

Change, Grow, Live

My Recovery Tameside

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 service stayed the same. We rated it as good because:

- My Recovery Tameside provided safe care. Both locations, Ashton and Hyde, 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 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.
- The introduction of the criminal justice team had allowed managers and staff to show their talents in developing a new treatment program which had received recognition as good practice from the government department responsible for the funding.
- 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.

However:

- Not all staff used the electronic care recording in the same way when updating new information about clients.
- The service was still establishing its full range of face to face support groups, community engagement and volunteer opportunities following the COVID-19 pandemic.
- Not all policies were up to date. The induction policy and the medicines management policy were overdue for review.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	

Summary of findings

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Summary of this inspection

Background to My Recovery Tameside

My Recovery Tameside is part of Change Grow Live has had been registered with the Care Quality Commission since July 2020. My Recovery Tameside provide services in Tameside with a clinic in Ashton and in Hyde 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 part of a larger Change Grow Live service.

What people who use the service say

We spoke with 10 clients; all spoke positively about the service. Several believed the service had changed their lives and they had been supported both physically and emotionally at a time when they had needed it the most.

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.

This was a comprehensive inspection focussing on all elements of the following key questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

The team that inspected the service comprised of one CQC inspector and two special professional advisors.

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

During the inspection visit, the inspection team:

- visited the provider's premises in Ashton and Hyde, looked at the quality of the environment and observed how staff were caring for clients
- spoke with 10 clients who were using the service
- spoke with both the service manager, deputy manager and the two project managers who had operational responsibility for service delivery
- spoke with other staff members including service doctor, nurses and recovery co-ordinators
- looked at 11 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.

Summary of this inspection

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>

Areas for improvement

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

Action the service MUST take to improve:

Action the service SHOULD take to improve:

- The service should ensure that all staff have the same understanding of the service electronic care recording system.
- The service should consider wider engagement within the community to reach out to diverse or isolated communities.
- The service should consider expanding its face to face support groups and continue to implement its volunteers approach following the impact of covid 19.
- The service should ensure that all policies are reviewed and updated in a timely way to ensure staff have relevant policies to follow
- The service should ensure privacy and confidentiality at Hyde is ensured by reviewing the reception area.

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

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 stayed the same. 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 mostly fit for purpose. There were two main operational centres one in Ashton and one in Hyde. These provided clinic rooms and group meeting rooms. However, at Hyde the reception area was next to the staff office with a large windowless square hole in the wall separating the two. This meant clients could overhear staff conversations and therefore potential issues around confidentiality.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The issue at Hyde regarding potential breaches in confidentiality had been identified through these audits and staff had been provided with a secure room in which to make calls to clients. Managers had also engaged building services and a permanent solution was planned.

All interview rooms had alarms and staff available to respond.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. These were well maintained, modern and spacious.

All areas were clean, well maintained, well-furnished and fit for purpose. We reviewed cleaning records and these demonstrated a comprehensive system to ensure infection control policies were being followed. The buildings, fixtures and fittings were well maintained.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning records and these demonstrated a comprehensive system to ensure infection control policies were being followed.

Staff followed infection control guidelines, including handwashing. Posters were displayed around buildings to advise staff and clients of good hand hygiene and to use hand sanitiser before entering premises.

Community-based substance misuse services

Staff made sure equipment was well maintained, clean and in working order. There was a clear system of record keeping to ensure equipment was checked regularly. All equipment had been checked and calibrated. There were stickers advising of the next checking date.

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.

The service had low and reducing vacancy rates. There were 6.5 vacancies at the time of inspection. One for the new role of health and wellbeing health care assistant, two recovery co-ordinators and 1.5 full time equivalent admin assistants. They had recruited a lead nurse and an associate specialist doctor and were waiting for employment checks to be completed.

Managers made arrangements to cover staff sickness and absence. Sickness rates had varied with a high of 12% due to covid infections to a current 7%, 2% of which was long term sickness. Managers supported staff who needed time off for ill health.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had used 15 agency staff in 12 months. These included support staff for additional admin and recovery co-ordinators. Mostly these staff covered the same post at different times.

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

Managers used a recognised tool to calculate safe staffing levels. The average caseload number per team member was 46. Managers had calculated caseload to reflect client risk. There was not a specialist team that dealt with the most complex cases therefore staff had a mixture of clients from high risk to those due to be discharged.

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. The service had a strong focus on physical health with health and wellbeing nurses and the service had introduced two new posts for health and wellbeing health care assistants. There was a GP with special interest to support that team.

The service could get support from a psychiatrist quickly when they needed to. These referrals were discussed through the multi-disciplinary meeting structure where clients needs were discussed.

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

Community-based substance misuse services

Managers monitored mandatory training and alerted staff when they needed to update their 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 integral part of recovery plans.

Assessment of client risk

Staff (Engagement workers) completed risk assessments for each new referral when they were first seen using a recognised tool, and reviewed this regularly, including after any incident. After the engagement workers had completed this assessment, initially via the phone and then face to face, clients were then allocated a recovery co-ordinator and a clinic appointment where appropriate.

We reviewed 11 care records and found in two that the clients voice was not represented and/or the assessments were brief in content. Not all staff had a clear understanding of the electronic care record system which meant that while all clients had a risk assessment and risk management plan in place staff would record further assessments or updates inconsistently.

Managers were aware of this issue and some staff were being supported through action plans to improve the quality and consistency of assessments.

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 also saw that clients waiting for an appointment (there was a three-week waiting list if assessed as low risk on initial phone assessment) were contacted and reassessed in case they had deteriorated.

Staff used a risk assessment tool. Staff used a checklist developed by the provider to identify a range of risks relevant to the client group.

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. Staff were able to identify the signs that clients' health may have deteriorated and respond accordingly. Staff made clients aware of the risks of continued substance misuse and harm minimisation / safety planning was an integral part of recovery plans. We saw evidence in care records that harm minimisation advice was provided to clients. Naloxone was offered and issued to clients and the service provided a needle exchange.

There were protocols in place for dealing with the disengagement of treatment of clients. Recovery co-ordinators consulted with team managers with a clear protocol in place. This included outreach attempts, safeguarding actions and contacting external agencies.

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.

Community-based substance misuse services

We witnessed a robust multi disciplinary meeting where clients having their prescriptions removed due to non-compliance were discussed and agreed.

Staff continually monitored clients on waiting lists for changes in their level of risk and responded when risk increased. We saw that clients waiting for an appointment were regularly contacted and reassessed in case they had deteriorated. During the time of the inspection there were 38 clients on the waiting list, those assessed as high risk were prioritised.

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 10 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 one adult safeguarding referral and three children referrals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had several designated safeguard leads. 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. The service had made six referrals to the local MARAC (Multi-Agency Risk Assessment Conferences).

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 always updated after consultations, and all staff could access them easily. Clients care records were fully recorded on the electronic system.

When clients transferred to a new team, there were no delays in staff accessing their records. Internal transfers between other Change Grow Live services could be completed electronically and arrangements were in place to assess new clients transferring from other service providers.

Records were stored securely. There was a password protected computer system for all records.

Community-based substance misuse services

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's 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, monitoring of medicines and physical health checks. 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. The service had introduced a system where clients referred to the service via criminal justice services were given a joint appointment with the prescriber and specialist criminal justice recovery worker to provide a quicker entry to the service and assessment of needs.

Medicines were dispensed at local pharmacies. Staff reviewed prescribing regularly and provided advice to clients about their medicines. Staff stored and managed all medicines and prescribing documents safely.

Staff learned from safety alerts and incidents to improve practice.

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance. Staff provided clients with naloxone kits. Naloxone is a medicine used in emergency treatment to reverse the life threatening effects of an opioid overdose. Staff trained clients on the use of naloxone before issuing the kit. The storage and issuing of naloxone was included in medicine audits.

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.

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.

Community-based substance misuse services

Managers debriefed and supported staff after any serious incident. Managers produced a bulletin looking at incidents and the lessons learnt. We saw one bulletin that looked at reported deaths and how the service quality assured its role in these incidents through the drug related deaths panels with Greater Manchester.

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. The service had supported three investigations into serious incidents not involving the service.

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 stayed the same. 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 11 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. The service had 2.2 full time equivalent health and wellbeing nurses and two health and wellbeing assistants (albeit with one vacancy). Clients had a full physical health assessment and staff 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.

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. We saw clients reviewed and updated care plans whenever there was a change in circumstances.

Community-based substance misuse services

Care plans were personalised, holistic and recovery-orientated. The personalised care provided was illustrated by the work of the criminal justice team who had developed a bespoke care package for clients entering through the criminal justice program. The program called “Reflect and Reconnect” was designed to meet the needs of that cohort. Protected time was maintained for emergency appointments or prison discharges. There was an eight-week program of face to face groups. Reflect was a harm reduction program and Reconnect helps support those who needed it reintegrate into the community. The program had been cited as good practice by the government department responsible for the funding.

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 harm reduction, community detoxification, substitute prescribing, and psychosocial interventions. Clients had access to a needle exchange on site and were offered hepatitis B and C testing.

However, we found that the service had not yet reached the number of support groups taking place before the pandemic. The current program offered 14 sessions, one of these on zoom, another one not at My Recovery Tameside premises, two were for the criminal justice cohort.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). The number of clients who had successfully completed their treatment within the last 12 months was 993 out of 2293. Clients were encouraged to access the service again if they needed it with the acceptance that relapse could happen.

The service had completed medical reviews of client's treatment in 92.66% cases and had plans in place to review those not yet reviewed.

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 or giving advice.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. Staff routinely recorded information relating to treatment and outcomes and reported these to the National Drug Treatment Monitoring System for monitoring and as a comparison to other services.

Staff used technology to support clients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements. These included audits concerning consent, safeguarding, infection control, risk and recovery planning, and prescriptions.

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 (access to) a full range of specialists to meet the needs of each client. Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care. These included non-medical prescribers, nurses, recovery co-ordinators, engage workers (who did initial risk assessments), health care assistants, and administrative staff.

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

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. At the time of our inspection, appraisal compliance was 90%.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Overall supervision compliance was 91%. Staff told us they had regular supervision and at times informal supervision with clinical staff and managers.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Managers had developed a newsletter to ensure those who could not attend were brought up to date.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Those with managerial responsibility were able to pursue formal management qualifications. Other staff members had completed suicide prevention, domestic abuse, child sexual exploitation and adverse childhood experiences.

Managers recognised poor performance, could identify the reasons and dealt with these. Staff been identified as needing support to improve the quality of their work and managers had implemented action plans for those staff.

Managers recruited, trained and supported volunteers to work with clients in the service. Throughout covid the numbers of volunteers had dropped but the service has recently appointed a member of staff to recruit volunteers and over 20 people were currently completing employment checks before commencing their roles as volunteers.

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.

Community-based substance misuse services

Staff held regular multidisciplinary meetings to discuss clients and improve their care. Each treatment pathway had their own meeting with prescribers and recovery staff discussing clients. Together they discussed strategies for helping clients move from one treatment stage to the next. We observed one MDT where staff discussed a range of patients some of whom were non-compliant with their care plan. Staff were robust in their decision making and were prepared to withdraw prescriptions in the best interest of those clients.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. In addition to 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 two of these meetings 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 other teams in the organisation.

Staff had effective working relationships with external teams and organisations. The service did engage with local organisations. A member of staff attended the local women's centre weekly. Staff had specialist interests such as the homeless, clients who were pregnant and blood borne virus networks. The service had developed an educational package which was delivered within all schools.

There was an Alcohol Exposed Pregnancy Programme, which in partnership with other health providers was a screening, intervention and referral programme to reduce the number of pregnancies exposed to Alcohol within Tameside.

However, other community engagement programs which had reached out to more diverse communities were no longer in place or were not as formal as they had been prior to covid-19. For example there was no formal links with BAME communities.

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.

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 issue 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.

Community-based substance misuse services

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. All clients confirmed that staff were caring, compassionate and responsive when they needed support. Clients said staff treated them well and behaved kindly. We observed staff treating clients with respect and compassion.

Staff gave clients help, emotional support and advice when they needed it. At Ashton the reception had been redeveloped and now had a café/casual atmosphere. We witnessed several staff members meet clients in this environment. Clients told us they had “called in for support” and appreciated the less formal arrangements within the reception area.

Staff supported clients to understand and manage their own care treatment or condition. All clients said they could contact their recovery worker quickly and easily when they needed them or wanted to talk. Clients said they were fully involved in their care and said staff supported them to understand their condition and manage their own care and treatment.

Staff directed clients to other services and supported them to access those services if they needed help. We saw that staff interacted with other health professionals to help clients understand and manage associated health conditions, for example, blood borne viruses. The service had led on the design and implementation of professional blood borne virus networks and this system design approach had been recognised internationally as good practice.

They directed clients to specialist health services where appropriate, and clients could speak with their prescriber about their medicines, including any side effects.

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.

Staff understood and respected the individual needs of each client. We spoke with staff members who had personal life experience to draw upon when supporting clients. The criminal justice discipline had drawn upon those experiences to design and develop a system that reflected the need to quickly and effectively engage with criminal justice clients to meet their particular needs. This included the provision of emergency appointments within the diary and efficient assessment appointments where medical and emotional support were offered at the same time.

Community-based substance misuse services

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. Clients confirmed they understand their plan and how the service would support them.

Staff involved clients in decisions about the service, when appropriate. Prior to the pandemic clients were involved in shaping the service and how it delivered care, but the number of volunteers had dwindled. A new volunteer co-ordinator had started in post prior to the inspection. They were already having an effect with over 20 volunteers waiting for employment checks before starting.

Staff told us that the remit of the new volunteer co-ordinator post was to further develop peer mentoring and service user representation, as well as wider community engagement.

Clients could give feedback on the service and their treatment and staff supported them to do this. The service carried out regular pulse surveys. They gave us examples of improvements they had made to the service as a result of client feedback. For example, the number of face to face appointments were increased in response to client feedback.

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. The service had a family support worker who worked with families/carers of clients. These were supported through the use of online forums.

Staff helped families to give feedback on the service. Families gave feedback and were asked to do so through the on-line forums. We saw evidence that families/carers had appreciated the support. Some had attended educational sessions to learn about addiction and several had responded thanking the service for their support and that their understanding of addiction would help them support a loved one.

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

Are Community-based substance misuse services responsive?

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

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.

Community-based substance misuse services

The service had clear criteria to describe which clients they would offer services to and offered clients a place on waiting lists. Clients could self-refer or be referred by a third party and all referrals were assessed. 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. There was dedicated assessment team who triaged all referrals before clients were given appointments to see recovery co-ordinators and/or prescribers.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. The service had been severely disrupted due to a covid outbreak amongst staff in early 2022 which had resulted in a waiting list of over 200 clients. The service had managed to reduce that list and at the time of inspection 38 new referrals were waiting for a first appointment, all of them would be seen within the three week waiting period. We saw evidence that during that time clients were contacted and reassessed to ensure their risk assessment was still accurate.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. The criminal justice team saw prison releases urgently and there were reserved appointment times of urgent referrals.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support. With clients who had failed to attend their appointments, staff were proactive in their attempts to re-engage. There was a clear 'did not attend' process in place that staff could follow which advised them of who they needed to contact such as friends, families, pharmacies and the police.

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. 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.

The service used systems to help them monitor waiting lists/support clients. Managers had information technology analysis available and all managers were able to recite numbers of clients waiting for appointments without referral to those systems. These were monitored in governance meetings and a clear focus of management.

Staff supported clients when they were referred, transferred between services, or needed physical health care.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

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 in Ashton and Hyde. Both locations had modern clinic rooms which were clean and tidy. Both had numerous meeting rooms, which were used for group sessions.

Community-based substance misuse services

Interview rooms in the service had sound proofing to protect privacy and confidentiality. However, patients in the waiting room at Hyde could hear staff talking in the office.

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. Public areas within the service displayed information for clients relating to care and treatment both within the service and information about services in the surrounding area. Leaflets were also available.

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 11 complaints in the previous year. Of these five were upheld, four were partially upheld. There were some core themes within the complaints. These involved the change of recovery co-ordinator and an inability to book and appointment or when an appointment was cancelled. Managers had created more appointment times and monitored frequency of contact on a weekly basis.

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.

Community-based substance misuse services

The service used compliments to learn, celebrate success and improve the quality of care. The service had received 29 compliments and managers shared these with staff at flash meetings. The core theme was around staff support from clients and carers.

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 manager worked across all teams with a deputy manager and three project leaders providing the operational leadership to staff.

Leaders were visible in the service. The project 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. Leaders took action to improve the quality of care by providing intensive support for those who needed it. Staff told us leaders were emotionally supportive and care about the wellbeing of staff and clients.

The service was commissioned on a budget that reduced every two years, this required managers to look at efficiency savings on a yearly basis while trying to grow the offer available to clients. New revenue streams had been found and this had led to an increase of staff to facilitate the care of criminal justice clients.

Managers had developed and published a bulletin which covered items relating to the service. Managers highlighted risks, incidents and good practice through this medium. Staff confirmed they found them interesting and informative.

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 organisations vision was to believe in people. The values were to be open, be compassionate and be bold. Staff knew, understood and believed in the vision and values of the team and organisation and what their role was in achieving them.

Managers had recently built upon those values by completing a “Developing Together” training program for all staff. This focused on how staff felt about the team and their role within. After this training staff had come forward with ideas on how to improve the service and managers had acted upon those suggestions. There had been changes to the staff duty roster and managers had erected a “you said we did” board.

All staff had a job description.

Community-based substance misuse services

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. The service had been provided by a different organisation previously and some staff had transferred over to the new service. Some staff still felt they were coming to terms with the different ethos of Change Grow Live, but they were motivated to provide a good service.

Staff said the job was busy and could be stressful, and some staff at Hyde felt that Ashton got most of the resources. The service had recently begun reaching out to stakeholders to develop partnerships and they had invited 15 agencies to speak with staff.

The service did attend events such as PRIDE but formal links to diverse groups which supported different communities had been lost during the covid-19 pandemic. The service had recognised this, and a newly appointed member of staff was beginning to rebuild those links.

The service had a Menopause support group which supported staff impacted by their own or someone else's menopause.

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.

The service had a suite of appropriate policies in place for staff to follow. However, there were three policies that were out of date. These were the medicines management policy, duty of candour policy and the induction policy.

There were systems and procedures in place to ensure that the service was safe, clean and well equipped, that there were enough staff, who were trained, supervised and had the skills and experience appropriate for the client group. Clients developed key relationships with staff aiding their recovery. Client feedback was positive, with clients commenting how supportive and fundamental staff were in their progress.

Processes ensured that clients risks were managed and that successful discharge from treatment were well planned.

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.

Community-based substance misuse services

The quality of care plans was regularly reviewed, and managers worked closely with staff to make improvements in the quality of care plans.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the clients.

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. However, they had been encountered considerable challenges for the service with staff absence. Managers responded and engaged extra staff and the service had now overcome those obstacles and had resumed to normal service.

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

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.