

Change, Grow, Live

CGL Rotherham

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

Requires Improvement



Are services safe?

Good



Are services effective?

Requires Improvement



Are services caring?

Good



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

- Staff did not always develop holistic, recovery-oriented care plans and they could not evidence that clients had been offered copies of their care plans.
- Some staff did not know how to handle complaints and recovery activities were not promoted effectively with clients receiving treatment through their GP.
- Some governance processes were not well embedded. Local governance meetings were not taking place and there was no guidance for staff about what they should discuss in team meetings. The provider did not have suitable guidance for staff on how to develop recovery orientated care plans.
- Some clients had to wait outside the building to be seen because of the provider's infection control policies there was sometimes a smell of drains in the building which could be off-putting.

However:

- The service provided safe care. The premises where clients were seen were safe and clean. 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. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff carried out comprehensive assessments and appropriate physical health monitoring. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received basic training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness, and understood the individual needs of clients. They actively involved clients in decisions and care was person-centred.
- The service was accessible and met the needs of clients, including those with a protected characteristic or with additional support needs.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to CGL Rotherham

CGL Rotherham is part of a national charity called Change, Grow, Live, (CGL). It is community-based organisation offering treatment and support to people with drug and alcohol problems. It operates from Carnson House, in Rotherham town centre. The service provides medication assisted treatment, advice and information, group work, psychosocial interventions and blood borne virus testing and immunisation. A large proportion of the service is delivered in conjunction with local GP's through a shared care arrangement. Staff can facilitate access to needle exchange provision through a network of local pharmacies.

This service was registered by CQC on 1 May 2019 to provide one regulated activity: Treatment of Disease, Disorder and Injury. When we inspected, there was no registered manager, but a new manager had been appointed and had been in post since early January 2022. This person was in the process of applying to become the new registered manager.

This is the first time we have inspected the service since it was registered.

What people who use the service say

We spoke with fourteen clients in total. Without exception they told us staff were compassionate, caring and went out of their way to provide person centred care and support. Some clients praised individual staff and one or two told us the help they received had save their lives. Clients felt safe using the service and thought they had really good access to mental and physical health services through pathways the service had with other primary and secondary healthcare services. Many of them missed the recovery activities that were on offer pre-pandemic, but they told us they had good access to telephone and virtual support throughout the restrictions. Two clients we spoke with that had been in treatment a long time thought the treatment on offer was not as relevant to them as it was to newer people.

How we carried out this inspection

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

- toured the building and looked at the quality of the environment
- observed how staff were caring for clients
- spoke with 14 clients
- spoke with the regional manager and the new service manager
- spoke with the clinical lead and the quality lead for the service
- spoke with thirteen other staff members including doctors, nurses, recovery workers and administrative staff
- attended and observed two group sessions with clients
- attended and observed a morning communication meeting
- looked at five care and treatment records of clients
- Spoke with the lead commissioner for the service
- reviewed the management of medicines and
- looked at a range of policies, procedures and other documents relating to the running 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>.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The testing and treatment pathway for hepatitis C was innovative and of great benefit to clients. Staff from CGL worked alongside nurses from the local hepatitis C service, supporting them to offer clinics from Carnson House. This meant clients could access hepatitis C testing and treatment directly at the substance misuse service, rather than attend secondary care which was some distance away.
- During the pandemic, staff provided some clients with laptops and smart phones and other accessories so they could continue their work in the structured groupwork programme by attending virtually. Other clients that needed them were provided with mobile phones so they could keep in touch with their recovery worker and access essential help. Through a partnership with a local supermarket, staff delivered food parcels to clients in need. They delivered clients' medicines to their homes when they had to self-isolate.

Areas for improvement

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

- The provider must ensure that care plans are recovery orientated and treatment goals reflect the full range of client need.
- The provider must ensure staff know how to handle complaints and who to pass them on to.
- The provider must ensure that systems and processes are operating effectively to assess, monitor and improve the quality of the service. This includes ensuring there is appropriate guidance for staff on care planning, what issues should be discussed in team meetings and timely review of procedures that impact on clients having to wait outside.

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

- The provider should ensure clients, especially in shared care and long-term treatment have good access to recovery activities.
- The provider should ensure staff can evidence whether clients have been asked if they wanted a copy of their care plan.
- The provider should ensure all staff update risks for every client following any incident including those who access the service purely for psychosocial interventions.
- The provider should ensure they continue to investigate and rectify the smell of drains in the building.






Our findings

Overview of ratings

Our ratings for this location are:

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

Substance misuse services

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

Are Substance misuse services safe?

Good 

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

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. A regional facilities team carried out regular risk assessments including fire, and other health and safety appraisals. Managers made sure staff were allocated each day to act as fire marshals and staff carried out daily checks to ensure any new risks were identified and dealt with. Managers had carried out a ligature risk audit and, as a result, they had made improvements to the building including fitting window restrictors in client accessible areas. The provider had completed a comprehensive risk assessment for violence and aggression. The staff and clients we spoke with at inspection told us they felt safe using the service.

All interview rooms had alarms and staff available to respond. Managers allocated specific staff each day to respond to any alarm. Staff reported there were very few incidents resulting in staff or clients needing to activate the alarms.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. Clinic rooms were well equipped. For example, they had a suitable couch, height and weight scales, blood pressure monitors, breathalysers and phlebotomy facilities.

All areas were clean, well maintained, well-furnished and fit for purpose. The clients we spoke with reported the building was always clean and the furnishings were of a good standard. We toured the building and saw that client areas were well maintained and furnished appropriately. Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control guidelines, including handwashing. The provider had carried out a thorough COVID-19 risk assessment and had implemented a one-way system in the building to reduce the spread of infection. Clients and staff had access to non-alcohol-based hand gel and there were posters demonstrating correct hand washing techniques. Staff wore face masks routinely and masks were available to clients and visitors, if they wanted them.

Staff made sure equipment was well maintained, clean and in working order. We checked that appropriate equipment had been calibrated correctly and staff had a schedule to ensure this was carried out annually.

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.

Nursing staff

The service had enough nursing and support staff to keep clients safe. At the time of our inspection, the service had approximately 1300 clients in a variety of treatment pathways including medically assisted treatment and shared care. The shared care scheme meant that clients could be prescribed treatment and seen by a recovery worker at a GP surgery local to them. The average caseload for support workers was around 75 but new staff were being appointed due to an increase in funding, and this meant that average caseloads would reduce. In addition to support workers, the service had four nursing staff including a team leader and a healthcare assistant.

The service had low and / or reducing vacancy rates. At the time of inspection, the service had vacancies for three recovery workers and one part time team leader. A new service manager had started in post on 4 January 2022 and was in the process of applying to be the new registered manager.

The service had low and / or reducing rates of bank and agency nurses. The service rarely used agency nurses, and none were being used at the time of our inspection.

Managers made arrangements to cover staff sickness and absence. When staff were absent, staff were required to provide cover for client appointments on a short-term basis. Where absence was protracted, managers booked agency staff. At the time of our inspection, there was one agency support worker being used to cover COVID related absence.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers only used agency staff that were experienced in substance misuse. The agency staff in use was familiar with the provider and had worked with them for an extended period.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates. Many staff had been with the service since before CGL took over the contract in 2019. Since then, there had been only a small number of leavers. The turnover rate for the location at February 2022 was 2%.

Managers supported staff who needed time off for ill health. They had access to regional occupational resources to support staff who needed it.

Sickness levels were higher than the provider average but there had been three staff absent from work with long-term sickness. Managers had support from a regional human resources department to support the management of sickness. The absences did not affect staffing levels because the provider had recruited temporary staff cover.

Managers did not use a recognised tool to calculate safe staffing levels. They were allocated a budget with an associated service specification that came directly from a lead commissioner in the local authority. The numbers and roles of staff were broadly in line with what was commissioned.

Medical staff

The service had enough medical staff. The service had a full-time consultant psychiatrist, a doctor and a part-time nurse prescriber.

Substance misuse services

Managers could use locums when they needed additional support or to cover staff sickness or absence. At the time of our inspection, there was one locum doctor that had been working in the service for the previous eight months. A new full-time doctor had been appointed and was due to start imminently.

Managers made sure all locum staff had a full induction and understood the service. The locum doctor had worked for other CGL services, so was familiar with the policies and procedures. Nevertheless, they had a thorough induction on starting at the location.

The service could get support from a psychiatrist quickly when they needed to. Staff had pathways in place with the local mental health trust to ensure clients with a dual diagnosis could be seen when they needed to. Staff had clear guidance to help them decide the urgency of referrals.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff reported they were up to date with their mandatory training and the provider reported 100% compliance at February 2022.

The mandatory training programme was basic and consisted of safeguarding, (adults and children), equality, diversity and inclusion, data protection and information security, health and safety, and mental capacity. We confirmed, through additional data requests, that all staff had received appropriate training in managing workplace violence and aggression. Medical staff had basic life support and anaphylaxis training and some recovery workers were trained first aiders.

Managers monitored mandatory training and alerted staff when they needed to update their training. The provider had a learning and development team that provided regional support to each location. They kept managers informed about training compliance rates for their team and reminded them when staff were due to have refresher training.

Assessing and managing risk to clients and staff

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

Assessment of client risk

Staff completed risk assessments for each client on arrival, but they did not use a recognised risk assessment tool. Staff used a checklist developed by the provider to identify a range of risks relevant to the client group. When we reviewed client care records, we found staff reviewed the risk assessment regularly, including after any incident. However, we saw one record where a client's risk of self-harm had not been updated despite them having had a recent intentional overdose. The provider immediately requested the worker to update this.

Staff could recognise when to develop and use crisis plans. The clients we spoke with confirmed staff had provided information about who to contact in a crisis and we saw examples in client care records. Clients were routinely asked to provide details of who could be contacted if they dropped out of treatment or if the staff were concerned for their safety.

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. Clients gave us examples of how staff had responded, for example, when their physical health deteriorated. Clients could see their prescriber quickly when needed and staff referred them for further investigations where their symptoms warranted this. In care records, we saw how staff requested police welfare checks where they were concerned for a client's safety.

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Risks to clients from prescribed medication were reviewed regularly by the medical team who instigated daily supervised consumption until they were sure that any risks could be safely managed. The provider had clear policies in place to ensure clients were not kept on supervised consumption unless this was necessary.

Staff continually monitored clients on waiting lists for changes in their level of risk and responded when risk increased. The only time the service had a waiting list was over the last Christmas and New Year period when COVID related absence meant that staffing was temporarily affected. In this instance, managers drafted staff from other CGL services to provide telephone support and monitoring to clients on the waiting list. At the time of our inspection, there was no waiting list for treatment in either the drug or alcohol service.

Staff followed clear personal safety protocols, including for lone working. Staff carried out home visits in pairs or used a buddying system. They kept their electronic calendars up to date and were provided with mobile phones.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. The service provided clear guidance to staff on which level of training was appropriate for their role and managers received a higher level of training. Training consisted of both adult and child safeguarding.

Staff kept up to date with their safeguarding training. Managers arranged safeguarding training through the local safeguarding board. This meant training was multi-agency and staff could learn from a wider multidisciplinary team. The safeguarding lead offered additional training and support to staff. At February 2022, the provider reported 100% compliance with staff safeguarding training.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff received training in equality diversity and inclusion as part of their mandatory training, and they demonstrated a good understanding of these issues.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The service had a full-time safeguarding lead to support and advise staff. We saw examples of joint working with social care agencies in the care records we looked at. However, we saw one record where safeguarding concerns had not been flagged to the safeguarding lead in line with the provider's procedures. The client was already involved with social care and staff had liaised appropriately with the relevant professionals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff made direct referrals to the local authority where appropriate but also could speak with the safeguarding lead who provided ad hoc support and access to regular safeguarding supervision for all staff.

Managers took part in serious case reviews but there had not been any serious case reviews in the 12 months prior to our inspection. The provider had not been required to participate in any serious case reviews in the locality since they started to deliver the contract.

Staff access to essential information

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

Substance misuse services

Client notes were comprehensive, and all staff could access them easily. We looked in detail at a sample of client care records. Notes were comprehensive and all staff could access them from computers in the staff office. Staff working in the shared care part of the service used different systems in GP practices, which meant they had to duplicate notes in order to also record them on the provider's system.

When clients transferred to a new team, there were no delays in staff accessing their records. Staff across the provider's portfolio used the same recording system which meant staff could share care records where appropriate with other CGL staff.

Records were stored securely in the provider's electronic system. Each member of staff had a discrete log-on identity and managers had information governance processes underpinning this.

Medicines management

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

Staff followed systems and processes to prescribe and store medicines safely. Medicine fridge temperatures were monitored, and staff took corrective action if they fell outside the recommended ranges. Clinic rooms were fitted with air conditioning to ensure emergency medicines were stored at the correct temperature.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Each client's medicine was reviewed face-to-face by a prescriber in line with national guidelines. We looked at recent data to confirm this and, when we spoke with clients, they told us they saw their prescriber regularly for reviews.

Staff completed medicines records accurately and kept them up to date. All clients' prescribing history was documented clearly in their care record.

Staff stored and managed prescribing documents safely. The provider had robust systems in place for the storage and administration of controlled drug and other prescriptions. Systems were highly secure and overseen by experienced administration staff.

Staff followed national practice to check clients had the correct medicines when they were admitted, or they moved between services. Staff checked the records of clients in shared care to ensure they were receiving their medicines in line with national guidance. The clinical lead provided advice and support to hospital staff about specialist prescribing when clients were admitted for general medical in-patient treatment. They also advised and supported local shared care GP's.

Staff learned from safety alerts and incidents to improve practice. The provider had national systems in place to cascade information about safety alerts. Some safety alerts about street drugs were posted in reception areas so clients could see them.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had a full-time consultant psychiatrist that reported to the provider's medical director. They carried out checks to ensure that all prescribing was done in line with national guidance.

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Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance. Medical staff could describe how they regularly assessed and monitored the impact of their prescribing on client's physical health. They had good links with secondary care to ensure clients that needed it had regular electrocardiograms and appropriate blood tests.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff reported incidents on an electronic reporting system, in line with the provider's policy. This included reporting near misses. All the staff we spoke with knew what incidents to report and how to report them.

Staff reported serious incidents clearly and in line with the service's policy. This included reporting client deaths, which they reviewed to identify learning.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. In the 12 months prior to our inspection, the service had not had any incidents that met the threshold for the duty of candour, but they had a policy about being open and honest when things went wrong.

Managers debriefed and supported staff after any serious incident. For example, following any client death, the quality lead convened a meeting involving the relevant recovery co-ordinator, the clinical lead and other managers, to support staff and reflect on any immediate learning. Staff found this process helpful and did not feel blamed or scapegoated.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations as appropriate. Serious incidents investigations were led by the quality and governance lead and involved an in-depth review of the client care records with a written report outlining any lessons learned including good practice. Managers met regularly with the local mental health trust to review learning from deaths where the client had been in receipt of mental health services. The learning from deaths and serious incidents procedures were well embedded in the service. Managers were part of a wider drug related death learning process led by the local authority.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents and deaths was shared with staff in team meetings and in the short briefing meetings that staff held every morning. Prior to the pandemic, the quality lead circulated a regular lessons learned bulletin to all staff, and this was due to start up again.

Staff met to discuss the feedback and look at improvements to client care. Staff discussed incidents in the morning communication meetings. We saw evidence that the quality lead followed up discussions with emails to all staff. Managers discussed lessons learned in regular leadership meetings.

There was evidence that changes had been made as a result of feedback. For example, staff incorporated any client hospital admissions or discharges into their morning briefing. This was as a result of an incident where a client had been discharged from hospital without the recovery team being aware.

Substance misuse services

Are Substance misuse services effective?

Requires Improvement 

Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans did not always reflect the assessed needs, and were not holistic or recovery oriented.

Staff completed a comprehensive mental health assessment of each client. We looked at a sample of care records and found that each client had an assessment that was holistic and covered a range of relevant domains including, substance use and social/psychological functioning.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. Clients that had identified health concerns were assessed by the nurse or by the health care assistant.

Staff could not evidence that they developed a comprehensive care plan for each client that met their mental and physical health needs. When we spoke with clients, most of them they told us they had care plans that reflected their broad goals. However, when we looked in detail at a five care records, we could not see evidence of a comprehensive care plan in any of the ones we looked at. Care plans were combined with risk assessments and consisted of over-arching goals. It was not always clear what actions would be taken to address the goals and by whom.

We saw examples of blank collaborative recovery plans that the recovery team used in the structured groupwork sessions, but we did not see these with clients using the alcohol or drug treatment service. The provider was aware of the limitations of the current case records system and had plans to improve it.

Staff reviewed and updated care plans only when clients' risks were reviewed rather than when their needs changed. Progress notes did reflect changing needs, but the care plans did not always reflect current goals. We saw one example where the client had become drug free but there was no mention of this in the care plan.

Care plans were personalised but not holistic or recovery orientated. Care plan goals were not always specific, measurable, or time bound. Goals were focussed mainly on substance use with no evidence of client strengths and resources and no clear actions describing who would do what and when. Overall, the care plans we looked at did not meet guidelines issued by the department of health, (drug misuse and dependence: UK guidelines on clinical management, 2017). The provider did not have a policy in place to guide staff on what constituted a suitable standard for a care plan.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the clients in the service. Staff provided prescribing and psychosocial interventions in line with guidance provided by the National Institute for Health and Care Excellence and the Office for Health Improvement and Disparities, (OHID). We observed two group work sessions facilitated by recovery workers. They used an evidence-based approach with workbooks to guide clients through recovery. There was a medical director and a pharmacy lead at provider level. They met regularly with the clinical lead in the service to review

Substance misuse services

the interventions on offer to ensure compliance with national standards. However, some of the visible recovery activities in the service had ceased due to the pandemic, although clients still had access to mutual aid groups, some of which ran in the provider's building. Managers had plans to re-start the the recovery café and other peer-led initiatives when the new volunteer coordinator started in post.

Staff made sure clients had support for their physical health needs, either from their GP or community services. We saw examples in care records how clients were referred to their GP and other health services as needed. Clients gave us examples of how they were referred for treatment which, in some cases, had identified more serious conditions. The service had innovative pathways with local services so that clients access treatment for hepatitis C from within the provider's building.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. Clients had very good access to blood borne virus testing and immunisation on site through an innovative partnership with a national charity. Staff signposted clients to health improvement services, such as quit smoking and weight management.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. The service had a full-time quality lead and a full-time safeguarding lead. They carried out regular audits, for example, to check how well safeguarding procedures were embedded in the organisation. The audit schedule had been reduced over the period of the pandemic, but was due to increase again as the service got back to business as usual.

Managers used results from audits to make improvements. Results from audits were shared with staff, and managers ran workshops when they identified issues for improvement. For example, the safeguarding lead was planning a staff learning event following the safeguarding audit.

Skilled staff to deliver care

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

The service had access to a full range of specialists to meet the needs of each client. The service employed specialist doctors and nurses as well as experienced recovery workers. Clients could access specialist in-patient detoxification and rehabilitation depending on need, and they had direct access to treatment for hepatitis C infection through a partnership with another service provider. The service employed a full-time specialist worker who could provide clients with advice and support on a range of housing and benefit issues.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care. Recovery workers were trained in motivational interviewing and other psychosocial interventions. They were very experienced, and some had lived experience in substance use. Medical staff were experienced and had undertaken specialist training in addictions. The clinical service was led by an experienced consultant psychiatrist with specialist addictions knowledge.

Managers made sure staff received specialist training for their role. Two administrative staff carried out screening and triage with new referrals. They were supported by recovery workers and, had received specialist training for their role.

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Managers gave each new member of staff a full induction to the service before they started work. We spoke with a new member of staff who confirmed that they were in the process of a full and structured induction programme. As part of this, they were allocated time to read policies and were required to sign to say they had read them.

Managers supported staff through regular, constructive appraisals of their work. We spoke with a variety of staff who confirmed they were up to date with their appraisal. Managers provided evidence that at February 2022, the appraisal compliance rate was 100%.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Each week, members of the multidisciplinary team met to discuss cases and staff attended regular safeguarding and casework supervision. In addition, managers made sure all staff had access to one-to-one well-being supervision from their line manager. We looked at data that showed current supervision compliance was at 100%.

Managers supported medical staff through regular, constructive clinical supervision of their work. The clinical lead for the service provided monthly supervision for medical staff and they in turn received supervision from CGL's medical director. Compliance with clinical supervision was 100% and formed part of the revalidation process for clinical staff. Medical staff met with other clinical leads from across the region each month for continuous professional development.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. As part of our inspection, we looked at a sample of team meeting minutes and saw that staff had access to weekly team meetings. Notes from meetings were sent out by email to staff who could not attend. Each treatment pathway had a separate team meeting but there was no standard agenda across the teams. This meant we could not be sure whether each team was discussing the issues that the provider thought were important.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The staff we spoke with confirmed they had access to a variety of training opportunities and medical staff had access to high quality continuous professional development. All staff had access to monthly discussion calls, where they could debate topical issues with other teams working across CGL nationally.

Managers recognised poor performance, could identify the reasons and dealt with these. Managerial staff were supported by the provider's human resources personnel. Each region had a named lead that provided specialist advice and support to managers to deal with any performance issues.

Managers were planning to recruit, train and support volunteers to work with clients in the service. They had appointed a full-time coordinator who was due to start imminently. They already had appropriate policies and procedures in place for this.

Multidisciplinary and interagency teamwork

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(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. Staff met with doctors and nurses weekly to discuss complex cases. Each treatment pathway had their own meeting and the clinical lead also met with prescribers and recovery staff every month to discuss clients on medically assisted treatment. Together they discussed strategies for helping clients move from one treatment stage to the next. We reviewed a sample of minutes from these meetings.

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Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. In addition to weekly multidisciplinary meetings, staff met every morning to share information about, for example, client admissions and discharges to in-patient care, significant risks and staff cover for client appointments. We observed one of these meeting and saw how staff worked effectively with each other, including with administrative staff to share relevant information about the day's events.

Staff had effective working relationships with external teams and organisations. Managers and service leads had good working relationships with other services in Rotherham including mental health services, GP's, domestic abuse organisations, housing agencies and criminal justice agencies. They were part of a multi-agency suicide prevention group and had representatives who attended the Multi-Agency Risk Assessment Conference, (MARAC). Each time a prescriber reviewed a client, they wrote to their GP to update them on progress and any concerns.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The clinical lead, a qualified consultant psychiatrist provided staff with regular refresher training and Mental Capacity Act training was on their mandatory training course. At February 2022, the compliance rate for this course was 100%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. The staff we spoke with confirmed they knew how to access the policy, which was on the provider's intranet.

Staff knew where to get accurate advice on Mental Capacity Act. The clinical lead for the service acted as a resource for staff and provided support with any issues of, for example, fluctuating capacity.

The service did not monitor how well it followed the Mental Capacity Act, but we found no concerns when we looked at care records and spoke with staff.

Are Substance misuse services caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for clients. All the clients we spoke with, without exception, confirmed that staff were caring, compassionate and responsive when they needed support. Clients said staff treated them well and behaved kindly. At inspection, we observed this for ourselves as we spent time in the service watching how staff interacted with clients.

Staff gave clients help, emotional support and advice when they needed it. We saw many examples of staff providing clients with practical and emotional support. The service ran a café and could supply clients with meals and food.

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Unfortunately, this had stopped due to the pandemic, but there were plans to re-start this when a new coordinator started in post. The service had less of a 'drop-in' feel due to the continued need for good infection control and social distancing. However, clients confirmed they got a lot of support from staff and missed the opportunities that were on offer pre-pandemic.

Staff supported clients to understand and manage their own care treatment or condition. We saw that staff interacted with other health professionals to help clients understand and manage associated health conditions, for example, blood borne viruses. They directed clients to specialist health services where appropriate, and clients could speak with their prescriber about their medicines, including any side effects.

Staff directed clients to other services and supported them to access those services if they needed help. Clients had access on three days per week to an expert by experience from a national charity that provided advice and testing for hepatitis C. Staff could facilitate quick access to treatment for hepatitis C because treatment nurses offered clinics at the provider's location. This meant clients did not have to travel to the nearest city for treatment as they had done previously. Staff facilitated access to other support, such as housing. Staff assessed clients' needs for specialist in-patient detoxification and rehabilitation and supported them to access the most appropriate provider.

Staff understood and respected the individual needs of each client.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. We spoke with staff including managers, administrative staff and prescribers who all confirmed they would raise concerns about negative attitudes towards clients. At inspection, we observed how staff displayed a non-judgemental approach towards clients.

Staff followed policy to keep client information confidential. The service had clear confidentiality policies which staff explained to clients at assessment. We looked at care records which showed evidence of staff sharing information with the appropriate consents. Clients had information sharing agreements in place so staff knew who they could share information with, and this included carers and other agencies.

Involvement in care

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

Involvement of clients

Staff involved clients and gave them access to their care plans. The clients we spoke with said they felt involved in their treatment and some of them told us they had a care plan. However, we could not see evidence in any of the care records we looked at that clients had been asked if they wanted a copy. We saw examples of collaborative recovery plan templates that the recovery team used in the structured groupwork sessions and some of the clients we spoke with referred to these. Clients in receipt of medically assisted treatment reported that prescribers worked in a person-centred way and they felt listened to.

Staff made sure clients understood their care and treatment (and found ways to communicate with clients who had communication difficulties). In one care record we saw that staff had made adjustments for a client with a hearing impairment.

Staff involved clients in decisions about the service, when appropriate. Prior to the pandemic clients were involved in helping to recruit new staff and, managers told us this was something they would re-start when the new volunteer

Substance misuse services

co-ordinator started in post. In the meantime, staff made sure clients could access service user representation through a regional expert by experience. This person was able to meet clients at the local service and feed back to the provider's national service user forum. Staff told us that the remit of the new volunteer co-ordinator post was to further develop peer mentoring and service user representation.

Clients could give feedback on the service and their treatment and staff supported them to do this. They had access to a suggestion box, and, throughout the pandemic, staff carried out regular pulse surveys. They engaged clients well in providing feedback and encouraged them to provide suggestions for improvement. Staff gave us examples of improvements they had made to the service as a result of client feedback.

Involvement of families and carers

Staff informed and involved families and carers appropriately. We saw evidence in care records that staff liaised with families and carers provided they had the relevant permissions and consents. Staff involved families through training programmes aimed at increasing the provision of naloxone, a drug used to reverse the effects of opiate overdose.

Staff helped families to give feedback on the service. This had been put on hold due the pandemic, but staff had plans to start this up again and including carers in the regular client feedback surveys.

Staff gave carers information on how to find the carer's assessment. Staff had access to a bank of up to date information about local services and help for carers, including, where appropriate, how to access an assessment of their needs.

Are Substance misuse services responsive?

Access and waiting times

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

The service had clear criteria to describe which clients they would offer services to and offered clients a place on waiting lists as needed. Ordinarily, the service did not have a waiting list except for a short period during the pandemic when sickness absence affected staffing levels. Staff told us the service interventions aimed at adults with substance use and associated problems. Managers had developed a separate alcohol treatment pathway to ensure the needs of this cohort of clients were responded to.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. The only time the service had breached the three-week waiting time was over the Christmas and New Year period of 2021/22 when staff illness due to COVID caused them to have a short waiting list. We spoke with the lead commissioner for the service who confirmed that the provider had previously met waiting time targets and, often exceeded them.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. Staff triaged new referrals to determine their priority for assessment. Clients that had just been released from prison or pregnant women were seen more urgently. We attended a morning meeting and saw that staff discussed urgent referrals. Medical staff had appointments reserved for clients with urgent needs for medically assisted treatment.

Substance misuse services

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. The service had a criminal justice team that worked alongside the police to provide interventions to people that had been arrested for drug and/or alcohol related offences. The housing worker had also done some work trying to engage rough sleepers in the town. The service did not have a needle exchange in the building but facilitated local pharmacists to carry out this function. We thought this might represent a missed opportunity to provide harm minimisation advice to clients not engaged in treatment.

Staff tried to contact people who did not attend appointments and offer support. Although the service did not have an assertive outreach function, staff followed a clear procedure for contacting clients or their carers when they failed to attend. Clients were asked during their treatment who they would wish to be contacted and staff checked they had the relevant permissions before getting in touch with clients' families.

Clients had some flexibility and choice in the appointment times available. There were also evening appointments available for clients that worked. Staff facilitated access to mutual aid that ran in the evenings and was hosted in the provider's building.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible. Appointments were transferred to other staff where this was possible, or the need was urgent.

Appointments ran on time and staff informed clients when they did not. When we spoke with clients, they told their appointments generally ran on time. Staff told us they did not receive complaints or feedback about having to wait too long to see their worker or prescriber.

Staff supported clients when they were referred, transferred between services, or needed physical health care. The clinical lead could provide guidance to hospital staff, when clients that needed specialist prescribing were admitted for in-patient treatment. Staff supported clients to transfer to local shared care services and the clinical lead provided advice and training to the GP's on the scheme. Prescribers regularly sent written referrals to the client's GP or secondary care services where they identified a need. Many of the clients we spoke with thought the service was highly responsive in this area.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity, but some clients had to wait outside due to the provider's infection control arrangements.

The service had a full range of rooms and equipment to support treatment and care. The provider had adapted the building to the best of their ability to provide adequate space for group work, individual work and clinical services. There was a fully equipped catering kitchen and dining area that was once a thriving café where clients got hot food at reduced prices. Unfortunately, this had closed due to restrictions imposed during the pandemic, but staff were hopeful this could soon start up again. In the meantime, clients could make themselves a hot drink whilst waiting for their worker and staff used a local community hub to run recovery groups. Staff told us they intended to carry out more recovery work in community hubs once the restrictions were lifted.

Occasionally, there was a very unpleasant smell of drains in the basement and ground floor of the building. The provider had sought professional advice and cleaning on more than one occasion, but the source of the problem had not been identified. This could be off-putting for clients, staff and visitors.

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Interview rooms in the service had adequate sound proofing to protect privacy and confidentiality and most rooms also had privacy windows.

At busy times, some clients were having to wait outside without access to shelter if they needed to see their worker. This was because the provider's COVID risk assessment limited the numbers of people allowed in the reception area at any one time. Clients and staff told us this created difficulty on both sides, but the policy was not due to be reviewed until May 2022.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Staff had created a separate entrance so people with mobility problems could be seen by prescribers and recovery workers. Staff confirmed the provider would support them with communication aids as needed and we saw on one record that staff had made adjustments for a client with impaired hearing.

During the pandemic, staff provided some clients with laptops and smart phones and other accessories so they could continue their work in the structured groupwork programme by attending virtually. Other clients that needed them were provided with mobile phones so they could keep in touch with their recovery worker and access essential help. Through a partnership with a local supermarket, staff delivered food parcels to clients in need. They delivered clients' medicines to their homes when they had to self-isolate.

Staff made sure clients could access information on treatment, local services, their rights and how to complain. The reception area contained information about local treatment services and staff were very experienced and knowledgeable about local resources. There was a poster in the reception area about how to complain but when we spoke with clients, many of them told us they had not been provided with information on how to complain. However, none of the clients we spoke with had any complaints and most said they would ask their key worker.

The service had information leaflets available in languages spoken by the clients and local community. Staff had access to appropriate interpretation facilities for clients whose first language was not English. The provider had a bank of leaflets in community languages that staff in local offices could print off as needed.

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

Listening to and learning from concerns and complaints

The service investigated complaints but staff did not always know who to pass complainants on to. Staff learned lessons from the results of investigations, and shared these with the team.

Some clients we spoke with told us they had not been provided with information about how to complain but felt comfortable asking their key worker if they needed to know. Managers told us the service was not commissioned to provide direct services to carers but that the complaints procedure was open to anyone.

Staff understood the policy on complaints, but did not always know how to handle them. Staff did not receive any formal training in how to handle complaints and we spoke with one person who told us they had rung the service to make a complaint but had not got anywhere. We raised this with the provider who contacted the complainant. The provider had a complaints policy in place and a complaints manager at provider level.

Substance misuse services

Managers knew how to acknowledge complaints and clients received feedback after the investigation into their complaint. Managers told us they did not receive many formal complaints but tried to respond to client concerns informally. Service managers allocated another appropriate manager to investigate the complaint and complainants were provided with verbal and/or written feedback. We looked at the records for recent formal complaints to confirm this.

Managers investigated complaints and identified themes. In the 12 months prior to our inspection, the service received five formal complaints. There were no themes, but managers told us they received some informal complaints about the difficulty of getting hold of recovery workers during the pandemic. One of the formal complaints was about this issue.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, managers had increased the number of telephone lines into the building so clients and other stakeholders could contact staff more easily.

The service used compliments to learn, celebrate success and improve the quality of care. The service encouraged clients to give feedback including compliments. In the 12 months prior to our inspection, the service received 21 compliments, both verbally and in writing. Most were from clients and many praised individual staff for the help and support they offered. Clients could also submit reviews on-line through an independent review site, which meant they were shared with the general public.

Are Substance misuse services well-led?

Requires Improvement 

Leadership

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

At the time of our inspection, the service did not have a registered manager in post. However, a new service manager had just started and was in the process of applying to become the registered manager. Staff had been supported locally by a regional manager and the local quality manager, both of whom were very experienced in managing substance misuse services. Together, they had an in-depth understanding of the service and the issues faced by staff and clients. Leaders were visible in the service. They were approachable and well respected by staff. Senior managers, including the regional manager met with local commissioners monthly.

Vision and strategy

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

The vision and values of the provider were integrated into the work of the team and formed part of the staff induction process. They were developed with staff as a result of a listening exercise by senior managers in 2019. We spoke with one newly recruited member of staff who confirmed that the vision and values were very accessible and seen as important to staff and clients because they meant something in practice. We saw evidence that staff were compassionate, which was one of the organisation's three values.

The provider had an organisational strategy which staff at local and regional level could contribute to.

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Culture

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

The staff we spoke with during the inspection felt supported and valued. They felt motivated and proud to work for the provider. Staff said the job was busy and could be stressful, but they had access to an employee assistance programme. When stakeholders including clients, provided positive feedback, it was shared with teams. Staff got on well with each other regardless of their different roles, and, they described it as a happy place to work.

Staff from across the whole organisation took part in regular staff satisfaction surveys but, for reasons of wanting to protect anonymity, the results were not disaggregated to the level of each individual location. The staff we spoke with reported that the service promoted equality and diversity in providing opportunities for career progression and this was confirmed by the latest regional staff survey carried out in 2021.

The provider had a comprehensive whistleblowing policy in place, the details of which were on the providers intranet. Staff had access to an electronic portal that allowed them to raise concerns with senior managers anonymously. The regional manager told us they had not had any serious concerns raised by staff locally since the provider took over the contract and all the staff, we spoke with confirmed they would feel able to raise concerns without fear of reprisal.

Governance

Our findings from the other key questions demonstrated that some governance processes did not operate effectively, but risks were managed well. Overall, performance issues were identified and acted upon.

The provider had taken over the contract for the service in April 2018, prior to the start of the pandemic. Staff locally had responded well to the challenges of the pandemic, but some governance processes had not been embedded locally. For example, the provider had an organisational clinical governance framework, but locally, it had not been fully implemented. Local clinical governance meetings were not happening regularly. Staff held team meetings but there was no standard agenda which meant managers could not be sure whether each team was discussing the issues that the provider thought were important.

Some clients had to wait outside the building for their appointment because there could only be limited numbers of people in the reception area due to the provider's infection control policies. The COVID risk assessment was not due to be reviewed until May 2022, which was several months away.

The assessment and care planning policy was not robust and did not provide staff with guidance about how to develop recovery orientated care plans with clients. Treatment policies were heavily geared towards prescribed treatment and managing risk with those clients. Recovery initiatives were not promoted effectively with clients in the shared care scheme and the electronic care record did not allow staff to evidence whether they had offered clients a copy of their care plan.

However, overall, there were effective systems to keep clients safe and medicines management and prescribing procedures were robust, including throughout the pandemic. There were enough staff to ensure clients' treatment was regularly reviewed and thorough safeguarding processes were in place. Serious incident procedures were well-embedded in the service and staff learned from adverse incidents.

Substance misuse services

Recruitment procedures had been strengthened and robust volunteer policies were in place. Staff worked well with external providers and had strong partnership arrangements in place to meet client need.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The provider had not met targets relating to the transfer of clients to shared care, but commissioners acknowledged this was largely out of their control due to the pandemic and the need for primary care to prioritise vaccination clinics. We could not see how recovery activities were readily accessible to shared care clients, but managers had recruited a new post at manager level to oversee the development of peer mentoring and visible recovery.

The provider had inherited a cohort of long-term clients from the previous provider and, some outcomes, such as planned completions were below target, partly because of this and the impact of the pandemic. Managers had developed an action plan to address this and this had been shared with commissioners.

The service had a local risk register to capture operational issues relevant to the location. Staff could escalate issues to a regional and national risk register as appropriate.

Incidents were reported and appropriate notifications made to external bodies where required. The service commissioner we spoke with confirmed managers kept them up to date with appropriate information about adverse incidents and client deaths. Staff made appropriate safeguarding notifications to the local authority and Care Quality Commission.

The service had business continuity plans, which staff had updated following a recent incident that had disrupted service provision for a short time.

Information management

Staff collected analysed data about outcomes and performance.

Managers had access to live performance data and were supported to collect and analyse client outcomes data by a full-time data manager. The data manager circulated weekly reports so staff could see when each of their clients had last been reviewed by a prescriber or seen for key working. Managers and staff had access to regular performance reports so they could see how the service was performing in relation to service targets, like waiting times and planned exits.

The provider monitored when clients did not attend appointments and they continued to do this throughout the pandemic. They found client attendance improved so they continued with more flexible measures, such as allowing virtual appointments and reducing the frequency that clients had to collect medicine from the chemist.

Staff reported client outcomes to commissioners on a monthly basis and provided a regular report concerning other aspects of service performance, including incidents, client deaths, safeguarding, complaints and compliments.

Regional staff supported local managers with live data concerning staff compliance with training and supervision. Managers had access to other personnel data, including, sickness and turnover rates, and, they could compare the performance of their service against other CGL services across the region and nationally.

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

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The provider must ensure staff know how to handle complaints and who to pass them on to.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must ensure that systems and processes are operating effectively to assess, monitor and improve the quality of the service. This includes ensuring there is appropriate guidance for staff on care planning, what issues should be discussed in team meetings and timely review of procedures that impact on clients having to wait outside.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider must ensure that care plans are recovery orientated and treatment goals reflect the full range of client need.