Addaction - Penzance

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Clients gave positive feedback about their care. They told us they felt respected and supported. The service engaged people and considered equality and human rights by catering for and valuing clients' differences . Staff provided clients with options for their recovery from a selection of evidence based psychological interventions and activities. Staff provided client led treatment with the emphasis being on the client regaining control of their life. There were no waiting lists for the service.
- The service had a strong ethos of working in partnership with other agencies to provide holistic care efficiently to support clients and their families. Collaboration with other agencies was a key part of the day-to-day work of the service.

Summary of findings

- Staff were happy in their work. They had manageable caseloads. Staff felt supported by their managers and colleagues. They were appropriately trained, appraised, supervised, and attended regular staff meetings.
- The service was well equipped to look after the physical and emotional safety and wellbeing of clients. The service managed medicines safely.
- Governance structures were in place to ensure the smooth running and development of the service. There was an audit programme and the service was evolving and developing in response to learning from audits, incidents and complaints.

  However, we also found the following issues that the service provider needs to improve:

- Staff did not always develop and update risk assessments and they did not currently plan for clients unexpectedly leaving treatment early. There were problems with the transfer of care records between the criminal justice bureau and the rest of the service, which meant records, including risk assessments, were not immediately available to staff who needed them. This was a breach of regulation and you can read more about at the end of the report.
- Although clients were involved in their care, they did not have copies of their recovery plans.
- There was no additional cover for staff absence. The sickness rate was 4.5%. Staff covered for colleagues who were absent from work and this led to them feeling pressured.
- There were no alarms in the building in Redruth although there were plans to install them. Staff at Redruth were concerned clients entered the building into a large open plan office and that this could potentially cause a breach of confidentiality. There were plans to change the layout to resolve this issue.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		Inspected but not rated

Summary of findings

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Addaction Penzance

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Summary of this inspection

Background to Addaction - Penzance

Addaction Penzance is a community service for adults affected by substance misuse. The service provides recovery focussed support through individual and group delivered interventions and includes a criminal justice team that supported offenders to address their substance misuse. The service is based in Penzance and Redruth which are the furthest West of three Addaction community services across Cornwall and the Isles of Scilly. They work closely with NHS services and local charities to provide holistic care.

The local authority drug and alcohol action team commissions the service. It is in its fourth year of a five-year contract.

The service is registered by the CQC to provide the following specialisms/services: diagnostic and screening procedures, substance misuse problems and treatment of disease, disorder or injury. The service had a registered manager.

CQC has not previously been inspected the service.

Our inspection team

Our inspection team was led by Francesca Haydon.

The inspection team comprised one other CQC inspector, and a specialist advisor who was a senior nurse with experience in substance misuse and mental health nursing.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well led?

Before the inspection visit, we reviewed information we held about the location, asked other organisations for information.

Before and during the inspection visit, the inspection team:

- visited the bases at Redruth and Penzance, looked at the quality of the physical environment including the clinic and observed how staff were caring for clients
- spoke with eight clients
- spoke with the registered manager, the lead nurse, acting operations manager and two team leaders
- spoke with nine other staff members employed by the service provider, including nurses and recovery co-ordinators.
- spoke with three volunteers

Summary of this inspection

- attended and observed a preparation for treatment group
- collected feedback using comment cards from one client
- looked at 11 care and treatment records, including medicines records, for clients
- spoke to nine stakeholders about the service including GP surgeries
- looked at staff records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with eight people who were using the service and they said they found the service supportive, patient and approachable. Clients said staff had time for them. They described the environment as safe. People felt the service gave them information and signposting to support their wellbeing and recovery. We received feedback from one client via our comments box. They liked the programmes that were on offer but wanted more programmes and for something to be offered every day. They were extremely likely to recommend the service to friends and family.

The service completed a review of 29 feedback forms from clients from 7 June 2016 to 3 February 2017. This showed 22 people were extremely likely and seven were 'likely' to recommend the service to their family and friends. Comments included staff being trustworthy, friendly, supportive and helpful.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Although the service had comprehensive risk assessments, they were not always fully completed or kept up to date. Existing risk assessments for clients who were treated by the criminal justice team were not available to staff when they transferred to the rest of the service. Staff did not currently create plans for unexpected exit from treatment although the service had drafted form for use with future clients and this was awaiting ratification.
- There was no additional cover for staff absence and remaining staff covered absences and sometimes travelled to other sites. The sickness absence rate was Two staff said this put them under pressure.
- There were no alarms in the building in Redruth although there were plans to install them.

However, we also found the following areas of good practice:

- There were equipment and facilities for physical health care and monitoring. Clinic rooms and needle exchange facilities were clean and tidy and checked regularly by staff.
- The provider had robust procedures for managing medicines safely and collaborated with community pharmacies.
- Staff had manageable caseloads and the service was fully staffed.
- The service fostered links with key local services including the police, probation, health, child protection, independent domestic violence advisors and other specialists to ensure the safety of clients and others.
- Service wide quality and clinical governance meetings reviewed service delivery and reflected on incidents. The provider made improvements to the service in response to learning from incidents and disseminated learning to staff.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff and volunteers had regular supervision and appraisals and attended regular multi-disciplinary team meetings.

Summary of this inspection

- Staff were appropriately qualified and received specialist training.
- Recovery plans were personalised, holistic and recovery orientated. They included appropriate focus on physical health and harm reduction.
- The service offered evidence based psychological interventions via one-to-one sessions and a range of groups and activities to engage clients in supporting each other towards recovery.
- The service linked with local services such as the job centre, benefits agency, housing and homeless services to provide holistic care.
- The service completed a regular programme of clinical and health and safety audits.
- The service considered equality and human rights and enabled people who might struggle to engage to receive help from the service.
- There were robust arrangements for referral, discharge and transition to other services.

Are services caring?

We found the following areas of good practice:

- Staff supported clients with empathy and respect. Clients were encouraged to support one another in group activities.
- Staff provided personalised care in partnership with the client, which emphasised the client's responsibility for their own recovery.
- Clients were invited to involve their families and friends in their care.
- Clients were involved in the development of the service and encouraged to give feedback.

However, we also found the following issues that the service provider needs to improve:

- Staff at Redruth felt the lay out of the building was not confidential because clients entered the building via their office. There were plans to change the lay out to resolve this issue.
- Clients said staff had not offered them copies of their recovery plans and care records did not show evidence of staff offering them.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- There were no waiting lists and the service was meeting its target to see all clients within 21 days of referral. There was a facility for clients to have urgent appointments.
- The provider used a variety of ways to proactively engage clients who were reluctant or difficult to engage. They catered for clients who spoke foreign languages. They followed up clients if they did not attend an appointment to ensure they were safe and to re-engage them.
- Clients said the service was flexible and asked what times suited them for appointments.
- There were good facilities including group rooms, clinic rooms, arts and craft facilities and free second hand clothes.
- Staff provided clients with welcome packs that gave them access to information about local services to support their recovery.
- Staff received feedback and learning from complaints through supervision and team meetings.

However, we also found the following issues that the service provider needs to improve:

- Clients who were unable to manage stairs could not access the Penzance office. Appointments were held in alternative locations but groups took place in the offices. In Redruth clients could enter the building but the group rooms were upstairs. Clients who were unable to manage stairs had to travel to Truro to access group delivered treatments.
- The service required clients to make complaints in writing and this could deter people with literacy or language barriers from complaining.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Governance systems and processes were in place to ensure staff were trained, appraised and supervised and to enable the smooth running of the service.
- The service was improving in response to learning from incidents and complaints.
- The provider used key performance indicators to monitor and improve the service.
- Staff said managers and team leaders were supportive and approachable.
- Morale was good and team members supported each other.

However, we also found the following issues that the service provider needs to improve:

Summary of this inspection

- Staff felt pressured when they covered for colleagues who were absent from work. There were no minimum staffing levels or arrangements for covering sickness.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- The percentage of staff who had completed training in the Mental Capacity Act was 82%. Three staff had not completed the training.
- Knowledge of the Mental Capacity Act amongst recovery co-ordinators was mixed. Three recovery co-ordinators were confident in their knowledge. Staff we spoke with had a good knowledge of how substances could affect mental capacity, and how this could trigger issues around consent for treatment. However, one member of staff was not aware of their obligation to support people under the Act. We saw clear examples of when and how staff discussed mental capacity during our inspection.
- Addaction had a policy on the Mental Capacity Act that staff could access via their intranet and staff could access advice from leads and prescribers.
- The service did not submit any applications under the Deprivation of Liberty Safeguards.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The provider undertook a schedule of environmental risk assessments. The consulting rooms in Penzance had panic alarms in them. There was a duty room in Penzance that was a low stimulus room next to the staff office where clients, including those in crisis, could be seen at short notice. The Redruth consulting rooms did not have alarms in them but the building was planning to fit them and the project was awaiting final agreement from management. Staff said they would feel safer in the building once the alarms had been fitted. They had personal alarms to use in the meantime.
- Clinic rooms were clean and tidy and contained a couch, weighing scales, height chart, blood pressure machines, breathalysers and drug testing swabs. All fridges and clinic rooms containing medicines were locked. Staff carried out daily fridge and clinic room temperature checks and records we reviewed showed that they were all in the correct range.
- Both sites we visited had needle exchanges that were fully equipped and complied with National Institute for Health and Care Excellence guidance. The needle exchanges were clean and tidy and needles and supplies were in date. There were guidelines for staff handling needles. Clinical waste was stored safely and securely and collected by a registered waste collection company. The needle exchange offered information and advice on safer injecting, advice on preventing the transmission of blood borne viruses and access to treatment.
- All the rooms on both sites we visited were clean and tidy and the furniture was of a good standard. There were handwashing advice posters on the walls beside washbasins.

Safe staffing

- There were 38 staff and 21 volunteers in total working in Penzance and Redruth. There were two psychiatrists, two non-medical prescribers and three GPs with special interests working across the county that covered three Addaction services including Penzance. Managers told us there was always a nurse on duty during the hours of operation.
- There were no staff vacancies.
- The provider reported an average permanent staff sickness of 4.5% for the 12 months leading up to 18 January 2017.
- The provider had an average substantive staff turnover of 8% for the year ending 18 January 2017. This equated to three staff leaving.
- The service estimated their staffing requirement when they bid for the service contract four years ago but it had not been formally reviewed since. However, the provider reviewed the service regularly with its commissioners and this provided opportunities to review staffing levels if needed.
- Staff had an average caseload of 39. The highest caseload was 45. Some of the staff worked part time. In addition, there were two psychiatrists who held an average caseload of 112 and two nurse prescribers who had average caseloads of 78. One member of staff we spoke to was new and worked with a small caseload while they gained experience. Staff saw clients once or twice per week or once every four to six weeks depending on the phase of their treatment. Criminal Justice staff had smaller caseloads due to the

complexity of their work. There was an item on the service risk register about high caseloads and managers told us caseloads had been too high but they were being recently been reduced through case management supervision. Team leaders provided caseload management supervision and this was recorded. One of the team leaders told us they had been supporting staff to reduce their caseloads and that previously staff had been feeling overstretched.

- There was no minimum requirement for staffing the service and no extra staff provision to cover for staff sickness. Staff also travelled to different offices to help cover. If the reception was short staffed they sometimes asked a volunteer to cover. Volunteers also assisted with workshops and activities. Two recovery workers complained of feeling overstretched because of providing sickness cover in addition to carrying out their own work.
- The service did not employ bank or agency staff. Managers said that if they needed more staff in order to ensure the service was safe, they could escalate the matter to the contracts manager but they had not done so yet.
- There were two Addaction doctors and a trainee psychiatrist was in the process of being appointed. Staff could contact doctors for advice.
- The provider reported the mandatory training compliance rate for the organisation was 100%. We looked at training matrices and these showed a small number of trainings were out of date because staff had not completed them or the manager had not verified the training certificate.

Assessing and managing risk to clients and staff

- Staff had a comprehensive risk assessment to complete with clients that included risk to self and risk to and from others, but this was not always completed. Staff were expected to review risk assessments every three months or sooner if risk changed. We reviewed 11 care records. One client did not have a risk assessment and had been in the service for three weeks. Four clients' risk assessments were completed and up to date but six risk assessments were both out of date and incomplete. Staff could not access the risk assessments of clients who had been treated by the criminal justice team and did not create new ones.
- The service was consulting with the care records software provider about records automatically transferring but had not mitigated the risks to clients of staff not having access to risk assessments and care plans in the meantime.
- None of the care records we reviewed contained plans for unexpected exit from treatment. None of the clients had advance decisions developed for them to enable them to have a say in what happens to them if they become too unwell to make decisions about their care.
- All staff completed safeguarding training annually by electronic learning. They also completed taught safeguarding, depending on their role at levels two, three or four. Recovery workers completed level three. The provider was sourcing level four training for managers and team leaders. Some staff had also attended child abuse multi-agency training. Staff discussed cases with their manager who supported them to make a referral to the multi-agency referral unit (local authority team that respond to child safeguarding concerns) if required. Staff showed awareness of the needs of clients' children and their safety. We saw evidence staff made safeguarding alerts to protect children.
- The service had good links with the multi-agency referral unit and consulted them for advice. Team leaders and managers attended a monthly multi-agency risk assessment conference, and shared information between local police, probation, health, child protection, housing practitioners, independent domestic violence advisors and other specialists. The operations managers were safeguarding leads. The criminal justice team worked in an integrated way with other agencies including social services, mental health services, the police and probation service. There was a national safeguarding policy for all Addaction's services. A national Addaction safeguarding group met every two months and reviewed national guidance and service development.
- Staff followed local lone working protocols that gave instructions for them to follow to maintain safety and in an emergency. Before meeting a new client, staff completed an outreach and lone working risk assessment and updated it after contacts. Staff had mobile phones but did not always have a signal when they were out on visits. They mitigated this by staff

signing in and out and phoning a named individual after their appointment to say they were safe. If there was known or unassessed risk, staff worked in pairs. Staff also contracted with clients using a treatment agreement that outlined expectations. There had not been any lone worker incidents.

- The provider had robust procedures for managing medicines. Adrenaline and naloxone which are medicines used to reverse the adverse effects of overdose, were kept in locked clinic rooms and staff were trained to provide and administer them. Staff logged and tracked prescriptions. Staff assessed clients' suitability to collect their prescription and store their medicine at home. Locked home storage boxes were provided to clients who kept prescribed medicines at home and needed extra security, for example those with children. Agreements were in place between Addaction, the client and the community pharmacy. Clients identified themselves before collecting prescribed medicines from the pharmacy. Clients who presented with high risk at initial triage, for example people at risk of suicide, pregnant women, or people with complex co-morbidities were referred to the Addaction doctor for an urgent initial prescribing assessment. There were three nurses across the county and they provided prescribing reviews.
- Clients were offered vaccination if appropriate at the initial assessment visit. Vaccines were administered to clients under a 'patient group direction' signed by competent staff.

Track record on safety

- There were 221 untoward incidents reported in the period from April 2016 to January 2017 of which 73 occurred in the Penzance area and 148 in the Redruth area. The most common incident was suicide prevention with 32 incidents. There were 25 deaths, 27 ill health and 15 cases of overdose. There were 11 safeguarding of vulnerable adult incidents and nine safeguarding referrals.
- The provider gave examples of improvements in safety following incidents. For example, following an incident, some staff took training in 'confidence in conflict' and the training was scheduled to be rolled out further. The Penzance based team developed a duty room that was a low stimulus room where clients with staff to de-escalate. At Penzance, the manager tightened security following a spate of people using drugs on the premises. CCTV cameras were put in place and the manager had additional signage placed to inform people drugs were not permitted. In Redruth, there were plans to change the building layout in response to an incident and feedback from staff. We reviewed the planned changes to the building that also included the installation of an alarm system. These changes were awaiting final agreement at the time of our inspection.

Reporting incidents and learning from when things go wrong

- The provider had an electronic system for managing incidents. The member of staff who witnessed an incident reported it themselves and the line manager reviewed it and made recommendations for learning or further actions. Reports from the provider indicated staff reported a range of incidents including lost prescriptions, missed doses and aggression towards staff.
- The team based in Penzance reported fewer incidents than the team in Redruth. The manager said there had been reticence among the staff to report incidents and that staff were not sure when to report an incident but that recent training had resulted in an improvement.
- Learning from incidents was on the service risk register and actions were identified to put procedures in place to discuss incident themes in quality and clinical governance group meetings and discuss case scenarios in team meetings. Quality and clinical governance group meetings reviewed and monitored service delivery including incidents, audits and actions resulting from them. A clinical incident review national group met every two months to review serious incidents across the country. The critical incident review group sent out bulletins and monthly newsletters to disseminate learning from incidents.
- Team leaders and managers shared learning from incidents at team meetings. Managers led discussions with their teams to review incidents and consider their practice.
- The provider had received a regulation 28 notice by the coroner's court in July 2016 following the death of a client in 2015. A regulation 28 report outlines actions the provider must take to prevent future deaths. The service

was required to review their methadone prescribing policy and to complete a formal review of the death to consider record keeping and inconsistency of care. The provider responded to these in full and outlined learning from the incident.

- Managers and team leaders offered support and employee assistance programme counselling following incidents. They revisited the impact of incidents in supervision and with informal support. The operations manager had oversight of every incident and disseminated learning across teams through team leaders. Team leaders debriefed staff if needed and gave them protected time to report the incident. One member of staff said they had not fully been supported after an incident although they were offered counselling.

Duty of candour

- Managers understood the meaning of duty of candour and were willing to admit to and apologise for mistakes. They were willing to do what they could to put things right and to learn from mistakes. There was evidence of this when they talked about complaints and incidents. Addaction had a 'being open and duty of candour' policy.

Are substance misuse services effective? (for example, treatment is effective)

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- We looked at 10 care records. In three cases the client was either new or had failed to engage so recovery plans had not yet been developed. Staff were required to update recovery plans every three months or sooner if circumstances changed. In one case, the recovery plan had not been updated for 10 months. All other recovery plans were up to date.

- Recovery co-ordinators asked clients about their goals for treatment and included them in the recovery plan, and this was the focus of their treatment. Staff described developing recovery plans with clients over time. Recovery plans were holistic and included appropriate focus on physical health needs including symptoms, details of drug use, injecting history, and assessment for blood borne viruses. There was evidence clients had been given harm reduction advice. The service used the 'treatment outcome profile tracker' to monitor progress every three months.

- When clients moved between the criminal justice bureau and the rest of the service, their records did not automatically transfer even though they used the same electronic records system. The provider was consulting with the software provider about this issue. However, records were not always available to each team. One client had been in the service for three years and their current record did not include a full assessment. This meant staff involved in the client's care did not have access to full details of the client's history, difficulties and goals. Volunteers did not have access to care records.

Best practice in treatment and care

- Staff followed national guidelines on substitute prescribing and supervised consumption. The provider produced a monthly prescribing and medical review report for all employed staff and GPs with special interest prescribers. This identified areas of prescribing outside of national guidelines and clients that need additional tests because they took a high dose or more than one prescribed medicine. Prescribers described how any medicine that was not on the prescribing formulary was risk assessed and approved by the pharmacist and/or medical director. We saw examples where staff changed clients' prescriptions to make them safer.

- The service offered evidence based psychological interventions including counselling, motivational interviewing and relapse prevention. Staff delivered a range of groups and activities. A weekly activities timetable included activities such as cooking, life skills, meditation and relaxation, crafts, allotment and photography. In their welcome pack, clients received a drinking/substance diary to complete for discussion with their recovery co-ordinator. We observed a 'preparation for treatment' group with seven clients. Clients were engaged in supportive discussion and goal setting. Staff explained what clients could expect from the service with a focus on individual goal setting. The service also ran a 'mutual aid partnership' group which encouraged clients to work together to develop their

skills in recovery. In the 'mutual aid partnership' group clients completed exercises such as identifying where they are on the cycle of change and planning steps to change.

- The service provided clients with holistic care. They had good links with local services including the job centre. The service had links with local housing and homeless services. The service provided free rooms for local services to use to see clients in, including a national women's charity and the NHS community mental health team, in order to maintain close working relationships.
- Most clients were subject to shared care arrangements where GPs were responsible for completing regular physical health checks and providing prescriptions. Addaction nurses were on duty twice per week and doctors once per fortnight at each location to see clients who had their physical health and prescribing managed by the service. There was an arrangement in place for GPs to carry out electrocardiogram tests for clients on high Methadone prescriptions. The team also received a monthly visit from a nurse from the hospital who provided liver scanning for clients using a portable scanner. There were plans to provide health and wellbeing clinics in future. Welcome packs given to all clients included information on drugs, alcohol and liver damage.
- Staff used rating scales to measure clients' difficulties including the 'alcohol use disorders identification test' and 'severity of alcohol dependence questionnaire' where applicable.
- The service completed a range of health and safety audits of the buildings and staff at regular intervals. Managers audited training and supervision to ensure staff were up to date. Managers also completed random checks of care records to ensure they were fully completed and up to date. Nurses undertook clinical audits including medicines management and infection control. Clinical governance meetings reviewed results of audits.

Skilled staff to deliver care

- The service had expectations of staff to ensure they were appropriately qualified and experienced. Recovery workers studied the gateway qualification. The objective of the Gateway Qualification that was available at levels two and three was to enable learners to develop a knowledge of substance misuse and an understanding of people who misuse substances. All other staff were medical or registered with the British Association for Counselling and Psychotherapy or the Federation of Drug and Alcohol Practitioners. Volunteers received training which included risk assessment, safeguarding, incident reporting and the complaints procedure. Most staff were experienced. New staff carried a reduced workload while they gained experience, this was confirmed when we spoke to a new member of staff.
- Staff received induction training in accordance with an induction plan. We reviewed the recovery co-ordinator induction plan that took place over a 26-week period. It included observed practice, and training in motivational interviewing, multi-agency child protection, needle exchange, blood borne viruses, naloxone, mandatory training and policy reading. Volunteers took part in a specific Addaction induction-training programme. The service used a 'sana' model which was a choice of evidence-based, group delivered interventions. Staff running the groups had ready-made and approved modules, programmes, tools and resources to deliver the groups.
- Staff received role specific supervision with a manager or team leader. Staff were required to attend monthly supervision (a minimum of 10 supervision meetings per year) and attend 80% of team meetings per year. Nurses had clinical supervision with a psychiatrist, attended a nurses forum and a monthly prescribers meeting in addition to management supervision. Volunteer counsellors had regular group and individual supervision with the service. Criminal justice staff attended their own monthly team meetings that covered their clinical work and multi-agency working. They also invited guest speakers. They were supervised every two months. In Penzance, none of the staff received supervision in January in the five records we checked but all had supervision dates booked.In Redruth, staff received supervision with their line manager every month. Staff appraisals were up to date. They completed an annual and mid-year review using a standard system that was based on the service key performance indicators and organisation values.
- Staff received specialist training in a variety of subjects including recovery planning, psychosocial interventions,

needle exchange, blood borne viruses, naloxone, domestic abuse, mindfulness and motivational interviewing. The doctors offered an overview of prescribing when new staff people joined the service.

- Most staff said access to training was good and that they had opportunities to progress and learn. However, one member of staff said they felt they needed guidance on maintaining their personal safety. All staff were trained in 'mutual aid partnership'. Managers completed leadership and management courses. The service adapted to meet the changing needs of clients. For example, staff had learned about the effects of Melanotan misuse, which was a tanning substance and steroid misuse in recognition of the evolving need to support clients with issues.
- There was good evidence of managers addressing staff performance that fell below requirements using performance improvement plans. There was a performance management policy. Managers addressed staff performance through supervision in the first instance, followed by the development of performance improvement plans if required.
- All staff were Disclosure and Barring Service checked before they started work and the service repeated these checks every three years.

Multidisciplinary and inter-agency team work

- Staff met fortnightly for multi-disciplinary team meetings between doctors, nurses, recovery co-ordinators, administrators and other health and social care professionals as needed.
- There was good communication between the service and a variety of services external to the organisation. Supplying community pharmacies and Addaction staff were in regular communication about new clients and any prescription changes. Staff worked alongside the alcohol liaison team at the local hospital. They placed a volunteer there to support potential clients to access the Addaction service. Team leaders and managers attended the multi-agency risk assessment conference alongside the police, local authority and other health services. Recovery co-ordinators delivered some of their sessions with clients from GP practices. We spoke with seven local services including GP practices, pharmacies and a residential rehabilitation service. They generally gave positive feedback about the care provided. Comments included the service being responsive to clients' needs, good at communicating and solving issues quickly. Pharmacists said prescriptions were always available on time. One GP surgery said they felt communication with the practice could be improved. Staff in the service felt there were difficulties in accessing care for their clients from community mental health teams. However, early intervention in psychosis services attended the provider's team meetings. There were links with specialist services such as a women's charity, the pain clinic, local rehabilitation and detoxification treatment services, housing, the job centre, and work based programs. The manager had delivered training in drug awareness to the local job centre staff.

Good practice in applying the MCA (if people currently using the service have capacity, do staff know what to do if the situation changes?)

- The percentage of staff who had completed training in the Mental Capacity Act was 82%.
- Psychiatrists completed mental capacity assessments or managers requested community mental health services or GPs complete these assessments as required. The service manager had a good understanding of the Mental Capacity Act and gave an example of work with a client who periodically lost capacity. Three recovery co-ordinators showed awareness of how they would apply the Act. Staff we spoke with had a good knowledge of how substances could affect mental capacity, and how this could trigger issues around consent for treatment. However, one recovery worker was not aware of the mental capacity act and their duty to support people who may lack capacity.
- Addaction had a policy on the Mental Capacity Act that staff could access via their intranet.
- In the ten records we reviewed, we saw two cases where mental capacity assessments had been made appropriately. Mental capacity according to the Mental Capacity Act should be assumed unless there is evidence to the contrary.
- Managers understood their responsibility to empower others to make decisions and supporting them to do so at an appropriate time. Staff said they would approach a prescriber for advice or the operations manager.

Substance misuse services

Equality and human rights

- Addaction had a national 'diversity and equality framework'. Equality and diversity training was mandatory for all staff. We found examples of the service enabling people to engage with the service. The service website had a 'browse aloud' facility. Staff tried to engage clients with written materials by providing them in easy read formats, alternative fonts and colours and foreign languages. The service triaged pregnant women as urgent. The provider referred clients to rehabilitation services in Devon if they required single sex treatment and accommodation. Clients were asked at assessment about their sexuality. Every year the service took part in the 'pride' festival which celebrates the diversity of lesbian, gay, bisexual, transsexual, queer, intersex and asexual people. Staff engaged sex workers by offering a recovery worker of the same gender if required. All staff were trained in 'domestic abuse, stalking and honour based violence.

Management of transition arrangements, referral and discharge

- The provider worked in partnership with rehabilitation and detoxification services in the area. They had a bed set aside for one of their clients at the community hospital alcohol project each week. Some clients detoxified at home supported by specially trained recovery workers. Following their treatment, clients were supported to gain work or enter education or they could become volunteers. The service informed the GP or social care team when a client was being discharged. The team managers were responsible for allocating new clients to staff and they were consulted before clients were discharged to ensure the service could not do any more to help. One client we spoke to said they had a detailed personalised discharge plan. Two clients told us about options for further input from other services they had been offered.

Are substance misuse services caring?

Kindness, dignity, respect and support

- We found staff interactions with clients supportive and respectful. During our observation of the preparation for treatment group, the group facilitator encouraged clients to take part in a discussion and listened actively and empathically. Facilitators gave clients equal attention and time and encouraged clients to support each other.
- We spoke to eight clients and received feedback from another. Clients described staff as interested, helpful, responsive and supportive.
- Staff understood clients had individual needs and aimed to offer personalised care in partnership with the client that emphasised the client's responsibility for their own recovery. Staff were aware of the challenges clients faced in trying to recover from addiction.
- Staff understood the importance of explaining to clients the limits of their confidentiality. Staff provided clients with information on confidentiality and asked clients to consent to information sharing and agreed where information could be shared. Clients could choose if they wanted friends or family, members involved in their care.
- At Redruth, staff complained clients could walk straight into the office area while they were on the phone and they were concerned this might lead to a breach of confidentiality. The proposed changes to the layout of the building that were awaiting final sign off would resolve this issue.

The involvement of clients in the care they receive

- Clients said they felt actively involved in planning their care. However, none of the clients we spoke could recall being offered copies of their recovery plans.
- Two clients gave examples of the service offering support to their family members. At the preparation for treatment group we observed, the facilitator explained how families and carers could be involved in clients' recovery.
- Managers and most recovery workers were aware of services they could signpost clients to if they required advocacy and said they themselves had advocated for clients. However, one recovery worker did not know how to access advocacy services. There were leaflets in the client areas for a local advocacy service.

Substance misuse services

- The provider involved clients in the development of the service. Clients were sometimes involved in interviews for new staff. The service ran a client forum every two months in each office. There were suggestion boxes and feedback forms for clients to complete.

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

Access and discharge

- The service had a target to see new clients within 21 days of referral. The first session included a triage and risk assessment. Following the first appointment, staff offered clients either a tier two treatment that was a low-level intervention such as advice or tier three structured treatment.
- There were no waiting lists for the service. Team leaders assigned referrals to a recovery co-ordinator within hours of the referral being received. In Penzance, the wait was one to seven days. If clients needed to see a doctor, their recovery coordinator booked them an appointment within one month. Managers monitored waiting times through case notes and supervision.
- Staff could see clients sooner if their referral was considered urgent.
- The team responded to clients if they phoned in or presented at the offices.
- The service leaflet set out the criteria for the service and the treatments available. The service was for anyone who wished to recover from dependence on drugs or alcohol.
- The service tried to reach clients who were reluctant or difficult to engage. They gave an example of work with a domestic violence service and homeless service to break down barriers for specific clients.
- The service enabled clients to self-refer if they wished but also facilitated referrals from other services. The service provided open access to clients and aimed to remove barriers to accessing treatment. The criminal justice team provided outreach support. There were links with specialist midwives in substance misuse. There was a Polish-speaking recovery coordinator. If needed, the service funded the bus fare for clients to come to meet the Polish recovery coordinator.
- Staff took action when clients did not attend their appointments. They used different means of contacting them and if they were concerned, they would visit the client's house. When all means of engagement were exhausted, staff sent clients who had disengaged a letter to say they would be discharged in ten days' time but that they would be welcome back to the service in future. Staff offered to send text reminders to clients to ensure they kept their appointments. Staff were flexible about where appointments took place in order to maximise the chances of the client attending. The service had recently drafted an unexpected exit form which would be completed with future clients to help staff and clients plan together what to do if the client disengages. The form was awaiting ratification.
- Clients said the service was flexible and asked what times suited them for appointments. One client said they fit appointments around their work.
- The service only cancelled appointments due to staff sickness. Clients said staff told them about any changes to appointments and offered them contact with another member of staff if they needed it. The duty worker phoned clients if their worker was off sick and unable to keep an appointment with them. The duty worker saw clients if they could not wait for a rescheduled appointment.

The facilities promote recovery, comfort, dignity and confidentiality

- Both sites we visited had a range of rooms and equipment to support treatment and care including group rooms, consulting rooms, clinic rooms, arts and craft facilities, tea and coffee making facilities for clients to use and a needle exchange.
- Interview rooms were sound proofed.
- All clients received a welcome pack when they joined the service which included a weekly activities timetable and a wide range of leaflets and information including addresses and timetables for Alcoholics Anonymous and Narcotics Anonymous meetings, food and homelessness services.

Substance misuse services

Meeting the needs of all clients

- There was disabled access to the building in Redruth but the groups were held upstairs. Access to the building in Penzance was by a flight of stairs. Clients who were unable to manage stairs had appointments at alternative locations such as at GP surgeries. Clients with disabilities requiring level access had to travel to Truro to attend groups.
- The service provided leaflets in different languages and had two foreign language-speaking members of staff. Leaflets were available in Czech, Polish and Russian. There was the facility to translate into other languages if needed.
- Staff encouraged clients to come to the cookery group by offering them a meal. There were free second hand clothes people could take and a facility to swap CDs, reading materials and DVDS. There were free condoms and sanitary towels available in the women's toilets. There were facilities for clients attending groups to make their own hot drinks. They had an arrangement with a local supermarket that provided free short dated food for clients to take.

Listening to and learning from concerns and complaints

- The service had received four formal complaints in the previous year and three formal compliments. One of the complaints was upheld and three were not upheld. The complaint that was upheld was about a change to a client's recovery worker when they left the organisation.
- Clients knew how to complain and received a leaflet about it in their welcome packs. There were also feedback boxes for anonymous complaints. Clients said they knew how to complain.
- Staff supported clients to make complaints. The manager saw complaints as an opportunity to improve the service. They tried to resolve complaints informally where possible. The service required complaints to be made in writing but staff supported clients to make the complaint if they had literacy difficulties. Complaints were investigated centrally at another office.
- Staff received feedback and learning from complaints through supervision and team meetings. The management team monthly meeting discussed complaints across Cornwall and developed learning from them. There was evidence of learning from complaints, for example, staff increased the frequency of drug tests and screening in response to a complaint. A system had been put in place to enable team leaders to have oversight of clients who were subject to safeguarding in response to a complaint.

Are substance misuse services well-led?

Vision and values

- Addaction's values formed the basis of appraisals to ensure they were central to the work. Managers said the team objectives were consistent with the values of the organisation.
- Managers said the senior managers in the organisation visited occasionally and were approachable.

Good governance

- Systems and processes were in place to enable the smooth running of the service. Managers ensured staff completed the training they needed and that they received supervision and appraisals. Staff said they had regular good quality supervision. Managers understood the importance of learning from complaints and incidents and had a mechanism to do this in team meetings. There were structures in place, including regular meetings with local services to ensure safeguarding procedures were followed. A quality and clinical governance group met to review the service and to develop action plans. For example, they were completing a survey of GPs and they were looking at ways to enable keyworkers and prescribers to work together more closely.
- The provider provided quarterly reports to their commissioners on ten key performance indicators including waiting times, numbers of clients in treatment, vaccinations provided and treatment outcomes. The report included action plans for improving the service. The recent report showed positive outcomes, for example, a steady increase in the numbers of clients being given naloxone, a drug supplied to reverse the harmful effects of overdose.

- Team leaders felt they had sufficient authority and support to carry out their roles. One team leader said they felt able to be creative and develop new ideas. Managers and team leaders told us they could escalate concerns and seek advice.
- We reviewed the corporate risk register and there were no items relating specifically to this service. There was a risk register for the Cornwall Addaction community services that included this service and two other registered CQC providers. Learning from incidents was on the risk register and there was a target to improve dissemination of learning from incidents.

Leadership, morale and staff engagement

- The leadership team focussed on the aim of enabling clients to achieve their own goals towards recovery. Collaboration with other services was encouraged and all interventions aimed to support and inspire clients to lead fulfilling lives. Managers and team leaders were focussed and compassionate in leading teams to achieve this aim. There were opportunities for staff to develop in the service and there was leadership and management training available that included coaching and mentoring.
- There were no reported cases of bullying and harassment.
- The service had a whistleblowing policy. No whistleblowing concerns had been raised in the 12 months ending 18 January 2017. Recovery coordinators felt they could use the whistleblower policy if they felt appropriate. One out of two staff we asked knew where the policy was.
- Recovery workers said they felt able to raise concerns without fear of victimisation. Staff said they could raise concerns in business meetings with managers.
- Morale in the service was good. Some staff said they struggled to cover when their colleagues were absent from work. Managers told us that a recruitment freeze which ended six months before our inspection had negatively influenced morale. Two staff said they still felt overstretched because of sickness in the teams. Staff and volunteers felt they could give feedback on the service. There had been difficulties in the team based in Penzance due to long-term sickness not being covered that led to staff not having regular supervision but this was reported to have been resolved. Staff described supportive and approachable leadership.
- Staff said team members were supportive of one another. Recovery workers said they felt good about their jobs and were enthusiastic about the work.

Commitment to quality improvement and innovation

- The criminal justice team were involved in a research project with hospital liaison regarding women transitioning from prison to the community. The aim of the project was to look at ways to reduce unnecessary hospital admissions.
- Annual Addaction life skills weeks celebrated the recovery that takes place in the drug and alcohol service to support people to develop skills, confidence and support networks in their recovery journey. In Redruth a cookbook was launched and the proceeds funded the cooking group. In Penzance a therapeutic garden was funded by Santander Foundation. Other activities in the life skills week have included beach cleans, allotment trials and a photography competitions.

Outstanding practice and areas for improvement

Outstanding practice

- The service was committed to meeting the holistic needs of clients. There was very good partnership working with services external to the organisation including pharmacies, the local hospital, job centres, police, local authority and other health services. Recovery co-ordinators delivered some of their sessions with clients from GP practices.
- The service was working with a local supermarket to provide free short dated food to clients.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure comprehensive risk assessments are fully completed and kept up to date. They must ensure information about clients, including risk assessments and care plans is readily available to staff caring for the client, including when they transfer between the criminal justice bureau and the rest of the service. The provider must also ensure staff develop plans with clients for their safety and wellbeing if they unexpectedly exit treatment.

Action the provider SHOULD take to improve

- The provider should carry out the planned works to fit alarms to the building in Redruth.
- The provider should review arrangements for covering staff absences to ensure the wellbeing of staff.
- The provider should consider offering clients a copy of their care plan if they wish to receive it and document this on the care record.
- The provider should review Mental Capacity Act training to ensure it adequately informs staff of their responsibilities.
- The provider should enable clients to make complaints in ways other than in writing so as to enable people with literacy or language barriers to make complaints without staff writing them for them.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments were not always fully completed or kept up to date. Information about service users including risk assessments and care plans was not readily available to staff. Staff did not create plans for unexpected exit from treatment. This was a breach of a regulation 12 (1), (2)(a)(b).

This section is primarily information for the provider

Enforcement actions

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.