appropriate discussions relating to CQC action plans or checks taking place relating to compliance.

We found that the governance arrangements in place for this location were not sufficient to provide assurance to the registered managers or provider for the location. The location oversaw 47 sites. We found that issues identified at the last inspection regarding waste, equipment, medicines and sinks had generally been addressed in the sites where they were identified, but these issues had not been identified and addressed at all the sites that sit under this registered location. When following up incidents, the provider had struggled to provide information about training rates for the location. This was also an issue at this inspection. Provider policies were not being followed for renewal of disclosure and barring scheme checks and completing risk assessments when checks were expired or not in place prior to staff starting work. Staff were also not following provider policies for emergency medicine storage and disposal of medicines. We found that audit findings were repeated and no action had been taken.

Prior to our inspection, we had engaged with the provider about concerns relating to accessing requested information and reporting of incidents and safeguarding. The provider had responded positively and identified that the way the service was registered was presenting challenges. The provider had told us they planned to increase the number of locations registered.

During our inspection, we reviewed the provider's plans to change the way the services were registered with CQC. The plans included registering seven locations across the north west and north east of England. The provider planned to have fewer services that were registered under one location, the plans we reviewed included no more than five services under one registered location.

The location was now reporting safeguarding and incidents to CQC in line with the Regulations.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff create a recovery plan with clients that includes and reflects client preferences and meets their needs.
- The provider must ensure that clinical waste is managed in line with Department of Health guidance.
- The provider must ensure that equipment used for delivering care and treatment is safe to use.
- The provider must ensure that medicines are stored and disposed of safely and securely.
- The provider must ensure that staff identify and mitigate the risks of the spread of infection.
- The provider must ensure that risks to clients are recorded appropriately.
- The provider must ensure that monitoring systems in place are effective in monitoring and improving the quality and safety of the services provided.

Action the provider SHOULD take to improve

- The provider should ensure that all clients are aware of how to complain.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met** Staff did not record all clients' needs or preferences within care records. Records did not always contain recovery plans. Recovery plans were not always recovery orientated and were not holistic. Client views were not always included in recovery plans. This was a breach of Regulation 9 (2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** Staff did not manage clinical waste appropriately at Hull and Mansfield. At Manchester, we found equipment that was out of date or not dated. We found that medicines were not stored or disposed of safely or securely. At Hull and Mansfield, the clinical wash hand basin in the clinic room was not compliant with the Health Building Note 00-09: infection control in the built environment. Staff had not completed a risk assessment to identify the risk of the spread of infection nor had actions been identified to mitigate the potential risks.

This section is primarily information for the provider

Requirement notices

Staff were not appropriately recording risks to clients. This meant that there was a potential risk of harm to clients.

This was a breach of Regulation 12 (2) (b)(e)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** The provider had not addressed all concerns identified at our last inspection. Monitoring systems in place were not effective in ensuring the safe storage of prescribed dressings. Monitoring systems in place were not effective in ensuring that the registered managers and the service managers had complete oversight of mandatory training, appraisals and disclosure and barring service checks: • Not all staff had received an appraisal. • Staff were not up to date with mandatory training. • Staff were not following the policy for pre-employment checks. The provider did not always act upon the outcomes of audits in order to improve clinical effectiveness. This was a breach of Regulation 17 (1)