Change, Grow, Live

CHART Kirklees

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

Our rating of this location improved. We rated it as good because:

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.

The service had improved risk assessment and care plans since the last inspection and had developed holistic, recovery-oriented 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. 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 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 planning. Feedback from clients, families and stakeholders was overwhelmingly positive.

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 was well led, and the governance processes ensured that its procedures ran smoothly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	Our rating of this service improved. We rated it as good

Summary of findings

Contents

Summary of this inspection

Background to CHART Kirklees

Chart Kirklees which is part of Change Grow Live has had been registered with the Care Quality Commission since March 2021.

Chart Kirklees provide services in Huddersfield and Dewsbury for specialist substance misuse which include substitute prescribing and recovery coordination.

The service is registered with the CQC to provide the following regulated activities:

Treatment of disease, disorder or injury.

The service prior to this registration had been inspected in November 2018 and rated as requires improvement in safe and effective and good in caring, responsive and well led.

The service had been issues two requirement notices;

Not all clients had a care plan which was holistic and personalised. Records did not include evidence of individual goal setting and were not recovery focused. Records did not include a plan for unexpected exit from treatment or discharge and did not evidence the range of interventions offered by the service. There was no evidence that clients were offered a copy of their care plan.

Not all clients had a completed and up-to-date individual risk assessment. Risk management plans were not in place to mitigate risks identified. Records did not include evidence of clients being offered physical health assessments in line with service policy.

During this inspection we found that both these requirement notices had been met.

What people who use the service say

We spoke with 14 clients and 3 carers; all spoke positively about the service citing incidents where staff had spoken to them on their days off and how they had been supported both physically and emotionally.

How we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

The team that inspected the service comprised of one CQC inspector and a special professional advisor. There was another CQC inspector who conducted interviews online and did not visit the provider.

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

Summary of this inspection

visited the providers premises in Huddersfield and Dewsbury, looked at the quality of the environment and observed how staff were caring for clients;

spoke with 14 clients who were using the service;

spoke with three carers/family members of clients who were using the service;

spoke with both the service manager and the two project managers who had operational responsibility for service delivery in Huddersfield and Dewsbury;

spoke with other staff members including service doctor, nurses and recovery co-ordinators;

looked at 12 care and treatment records of clients;

observed two multi-disciplinary team meetings or flash meetings and one group work session;

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.

Outstanding practice

We found the following outstanding practice:

At the previous inspection the service had been recognised for outstanding practice because of a recent introduction of their 'wellbeing wheels'; a mobile van enabling the service to provide a dedicated outreach service whereby staff can conduct assessments and give harm minimisation advice in the community. The wellbeing wheels provided support to those clients who may find it difficult to travel to the service and was being used to travel to areas with the highest client populations and lowest client engagement.

The service had continued to improve this resource developing innovative ways to reach out to clients. The vehicle was now being deployed according to intelligence targeting clients. During our inspection the vehicle was at identified pharmacies based upon which clients were due to collect prescriptions that day. For example, clients known to require blood borne virus testing were picked up this way. This targeted approach was enhancing community health safety.

The service had made great efforts to engage the Asian population. They delivered a community champions course aimed at that demographic. The course uniquely looked at substance abuse not only from a harm reduction perspective but also from a faith perspective. Delivered in faith settings the course had been welcomed by faith leaders and had increased understanding in a community that has not previously engaged with substance misuse services. The course had been so successful faith leaders had asked the service to deliver a version for youth groups.

The service had appointed two recovery co-ordinators as specialists in over the counter prescribed medicines such as codeine. They supported a growing number of clients with specialist needs.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community-based substance misuse services

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

Are Community-based substance misuse services safe?

Good

Our rating of safe improved. We rated it as good.

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. There were two main operational centres one in Huddersfield and one in Dewsbury. These provided clinic rooms and group meeting rooms. Most group work with clients took place in other premises away from the operational centres.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. All health and safety checks and certificates were in place. There were personal emergency evacuation plans in place for staff who had disabilities.

All interview rooms at Huddersfield had alarms, in Dewsbury staff carried personal attack alarms.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations.

All areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control guidelines, including handwashing. Managers prompted visitors to wear appropriate personal protective equipment and use hand sanitiser before entering premises. Posters were displayed around buildings to advise staff and clients of good hand hygiene and masks were being worn inside the premises.

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

Safe staffing

Good

Community-based substance misuse services

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.

The service had low vacancy rates. The vacancy rate for the service was 9%. There were eight vacancies of which six had been filled or being interviewed for, two had been placed on hold pending the recommissioning of the service. The service did not use bank or agency staff.

Managers made arrangements to cover staff sickness and absence. The service sickness rate was 4.31%.

Managers supported staff who needed time off for ill health.

Managers used a recognised tool to calculate safe staffing levels. The average caseload number per team member was 43. Managers had calculated caseload to reflect client risk. The navigator team who dealt with the most complex cases had an average of 13 cases and the opiates workers carried on average 55 clients. This was a mix of face to face or online appointments including clinics.

The number and grade of staff matched the service's staffing plan.

Medical staff

The service had enough medical staff. The service employed non-medical prescribers. There was a doctor who supported the non-medical prescribers. Staff worked closely with local GPs where possible and we saw letters to a client's GP once they started treatment. They had shared care workers within local GP surgeries.

The service could get support from a psychiatrist quickly when they needed to. The service had a dual diagnosis psychiatrist, and referrals were made via a weekly mental health meeting.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff were required to complete a range of mandatory training. The completion rate for all staff undertaking mandatory training was 100%. The completion rate for mandatory training excluded a new member of staff completing their induction.

The mandatory training programme was comprehensive and met the needs of clients and staff.

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

Assessing and managing risk to clients and staff

Good

Community-based substance misuse services

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

Assessment of client risk

Staff (Recovery workers) completed risk assessments for each client when they were first seen using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed 12 care records and found that clients had a risk assessment and risk management plan in place. Risks concerning clients' physical and mental health were assessed, in addition to specific risks regarding substance misuse. The risk assessment of clients misusing alcohol included assessing the risks of alcohol withdrawal seizures and delirium tremens. With clients using opiates, the risk assessment included the risk of overdose.

We found that the service had made improvements since the last inspection and clients now had risk management plans in place which detailed what was required to mitigate and manage risks.

Staff used a recognised risk assessment tool.

Staff could recognise when to develop and use crisis plans and advanced decisions according to client need. We saw evidence of risk management plans in the records which included the identification of protective factors.

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. Clients receiving opiate substitution treatment, such as methadone, had varying levels of medicines supervision, based on assessed risks. Some clients attended a community pharmacy daily for a pharmacist to supervise them taking medicine. Other clients, with lower assessed risks, collected their medicine weekly from the pharmacy. When clients took methadone home, they were provided with lock boxes to minimise the risk of children or others getting access to it.

At the start of the COVID-19 pandemic, the provider advised all services that clients taking their medicine under the supervision of a pharmacist should have their prescription changed so that they could collect it once a week or fortnight. Operational and clinical leaders in the service identified some clients where the risks of overdose or diversion of their prescribed medicines would be too high if this happened. Those clients continued to be supervised by pharmacists taking their daily medicines.

Staff gave clients information on harm minimisation to minimise risks to them. This included information to prevent clients getting blood borne viruses and about the risks to clients of drinking alcohol or taking drugs with their prescribed medicines. Peers had been trained in the use of naloxone, and this was now available within the community. Clients had access to a needle exchange and harm minimisation at the premises.

There were protocols in place for dealing with the disengagement of treatment of clients. Recovery co-ordinators had to complete a check list which was quality assured by the team manager. This included a disengagement plan, outreach attempts, safeguarding actions as well as any referrals to the senior leadership team.

The service had processes in place for what to do when there were suspicions or there was evidence that clients had passed their substitute medicine to a third-party for illicit purposes (an act commonly known as diversion). We saw evidence that the service acted when they identified this practice. They had placed several clients back on daily supervised consumption.

The service did not have a waiting list.

Staff followed clear personal safety protocols, including for lone working.

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 had made 48 safeguarding referrals in the last 12 months.

Staff kept up-to-date with their safeguarding training. Staff completion rate was 100%.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. They had made 33 adult safeguarding referrals and 15 children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had two social workers who advised staff on safeguarding issues. Staff described looking out for vulnerabilities including domestic violence and neglect either for or against the client. Staff reported good links with the local authority and felt able to ring colleagues for advice if needed.

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

Staff access to essential information

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

Client notes were comprehensive, and all staff could access them easily. Staff used electronic clients records to record and access information concerning clients.

When clients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

Good

Community-based substance misuse services

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

Staff followed systems and processes to prescribe and administer medicines safely. There was a mixture of nurses and non-medical prescribers responsible for the prescribing and monitoring of medicines.

Prescriptions for clients' medicines were carefully controlled and a system was in place to record changes to prescriptions and to track each prescription. This included tracking the delivery of each prescription to community pharmacies.

Naloxone was stored on site and regular checks were in place.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Staff provided advice on safe storage of methadone and this had been a consideration during the review of clients. Managers had introduced a three-way consultation in the which the client met with the prescriber and the recovery co-ordinator at the same time. This ensured clients did not have to retell lived experience and the prescriber and recovery co-ordinator both understood the client's needs and treatment decisions.

Staff offered clients alternative treatment where appropriate. We saw an example where a client had requested an alternative prescription. The client began to have anxiety as a side effect of that medication and the recovery co-ordinator and prescriber discussed the options available with the client eventually accepting a different treatment than they had initially requested.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

Staff learned from safety alerts and incidents to improve practice.

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

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance.

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. A range of incidents were reported, and these were discussed at team meetings and 'flash' meetings. Staff were involved in feedback from incidents and had the opportunity to discuss incidents.

Good

Community-based substance misuse services

There had been no serious incidents. Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service had no never events.

Staff understood the duty of candour. They could clearly describe their responsibilities under duty of candour. However, there had been no incidents requiring such a response.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service and made changes as a result of that feedback. For example, a serious incident outside the scope of the service involved the death of an infant sleeping with an adult. The service took on the advice circulated and trained staff to advise clients on infant safety.

Staff met to discuss the feedback and look at improvements to client care.

Managers shared learning with their staff about never events that happened elsewhere.

Are Community-based substance misuse services effective?

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each client. We reviewed 12 records and found that all clients had a full assessment completed.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. Records contained information of ongoing physical health problems and actions taken to support clients to attend appointments.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. Clients seeking treatment for alcohol misuse were assessed using the alcohol use disorder identification test and the severity of alcohol dependence questionnaire. Use of these assessment tools followed best practice guidance. A Doctor, nurses and non-medical prescribers assessed these clients for community alcohol detoxification with a focus on risk factors associated with community alcohol detoxification.

Good

Community-based substance misuse services

When clients needed a prescription for opiate substitution treatment they were assessed in person. Physical health checks including blood and urine drug screen tests were part of clients' assessment.

Staff regularly reviewed and updated care plans when clients' needs changed. Prescribers and recovery co-ordinators supported clients together through the three-way appointment system to identify appropriate treatment goals based on their needs. This resulted in a comprehensive care plan for each client that met their mental and physical health needs. The care plans reflected the stage that the client was in on their treatment journey. Recovery plans identified the named recovery co-ordinator involved in their treatment.

Care plans were personalised, holistic and recovery-orientated.

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 client group and consistent national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The number of clients who had successfully completed their treatment within the last 12 months was 462 out of 2657. Clients were encouraged to access the service again if they needed it with the acceptance that relapse could happen.

Staff provided a range of care and treatment suitable for the clients in the service. Staff provided community detoxification, substitute prescribing, harm reduction and psychosocial interventions. Clients had access to a needle exchange and were offered blood borne virus testing. The service targeted clients needing blood borne virus testing by offering tests at pharmacies on the day clients were due to pick up prescriptions.

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

Staff supported clients to live healthier lives by supporting them to take part in programmes which encouraged exercise, smoking cessation and group work to support their recovery.

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

Staff used technology to support clients. The service had a licence for online groups so that anyone, regardless of access to modern technology, could call into the group. This had been in response to COVID-19. Several carers spoke about how useful they found the online group sessions they had attended during COVID-19.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. These included audits concerning consent, safeguarding, infection control, risk and recovery planning, and prescriptions.

Managers used results from audits to make improvements.

Good

Community-based substance misuse services

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 a full range of specialists to meet the needs of each client. The team included non-medical prescribers, nurses, recovery co-ordinators, recovery workers (who did initial risk assessments), health care assistants, social workers and administrative staff. The service did not provide psychology and had a contract with another provider for group work provision.

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

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

Managers supported staff through regular, constructive appraisals of their work. All staff told us they received regular clinical and managerial supervision at least monthly. When staff on maternity and long-term sick were excluded the service recorded 100% of staff receiving supervision and appraisal.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were encouraged to continue their professional development and further specialist training in domestic violence issues, child exploitation, trauma informed practice, multi systemic therapy, parenting training, motivational interviewing, nursing and social work qualifications had been supported by managers.

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

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

Managers recruited, trained and supported volunteers to work with clients in the service. We spoke with several staff who had been recruited after volunteering in the service.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The 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 made sure they shared clear information about clients and any changes in their care, including during transfer of care.

Good

Community-based substance misuse services

There was a daily "flash" meeting. These were used for staff to share updated information regarding clients and to ensure that staff sickness or absence did not affect clients' appointments or treatment. This was also an opportunity for managers to discuss incidents and changes to service.

There were several multidisciplinary meetings held in the service. Every morning after the flash meeting staff could discuss with managers any client appointments that day. There was also an afternoon session for more complex cases. Staff were further supported with weekly opioid and alcohol case discussions.

A monthly governance meeting focused on a specific area, such as incidents, performance or client deaths. The weekly managers' meetings focused on service-wide matters, such as business continuity, performance, staffing and operational risk management.

Staff had effective working relationships with other teams in the organisation.

Staff had effective working relationships with external teams and organisations. Managers and staff in the service developed and maintained effective links and joint working with a wide range of organisations. There was a strong relationship with specialist midwives. Staff attended weekly sessions at a health-based location to provide immediate support for sex workers, this enabled staff to assess and prescribe immediately if appropriate.

The navigation team had been developed to pick up cases from the local hospitals, allowing staff to speak directly with clients before they were discharged providing an immediate support.

The service had a mobile van from which they could deliver services, they attended pop up events within local communities often in conjunction with other services. One example was the use of the vehicle in partnership with pharmacies. Staff would deploy the vehicle to pharmacies where they knew clients were due to collect prescription who were due a blood borne virus check and offer hepatitis vaccinations. The vehicle had been used during Covid-19 to inoculate hard to reach groups within their communities.

The service had staff seconded into custody suites at police stations, courts, probation service, prison, housing associations to help rough sleepers. Out reach workers attended local job centres to facilitate referrals.

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. All staff within the service had completed their Mental Capacity Act training.

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

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

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

Good

Community-based substance misuse services

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

When staff assessed clients as not having capacity, they made decisions in the best interest of clients and considered the client's wishes, feelings, culture and history. Where staff had a concern about capacity the service had processes in place to assess the client. If intoxication was the issues another appointment would be made, if there were concerns about capacity due to a mental health condition staff could seek professional help for a fuller assessment.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Are Community-based substance misuse services caring?

Good

Our rating of caring stayed the same. We rated it as 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. We spoke to 14 clients and three carers who all praised the service.

Staff gave clients help, emotional support and advice when they needed it. We observed staff in the reception and waiting room treating clients with compassion and kindness.

The clients we spoke to told us the importance of having someone believe in them and encourage them. One client who was in an occupation for which an addiction to over the counter medicines could cause them some embarrassment was reticent to attend group sessions. They told us their recovery co-ordinator although on a day off arranged to meet them to support them on their first session.

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

Staff directed clients to other services and supported them to access those services if they needed help. A client told us that they believed they were still alive because of the recovery co-ordinator. They were becoming more isolated and more depressed with suicidal thoughts. On a phone consultation the recovery co-ordinator became concerned, they immediately attended the clients home address and supported them to attend hospital to seek help and support.

We saw examples of clients being encouraged to access mental health services, attend GP and/or hospital appointments. Staff frequently advocated for their clients with other agencies to ensure their wider psychosocial needs were met. Staff clearly knew their clients and spoke very positively about them, challenging stereotypes. Staff were passionate about their work.

Clients said staff treated them well and behaved kindly.

Good

Community-based substance misuse services

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.

Staff followed policy to keep client information confidential.

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.

Staff made sure clients understood their care and treatment.

Staff involved clients in decisions about the service, and give feedback about the service, and their treatment. We reviewed the client survey and found that 281 clients had responded. The provider had changed this to a qualitative process asking three questions. What do you like, what do you dislike, what can we do differently? This enabled the provider to trace service changes to reflect client needs. For example, when asked what do you disliked 57% said they had no dislikes but 6% said they disliked the appointment system. The service responded by increasing appointment times up to 8pm three nights a week.

Involvement of families and carers

Staff informed and involved families and carers appropriately. We saw evidence in records of where family members were involved, and important contact numbers were contained within client records.

Carers all mentioned the level of support they had received to understand addiction and the behaviours of their loved ones. When face to face groups were not allowed the service provided group tele-conference sessions for carers.

Staff helped families to give feedback on the service.

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

Are Community-based substance misuse services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times

Good

Community-based substance misuse services

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. The service was easy to access. Its referral criteria did not exclude clients who would have benefitted from care, for example the service had developed a response to those requiring support as the result of addiction to over the counter prescribed medication. Staff assessed and treated clients who required urgent care promptly and clients who did not require urgent care did not wait too long to start treatment. They had assessment staff at other locations where clients could drop in or do group work ensuring any new clients walking in were assessed as soon as possible. Staff followed up clients who missed appointments.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. At the time of our inspection the service did not have a waiting list. Clients could self-refer or be referred by a third party and all referrals were assessed. To make access to the service easier clients needing an appointment with a prescriber following initial assessment had an appointment allocated not only with prescriber but also with their recovery co-ordinator. This prevented the client from retelling their lived experience but also saved more appointment time for staff as both saw the client at the same time.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. A community champions course has been developed targeting the Asian population discussing substance misuse through the mosque network.

A weekly mental health referral meeting ensured that those who require a dual diagnosis are referred appropriately.

Staff attended LGBT groups including drop-in sessions at community events

Staff tried to contact people who did not attend appointments and offer support. The service had processes in place for when clients arrived late or failed to attend their appointments which were fair and reasonable and did not place the client at risk.

Clients had some flexibility and choice in the appointment times available.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible.

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

Staff supported clients when they were referred, transferred between services, or needed physical health care. When clients were ready to be discharged from the service, staff ensured that other agencies had relevant information to support clients. Any safeguarding concerns were also communicated to other relevant agencies before a discharge took place.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

Good

Community-based substance misuse services

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

The service had a full range of rooms and equipment to support treatment and care. These were in two well-appointed buildings with the service moving to new premises since the previous inspection in Huddersfield. Therapeutic groups and drop-in sessions were delivered in different buildings in partnership with another provider. Both buildings had several toilets for clients to use to produce urine drug screen samples.

There were large office spaces for staff, meeting rooms and modern spacious reception areas.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

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. The service was accessible for clients using wheelchairs and clients with other mobility needs. Interpreters were available for clients who did not speak English. Leaflets and information in other languages and easy read versions could be downloaded by staff to provide to clients.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. Staff helped clients with communication, advocacy and cultural and spiritual support. The service had supplied clients with electronic devices during COVID-19 to ensure those who were vulnerable were supported.

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

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

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

Listening to and learning from concerns and complaints

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

Clients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. The service had received 10 complaints in the previous year. Of these 4 were not upheld, 4 were upheld and 2 were partially upheld.

Good

Community-based substance misuse services

Further examination of these revealed one of these was about a different provider received by the service which they treated as a complaint received, 4 complaints were in relation to prescribing and 5 complaints were in relation to the quality of care received from the recovery co-ordinators.

No complaints had been forwarded to the ombudsman.

Staff protected clients who raised concerns or complaints from discrimination and harassment.

Clients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. The service had received 42 compliments and managers shared these with staff at flash meetings.

Are Community-based substance misuse services well-led?

Good

Our rating of well-led stayed the same. We rated it as 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 the team worked well together. The manager had a good understanding of the service and the issues faced by the client group. The service had adapted well to changes in the last 18 months due to COVID-19.

The service manager worked across all teams with two project leaders providing the operational leadership to staff. Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

There was a positive staff culture in the service. More than one member of staff could recount when the managers had shown leadership through COVID-19. They cited incidents of personal support they had received directly from managers.

Vision and strategy

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

All staff had a job description and understood their roles and responsibilities in the team.

Good

Community-based substance misuse services

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Several staff members gave examples where they had approached managers with ideas on how to improve the service and they had been encouraged to deliver change.

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.

Staff felt proud, positive, satisfied, valued and part of the organisation's future direction.

Staff appraisals included conversations about career development.

Staff felt able to raise concerns at all levels without fear of reprisals.

Managers were open and approachable at all levels. Staff members praised the support they had received from the manager which made them feel especially valued.

The provider had a whistle blowing policy in place that was accessible to all staff.

The service responded proactively to bullying and harassment cases.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

Managers monitored staff morale, job satisfaction and sense of empowerment.

The manager fully understood the issues faced by the staff team and encouraged staff to raise issues and concerns with senior managers within the organisation.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

There were systems and procedures in place to ensure that the service was safe and clean, that there were enough staff, that staff were trained and supervised, that clients were assessed and treated well, and that staff adhered to the mental capacity act. Processes ensured that clients risks were managed and that successful discharge from treatment were planned. Regular meetings were in place to review and investigate incidents and structured to allow regular feedback to staff.

Good

Community-based substance misuse services

There was a clear framework of what must be discussed at a local and national level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

There was an annual audit plan, a service risk register and a business continuity plan. Systems and tools, such as staffing levels and the business continuity plan, were reviewed and tested to ensure they continued to reflect the service.

Staff undertook or participated in local clinical audits. The audits were enough to provide assurance and staff acted on the results when needed. Managers regularly audited patient records to ensure that risk assessments and management plans were up to date. The quality of care plans was regularly reviewed, and managers worked closely with staff to make improvements in the quality of care plans. These audits had ensured the areas of concern found at the last inspection had been improved upon.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the clients. Staff understood the importance of having good links with safeguarding and domestic violence staff.

Regular governance meetings took place where policies and procedures and audit outcomes were discussed and tracked.

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.

There was a clear quality assurance management and performance framework in place that was integrated across all organisational policies and procedures. The service had a contract in place with commissioners and had good links with the local public health community. The contract contained key performance indicators which were regularly reviewed.

Staff maintained and had access to the risk register at a service level. Staff felt able to escalate concerns when required to the manager who either dealt with them locally or escalated if needed. Staff were able to submit items to the provider's risk register which was accessible online. Staff concerns matched those on the risk register which included staffing.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. The service had responded to COVID-19 in a positive way, staff had been allocated into teams and given certain days to attend the office. There was a clear business continuity plan and all staff we spoke with felt the manager had shown real leadership.

Information management

Staff collected analysed data about outcomes and performance.

The service reported to the National Drug Treatment Monitoring Service. The service used these collated reports to review their performance compared to national findings.