Change, Grow, Live

Bromley Drug and Alcohol Service

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated it as good because:

- The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. They responded promptly to sudden deterioration in clients' physical and mental health. Staff assessed and managed risk and followed good practice with respect to safeguarding.
- The service provided safe care. The premises where clients were seen were safe and clean, well equipped and fit for purpose. The service had appropriate COVID-19 measures in place. The service managed client safety incidents well.
- Managers investigated incidents and shared lessons learned with the whole team. The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health
- Staff developed care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. They ensured that clients had access to physical healthcare and supported clients to live healthier lives.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients, including those with protected characteristics. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet. The service treated concerns and complaints seriously, investigated them and learned lessons from the results.
- The service was well led. Leaders had the skills, knowledge and experience to perform their roles, and were visible in the service and approachable for clients and staff.

However:

- Risk mitigation plans were not found in seven client records, although staff were able to explain how they managed client risks.
- Staff were unaware of how to access ligature cutters in the event of an emergency.
- Care plans could be further improved by ensuring that long term recovery goals were listed.
- Governance processes could be further improved, some key documents were kept up-to-date in an ad-hoc manner, rather than being systematically reviewed and there had been some slippage with the medicines policies reviews.
- Staff compliance with the assessment audit, case record audit and risk and recovery planning was low and one audit had not been completed for the prescription and controlled drug stationery.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Bromley Drug and Alcohol Service

Bromley Drug and Alcohol service is part of the national provider Change Grow Live who deliver a not-for-profit drug and alcohol treatment service. The service provides specialist community treatment and support for adults and young people affected by substance misuse who live in Bromley.

Bromley Drug and Alcohol service offers a range of services including, initial advice, assessment and harm reduction services; prescribed medicines for alcohol and opiate detoxification and stabilisation; naloxone dispensing; group recovery programmes; one-to-one key working sessions; counselling; health and blood borne virus checks and hepatitis C testing. CGL Bromley also provides an outreach service to engage certain groups through a criminal justice team and a young person's service. The young person's team provided advice and support to clients aged 5 and above and their families impacted by substance misuse.

This was the first inspection of this location, which has been running an integrated substance misuse service in Bromley since 1 December 2018. During this time, the service has established partnerships with health and social care, probation services, GPs and pharmacies to provide help and support to clients within the London Borough of Bromley. At the time of our inspection, the service had 11 recovery coordinators, two team leaders, one admin staff, one data lead, one volunteer and peer mentor Lead, one quality and safeguarding lead, four clinical staff and one service manager.

The service received most of its funding from the local authority and the Office for Health Improvement and Disparities and had recently received funding for four new roles; one recovery co-ordinator, one health care assistant, one data administrator and one recovery motivator.

The service is registered for the following regulated activity:

• Treatment of disease, disorder or injury.

At the time of inspection there was a registered manager in place who was due to leave the service and the new service manager was in the process of becoming the new registered manager.

What people who use the service say

Clients told us that staff were kind, caring, non-judgemental and genuinely interested in their wellbeing and recovery.

One client commented that 'after initial assessment it was a relief to find a place where you were heard, understood and not alone.'

A recently discharged client said that 'staff had treated me with compassion and sympathy and their support and treatment had been life changing.'

The service adapted its contact with clients during the restrictions of the Covid-19 pandemic and facilitated virtual and telephone contact, to ensure that clients still received therapeutic interventions, including counselling. Clients told us that they felt supported during the pandemic and they received advice from staff about their care and treatment, including access to virtual support sessions.

Summary of this inspection

How we carried out this inspection

This inspection was carried out by two inspectors and a specialist professional advisor with expertise and experience in delivering substance misuse services also attended.

This inspection involved a one-day site visit and was followed up by interviews with staff and clients carried out by video calls.

During this inspection, the inspection team:

• visited the service and observed the environment and how staff were caring for clients

• spoke with the registered manager

• spoke with 11 staff, including the service manager, consultant, team leaders, recovery practitioners and registered nurses.

• spoke with six clients

• reviewed seven clients' care and treatment records

• observed a criminal justice alcohol treatment requirement (ATR) group

• reviewed prescribing and the medicines prescription process

• reviewed other documents concerning the operation of the service.

You can find information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service had formed a partnership with a gym in the local area to provide ten free gym passes to help improve the physical wellbeing of clients.
- As of July 2022, 100% of clients had been offered a test for hepatitis C, 75% of clients identified as having Hepatitis C had started to receive treatment.
- The service was the first CGL to receive an external trauma informed care evaluation conducted by an independent psychologist, which identified a number of recommendations to improve the service. Staff subsequently received levels one and two of trauma-informed training.

Summary of this inspection

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that mitigations against identified risks are always recorded in the electronic record system.
- The service should ensure that governance processes include regular review of key documents that need to be kept up-to-date.
- The service should ensure that long term goals are listed in client recovery care plans.
- The service should ensure that staff compliance with audits is improved.
- The service should ensure that all staff know the location of, and how to use, the ligature cutters.
- The service should ensure that accessible information is easily available for clients when required.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Substance misuse services

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

Are Substance misuse services safe?

Good

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, furnished, maintained and fit for purpose, however some small improvements were needed to make the environment safer.

During the inspection we identified some improvements that needed to be made to the environment. In one of the group rooms there was some exposed wiring, managers took immediate action to rectify this by covering up the wires whilst they arranged for their removal. One fire extinguisher was on the floor due to a loose bracket and one fire blanket was not attached to the kitchen wall. Managers took action to rectify this by ensuring they were firmly affixed to the wall. There was one broken chair in the clients' waiting room which had not been removed; managers immediately arranged for the removal of this chair during our visit.

Managers completed a monthly and bi-annual health and safety audit, which included a check on the environment, although these issues had not been identified during any of these checks.

The premises had assigned fire wardens, an up-to-date fire risk assessment and fire alarms were tested weekly. Equipment had received up-to-date portable appliance testing (PAT). All interview rooms had panic alarms and staff available to respond. Staff tested alarms on a weekly basis.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. Staff made sure equipment was well maintained, calibrated, clean and in working order and completed daily checks, including the room temperature. During our visit staff informed us that there were no ligature cutters accessible within the service, managers immediately rectified this by producing the ligature cutters held within the service.

Clinical and confidential waste was disposed of, however, we noticed that there was one waste bin overflowing in the garden area, managers immediately followed this up with the external service responsible for this.

Staff made sure cleaning records were up-to-date and the premises were clean. The premises were cleaned daily and there was 93% compliance with the latest cleaning audit. Staff followed infection control guidelines, handwashing signs were on display and hand sanitizer was available throughout the building.

Good

Substance misuse services

Safe staffing

The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.

There were 22 staff working within the service with experience and/or qualifications related to working within substance misuse services. Staff told us the service would benefit from an additional alcohol recovery practitioner, but the service had enough staff to keep clients safe. Staff and clients could access other professionals for support, for example, nurses from a local acute hospital provided a monthly drop-in to the service to deliver hepatitis C screening and treatment.

The service had two vacancies at the time of our inspection, one was a harm reduction worker and the other was an alcohol recovery practitioner. One of these vacancies was covered by a long-term agency worker. Managers were proactively recruiting to these roles and had arranged interviews at the time of our visit. The service had been successful in obtaining funding for four new additional roles and managers were beginning to start recruiting to these; one non-opiate recovery worker, one health care assistant, one data administrator and one recovery motivator.

Managers supported staff who needed time off for ill health but sickness levels were low, with no staff on long term sickness. Managers could cover long term staff sickness and absence through the use of long-standing agency staff who were familiar with the service.

Staff in the alcohol team had an average case load of 50, staff in the non-opiate team had an average caseload of 47, staff in the opiate team had an average caseload of 53 and the criminal justice practitioners had an average caseload of 40. Caseloads were not too high to prevent clients receiving the expected care and treatment within the service. Staff told us that they were able to manage their caseloads safely and clients informed us that they had regular contact with their keyworkers.

The service had enough medical staff. The service had one full-time consultant psychiatrist with a specialism in substance misuse. The service had three full-time nurses to carry out nursing and medical reviews. The consultant psychiatrist was solely responsible for prescribing as there were no nurse prescribers within the service. The service had a contingency plan in place with a neighbouring service to ensure that clients could continue to access medicines, if the consultant had any unplanned or planned absences. Clients said that there was no issue in accessing medical staff when they needed to.

Staff had completed and kept up to date with their mandatory training. Staff had completed 99% of their mandatory training. The mandatory training programme met the needs of staff and clients. The training included health and safety, equality and diversity, data protection, the Mental Capacity Act and safeguarding adults and children. Clinical staff had additional basic life support training as part of their mandatory training. Managers had an overview of mandatory training and could see what had been completed and training that was expired or due to expire.

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

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans, but, although staff had identified risks for clients, we could not always see how risks were mitigated.

Good

Substance misuse services

Administrative staff prioritised referrals according to some basic risk criteria, for example, staff ensured that referrals from clients who were under probation services were triaged by clinical staff on the same day. The service also had a 'prison release tracker' to ensure that weekly contact was made with people who had been released from prison.

The clinical team reviewed all new referrals and clients' risks in the daily morning handover meeting as it was recognised that administrative staff were not trained to make clinical judgements surrounding risks.

We reviewed seven client records. Staff reviewed initial risks for each client on referral and used a recognised tool to complete a detailed risk assessment after the initial meeting with the client. We could not see how risks were mitigated in the records viewed but staff we spoke with were clear on how to manage the risks identified.

Risk assessments included the risks of clients experiencing alcohol withdrawal seizures, delirium tremens and the risk of overdose for clients using opiates. Delirium tremens is the effect of suddenly withdrawing from alcohol, which can be fatal. Risk assessments also covered the potential risk to others, such as children.

Staff responded promptly to deterioration in a client's presentation and any changes to risks, client records were updated to reflect these changes.

Staff assessed clients' risks surrounding their substance misuse, physical and mental health in addition to any safeguarding concerns and social risks, such as housing and social networks. Staff responded to changing risks to clients, which were reviewed in daily handover meetings and at weekly multidisciplinary team (MDT) meetings. Staff decided at MDT meetings whether a client was suitable for the service or required a higher level of support. For example, staff reviewed whether community detoxification from alcohol was suitable or whether a client's needs or living arrangements meant it was safer to complete this in an inpatient setting.

Staff followed structured assessments to determine the severity of clients' alcohol use, such as the alcohol use disorder identification test (AUDIT), the severity of alcohol dependence questionnaire (SADQ) and used the clinical opiate withdrawal scale (COWs) to assess opiate withdrawal levels for clients who were under medication assisted treatment.

Staff made clients aware of harm minimisation and the risks of continued substance misuse. This included verbal and written information about the risks to clients of drinking alcohol or taking drugs with their prescribed medicines. Staff provided clients in the pre-detoxification group with written information about the risks of alcohol withdrawal.

Staff followed a protocol for clients who unexpectedly exited the service. Staff asked clients in their initial assessment how to best engage with them if they were to unexpectedly exit from treatment, including contact details of their next of kin. Clients who missed appointments were discussed in the daily handover meeting and weekly multidisciplinary team meeting (MDT). Staff carried out home visits jointly with external professionals or in pairs and never alone.

Recovery workers referred clients to the nurse when assessments indicated that this was appropriate. Clients were offered tests for blood borne viruses such as hepatitis B, hepatitis C and HIV.

Safeguarding

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

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. At the time of the inspection, 99% of all relevant staff had completed safeguarding adults training and 100% had completed safeguarding children training.

Staff were able to identify risks to and from clients and knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave examples of where they had to make a safeguarding referral, such as when a client had a child at home. Records showed that safeguarding risks were assessed, including any historical safeguarding concerns.

The quality and safeguarding lead was new in post and planned to introduce weekly drop-in sessions for staff to receive advice and guidance surrounding client safeguarding concerns.

Staff discussed current safeguarding concerns in the daily handover meetings and the weekly Multidisciplinary team meetings. Managers had oversight of current safeguarding referrals and were able to access a list of current safeguarding issues to review in the daily handover meetings. Managers had also completed a safeguarding audit and this showed 92% compliance as of November 2021.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff had close working relationships with the local authority safeguarding teams. Staff attended multi-agency risk assessment conferences (MARAC) meetings monthly and multi- agency safeguarding hub (MASH) meetings.

The young person's team provided advice and support to clients aged 5 and above and their families impacted by substance misuse. Staff mainly met young people in the community and at another suitable premises. Staff ensured that the service was closed to adults if young people had to attend the building to meet with the clinical team for an assessment or prescription. Staff supervised young people in the building and young people could use a different entrance if necessary.

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

Staff carried out home visits to ensure that clients stored medicines appropriately if they had children or young people in their household.

Staff access to essential information

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

Staff used electronic client records to record and access information concerning clients. Staff kept comprehensive and detailed records of clients' care and treatment. We looked at seven records, they were clear, up-to-date and all staff could access them easily. Clients had clear paper recovery plans, although staff had yet to upload these on to the electronic record system.

Managers completed an annual case record audit; staff had achieved 55% compliance in November 2021, managers responded to this by ensuring that staff had received refresher training in recording full risk reviews and client recovery plans on the record system in June 2022 and planned to complete another audit in September 2022 to see if improvements had been made.

Good

Substance misuse services

Medicines management

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

Staff followed clear pathways when assessing clients. Nurses and doctors assessed clients for

community alcohol detoxification and doctors assessed clients on the opiate substitute treatment programme. Clients were expected to attend a face to face assessment with the doctor before being prescribed any medicines. Staff followed systems and processes to store, prescribe and administer medicines safely. Medicines and controlled stationery were stored securely, and electronic records were kept of their use.

Clinical staff were responsible for producing and signing printed prescriptions. All prescriptions were logged and recorded on the electronic client record system, including any void prescriptions. Clients who visited the service were asked to sign to confirm that they had received their prescription. Prescriptions were posted to the pharmacy or client using a secure postage method.

Staff reviewed the effects of each client's medication on their physical health according to NICE guidance. Clients agreed to be subject to random urine drug screening (UDS) to determine if they had used any illegal substances on top of their medicines. Clients were offered blood borne virus tests prior to treatment (hepatitis B, hepatitis C, and HIV). Nursing staff carried appropriate screening for blood borne viruses and nurses from a local acute hospital provided a monthly drop-in to provide screening and treatment for hepatitis C. As of July 2022, 100% of clients had been offered a test for hepatitis C, 75% of clients identified as having Hepatitis C had started to receive treatment.

Staff wrote to GP practices to keep them informed of treatment provided to clients. Staff obtained clients' consent to share information with their GPs. This enabled clinical staff to get access to medical and drug histories prior to the prescribing of medicines and to limit the risk of double prescribing. Clients who disengaged from the service and then re-entered the service were re-assessed by the consultant before they were prescribed any medicines.

Staff reviewed each client's medicines regularly in multidisciplinary meetings and provided advice to clients and carers about their medicines. Staff provided training to clients on how to use Naloxone, which is used in an emergency to reverse the effects of an opioid overdose. Staff were able offer clients Naloxone kits at the service. Clients using the opiate substitute prescribing service were given medicine information leaflets when prescribed methadone, buprenorphine, naltrexone and espranor and the risks of using illicit drugs on top of these medicines were explained to them.

Clients were also given leaflets on how to keep medicines safe with children at home and a safer injecting guide. Staff offered clients advice and support to keep their medicines as safe as possible. Staff offered clients a safe storage box so that children and other people could not access controlled medicines.

Clients received varying levels of supervision, depending on their pathway and assessed risks. Clients completing the community detoxification treatment for alcohol were expected to meet with a nurse for the first five days and would be prescribed medicines to stop withdrawal symptoms. Clients on the opiate substitute treatment programme attended a community pharmacy daily for a pharmacist to supervise their consumption of the medicine. Clients who were suspected of using illicit substances on top of their medicines were asked to take their medicines under supervision.

The service had a protocol in place for staff to follow if clients were suspected of passing their medicines to third parties, known as diversion. Clients who were assessed as lower risk were able to collect their medicine weekly from the pharmacy. The service offered needle exchange to clients and provided a list of local pharmacies that also offered needle exchange.

Clinical rooms were clean, spacious and equipped with handwashing facilities. Staff had access to emergency equipment, medicines and disposal facilities. The service had a contract with a waste management company who disposed of all their use sharps bins and clinical waste.

Staff monitored the temperatures of medicines storage areas. If temperatures went outside the recommended range, staff acted to safeguard the medicines. This included liaison with the pharmacy team. Staff completed monthly audits to ensure medicines were stored appropriately. Staff completed monthly checks on prescriptions, medicines and controlled drug stationery. There were medicine management policies in place. However, the medicines management policy, the opiate medication assisted policy and controlled stationary policy were due to be reviewed by May 2022 and had not been reviewed by July 2022

The service had systems to ensure staff knew about safety alerts and incidents so clients received their medicines safely. Medicines incidents were reported on an electronic system and investigated by the clinical lead. There were 12 medicine incidents within the last 12 months which were reported to the regional pharmacist for the service. Incidents were reviewed in the monthly internal governance team meeting. Learning was shared with staff and agreed changes were implemented.

The service contributed to the National Drug Treatment and Monitoring System (NDTMS) programme. The service had a pharmacy lead who was responsible for maintaining the relationship with contracted pharmacies, the service also offered clients a list of local pharmacies where they could access supervised consumption.

Track record on safety

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

The service had a good track record on safety, there had been no serious incidents within the previous 12 months. The service had identified that seventeen clients using the service had died within the previous 18 months up to March 2022. None of these deaths were directly related to the treatment provided by the service, however, the quality and governance lead had conducted a full review of the deaths to identify trends and themes and where improvements could be made.

They identified that the hospital discharge pathway could be further improved and the service now ensured that a practitioner was allocated to obtain timely discharge summaries from the hospital team. They also identified that there was a lack of contingency planning for when staff were on sick leave and work was ongoing to rectify this. Findings were shared with the staff team and the areas that needed to be addressed were incorporated into a service-wide quality improvement plan.

Reporting incidents and learning from when things go wrong

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Good

Substance misuse services

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

Staff understood their responsibilities to raise concerns and report incidents in line with the service's policy. Staff felt confident and supported when reporting and discussing incidents. The service had 39 reported incidents within the last 12 months. The highest reported incidents were deaths and medicine incidents. The service had no never events.

Incidents were reviewed in the monthly internal governance team meeting and urgent incidents were discussed in the daily handover meeting and reported on the electronic system. Staff ensured clients, and, where appropriate, family members and other professionals, were kept informed. Staff also ensured care records were updated after an incident.

There was evidence that changes had been made as a result of staff feedback. The opiate team created a scripting handbook after newer recovery workers stated that there was not enough guidance around scripting and medicines, such as the process to follow if a client needed to be restarted on a medicine. This was then added to the staff induction pack.

Are Substance misuse services effective?

Good

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients when they accessed the service. They worked with clients to develop individual recovery plans and updated them as needed. Care plans reflected assessed needs and they were holistic and recovery-oriented, although they could be more personalised and recovery goal orientated.

We looked at seven care and treatment records. Staff completed a comprehensive assessment of each client. Assessments covered drug and alcohol history, mental health and physical health needs, consent to treatment, safeguarding concerns and social needs. Records showed that staff met regularly with clients, whether in person or virtually.

Recovery plans were holistic and reflected the needs of each client, including mental health, social circumstances and physical health needs. However, four out of the seven recovery plans did not contain the client's views and four out of the seven did not have clear recovery goals. Five clients told us that they were involved in developing their recovery plans with their keyworker. Staff regularly reviewed and updated recovery plans with clients when their needs changed.

Staff made sure that clients had a full physical health assessment and knew about any physical health risks. Records showed that clients received a physical health assessment when they started with the service and these were frequently reviewed. Records showed that staff supported clients to safely reduce and stop their alcohol and drug use through the appropriate use of withdrawal tools and by following national guidance on detoxification. Staff ensured that all appropriate correspondence was recorded, such as assessments, GP summaries, blood test results and urine drug screen testing.

Best practice in treatment and care

Good

Substance misuse services

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

Staff delivered care and treatment in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence (NICE) and the Office for Health Improvement and Disparities guidance. The service had clear treatment pathways for clients using opiates, non-opiates and alcohol. The service offered a 12-week harm reduction programme which included one to one key working, substitute prescribing, community alcohol detoxification, self-management guidance, psycho-social therapy groups, counselling and volunteering opportunities.

The service had a psycho-social therapy group timetable for clients, including alcohol pre-detox and detox groups, opiate and non-opiate groups, older adults harm reduction group and a group for offenders who required drug or alcohol misuse treatment. Staff told us that evening groups were offered to clients who had other commitments such as work or childcare, but we could not see this on the group timetable. Clients could also access an aftercare service held at a different location, with post detoxification groups and up to 12 free individual counselling sessions.

The service offered both virtual and face to face groups as managers recognised that this benefitted different groups of clients. We observed a face to face group taking place. The focus of the group was 'the impact of drinking on myself and others'.

Staff were aware of NICE guidelines and used these to help clients access mental health services.

Managers had created a partnership with a local NHS trust, a mental health link worker ensured that clients with a dual diagnosis were referred to and subsequently supported by the community mental health team. They attended weekly multidisciplinary meetings with the team to facilitate good communication.

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

Staff made sure clients had support for their physical health needs. Clients with opiate dependence had a prescription for methadone or buprenorphine depending on their individual needs and circumstances in line with national guidance. Clinical staff ensured that clients were seen face to face and medical summaries were obtained from GPs prior to prescribing medicines to clients, including blood test results.

Clients' prescriptions were reviewed regularly, and clients had urine drug tests to monitor their use of illicit drugs. Clients were prescribed thiamine and pabrinex in line with national guidance to minimise memory loss as a result of alcohol misuse.

Staff supported clients to live healthier lives by supporting them to take part in programmes or by giving advice. The service signposted clients to a health and wellbeing support service in the local community. Staff also supported clients to access mutual aid groups, such as Alcoholics Anonymous.

Staff used technology to support clients. Staff offered clients telephone and video call support and also sent reminder text messages to clients. Staff could access GP medical summaries on the client record system.

The service had a clear pathway for clients who were subject to medication assisted treatment. Medication assisted treatment involves the use of medicines, in combination with other treatments, such as psychotherapy, counselling and group therapy. There were 216 clients in medication assisted treatment when we visited the service. The service was expected to complete a medical review for each client under medication assisted treatment annually in line with national guidance.

Client records evidenced that this was happening.

Monitoring and comparing treatment outcomes

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

Staff told us that they used treatment outcomes profiles (TOPS) to assess clients' progress and outcomes before, during, and at the end of treatment. Managers had access to a dashboard to monitor and compare data, including treatment outcomes. For example, the latest report showed that there were 117 overdue TOPS reviews reduced from 132. Managers had actioned for this to be followed up with staff in individual supervision sessions and reviewed in monthly staff team meetings.

Managers were able to evidence that staff had helped 73 out of 93 clients to have a successful alcohol detoxification within the previous 12 months.

The service also contributed to the National Drug Treatment and Monitoring System.

Staff took part in clinical audits and these included medication assisted treatment, prescription and controlled drug stationery, vaccine storage and infection prevention and control, although the prescription and controlled drug stationery audit was due to be completed by January 2022 and had not been.

The service was the first CGL to receive an external trauma informed care evaluation in March 2022 conducted by an independent psychologist. The psychologist made a number of recommendations as to how the service could improve, which were added to the service quality improvement plan for action. Recommendations included improvements to the environment, staff considering trauma as part of the initial client assessment and staff receiving training in trauma-informed care. Staff subsequently received levels one and two of trauma-informed training in July 2022.

Managers were able to benchmark data against the other 52 services under the same provider. They showed us that the service was fourth out of 52 for the number of successful alcohol detoxification treatments.

Skilled staff to deliver care

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

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

Staff included opiate, non-opiate and alcohol recovery practitioners, criminal justice practitioners, including a complex needs worker, nurses, peer support workers, volunteers, doctors, a family and carers and older adults' practitioner and a young person's practitioner.

Managers informed us that the current supervision rates were 77%. Clinical staff received monthly clinical supervision and non-clinical staff received quarterly supervision at a minimum.

Managers supported staff through regular, constructive appraisals of their work. Managers had completed 97% of annual appraisals by July 2022. Staff said they were able to access support from senior staff whenever they needed to.

All staff received a comprehensive two-week induction before starting work. Managers made sure agency staff understood the service before they worked within it, and supplied them with contact numbers and necessary policies and procedures. New staff were given an induction pack which covered medication assisted treatment, the scripting handbook, needle exchange, naloxone administration, mandatory training and a competency assessment.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received specialist training for their role. For example, staff told us they had recently completed training in trauma-informed care.

Staff attended a monthly training workshop covering various topics relating to substance misuse, this was provided by an appropriate member of the staff team or by an external professional. The manager delivered training to the team around domestic violence and the consultant psychiatrist delivered a training workshop on understanding benzodiazepines. Staff within the opiate team had completed the training programme for 'Best practice in Optimising Opioid Substitution Treatment' (BOOST). Managers also offered this training to staff within the alcohol team; the service had yet to complete the BOOST self-assessment tool.

Staff informed us that progression in their career development was encouraged, for example, some practitioners had started off as volunteers within the service after completing their own recovery journeys.

Managers recruited, trained and supported volunteers to work with clients. The service had ten peer support workers and 11 volunteers. The service had a volunteer lead who trained new volunteers to work within the service.

Multidisciplinary and inter-agency team work

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

Staff attended weekly multidisciplinary team meetings (MDT) to discuss clients' progress and improve their care. Staff had a good detailed knowledge of clients and there was strong team working amongst the clinical and non-clinical staff. Discussions included physical health and mental health, social circumstances, prescriptions, safeguarding concerns, risks and engagement with the service. New assessments were also discussed and reviewed in the weekly MDT meetings.

Staff made sure they shared clear information about clients and any changes in their care, including during daily handover meetings. Staff took minutes of the meeting and actions were noted and followed up at the next meeting.

Good

Substance misuse services

There were effective working relationships between the different teams within the service. For example, the young person's service, the criminal justice service and the volunteer counselling service supported each other to provide the best possible service to individual clients. The service had a complex needs worker who supported clients who were assessed to be of high risk, such as those with a mental illness or clients who were not stable with their medicine scripts.

Staff had effective working relationships with external teams and organisations. Staff gave us examples of how they worked with a range of other agencies to help meet clients' holistic needs. These included probation services, local acute hospitals, local authority safeguarding teams, pharmacies, housing services and voluntary sector organisations. Managers had formed a partnership with a local NHS trust.

Good practice in applying the MCA

Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff received training in the Mental Capacity Act and knew to seek support from the service managers if needed. Completion of Mental Capacity Act training stood at 92% of all relevant staff members.

Staff knew where to get accurate advice on the Mental Capacity Act. Staff gave clients all possible support to make specific decisions for themselves. Clients' records showed consideration and assessments of capacity were in line with the underlying principles of the Mental Capacity Act. Staff gave examples of when a client's mental capacity to make decisions about their care could become temporarily impaired, such as when a client was intoxicated or under the influence of substances. Staff discussed clients' capacity in multidisciplinary meetings.

Staff checked that clients consented to their care and treatment and this was recorded in the initial assessment form, it also covered consent to share information with other relevant professionals.

Are Substance misuse services caring?

Good

Kindness, dignity, respect and support

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

We observed staff treating clients with compassion, respect and kindness. They spoke with understanding about clients and the problems they were facing. We spoke with six clients, they said staff were respectful, non-judgemental and provided care that met their needs.

One client commented that staff 'were amazing, my keyworker was in contact with me throughout, they gave me amazing support and they were brilliant', another said that 'the service was crucial to my recovery and saved my life'.

Good

Substance misuse services

Staff clearly understood and respected the individual needs of each client. Clients told us that their keyworkers were contactable. Staff provided help, emotional support and advice when they needed it. Staff supported clients to understand and manage their own care treatment or condition through one to one key working sessions and groups. Clients told us that it was helpful to have recovery workers who had lived experience of addiction issues, to encourage and empower their recovery.

We observed a preparation for alcohol detoxification group. Clients were informed of what they could expect when starting their detoxification journey, including a discussion of coping strategies and recovery goals they wished to achieve. Clients informed us that they received information and advice on substance dependency and side effects of medicines.

Staff kept client information confidential in line with the confidential policy.

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

The involvement of people in the care they receive

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

Clients told us that they were given information as to what they could expect from their care and treatment and help to understand their addictions and triggers. Staff provided clients with written information in addition to verbal information, including leaflets. Clients said staff were responsive to their needs and were easy to contact.

Staff involved clients in decisions about the service, when appropriate. Clients were informed of updates to the service and could give feedback through the monthly service user forum, chaired by the peer mentor. For example, clients were asked for their feedback as to how the service has helped them and what could be improved.

Clients felt confident to give feedback on the service and their care and treatment. Staff gathered feedback from clients using the treatment outcome profiles (TOPs) by adding an additional two questions. Clients could also use the suggestion box located in the waiting area and were reminded of the compliments and complaints process. Staff listened to client feedback and implemented changes. For example, staff planned to introduce a rights and responsibilities leaflet to inform clients as to what they could expect from the service after a client had fed back that their expectations were not met.

Staff directed clients to other services and supported them to access local services if they needed help, such as emotional and physical wellbeing support services to stay well.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff gave families and carers client information and were invited to attend appointments, when the client consented. The service had a dedicated carers and families lead who gave advice, information and support to carers and families and signposted them to other agencies when required.

Good

Substance misuse services

Staff gave interventions to families and carers who were directly or indirectly impacted by substance misuse; staff offered one to one support and six-week counselling sessions. Carers were also helped to access carers assessments so their own needs could be considered. Staff helped carers and families to understand addictions and the effects of substance misuse. One carer commented 'thank you so much for the support that you gave our family throughout the difficulties we experienced recently due to our son's alcohol addiction, in particular for your advice on how to deal with the situation and encouragement to continue with my counselling sessions'.

The service held a weekly carers and family group to provide support and to obtain feedback from them about the service in order to improve. One family member commented 'hearing others with similar problems helped us to heal from our family breakdown'.

Are Substance misuse services responsive?

Good

Access and discharge

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

The service had clear criteria to describe which clients they could safely offer services to. Clients could access the service by self-referring or through referrals from third party agencies, which included GPs, probation services and social services. Managers were keen to reintroduce a drop-in service to allow ease of access for new clients to access the service. This was currently suspended due to Covid-19 measures.

The service aimed to offer a first assessment appointment within five working days of receiving the referral. New referrals were prioritised and allocated in the morning briefing meeting. Urgent referrals were seen within 48 hours and the service did not have any waiting lists. Staff assessed whether clients were suitable for the service or whether they required a higher level of support, for example, staff referred clients for inpatient detoxification if they assessed that a community alcohol detoxification was not safe.

Staff attempted to contact clients who missed appointments to offer further appointments and support, including signposting clients to other community services, contacting third party agencies and carrying out home visits if necessary. Staff followed a clear protocol for clients who disengaged from the service. Clients were asked at their initial appointment as to what the best communication method would be if they were to ever disengage from the service. Clinical staff ensured that clients who disengaged received a new medical assessment before re-starting any prescriptions.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support. The young person's service provided advice and support to clients aged 5 and above and their families impacted by substance misuse. The criminal justice pathway supported clients subject to an alcohol treatment requirement (ATR) or drug rehabilitation response (DRR), which required clients to attend a drug or alcohol treatment programme with regular testing for between three and six months.

Clients said that appointments were rarely cancelled. When clients did not attend planned appointments, records showed that staff made repeated attempts to contact them. Staff supported clients when they were referred, transferred between services, or needed physical health care whilst using the service.

When clients were ready to be discharged from the service, staff followed a clear discharge process. Staff sent clients and their GP a letter of discharge and signposted clients to other services in the community if required. Managers reviewed discharges weekly to ensure that they were appropriate.

The facilities promote recovery, comfort, dignity and confidentiality

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

The design and layout of treatment rooms supported clients' treatment, privacy and dignity, however some furnishings could be improved; one chair was broken and had not been removed and some of the sofas were worn. One sofa was fabric which was not in line with good infection prevention and control (IPC) measures. Managers subsequently provided evidence that the chair and sofas had been removed. Managers had also identified that more comfortable seating should be provided as an action in their quality improvement plan.

Staff maintained general infection prevention and control measures, such as handwashing facilities and they had access to PPE.

The service had a range of rooms and equipment to support treatment and care. Staff had access to a clinic room with equipment suitable for the physical examination of clients. Interview rooms in the service had sound proofing to protect privacy and confidentiality. The premises had a waiting room for clients, including a water dispenser.

Meeting the needs of all people using the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Staff understood and respected the individual needs of each client, including the issues facing vulnerable groups, including homeless clients, older adults and clients subject to domestic abuse. The service had an older adult's recovery worker to provide support and access for adults aged 65 and older.

The service provided a women's only group and a separate men's only group. Staff told us that evening groups were offered to adults with work or childcare commitments, although we could not see this on the group timetable. The service also offered clients a choice of face to face groups or virtual attendance.

The service provided information leaflets to clients on substances and medicines. Clients could access interpreters if they did not speak English, although we did not see any leaflets in different languages or in an easy-read format. Managers had identified on their quality improvement plan that treatment pathways should be displayed in the client waiting area.

The service had ground floor disabled access and an accessible toilet for clients to use.

Staff promoted the service to clients within the community, such as within local churches, hostels, probation services and homeless services. The young person's service promoted the service to young people and provided training in substance misuse to external organisations, such as schools and children's local authority teams.

The service worked in partnership with other agencies to meet the needs of clients. The service had formed a partnership with a gym in the local area to provide ten free gym passes to help improve the physical wellbeing of clients.

Staff recognised groups of people who were marginalised and harder to reach in the community and took action to address this. For example, staff were aware of the stigma attached to alcohol misuse and had introduced an 'inbetweeners' group. This provided support and motivation to clients who were dependent on alcohol but were not ready to begin their detoxification journey and did not fit into the current treatment pathway. These clients were also reviewed in the weekly MDT meetings. The service also offered relapse prevention groups to provide support and motivation to clients who were at risk of relapsing.

Staff made sure people could access information on treatment, local services and how to complain. Managers planned to introduce a document for clients detailing what they can expect from the service and their rights. Staff signposted clients to online resources to aid their recovery, such as 'breaking free' which provided resources to help clients stay abstinent from substances.

Listening to and learning from concerns and complaints

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

The service had received one complaint in the previous year; investigation was still ongoing.

Clients knew how to complain or raise concerns. Clients could feedback on the service through suggestion boxes located in the waiting area, complaint information was also on display. Clients we spoke with said they felt confident in raising concerns or a complaint if they needed to.

Staff knew how to acknowledge complaints and the client or family member received feedback on the outcome of a formal complaint within 28 days of it being made.

Managers investigated complaints and identified learning to improve the service. For example, the service had identified that staff would benefit from receiving training in de-escalation techniques for clients who present with distressed behaviour.

Complaints were reviewed as part of the quarterly management governance meeting, and feedback from complaints was shared with staff in the monthly integrated governance team meetings.

The service used compliments to learn, celebrate success and improve the quality of care. The service had received 37 compliments within the last 12 months and managers ensured that compliments were recorded. One client said, 'I don't think I have thanked you enough for your support, I couldn't have got to where I am now without your help understanding and encouragement during our telephone sessions at the start of my journey.'

Good

Substance misuse services

Are Substance misuse services well-led?

Good

Leadership

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

Staff felt supported and could approach the management team with any issues. The clients we spoke with felt the same. Staff spoke highly of the service manager. The service manager was due to leave to manage a neighbouring service under the same provider, the new service manager worked within the service and knew the service well. They were shadowing the current service manager as part of their induction to the role.

Visions and values

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

Staff understood the vision and values, and these were displayed in the service. The values were compassion, openness and being bold. The service mission statement was 'to help people change the direction of their lives, grow as individuals and live life to its full potential'.

Culture

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

Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.

Staff wellbeing was a priority for the service's managers. It was included on the service's quality improvement plan. Managers asked staff in a recent internal governance meeting to rate from one to ten as to how they felt in terms of motivation, trust, ethical behaviour, self-interest and happiness. This was to measure the current culture and morale within the service.

Staff reported that the service promoted equality and diversity in its day to day work and in providing career opportunities to staff who had experience of misusing substances.

Good governance

Our findings from the other key questions demonstrated that performance was managed well, governance processes operated effectively but could be further improved.

There was a governance structure in place which facilitated learning from incidents, deaths and complaints, which were discussed in the monthly governance meetings. The service had an internal governance team meeting for all staff with a set agenda and minutes were shared with staff. Staff also attended fortnightly business meetings. There were robust referral processes, safeguarding procedures and consideration of client risk. However, we could not see where the risk register was regularly reviewed.

The service produced a fortnightly data report to monitor outcomes against key performance indicators. This enabled managers to have oversight of the service in terms of areas that were meeting expected performance targets and areas that needed to improve. For example, managers were able to identify that staff needed to improve the recording of treatment outcome profiles (TOPs). Managers had access to client data, including clients who were currently accessing treatment, and this was aligned to each treatment pathway. Managers also had oversight of annual appraisal and mandatory training completion rates.

The service had an annual audit schedule which included health and safety, safeguarding, infection prevention and control, vaccine storage, prescriptions and controlled drug stationery, case records, risk and recovery planning, assessments, business continuity plan, consent and medically assisted treatment. The prescriptions and controlled drug stationery audit had not been completed by its planned completion date of January 2022.

Managers recognised that compliance with some of the audit targets was low so they had put plans in place to address this. For example, from November 2021 there was 40% compliance with the items covered by the assessment audit, 55% compliance with the case record audit and 63% compliance with risk and recovery planning. Staff had subsequently received training in recording assessments, updating case records and risk and recovery planning in June and July 2022 to try to address this, with a plan to re-assess their compliance in September 2022 and the delivery of refresher training if needed.

The service had a range of suitable policies and procedures which staff could access, these included the alcohol detoxification policy, safeguarding adults and children's policy, opiate medication assisted policy, controlled stationery policy and the medicines management policy. However, the medicines management policy, the opiate medication assisted policy and controlled stationery policy were scheduled for review by May 2022 and had not been reviewed by July 2022.

The service submitted data and appropriate notifications to the CQC when required.

Management of risk, issues and performance

The service had a quality improvement plan in place to identify and address risks also identified in the service's risk register. Managers could identify the top risks to service delivery, such as maintaining a safe working environment, addressing safeguarding concerns effectively, managing a clinical service with one clinical prescriber, staff wellbeing and caseload management. Managers were in the process of reviewing the business continuity plan at the time of our visit.

The service had well developed risk assessments for clients which were kept up-to-date, but written plans to manage those risks were less well developed although the staff we spoke with could describe them verbally.

Information management

Staff collected and analysed data about outcomes and performance.

Staff collected and analysed data against the service's key performance indicators. Managers were able to access data on the number of clients currently in treatment and which pathway they were using. Managers were able to identify where the service was performing well and areas that needed to improve, such as treatment outcome profile completion. Managers met with the data lead on a fortnightly basis to gauge performance by reviewing the service's performance report, which was subsequently presented in the monthly quality and data leadership meetings. This data was also shared with their commissioners on a quarterly basis.

Staff informed us that they had the technology and equipment to do their work and the telephone system worked well. Clients told us that they did not face any problems when trying to get through to staff by phone. The service used a secure electronic client record system. Staff ensured that clients understood how their information was stored and recorded their consent on the initial assessment form. Staff ensured that incidents were recorded on the service's incident reporting system.

Leadership, morale and staff engagement

Staff described good morale and were very positive about their colleagues. They felt respected, valued and supported by managers and colleagues. Staff were passionate about working together to help clients achieve their recovery goals. Staff expressed that they proud to work for the service.

Staff told us that they received regular updates via the intranet about changes impacting the provider and were also asked to complete an annual staff survey to gauge staff satisfaction and to give feedback on what could be improved.

Staff wellbeing was considered as part of the quality improvement plan. The provider offered an hour of wellbeing within working hours each week, information about this was provided in the 'wellbeing zone' on the staff intranet. Staff could access tools and information on maintaining a healthy lifestyle, including diet, exercise and stress. Staff had access to an employee assistance programme.

Managers made sure that staff regularly attended multidisciplinary meetings and monthly internal team governance meetings. There were opportunities within meetings to give feedback to managers. However, managers recognised that not all staff felt comfortable feeding back in a group setting so planned to nominate a staff representative to obtain feedback from staff.

Commitment to quality improvement and innovation

Even though the service did not use recognised quality improvement models, they undertook improvement projects to further develop the service.

The consultant psychiatrist had completed a research project entitled 'Helping the realisation of the Covid-19 vaccination programme amongst our service users in Change, Grow, Live Bromley'. In July 2021 40% of clients in Bromley were reluctant to receive the Covid-19 vaccine. The project identified the reasons for this and what practical steps staff could take to encourage clients to receive the vaccine, such as by having an open dialogue conversation. Findings were presented to other medical professionals within the wider Change, Grow, Live provider.

The service recognised that there were a high number of clients who required support around benzodiazepine use. Staff worked with the consultant psychiatrist to introduce a local treatment pathway, which was shared with other Change Grow Live services. The service also nominated a recovery worker to be the lead on the benzodiazepine treatment pathway.

Good

Substance misuse services

At the time of our visit, the consultant psychiatrist had also begun working on a project to support opiate users over the age of 70.

The service worked closely with the local authority, commissioners and the Office for Health Improvement and Disparities to recognise and respond to the needs of the local population. The service actively engaged, and formed partnerships, within the local community to ensure that clients with substance misuse problems received quality care and support to meet all their needs.

The service was involved in a social research project in partnership with a local university called 'If young people are taking risks, why are professionals playing it safe?'. This was at the early stages of development at the time of our inspection but would involve workshops in schools, focus groups and analysis of the data surrounding this topic. Staff were being supported by the Change Grow Live research team and, upon completion, the aim was to apply the learning by offering an evidence-based package of training to professionals and schools.