# CGL Norfolk Alcohol and Drug Behavioural Change Service

## Quality Report

5 Barton Way
Norwich
Norfolk
NR1 1DL
Tel: 01603 514096
Website: www.changegrowlive.org

Date of inspection visit: 09 -12 July 2019
Date of publication: 12/09/2019

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

### 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.

## Overall summary

We rated CGL Norfolk as requires improvement overall because:

- Information relating to the safety of clients was not always comprehensive or timely. During the inspection we found risk assessments for clients that were out of date and not reviewed following an incident. Not all records contained GP summaries and there was a lack of crisis plans throughout. Care plans lacked detail. Overarching recovery goals were not routinely documented and did not reflect discussions held with the client. There was a lack of discharge planning and clients' plans did not always address the potential risks of early exit from the programme.
- The service did not keep a safeguarding log. Therefore, managers were not able to review outcomes and did not have oversight of reporting.
- Staff compliance with basic life support skills was 19%.
- Staff had not received an annual appraisal of their work performance.

# Summary of findings

- We found some incidents reported had passed the timeframe for review by managers of the service.
- The provider did not always have governance systems in place to effectively manage the service. Governance policies, procedures and protocols were regularly reviewed and improved to ensure the service delivered safe, good quality interventions in line with national best practice. however, these were not fully embedded.

However:

- The service had robust health and safety systems in place to manage the safety of the environment. All areas at the services were clean and well maintained. Clinic rooms, testing rooms and needle exchanges were well stocked and were kept locked when not in use.
- Staff held daily flash meetings where all staff engaged in detailed discussion of client risks. Where appropriate these risks were shared with relevant stakeholders. Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing.
- Staff completed an initial assessment for clients in a timely manner and the care plan identified the person's recovery worker. The service ensured multidisciplinary input into people's initial assessments and staff provided a range of care and treatment interventions suitable for the client group.
- Staff were open and welcoming to all who attended. Clients were able to drop in to the service and staff would see them. Staff would offer responsive and emotional support. Staff talked about clients with compassion and respect.
- Clients we spoke with told us that staff were always available and they received positive support. Clients felt safe and said that staff were caring and welcoming. Staff enabled families and carers to give feedback on the service they received.
- The service was able to see clients who were urgently referred quickly. There was a system in place to ensure priority cases were given the earliest appointment available. Those people discharged from hospital were also made a priority and seen quickly. The service had alternative care pathways and referral systems in place for people whose needs could not be met by the service.
- Staff demonstrated an understanding of the potential issues facing vulnerable groups. Staff at the service promoted equality and diversity, this included lesbian gay bisexual transgender+ and black and minority ethnic groups. Staff were passionate in this area and were involved in events in the local community to support this.
- 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. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Community-based substance misuse services | Requires improvement  | |

# Summary of findings

## Contents

Requires improvement

# CGL Norfolk

**Services we looked at**
Community-based substance misuse services;

# Summary of this inspection

## Background to CGL Norfolk Alcohol and Drug Behavioural Change Service

Change Grow Live Norfolk 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 April 2018 from the previous provider.

Change Grow Live Norfolk operates a hub and spoke model. The Norfolk services are across four bases, the main base being Norwich and three further hubs at Great Yarmouth, Kings Lynn and Thetford. Satellite sites are strategically planned to maximise the geographical region where the service is provided and 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, hepatitis C treatment and counselling. Complementary therapies, such as mindfulness, are also provided. Change Grow Live Norfolk offers hospital liaison, 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, complex needs team and engagement and rapid recovery, hospital liaison, and safeguarding of vulnerable adults' team.

Change Grow Live Norfolk 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.

## Our inspection team

The team that inspected the service comprised three CQC inspectors and a specialist advisor nurse.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients.

During the inspection visit, the inspection team:

- visited all four hubs for this service, looked at the quality of the environment and observed how staff were caring for clients
- spoke with 15 clients who were using the service

# Summary of this inspection

- spoke with the registered manager and the managers for each of the hubs
- spoke with 21 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker
- attended and observed two hand-over meetings, one team meeting and one welcome meeting
- looked at 26 care and treatment records of clients
- carried out a specific check of the medication management and clinic rooms
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

- Clients told us that staff were always available and they received positive support. They said that the service was always clean and easily accessible. Clients felt safe and said that staff were caring and welcoming. However, one client was not clear about the discharge process and found getting out of hours support difficult at times.
- Clients we spoke with said they had a recovery plan and risk management plan in place and could give examples of their preferences and goals. However, this was not always evident or well documented in the care plan.
- Clients we spoke with knew how to complain and felt they would be supported if they wished to raise a complaint.

# 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?

Requires improvement

We rated safe as requires improvement because:

- We found 10 out of 26 risk assessments were out of date and four risk assessments viewed were not updated following an incident. Only five of those records contained GP summaries and there was a lack of crisis/relapse plans throughout. Care plans did not always address the potential risks to people of early exit from the programme.
- The service did not keep a safeguarding log. Therefore, managers did not review outcomes and there was no oversight of reporting.
- The completion rate for basic life support training for staff was 19%.

However:

- The service had robust health and safety systems in place to manage the safety of the environment. The provider had completed a basic ligature risk assessment in all four hubs and had put control measures in place to mitigate risk. Fire risk assessments and evacuation tests were up to date.
- All areas at the services were clean and well maintained. Clinic rooms, testing rooms and needle exchanges were well stocked and were kept locked when not in use. All hubs we visited had a daily dedicated cleaning contract in place and cleaning schedules were up to date.
- The service provided detailed and informative harm minimisation advice across all four hubs to clients making them aware of the risks of continued substance misuse.
- Staff held daily flash meetings. All staff engaged in detailed discussion of client risks. Where appropriate, these risks were shared with relevant stakeholders.
- Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing.

### Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care plans lacked details; overarching recovery goals were not routinely documented and did not reflect discussions held with the client.

# Summary of this inspection

- The provider did not deliver or participate in smoking cessation schemes.
- Staff had not received an annual appraisal of their work performance.

However:

- Staff completed an initial assessment for clients in a timely manner and the recovery plan identified the person's recovery worker. Staff provided a range of care and treatment interventions suitable for the client group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.
- The service ensured multidisciplinary input into people's initial assessments. Nurses and recovery workers co located in local hospitals and had effective protocols in place for the shared care of people who use their services.
- Staff supported clients to minimise risks associated with substance misuse. The service offered safe storage for the return of needles and offered safe storage boxes for clients to use at home to safely store their medicines.
- Blood borne virus testing was routinely offered and the provider worked closely with an NHS trust who facilitated hepatitis C clinics.
- Recovery workers reviewed care plans and used recognised recovery tools such as the Severity of Alcohol Dependence Questionnaire, Alcohol Audit and the Treatment Outcomes Profile.

## Are services caring?

Good

We rated caring as good because:

- Staff were open and welcoming to all who attended. clients were able to drop in and someone would see them and offer responsive and practical emotional support. Staff talked about clients with compassion and respect.
- Clients we spoke with told us that staff were always available and they received positive support. Clients felt safe and said that staff were caring and welcoming.
- Staff were able to demonstrate they knew their clients well to meet their individual needs and to manage their care, treatment or condition through group work, interventions, self-help and drop in recovery cafes. Staff directed clients to other services when appropriate and, if required, supported them to access those services.

# Summary of this inspection

- Staff enabled families and carers to give feedback on the service they received. For example, surveys, and suggestion boxes were available in all hubs. We saw outcomes of surveys displayed in reception areas.

## Are services responsive?

Good

We rated responsive as good because:

- The service had alternative care pathways and referral systems in place for people whose needs could not be met by the service. We saw evidence of alternative treatment options being discussed if a person was not able to comply with specific treatment requirements.
- The service was able to see those urgently referred quickly. There was a system in place to ensure priority cases were given the earliest appointment available. Those discharged from hospital were also made a priority and seen quickly.
- Staff demonstrated an understanding of the potential issues facing vulnerable groups. For example, female clients who had experienced domestic abuse, and sex workers, were able to access women-only services.
- Staff at the service promoted equality and diversity, this included lesbian gay bisexual transgender+ and black and minority ethnic groups. Staff were passionate in this area and were involved in events in the local community to support this.
- There was a system in place for finding support and treatment for homeless clients who were sleeping rough in the community.
- The provider's complaints procedure was well advertised at all hubs and complaint forms were easily accessible. Complaints records demonstrated that individual complaints had been responded to in accordance with the provider's complaints policy. We saw evidence that hub managers discussed complaints at team meetings. Staff learned from complaints.

## Are services well-led?

Good

We rated well-led as good because:

- Although some elements require improvement, the overall standard of service provided outweighs those concerns. We have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

# Summary of this inspection

- The registered manager of the service had strategic oversight of all four hubs. Locality managers and team leaders at the hubs felt the manager was visible in the service and accessible to clients and staff.
- 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. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.
- All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. Staff had good understanding of confidentiality and clearly explained to clients the process in place for sharing information and data. The service had confidentiality agreements in place which clearly explained this for clients.
- Clients and carers had the opportunity to give feedback about the service they received. Clients had been present in interview panels for recruiting staff.

However:

- The provider did not always have governance systems in place to effectively manage the service. Governance policies, procedures and protocols were regularly reviewed and improved to ensure the service delivered safe, good quality interventions in line with national best practice. However, these were not fully embedded.
- We found some incident reports had passed the timeframe for review by managers.

# Detailed findings from this inspection

## Mental Health Act responsibilities

The service did not support clients detained under the Mental Health Act.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a policy on the Mental Capacity Act which staff were aware of and could refer to. Staff assumed capacity in line with the Mental Capacity Act.
- Staff ensured clients consented to care and treatment, that this was assessed, and well documented thoroughly in the clients care and treatment records and reviewed in a timely manner.
- The service ensured all staff were provided with Mental Capacity Act training. At the time of inspection, 84% of staff had completed this.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Community-based substance misuse services** | Requires improvement | Requires improvement | Good | Good | Good | Requires improvement |

### Notes

Requires improvement

# Community-based substance misuse services

| | |
|---|---|
| Safe | Requires improvement |
| Effective | Requires improvement |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are community-based substance misuse services safe?

Requires improvement

### Safe and clean environment

### Safety of the facility layout

- 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.
- The service had health and safety systems in place to manage the safety of the environment in all four hubs we visited. This included monthly premises checks and six-monthly health and safety assessments. The provider had recently completed basic ligature risk assessments in all four hubs, these were appropriate to the service provided and any risks identified had been reported for work to take place. The provider had control measures in place to mitigate risk. For example, all clients were escorted in the building and were not left unattended. Fire risk assessments were up to date including checks on equipment such as fire extinguishers. There was an allocated fire marshal at each hub who conducted daily checks. We saw evidence that fire evacuation tests had taken place.
- The provider had closed circuit television in all four hubs to monitor public areas and access to the building where appropriate. Closed circuit television screens were observed throughout the day. All rooms where clients were seen had portable panic alarms and were easily accessible to staff.

### Maintenance, cleanliness and infection control

- All areas at the services we visited were clean and well maintained. Clinic rooms, testing rooms and needle exchanges were well stocked and were kept locked when not in use. All hubs we visited had a daily dedicated cleaning contract in place. Cleaning schedules were completed daily and were up to date in all areas.
- The provider had a facilities service for maintenance issues. Staff were able to raise maintenance issues by completing a maintenance request form. All requests were logged on the database and approved contractors were used to complete the works. We saw an example of this at Thetford where improvements were being carried out to the building during our visit.
- Staff adhered to infection control principles, including hand washing and the disposal of clinical waste. The provider had a contract in place with a clinical waste company who regularly disposed of the waste. All sites had a testing room with a built-in toilet and hand washing facilities for clients.

### Safe staffing

- There were enough skilled staff to meet the needs of clients. The provider employed a total of 95 substantive staff, four volunteers and two peer mentors at the time of inspection. This included a range of health care professionals, for example consultant psychiatrist, non-medical prescribers, nurses, recovery workers, administrative staff and data analysts. At the time of inspection there were vacancies across the four hubs for a cluster lead nurse, a consultant psychiatrist, two health and wellbeing nurses and a “think family worker”.
- The managers at the services planned for staff shortages in advance by booking agency staff to cover vacant

posts. The clinical lead ensured that agency staff used by the service were given an induction and training on processes. The agency staff in place at the service were regular and were familiar with the clients. Workloads were distributed amongst the team to meet the needs of clients. Staff and managers told us that caseloads were high for staff in some areas, particularly the Norwich hub where caseloads were up to 112. Managers told us the aim was to reduce this to 80 once vacancies were filled. The remaining hubs caseloads held varied from 55 up to 80.

- Recruitment was an ongoing process. Vacant posts had been filled and there were staff checks underway for those staff offered a post. In areas where staff had started in post, some caseloads had recently reduced to a more manageable level for staff. Managers told us recruitment could be difficult, so posts were continually advertised.
- When a staff member went on leave they were required to complete a portfolio handover form. This detailed key information such as the service user's risk and planned appointments for continuity of care.
- Managers monitored recovery workers' caseloads. The provider did not use a formal caseload management tool. However, we were told this was regularly reviewed and managers were aware that caseloads in the Norwich hub were high. There were plans in place to reduce these once new staff were in post.

**Mandatory training**

- All staff received mandatory training suitable to their role. The provider set a 75% completion target which was monitored by team leaders and locality managers. During the inspection we found that the staff refresher training for basic life support was below the target at 19%. We raised this as a concern at the time with the service manager. We were told that this training was given to nursing staff only. We saw evidence of training dates booked for the nursing staff who required this refresher. All other mandatory topics were over 84%.
- Staff we spoke with were fully aware of the lone working policy which included the hubs, satellite sites and home visits. New clients not known by staff and those assessed as high risk would be seen by two workers. Staff who worked in the community were provided with a personal panic alarm and a mobile phone.
- At the time of inspection, 86% of staff had completed mandatory health and safety awareness training.

**Assessing and managing risk to patients and staff**

**Assessment of patient/client risk**

- We reviewed 26 client records. We found a difference in the quality of recording in the electronic records of historic clients and clients' records completed since Change Grow Live had taken over the Norfolk services. Historic clients only had the last year of history available. In addition, these clients' risk assessments were poor and missing information. The risk assessments for clients accepted into service since April 2018 were better and had more detail. However, across all those client records reviewed there were still areas which lacked information. There was a lack of crisis plans throughout. The care plans had nowhere for this to be documented. Care plans did not always address the potential risks to people of early exit from the programme. We found 10 out 26 risk assessments out of date and four risk assessments viewed were not updated following an incident. For example, a client had been a victim of domestic violence and the alleged perpetrator also used the service. We found that the victim's risk assessment was fully up to date and appropriate, however, the alleged perpetrator's risk assessment had not been updated. We highlighted the risk assessments that needed to be updated to managers during the inspection and they took action to rectify the problems immediately.

- Out of the 26 records we reviewed, only five had the GP summary for the client uploaded into their electronic records. However, the clients' physical health was assessed during the first assessment. Where physical health issues were identified or if the client was prescribed medication by the service, their physical health was monitored appropriately. Staff identified warning signs and deterioration in people's health. The service had a first and second responder identified daily, and if needed they would support the client to attend the local walk in centre or local accident and emergency department to receive the appropriate support.

**Management of client risk**

- The service provided detailed and informative harm minimisation advice across all four hubs to clients

making them aware of the risks of continued substance misuse. All recovery workers promoted harm reduction and offered support and advice throughout the Norfolk hubs.
- Staff held daily flash meetings across the four 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.
- Staff adhered to best practice in implementing a smoke-free policy across the four hubs.

**Safeguarding**

- Eighty-seven percent of eligible staff had received both safeguarding children and adults training. Staff we spoke with could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with were able to describe the process for making a referral to raise a safeguarding concern. This process was displayed for staff to follow in office areas. Each hub had an identified safeguarding lead.
- Staff worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. We reviewed an example of a professionals meeting held with the client, mental health services, and housing, where concerns and risks were discussed, and a safeguarding referral was made. However, the service did not keep a safeguarding log. Therefore, managers did not review outcomes and there was no oversight of reporting. We raised this with the provider at the time of inspection.
- Staff implemented statutory guidance around protecting vulnerable adults and children. All staff we spoke with were aware of where and how to refer as necessary. The provider employed the staff from Sova this was a separate organisation providing community mentors under a sub-contracting arrangement which then merged with Change Grow Live in March 2019.

**Staff access to essential information**

- The provider used an electronic recording system for client records. The system was easy to use. Recovery workers updated the system regularly after appointments and interventions. The relevant staff had prompt and appropriate access to care records for clients.

**Medicines management**

- The provider had effective policies, procedures and training related to medication and medicines management including prescribing, detoxification, assessing people's tolerance to medication, and take-home medication. Clients who were given naloxone (naloxone is used to reverse the effects of opioids in case of overdose) were trained in its use in case of an emergency.
- Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording and disposal) and did it in line with national guidance.
- Clinical staff regularly reviewed the effects of medicines on client's physical health in line with NICE guidance. Clients had electrocardiogram and blood tests when required and these were documented in line with best practise.
- Clinic rooms were clean and tidy. All equipment was calibrated. Clinic room temperature checks were conducted daily and recorded on the electronic system. Trained staff had access to emergency drugs such as adrenaline and naloxone. The provider did not use automated defibrillators or oxygen. In the event of a medical emergency staff would call 999.

**Track record on safety**

- The service did not have any serious incidents in the 12 months prior to inspection. We reviewed a sample of incidents and did not find any incidents recorded which met the provider's threshold for a serious incident.

**Reporting incidents and learning from when things go wrong**

- All staff we spoke with knew what incidents to report and how to report them. The service used an electronic incident reporting system to log incidents.
- Staff told us they understood their roles and responsibility for reporting incidents and reported incidents in a consistent way.

Requires improvement

# Community-based substance misuse services

- Not all staff we spoke with understood the term duty of candour. However, staff were open and transparent, and gave people using the service and families a full explanation if and when something went wrong.
- We saw evidence that changes had been made as a result of feedback. The quality team looked at the policy for clients who did not attend scheduled appointments at the service. This resulted in a change to policy being made and this was being implemented during our visit.

## Are community-based substance misuse services effective?

(for example, treatment is effective)

Requires improvement

### Assessment of needs and planning of care

- We reviewed 26 care and treatment records and found that staff completed an initial assessment for clients in a timely manner.
- Staff developed care plans. We found these lacked details; overarching recovery goals were not routinely documented and did not reflect discussions held with the client. We found this area of the care plan for historic clients who remained in treatment was blank. The manager stated he was aware of this and efforts had been made to input missing information. However, overall client care and treatment records since April 2018 were better.
- The recovery plan identified the person's recovery co-ordinator.
- Staff did not develop a risk management plan that included unexpected exit from treatment. However, we found exit from treatment was discussed at assessment.

### Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. These included medicines and psychosocial interventions.
- 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. The provider worked closely with an NHS trust who facilitated hepatitis C clinics. Staff told us clinics were effective in supporting and treating clients.
- The provider did not deliver or participate in smoking cessation schemes. However, staff discussed smoking cessation, dietary advice, and how to access dentist and opticians with clients.
- Staff used technology to support clients effectively. For example, access to technology at the hubs and online access to self-help tools which were promoted in all hubs by leaflet and posters.
- The provider supported clients with ambulatory (outpatient) detoxification. Clients who were in stable accommodation and wanted detoxification from substances were supported through this service. The service focused on and prioritised detox and after care. However, the teams were also aware of the process and pathway for residential rehabilitation.

### Monitoring and comparing treatment outcomes

- Recovery workers reviewed care plans with the person using the service. These reviews included the use of recognised recovery tools such as the Severity of Alcohol Dependence Questionnaire, Alcohol Audit and the Treatment Outcomes Profile.
- Managers told us they benchmarked their services against Public Health England treatment outcomes. For example, the service was taking part in the unlinked anonymous monitoring survey of HIV and Hepatitis in people who inject drugs.

### Skilled staff to deliver care

- The service provided all staff with a comprehensive induction plan over a 2-week 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 drug testing principles, needle exchange, assessment processes and workshops. Managers told us staff were expected to complete competency-based assessments. This

assessment helped identify training needs and ensured staff were competent to work with clients. Agency staff used by the service were given an induction and training on processes.

- 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 that there were learning opportunities available within the organisation. These could be accessed on line and staff were also able to request training opportunities and attend training courses. Managers told us they could request for a course to be facilitated at their service if numbers were sufficient, and the organisation would accommodate this to support learning and development within teams.
- Managers ensured that robust recruitment processes were followed. Staff records following completion of recruitment checks were held centrally within the human resources department. During the inspection we were able to review four records of recently recruited staff through the locality manager. Staff had received relevant recruitment checks including a disclosure barring service (DBS), references, interview questions, application forms, eligibility and identification.
- There was a clear supervision structure in place and this was in line with the organisation's policy. Non-medical prescribers attended monthly meetings nationally which included group supervision. Staff said they received regular supervision. We reviewed six supervision records which evidenced this. Staff knew who their supervisor was. However, one member of staff stated they had not had regular supervision.
- Staff appraisals were not taking place for staff at this service. This was confirmed by all staff we interviewed across all four hubs. Appraisals had not been conducted in the last year prior to inspection. We raised this on inspection with the service manager who informed us that the system was under review in the organisation. The mitigation for this was the organisation had submitted a positional statement regarding the appraisal process. We were told a process was in place for staff in the interim. However, all the staff we spoke with did not confirm this arrangement was in place for staff.
- We saw evidence of performance being managed promptly and effectively. Action taken was appropriate and supportive to all those concerned, and confidentiality was maintained throughout.
- Managers recruited volunteers as members of staff within the teams. Staff valued this role as part of their team. Volunteers were supported and there was a robust training policy to ensure volunteers were trained in their roles. The service had a plan to recruit more volunteers in the future.

**Multi-disciplinary and inter-agency team work**

- The service ensured multidisciplinary input into people's initial assessments. For example, community mental health teams (CMHT), GPs, maternity services, children and family services, social workers and criminal justice services. Each hub held a flash meeting daily this meeting was minuted. staff discussed concerns and needs of high-risk cases and clients who had not attended the service and were at risk. The service had in place complex case workers and complex case meetings were held on a need basis. Risks would be discussed, and advice given to recovery coordinators on how to support the client. At the end of each day a debrief would be held to ensure risk were managed and outcomes were documented.
- Care coordinators were clearly identified for all clients. There was evidence that recovery workers worked closely with external agencies. The service had nurses and recovery workers collocated in local hospitals and had effective protocols in place for the shared care of people who use their services. We saw evidence of meetings held with other agencies such as police and housing for particularly risky clients. Complex needs workers attended weekly meetings with mental health teams to promote information sharing. We saw further evidence of collaborative working with the anti-social behaviour action group and regular engagement with probation services.
- Recovery plans included signposting to other supporting services. The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care to meet the needs of different groups.
- We were told that clients' information was shared with relevant supporting services to ensure timely transfers.

Requires improvement

# Community-based substance misuse services

**Good practice in applying the Mental Capacity Act**

- The service had a policy on the Mental Capacity Act which staff were aware of and could refer to. Staff assumed capacity in line with the Mental Capacity Act.
- Staff ensured clients consented to care and treatment, that this was assessed, and well documented thoroughly in the clients care and treatment records and reviewed in a timely manner.
- The service ensured all staff were provided with Mental Capacity Act training. At the time of inspection, 84% of staff had completed this.

## Are community-based substance misuse services caring?

Good

**Kindness, privacy, dignity, respect, compassion and support**

- We observed staff interactions with clients during our visit and the service was open and welcoming to all who attended. Clients were able to drop in and someone would see them and offer responsive and practical emotional support. Staff talked about clients with compassion and respect at all the hubs we visited in the Norfolk services.
- Clients we spoke with told us that staff were always available and they received positive support. Clients felt safe and said that staff were caring and welcoming. However, one client was not clear about discharge process and found getting out of hours support difficult at times.
- Staff were able to demonstrate they knew their clients well and were able to meet their individual needs, and manage their care, treatment or condition through group work, interventions, self help and drop in recovery cafes.
- Staff directed clients to other services when appropriate and, if required, supported them to access those services. For example, local housing, education, employment and charitable organisations. Specialist support for individual situations experienced by clients could be provided in a confidential space.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to clients from other staff without fear of the consequences. Staff we spoke with understood the whistle blowing policy and we saw evidence in a staff meeting where training on this policy had been delivered to staff.
- The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients. A confidentiality and information sharing agreement was in place and stored on the electronic system. All staff were fully aware of this and this was explained and understood by people who used the service.

**Involvement in care**

**Involvement of clients**

- Staff communicated with clients so that they understood their care and treatment, including finding effective ways to communicate with clients with communication difficulties. The provider had access to sign language and interpreters who could attend the service when required. All hubs we visited displayed information about the service in different languages and were aware of specific communities and language barriers within their areas. The Great Yarmouth hub had recognised the need for regular groups for a growing Lithuanian community and worked with another local service to provide this support.
- The service did not promote access to appropriate advocacy for people who used services. Staff we spoke with confirmed this was an area of improvement that needed to be explored.
- Clients we spoke with said they had a recovery plan and risk management plan in place, and could give examples of their preferences, and goals. However, this was not always evident or well documented in the client care and treatment plan.
- Staff engaged with people using the service, their families and carers to develop responses that met their needs and ensure they had information to make informed decisions about their care. The service ran recovery cafes for carers and clients to attend. There was a carer lead for the service providing a link to carers. This member of staff offered support and engagement for family members, which could be a one to one or group basis. The service also had a social media site for

carers and families to access. The cafés provided were well attended and those carers spoken with felt this was a valuable service to meet other carers in the same situation and offer each other peer support.
- During our visit, we observed that staff actively engaged people using the service, and their families and carers where appropriate, in planning their care and treatment.

**Involvement of families and carers**

- Staff enabled families and carers to give feedback on the service they received. For example, surveys, and suggestion boxes were available in all hubs. We saw outcomes of surveys displayed in reception areas.

## Are community-based substance misuse services responsive to people's needs? (for example, to feedback?)

Good

**Access and discharge**

- The service had alternative care pathways and referral systems in place for people whose needs could not be met by the service. For example, where mental health difficulties were impacting on the client, and their addiction, a referral was made to the community mental health team.
- We saw evidence of alternative treatment options being discussed if a person was not able to comply with specific treatment requirements. For example, when clients were attending a chemist to collect a prescription, but not engaging with the service, the service arranged for the prescription to be collected from the local hubs to try and re-engage and offer alternative support and intervention.
- The provider had a clear documented referral and acceptance criteria agreed with relevant services and stakeholders.
- The service had not set a target for time from referral to triage to an initial assessment or from assessment to treatment. The service delivered an open-door policy and those referred were offered a time and date to attend a welcome pod where they would be seen and assessed in a timely manner. Most clients were seen within a five-day period. Once the assessment was completed the client was able to access structured treatment quickly.
- The service was able to see those with an urgent referral quickly. There was a system in place to ensure priority cases were given the earliest appointment available. Those discharged from hospital were also made a priority and seen quickly.

**Discharge and transfers of care**

- We reviewed 26 care and treatment records. Staff could not evidence that they planned for clients' discharge. However, there was evidence of liaison with other agencies for clients, and they were signposted to other agencies and support services to meet their diverse and complex needs. This included a referral pathway for aftercare in the community once treatment had been completed. The hub managers monitored the rates of completion and discharge from the service.
- Staff supported clients during referrals and transfers between services – for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

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

- The service was bright and clean throughout all the hubs. Clients confirmed this and told us hubs were easily accessible.

**Patients' engagement with the wider community**

- Staff encouraged clients to maintain relationships with people that mattered to them, both within the services and the wider community. This was evident during our inspection. We observed clients, carers and family members drop into the service and attend the recovery cafes.
- When appropriate, staff ensured that clients were signposted to education and work support in the community. For example, one client told they were accessing a college course, and this had been supported by the service.

**Meeting the needs of all people who use the service**

- Staff demonstrated an understanding of the potential issues facing vulnerable groups. For example, female

clients who had experienced domestic abuse, and sex workers, were able to access women-only services. During the inspection, we observed there was lots of information available to these vulnerable clients and there had been thought put into how clients could access this information in a confidential manner. For example, support information was displayed in the ladies toilet facilities in addition to the reception area of the hubs.

- Staff at the service promoted equality and diversity, this included for lesbian, gay, bisexual transgender+ and black and minority ethnic groups. Staff were passionate in this area and were involved in events in the local community to support this. There was information and support available for clients from the traveling community. There was clear evidence of information and advice to support groups and projects in the local area.
- There was a system in place for finding homeless clients who were sleeping rough in the community to provide them with support and access to treatment, which encompassed the support of the local business community.
- People using services reported that treatment was rarely cancelled or delayed. Psychosocial Intervention sessions were run regularly. When a staff member went on leave, there was a portfolio handover process in place to ensure clients' timetables and appointments were continued in their absence.

### Listening to and learning from concerns and complaints

- Staff told us they would protect clients who raised concerns or complaints from discrimination and harassment.
- The provider's complaint procedure was well advertised at all hubs and complaint forms easily accessible. Clients we spoke with knew how to complain and felt they would be supported if they wished to raise a complaint. There were suggestion boxes available in all areas and these were easily accessible to clients and carers.
- Complaints records demonstrated that individual complaints had been responded to in accordance with the provider's complaints policy. In total the service had received nine formal complaints and 21 compliments over the 12 months prior to inspection. We reviewed a sample of complaints and found the provider had taken appropriate action.
- We saw evidence that hub managers discussed complaints at team meetings. Staff told us that if there was learning from a complaint, they would be told via meetings and that emails were also sent to their work email address.

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

Good

### Leadership

- The registered manager of the service had strategic oversight of all four hubs. Locality managers and team leaders at the hubs felt the manager was visible in the service and accessible to clients and staff. Those 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 is was understood by all staff.
- 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. For example, the service had a quality improvement plan in place and target dates set for those improvements to be completed by. This was in place as a result of lessons learnt by the service.

### Vision and strategy

- Staff knew and understood the vision and values of the team and organisation and what their role was in achieving that.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, one locality manager told us a 'world café' was held across the north and south of the county to gain staff feedback on the appraisal and supervision process. Feedback from this was cascaded to staff through the intranet system.

Requires improvement

# Community-based substance misuse services

**Culture**

- Most staff we spoke with felt respected, supported and valued by the provider. Staff reported that work related stress was minimal. It was clear that most staff felt a part of the organisation's future direction and saw opportunities for their own personal and professional development. We were told that money had been invested in hubs that needed it. However, there were some staff we spoke with who did not feel this was the case due to their current caseloads.
- Staff appraisals were not taking place for staff at this service. This was confirmed by staff we interviewed across all four hubs. Appraisals had not been conducted in the year prior to inspection. We raised this on inspection with the service manager who informed us that the system was under review in the organisation. The mitigation for this was the organisation had submitted a positional statement regarding the appraisal process. There were interim arrangements in place nationally for staff while this process was underway. However, the staff we spoke with at the Norfolk service were not receiving this. The impact of this was staff were unable to have conversations about career development and how it could be supported.
- The service had a policy in place to support and manage staff who were subject to bullying and harassment. There were no cases of bullying and harassment at the time of inspection.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. For example, team leader training. Staff told us the provider had a range of advanced alcohol training courses, improving engagement and acupuncture that staff could access.
- Teams worked well together and where there were difficulties managers dealt with them appropriately. Managers were open and transparent that there had been some challenges for staff with the process of changing from one service provider to another and recognised that different ways of working and support to transition was still ongoing in some areas. However, the change had become more embedded and in line with the provider's vision and values and staff felt the service was continuously moving forward. There was recognition by managers of the service there was still some work to be done to move forward in this area.

**Governance**

- The provider did not always have governance systems in place to effectively manage the service. Governance policies, procedures and protocols were regularly reviewed and improved to ensure the service delivered safe, good quality interventions in line with national best practice. However, these were not fully embedded.
- We reviewed three months of meeting minutes held across all four hubs. There was a clear framework and agenda of what must be covered, to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. The service ensured that reviews of unexpected deaths of clients were completed in a timely manner. Death mortality reviews were held by the provider at local and national level. The learning identified was cascaded to the staff intranet page for all staff to view. However, there were some incidents which had passed the set timeframe for review by managers of the service.
- The service was running a pilot scheme where staff undertook or participated in local clinical audits. The current audits were yet to be completed and outcomes provided. However, these were underway during our inspection of the service. Staff had a good understanding of their importance in improving service delivery.
- Data and notifications were submitted to external bodies and internal departments as required. For example, referrals were sent to the local authority and the Care Quality Commission.
- Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of clients.
- The service had a whistleblowing policy in place. Staff we spoke with fully understood this and were confident they would use this if required. Managers had delivered training on this policy during a team meeting.

**Management of risk, issues and performance**

- There were clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures.

- Staff maintained, and had access to, the risk register at hub level. We reviewed the risk register for the last six months and found the provider taking appropriate action. Staff were able to submit items to the provider risk register.
- The service had plans for emergencies – for example, adverse weather or a flu outbreak.
- The provider had a business continuity plan in place which was regularly reviewed by the hub managers. The plan detailed actions to be taken during an adverse event. For example, flooding or IT failure.
- Managers had oversight and monitored staff sickness and absence rates. The overall sickness rate for 12 months leading up to the inspection was 4.7%.

**Information management**

- The service used systems to collect data that were not over-burdensome for frontline staff. The service had a data team in place for this. 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.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The provider used staff feedback to improve the electronic recording system.
- Information governance systems-maintained confidentiality of clients' records.
- All staff had access to the right information to fulfil their role. For example, the doctor and nurse medical prescribers had access to the prescription database. Managers had access to information to support them with their role, this included information on the performance of the service, staffing and patient care.
- The service did not keep a safeguarding log. Therefore, managers did not review outcomes and there was no oversight of reporting. However, staff made notifications to external bodies as needed, and this was evidenced on individual clients' electronic records.

**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.
- Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Survey results were displayed in individual hubs. Clients and carers spoken with all felt that they had this opportunity given to them. Clients had been present in interview panels for recruiting staff. This included the registered manager and peer support staff.
- Senior leaders engaged with external stakeholders – such as commissioners through quarterly contract monitoring meetings and monthly quality review meetings.

**Learning, continuous improvement and innovation**

- Examples of innovative practices or involvement were evident across all hubs within the county.
- At Kings Lynn service exit cards had been introduced and the idea shared with the other hubs. This was where the clients on entry to treatment were asked to write to themselves saying what it would be they said to themselves if they exited treatment. This card was then placed in a stored area. If the client was to suddenly exit treatment the card would be sent to encourage their re-engagement into service, using their own words. This was a recent idea by staff and was going to be used across the hubs.
- Staff at Great Yarmouth set up an outreach and engagement service where an email address was set up for local businesses who could use this to inform the service where rough sleepers and homeless clients could be found to continue to engage them in treatment.
- Staff were given the opportunity to visit other substance misuse services to shadow other teams to improve ways of working through sharing ideas.
- At Kings Lynn a newly appointed staff member had contributed to improving the induction process for the provider following their own experience.
- At the Thetford hub one worker had set up a 12-step yoga class for clients to access. We observed clients requesting to access this service.

# Outstanding practice and areas for improvement

## Outstanding practice

- Staff at Great Yarmouth set up an outreach and engagement service at the hub and after being supported by the provider to visit other services the staff returned to look at what innovative ideas they could come up with to meet the need of local population and engage with the community. The staff set up an email address which was for local businesses to use when they found rough sleepers and homeless clients in their shop doorways. The businesses could use this to inform the Great Yarmouth hub of their location. This meant that staff considered people's individual needs and were flexible and delivered a tailored service. The outreach and engagement workers went out daily to engage rough sleepers and homeless clients and keep them actively in treatment. This was an outstanding practise and good example of a substance misuse service engaging with the community and building relationships through the local business, who were integral in ensuring the service met those people's needs.

## Areas for improvement

### Action the provider MUST take to improve

- The provider must review risk assessments regularly and update these following an incident. Risk assessments should include plans for managing risks.
- The provider must ensure that safeguarding referrals are logged to have the right level of scrutiny and oversight.
- The provider must ensure staff receive regular appraisal of their performance in their role.

### Action the provider SHOULD take to improve

- The provider should ensure that client care plans reflect the discussions and are personalised and include clients' own goals.
- The provider should ensure risk management plans document potential risks from early exit from treatment.
- The provider should ensure that care plans include discharge planning.
- The provider should ensure that GP summaries are uploaded to care and treatment records.
- The provider should ensure that mandatory training compliance rates are met.
- The provider should ensure reviews of incidents are completed within the set timeframes.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider had not ensured risk assessments were reviewed regularly and updated following an incident.<br><br>The provider had not ensured risk assessments included plans for managing risks.<br><br>This was a breach of regulation 12 (2) (a) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance<br><br>The provider had not ensured that safeguarding referrals were logged to have the right level of scrutiny and oversight.<br><br>This was a breach of regulation 17 (1) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing |

This section is primarily information for the provider

# Requirement notices

The provider had not ensured staff received regular appraisal of their performance in their role.

The was a breach of regulation 18 (2) (a)