Good

Mersey Care NHS Foundation Trust

Substance misuse services

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW12	Liverpool Community Alcohol Service	Substance Misuse Services	L9 7AL
RW12	Windsor Clinic/Kevin White Unit	Substance Misuse Services	L9 7AL
RW41R	Ambition Sefton	Substance Misuse Services	L20 8AH
RW41T	Ambition Sefton	Substance Misuse Services	PR9 0QT
RW439	Community Drugs Team	Brook Place Substance Misuse Services	L6 7UN
RW439	Community Drugs Team	Community Drug Team (DRR) Substance Misuse Services	L6 7UN
RW439	Community Drugs Team	Community Drug and Alcohol Team (DART) Substance Misuse Services	L6 7UN

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Mersey Care NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Mersey Care NHS Foundation Trust and these are brought together to inform our overall judgement of Mersey Care NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated substance misuse services as good because:

- All the services we visited were tidy and well maintained. The furniture was in good repair and the clinic areas were clean and well organised. Staff understood infection control procedures.
- Staffing levels and skill mix were planned and reviewed to keep patients safe and meet their needs. There were effective procedures for escalating concerns about staffing levels. There were effective handovers to ensure staff were aware of the risks to patients.
- There were clearly embedded systems, processes and standard operating procedures to keep patients safe. The staff knew how to look for signs of abuse and how to make a safeguarding alert if necessary. This meant that patients were protected from avoidable harm.
- Managers encouraged openness and transparency about safety. Staff knew what to report and how to report it. They understood their responsibilities relating to the duty of candour.
- In most cases, patients' needs assessments included consideration of clinical needs, physical and mental health and wellbeing, and nutrition and hydration needs.
- Staff planned care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Links to best practice guidance were available on the trust's website.
- Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.
- Staff respected patients' diverse needs. Patients were supported, treated with dignity and respect, and involved as partners in their care. There was a visible person centred culture.
- Patients were involved and encouraged to be partners in their care and in making
- decisions, with any support they need. Staff spent time talking to patients so that they understood their care, treatment and condition.
- Staff took into account the needs of different groups so that they met patients' needs.
- Patients understood how to complain or raise a concern. Staff took complaints and concerns seriously. They listened and responded to in a timely way.
- The service was transparent and open with stakeholders about performance. Information was used to support effective decision-making and drive improvement. Staff reported and reviewed information on patients' experiences alongside other performance data.
- Staff felt respected, valued and supported. They were committed to their roles and enjoyed working with the patient group. They described a strong and supportive team.
- Managers supported staff to work in innovative ways. They encouraged staff to discuss issues and ideas for service development.

However:

- At the Windsor Clinic, the fire risk assessment was out of date and actions had not been completed.
- Not all patients had a comprehensive risk management plan that staff reviewed regularly.
- Care records were not always comprehensive and holistic. They did not always take account of patients' views. Some were not recovery focused and were not reviewed regularly.
- Systems for audit and review in relation to care records were not always effective.
- Some care records did not contain individual plans for unexpected exit from treatment.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as good because:

- All the services we visited were tidy and well maintained. The furniture was in good repair and the clinic areas were clean and well organised. Staff understood infection control procedures.
- Staffing levels and skill mix were planned and reviewed to keep patients safe and meet their needs. There were effective procedures for escalating concerns about staffing levels. There were effective handovers to ensure staff were aware of the risks to patients.
- Most staff had completed all mandatory training.
- Staff used a tool that followed the Care Programme Approach model to assess patients' individual risks. They recognised and responded appropriately to changes in risks to patients.
- There were clearly embedded systems, processes and standard operating procedures to keep patients safe. The staff knew how to look for signs of abuse and how to make a safeguarding alert if necessary. All patients were asked about their contact with children. There were policies for the safeguarding of both adults and children. This meant that patients were protected from avoidable harm.
- There were processes and policies to ensure staff were safe.
- Good medicines management practice was evident.
- Managers had carried out audits and produced action plans that set out the steps to be taken to resolve identified issues.
- Managers encouraged openness and transparency about safety. Staff knew what to report and how to report it. They understood their responsibilities relating to the duty of candour.

However:

- At the Windsor Clinic, the fire risk assessment was out of date and actions had not been completed.
- Not all patients had a comprehensive risk management plan that staff reviewed regularly.

Are services effective?

Good

We rated effective as good because:

Summary of findings

- In most cases, needs assessments included consideration of clinical needs, physical and mental health and wellbeing, and nutrition and hydration needs.
- Staff planned care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Links to best practice guidance were available on the trust's website.
- Information about patients' care and treatment and their outcomes was routinely collected and monitored. The information was used to improve care.
- Staff took part in relevant audits, including clinical audits and other monitoring activities, such as pilot projects. Accurate and up-to-date information about effectiveness was shared and used to improve care and treatment.
- Staff had the skills they needed to carry out their roles effectively and in line with best practice. Their learning needs were identified and training put in place to meet these learning needs.
- Patients received coordinated care from a range of different staff, teams or services. All relevant staff, teams and services were involved in assessing, planning and delivering care and treatment.
- Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.
- Staff respected patients' diverse needs.

However:

- Care records were not always comprehensive and holistic. Some were not recovery focused and were not reviewed regularly.

Are services caring?

Good

We rated caring as good because:

- Patients were supported, treated with dignity and respect, and involved as partners in their care. There was a visible person-centred culture.
- Feedback from patients and the people close to them was positive about the way staff treated them.
- Patients were involved and encouraged to be partners in their care and in making decisions, with any support they needed. Staff spent time talking to patients so that they understood their care, treatment and condition.

Summary of findings

- Staff respected patients' privacy and confidentiality at all times.

However:

- Care records did not always clearly document patients' views.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff planned and delivered the service in ways that met the needs of the local population.
- They took into account the needs of different groups, so that patients' diverse needs were met.
- Care and treatment was coordinated with other services and other providers.
- Staff managed access to care to take account of patients' needs, including those with urgent needs.
- Patients understood how to complain or raise a concern. Staff took complaints and concerns seriously. They listened and responded in a timely way.

Are services well-led?

Good

We rated well-led as good because:

- All staff knew and understood the vision, values and strategic goals.
- Staff received appropriate training and were appraised and supervised, complaints were investigated, incidents were reported and investigated, changes were made where needed and safeguarding procedures were followed.
- Audit processes fed into quality governance, with evidence of action to resolve concerns.
- There were effective structures and processes to address current and future risks.
- The service was transparent and open with stakeholders about performance. Information was used to support effective decision-making and drive improvement. Staff reported and reviewed information on patients' experiences alongside other performance data.
- Managers championed a culture of no blame and encouraged staff to be open and honest when things went wrong.

Summary of findings

- There were systems to support staff and promote their positive wellbeing. All the teams worked together to promote a collaborative culture.
- Staff felt respected, valued and supported. They were committed to their roles and enjoyed working with the patient group. They described a strong and supportive team.
- Managers supported staff to work in innovative ways. They encouraged staff to discuss issues and ideas for service development.

However:

- The systems for audit and review in relation to care records were not always effective in highlighting problems with the recording of patient care.

Summary of findings

Information about the service

Mersey Care NHS Foundation Trust provides drug and alcohol services in Liverpool, Sefton and Knowsley.

The teams providing services are:

- Liverpool Community Alcohol Service
- Windsor Clinic
- Ambition Sefton
- Brook Place Substance Misuse Services

The services support people who have difficulties with alcohol or drug use into treatment. Patients are assisted with stabilisation and a journey into recovery. The trust offers a range of interventions including prescribing, medication management, specialist advice, psychosocial support, and recovery support.

The trust is subcontracted to provide the community element of the Liverpool Community Alcohol Service. Another trust provides the acute hospital component.The Liverpool Community Alcohol Service works in local communities across Liverpool. Around 69 clinics are held each week at local sites such as GP surgeries. Patients are able to self-refer or ask their GP or any other health or social care professional they are involved with to refer them.

Specialist alcohol nurses and health workers deliver a recovery focused service that includes:

- Advice and guidance on drinking and the help available
- Assessments and triage
- Community based alcohol detoxification programmes and referral for inpatient treatment
- Brief intervention sessions
- Referral to specialist services.

The Windsor Clinic is a 16-bedded inpatient unit that offers medically assisted detoxification programmes for people who are unable to detoxify from drugs and/or alcohol within the community and need 24 hour care to enable them to do so. The service takes referrals from community drug and alcohol services, GPs or another health professional. In August 2016, the service merged with the Kevin White Unit. Before the merger, drugs detoxification was provided at the Kevin White Unit and alcohol detoxification at the Windsor Clinic.

In October 2016, the provider had taken over the service level agreement for Ambition Sefton from a different provider. Ambition Sefton provides help and support to the residents of Sefton who have a drug and/or alcohol problem. Patients attend either Bootle or Southport sites. This service offers recovery focused treatment pathways including:

- Open access
- Access to community detoxification
- Specialist prescribing services
- Specialist alcohol services
- Take home naloxone
- Harm reduction advice service including needle syringe exchange
- Blood borne virus screening and vaccination
- Brief interventions: one to one support
- Access to inpatient detoxification pathways
- Access to ‘intuitive thinking’ courses
- Peer support mentoring and access to mutual aid groups
- Psychosocial support and services
- Reintegration via Mersey Care's recovery college.

The team consists of doctors, drug and alcohol workers, mental health and general nurses, social workers and peer support workers.

Patients who live in Liverpool can be referred to the community substance misuse services based at Brook Place.

The teams offer treatment and recovery focused services including:

- Assessment, advice and information
- Psycho-social interventions
- Blood borne virus testing
- Hepatitis B vaccinations
- Peer mentors and support
- Substitute prescribing
- Community detoxification programmes and referral for inpatient treatment
- Support and signposting to partnership agencies

Summary of findings

Mersey Care NHS Foundation Trust has been inspected under the CQC new methodology once before. Substance misuse services were not included in that inspection.

Our inspection team

The team was led by:

Head of Inspection: Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Team Leaders: Lindsay Neil and Sharon Marston, Inspection Managers, Care Quality Commission

The team that inspected substance misuse services comprised two CQC inspectors, a specialist advisor with a professional background in substance misuse and an expert by experience. Experts by experience are people who have experience of using services. The team had support from a CQC business administrator and a pharmacy inspector.

Why we carried out this inspection

We undertook an announced focused inspection of Mersey Care NHS Foundation Trust because there had been a significant change in the trust's circumstances. The trust had acquired Calderstones NHS Foundation Trust on 1 July 2016.

We also planned this inspection to include high secure services (a new core service) and to assess if the trust had addressed some of the areas where we identified breaches of regulation at our previous inspection in June 2015 (published October 2015).

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

This was an announced inspection. Before the inspection visit, we reviewed information that we held about the services.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- visited all the community substance misuse services and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service and one carer of a patient
- spoke with the managers for the ward and each of the community substance misuse services
- spoke with 22 other staff members including doctors, nurses and social workers
- attended and observed one team meeting
- attended and observed six group activity sessions, four assessment appointments and five key worker sessions
- collected feedback from 22 patients using comment cards
- looked at 31 treatment records of patients, plus eight prescription charts
- carried out a specific check of the medication management on the ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We spoke with 11 patients and one carer. We received feedback from 22 patients using comment cards. Four made negative comments relating to the reduced number of groups.

Patients said that the services were responsive and met their needs. They told us they felt well supported by the staff. They said the staff were kind and respectful towards them. All agreed that the staff were approachable, available and caring and listened to their concerns. Patients felt they had good relationships with all staff. They said staff were always available for one-to-one sessions.

All the patients we spoke with were able to tell us about their treatment but two patients at the Windsor Clinic said they did not have a copy of their care plan. They said staff actively encouraged them to engage. Their families and carers were encouraged to be involved in the care planning process. Their physical health was also monitored.

Most patients said there were activities available to meet their individual needs. They said activities were rarely cancelled. However, three patients at the Windsor Clinic and one at Ambition Southport said that more activities and groups were needed.

Patients said there were opportunities to be involved in service provision through community meetings.

All said they knew how to make a complaint and that they would feel confident to speak to staff if they needed to.

Good practice

Managers had set up a partnership project to provide support for veterans and reservists seeking military-specific addiction treatment by delivering seamless access to detoxification, rehabilitation and reintegration to veterans.

Managers had exchanged practice ideas with a substance misuse clinic in Vancouver. They trained and supported staff to set up a harm reduction programme based on the information and experience from Vancouver.

Patients were involved in the refurbishment of Windsor Clinic.

Liverpool Community Alcohol Service had conducted a clinical study to evaluate care pathways for managing dependent drinkers and had developed a care pathway for ambulatory detoxification.

Staff at Brook Place had conducted a hepatitis C screening pilot and a study of antibody mouth swabbing. This led to setting up community blood borne virus clinics and a care pathway for hepatitis C with treatment outcomes that exceeded the national average.

Ambition Sefton and the Windsor Clinic were providing take-home naloxone. Naloxone is an emergency antidote that patients can administer themselves in the event of an opioid overdose. It is recommended by the Advisory Council on the Misuse of Drugs and the World Health Organisation.

Areas for improvement

Action the provider SHOULD take to improve

- At the Windsor Clinic, the fire risk assessment should be updated and actions completed.
- Each patient should have a clear risk management plan that is regularly reviewed.
- All care records should be comprehensive, holistic and recovery focused and reviewed regularly. They should take account of patients' views.
- All care records should contain individual plans for unexpected exit from services.

Summary of findings

- Ensure all patients at Ambition Bootle have a review as per trust policy.
- There should be effective systems for audit and review in relation to care records.
- Ensure the action plan to ensure the completion of risk management plans and care records at Ambition Bootle is implemented.

Mersey Care NHS Foundation Trust

Substance misuse services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Substance Misuse Services	Liverpool Community Alcohol Service
Substance Misuse Services	Windsor Clinic/Kevin White Unit
Substance Misuse Services	Ambition Sefton (Bootle)
Substance Misuse Services	Ambition Sefton (Southport)
Brook Place Substance Misuse Services	Community Drugs Team
Community Drug Team (DRR) Substance Misuse Services	Community Drugs Team
Community Drug and Alcohol Team (DART) Substance Misuse Services	Community Drugs Team

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had received training in the Mental Capacity Act 2005. They understood the statutory principles of the Mental Capacity Act. They could describe situations where they would consider whether it was appropriate to use the Mental Capacity Act.

The trust had a Mental Capacity Act policy that staff could refer to for guidance.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

All the services we visited were tidy and well maintained. The furniture was in good repair.

Access to each service and to all areas inside the buildings was by key fob entry or a door code. This meant that unauthorised persons could not gain access. The waiting areas were well-lit and fully visible from the reception desk.

The clinic areas were clean and well organised. All clinical equipment, including resuscitation kit, first aid boxes, scales and blood pressure machines had been checked or calibrated within the last 12 months. Emergency medication was kept in a safe or a locked fridge. Staff who were trained to administer this medication had the combination to open the safe and fridge. Staff checked the temperature of the safe and fridge daily to ensure that medication was being stored safely. There was a clear protocol for the safe disposal of sharps and clinical waste. However, sharps bins at the Windsor Clinic and Ambition Southport did not have the date of assembly on them; this was not in accordance with the trust policy on managing clinical waste, which stated that partially used sharps bins must be disposed of every three months. The trust had contracts for the collection of clinical waste from all the services.

All the services had a number of rooms available for consultations, interviews and therapies. At Brook Place, one of the consultation rooms contained a table and stools that were fixed to the floor. This meant the furniture could not be used to cause harm.

The Liverpool Community Alcohol Service and the detoxification ward were located at the Windsor Clinic, an old two-storey building. There was a stair lift so that patients with reduced mobility could access the upper floor. There were communal rooms including activity areas, lounge, dining area and a kitchen. Patients in the detoxification ward were able to make their own drinks and snacks. There was a low stimulation relaxation room. There were visiting rooms and a family room and play area that people visiting with children could use. There was a CCTV system in the family room. This meant staff were able to ensure the welfare and protection of visiting children. The ward had access to garden space and there were outside recreation rooms.

The bedrooms had en-suite facilities. The en-suite areas had a large concrete step into them. This posed a tripping risk and staff had used hazard tape to mitigate the risk until the ward relocated to the refurbished Kevin White unit later in the year. The ward complied with same-sex accommodation guidelines by separating male and female sleeping areas. Patients had personalised their bedrooms with photographs and personal belongings. There were separate lounge areas for males and females. Each area had a bathroom and toilet.

There were named staff leads for infection control. They completed regular handwashing audits. All the areas we inspected were clean. The cleaning records were complete and up-to-date. We saw up-to-date clean stickers on equipment. Staff explained the infection control procedures they followed.

Maintenance records were up to date. Portable appliance testing had been carried out. Firefighting equipment was maintained and up to date. Fire wardens and first aiders were identified on a fire board. However, at the Windsor Clinic, the fire risk assessment was out of date and actions had not been signed off as completed. This meant that any changed risks had not been evaluated and staff had not taken steps to mitigate identified risks.

Staff were never alone in the buildings and they used personal alarms to call for assistance from other staff if there was an emergency.

The services displayed a range of information that reflected the needs of the local populations for each service, such as information about alcohol and alcohol limits, overdose, harm reduction, needle exchange, suicide, cancer, pregnancy, breast screening, sexual health, dementia, carers, support groups and advocacy. Staff could arrange interpreters if needed, and for leaflets to be translated into other languages and formats, including Braille.

Staff at the Windsor Clinic had undertaken an environmental suicide risk assessment on 4 October 2016. There were identified ligature points on the ward. A ligature

point is anything that a patient could use to harm themselves by strangulation. The audit included photographic examples of potential ligature points. There was an action plan that set out how staff mitigated risks, including clinical risk assessment and staff awareness but staff had not signed as required to indicate they had read the audit. However, the staff we spoke with were aware of the risks on the ward and explained how they managed them. Staff could contact a suicide lead and safety team for guidance. The document included a significant ligature risk assessment report and we saw that there had been no incidents. Staff also reviewed risks at ward rounds.

Safe staffing

Information gathered from managers and records demonstrated that staffing levels were adequate to keep patients safe and meet their needs.

As of 07 February 2016, there were 8.7 whole time equivalent qualified nurse vacancies across the substance misuse services, which was 23% of the qualified nurse establishment. There were 14.6 whole time equivalent healthcare support worker vacancies, which was 36% of the healthcare support workers. Substance misuse services had a staff turnover rate of 20% in the 12 months between 01 January 2016 and 31 December 2016, which was higher than the trust average by 14%.

In the 12 months between 01 January 2016 and 31 December 2016, the average qualified nurse vacancy rate for this service was 23%, which was higher than the trust average of 16%. The average healthcare support worker vacancy rate was 36%, which was 31% higher than the trust average of just under 5%. However, vacancies were due to be filled by trust staff undergoing organisational change.

The average sickness rate for substance misuse services in the same 12 month period was 6%, which was better than the trust average of 12%. Across the 12 month period there were peaks in staff sickness in July (17%), January (12%) and August (10%) 2016. Staff sickness in August also coincided with a peak in overall vacancies across the year at 25%.

At 31 December 2016, the Liverpool Community Alcohol Service had six qualified nurses, with three vacant posts, and six healthcare support staff.

The Windsor Clinic and the Kevin White inpatient unit had merged in August 2016. In total there were 21 qualified nurse posts with 11.9 vacancies and 19.4 healthcare support staff with 11.6 vacancies. However, due to service transformation, the number of beds had reduced from 33 across the two units to 16. Two consultant psychiatrists, a specialty doctor and a trainee doctor were attached to the ward.

The Ambition Sefton service had a total of 53.3 staff across the two sites at Bootle and Southport. This included 6.8 qualified nurses who worked across both sites. Five staff had left during the 12 months prior to this inspection but service transformation plans meant the staffing establishment was changing and the service was fully staffed.

The community teams based at Brook Place had 10.4 qualified nurse posts with 5.8 vacancies and 15.5 healthcare support staff with 8.8 vacancies. However, due to service transformation, the staffing establishment had reduced to 5 qualified nurses and 7 healthcare support staff.

Managers used a safer staffing tool to estimate the numbers of staff needed. They monitored staffing levels on a daily basis. Where the service did not have enough permanent staff to meet patients' needs, managers brought in agency and bank staff to cover the shifts required. Information that the trust provided showed that bank and agency staff had filled 1092 shifts in the period from 01 December 2015 to 30 November 2016. During this period, 66 shifts were not filled by bank or agency staff, of which 52 were healthcare support staff absences and 14 qualified nursing absences. This meant that at these times, shifts were not fully staffed, increasing the risk of harm to patients due to their needs not being met.

Where the managers had concerns regarding the number of staff available, the skills mix or a high level of bank or agency staff, they could escalate those concerns using the bronze on call procedures. If issues could not be resolved at this level then escalation would be to the silver on call. The chief operating officer monitored safe staffing levels and would in turn escalate concerns for review at weekly surveillance meetings.

If agency staff were required, there was a facility within the system to request staff who knew the patients well. The

teams carried out an induction process with agency staff. Each service held a file of one page individual care plans to ensure temporary staff had an overview of each patient they were working with.

Temporary staff participated in the handover with the team at the start of their shift and staff meetings when on their shift. If agency staff were used regularly, they had access to the trust IT systems and were able to access clinical notes. Regular agency staff were added to staff circulars so that they received relevant trust and service communications.

Annual leave was booked in advance so that cover could be arranged.

Staff caseloads were managed and reassessed regularly. Caseload per staff member was determined by their role and patient acuity, and ranged from 30 to 75. In the Liverpool Community Alcohol Service, staff delivered interventions over six to eight brief treatment appointments and did not carry a caseload. In the other community services, the complexity of the client's presentation and risk factors influenced allocation and management within the teams. Caseload management was reviewed and discussed at client allocation. Staff also discussed their caseloads with their immediate supervisor every four to six weeks and with the team manager every two months.

At Ambition Sefton and Brook Place, staff used a 'red, amber, green' risk rating to help manage caseloads. Patients rated red needed to be seen more than once every two weeks, patients rated amber needed to be seen once every two to four weeks, and patients rated green were working towards discharge. We saw these ratings on patients' care records. Staff told us that their caseloads were high and that there were many demands on their time. However, we saw that they were seeing patients regularly and that paperwork was up to date.

The community teams had access to a consultant psychiatrist, who was based at the service for one day a week. Staff could easily contact this consultant or another named consultant for advice at any time. Specialty doctors trained in substance misuse were available in the clinics every day.

The trust had mandatory training requirements for all eligible staff (meaning staff who were not on long term sickness absence). Data provided by the trust showed that, at 17 March 2017, compliance with mandatory training across all the services was below the trust's target of 95%. Training compliance rates ranged from 43% to 98%. However, on the days we inspected we reviewed staff training records and found that compliance had improved, with figures across the teams ranging from 92% to 100%.

Assessing and managing risk to patients and staff

Staff used a risk assessment tool that followed the Care Programme Approach model.

We reviewed 31 patients' records across all sites. All the records contained risk assessments but four had not been formulated into a risk management plan.

At Liverpool Community Alcohol Service we reviewed six patients' records. All the records contained risk assessments. The assessments had been formulated into risk management plans but these plans were not reviewed. However, staff explained how they assessed risk at each appointment and we saw a checklist that they had developed to monitor progress.

At Windsor Clinic, we reviewed five out of 16 records. All the records contained risk assessments and risk management plans.

At Bootle, we reviewed 10 records. All had risk assessments but only six were formulated into risk management plans. Three of these were not complete. This meant that staff did not have easy access to up-to-date risk management information. However, staff we spoke with were able to explain how they managed individual risk and give examples of situations when they had taken action to mitigate risk. Staff discussed risks every day at their morning meeting. A quality review visit at Ambition Bootle in January 2017 had identified that risk assessments and risk management plans were not compliant with trust recording processes. There was an action plan on the trust's tracker system to ensure these were completed.

At Southport, we reviewed five records. All contained a comprehensive, up-to-date risk assessment that had been formulated into a risk management plan. All were complete and up-to-date.

We reviewed five care records at Brook Place. All contained an up-to-date risk assessment and risk management plan.

Staff received safeguarding training at level one as part of their induction and mandatory training, although compliance was below the trust's target of 95%, ranging

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

from 72% to 100% across the services. Further training at levels two and three was available and 62% of staff had completed these modules. The staff we spoke with knew how to look for signs of abuse and how to make a safeguarding alert if necessary. They discussed safeguarding at team meetings. The services all had named safeguarding ambassadors who met monthly with the local authority. The meetings were to discuss policy and procedures, referrals, concerns and learning from incidents. Minutes were circulated to the rest of the teams. There were policies for the safeguarding of both adults and children to provide guidance for staff.

All patients were asked about their contact with children. Staff documented the name, date of birth and school of any child that was living with the patient. Recording this information makes it easier to share information and keep the child safe if any concerns arise during treatment.

Substance misuse services made no safeguarding referrals regarding adults or children to the local authority in this 12 month period. The trust was also not involved in any external investigations in relation to this core service.

Staff followed the trust's lone working policy. Staff and visitors signed in and out of the buildings. Staff seeing patients in the community logged the details of their visit and contacted colleagues to confirm they were safe. Home visits were risk-assessed. Staff knew the procedure to follow if an alarm was activated.

The community drug and alcohol services did not dispense medication. Good medicines management practice was evident in prescribing. Prescription forms were stored securely. Staff followed processes for collecting and signing out prescription forms and for reporting lost forms. Staff recorded the rationale for prescribing in patients' care records. Patient group directions were in place. A patient group direction is a written instruction, signed by a doctor and agreed by a pharmacist, for the supply and/or administration of medicines to groups of patients who may not be identified individually before presentation for treatment. In practice, this means that a patient group directive can act as a direction to a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. Staff contacted the pharmacy to let them know when patients did not attend appointments.

At the Windsor Clinic, we found that medicines, including controlled drugs, were managed safely. Storage and fridge temperatures were checked twice daily.

We checked eight prescription charts. We found that modified early warning scores and clinical institute withdrawal assessment scores were being completed regularly.

The modified early warning score is a simple, physiological score that may allow improvement in the quality and safety of management provided to patients. The primary purpose is to prevent delay in intervention or transfer of critically ill patients.

The clinical institute withdrawal assessment is a scale used in the management of alcohol withdrawal. The total score gives a combined value that relates to the severity of alcohol withdrawal. The ranges of scores prompt specific management decisions, such as the administration of benzodiazepines.

This meant that staff had accurate information on which to base clinical interventions.

We reviewed information sent to us by the provider relating to the management of violence and aggression, which included information about the trust's 'No Force First' programme to reduce restrictive interventions on their wards. Data related to the 12-month period between 01 January 2016 and 31 December 2016. There were no episodes of seclusion, segregation or restraint within this core service during this period.

Track record on safety

Between 01 November 2015 and 31 October 2016, substance misuse services reported two serious incidents that required investigation.

Following the investigations into these incidents, staff had incorporated harm reduction advice into discharge planning.

Another recommendation was that care plans and risk assessments should be subject to regular audit and review.

Reporting incidents and learning from when things go wrong

All the substance misuse services used the trust's electronic recording system for reporting incidents. All staff could access and record incidents direct to the system, which

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

were then sent to service managers. We reviewed all 163 incidents reported in the six months prior to this inspection. We were assured that staff knew what to report and how to report it.

In the six month period we reviewed, staff had reported two incidents involving patients that were categorised as a serious threat or requiring more than minor, precautionary measures. One of these concerned a patient who left the ward at Windsor Clinic and another involved a community patient at Brook Place.

Examples of other incidents related to issues such as medication errors, infection control and low-level verbal aggression or threats, which staff dealt with locally.

Staff discussed incidents at morning 'flash' meetings and monthly business meetings. Managers disseminated lessons learnt to staff at team meetings and during one-to-one sessions.

We reviewed minutes of team meetings, managers' meetings and unit meetings that took place between September 2016 and March 2017. They showed that staff had received feedback from investigation of incidents that had happened in the service and in the wider trust. For example, staff at another site had accidentally allowed a member of the public claiming to be a medical student into the building. We saw that all staff had been reminded to check visitors' identification.

We also saw an example of the advice and support given to staff following an incident where a patient had been verbally aggressive.

The trust disseminated information through Quality Practice Alert newsletters to staff regarding events that had happened and actions taken to prevent them happening again. The trust also held Oxford model events, where staff discussed lessons learnt from serious untoward incidents or complaints to identify further issues or concerns and how similar events could be prevented from happening in the future.

There had been no 'prevention of future death' reports received by the trust since 14 October 2013.

Duty of candour

Staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They explained that they would be open and honest with patients. Staff were able to give examples of when they had apologised after making errors. They were clear that they would explain and apologise to patients and their families in any event.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We reviewed 31 patients' care records. Three did not contain a needs assessment and three did not contain a recovery plan.

At Liverpool Community Alcohol Service, we reviewed six records. The records contained needs assessments and recovery plans. Treatment consisted of one to six brief interventions that could take up to six months to complete. Staff said that they would document changes to needs in the daily records. However, this made them difficult to locate on the electronic case management system. This meant that staff who were not familiar with the patient did not have easy access to up-to-date information about their needs, care and treatment.

At Windsor Clinic, we reviewed five out of 16 records. All contained a needs assessment but none of the five was complete. Detoxification care plans were present in four of the five records. These plans focused on medical detoxification regimes, which could take from seven to 21 days. Staff based clinical interventions on clinical institute withdrawal assessments and clinical opiatewithdrawal scale scoring. The admission criteria included agreeing plans for aftercare and follow up as part of the recovery pathway. Staff recorded patients' progress in the daily notes.

At Bootle, none of the 10 records we reviewed were complete. Three records did not contain a needs assessment. Of the seven that did, five were not complete. Only one record contained a complete recovery plan but this record did not contain a full needs assessment so we were not assured that the recovery plan was accurate. Two did not have any recovery plan recorded. The remaining seven were brief and not recovery focused.

This meant that staff did not have access to up-to-date information about patients' needs, care and treatment. A quality review visit in January 2017 had identified that care plans were not compliant with the trust's recording processes. An action plan had been completed on the trust's tracker system.

In October 2016, the provider had taken over the service level agreement for Ambition Sefton from a different provider. At Bootle, there had been issues transferring patients' records from the previous provider. Six months into the new contract, there was a programme under way to review all patients. Sixty seven per cent of patients had been offered a review appointment.

We reviewed five records at both Southport and Brook Place. All contained an initial assessment completed within two working days of the patient's referral into the service. Assessments covered drug and alcohol use, mental health, physical health and social circumstances. Care records also contained up to date, holistic, recovery-oriented care plans. Staff and patients reviewed care plans regularly. The team carried out an annual review and non-medical prescribers reviewed their patients every six months.

The trust used an electronic care record system. The information that staff needed to be able to deliver care was stored securely on this system.

Best practice in treatment and care

Links to best practice guidance were available on the trust's website.

The community drug and alcohol services provided treatment for patients withdrawing from opiates following National Institute for Health and Care Excellence guidance TA 114 Methadone and buprenorphine for the management of opioid dependence.

Staff at the Windsor Clinic used clinical opiate withdrawal scales and clinical institute withdrawal assessments to inform monitoring, administration and prescribing. This is in line with National Institute for Health and Care Excellence guidance CG52 Drug misuse in over 16s: opioid detoxification. We found evidence that the provider had monitored compliance with the guidance.

We checked 31 care and treatment records and eight prescription charts. Records showed that patients had the opportunity to discuss their treatment with the doctor. Prescribers followed National Institute for Health and Care Excellence clinical guidance CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. A formulary document was available for substance dependency and dual dependency that contained links to relevant national clinical guidance. There were local guidelines relating to using street diazepam or buying opiates on the street.

Ambition Sefton and the Windsor Clinic were providing take-home naloxone. Due to funding restraints the Windsor

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Clinic could only provide take-home naloxone for Sefton patients. Naloxone is an emergency antidote that patients can administer themselves in the event of an opioid overdose. The Advisory Council on the Misuse of Drugs and the World Health Organisation recommend its use. The medicines management procedure set out guidance for staff, detailing their responsibilities, training, monitoring and recording. We saw plans for the teams at Brook Place to start this provision at the end of April 2017.

Staff directed patients to local mutual aid groups, which is in line with recommendations of National Institute for Health and Care Excellence guidance CG51 Drug misuse in over 16s: psychosocial interventions, for people recovering from substance misuse.

The Liverpool Community Alcohol Service had developed an assessment tool and a pathway for community based ambulatory detoxification. This meant that eligible patients could undergo detoxification in their own homes, without needing to be admitted to hospital.

We observed five one to one sessions. Staff and patients discussed harm minimisation, motivation to change, safe storage of methadone, relapse prevention and coping skills.

Many patients were engaged in psychological therapies. Staff described interventions they used to support patients in their recovery, including:

- intuitive thinking groups
- relapse prevention therapy
- motivational interviewing
- cognitive behavioural therapy
- dialectical behaviour therapy
- counselling
- eye movement desensitisation and reprocessing

Staff linked in with other agencies to ensure that patients received appropriate support with employment, housing and benefits.

Staff considered patients' physical health needs. Staff checked whether patients had had an annual health check and, with consent, referred any who had not. The records we reviewed all contained full physical healthcare checks. Staff completed these on admission to treatment. The physical health assessment included, for example, eating, allergies, pain, current treatment for physical health issues and any medication.

A doctor or a non-medical prescriber reviewed patients prescribed an opioid replacement at least once every six months.

Staff at Brook Place had liaised with a local acute trust to arrange for a nurse to offer blood-borne virus testing at Brook Place. They had also applied for funding to provide treatment for hepatitis C. This is in line with recommendations made by the Public Health England Hepatitis Report (2014), the Global Health Sector Strategy and National Institute for Health and Care Excellence quality standard QS23 drug use disorders in adults, which states that all patients attending drugs services should be offered blood borne virus testing and hepatitis B vaccination.

Staff used clinical tools to audit the effectiveness of interventions. They were using nationally recognised tools, such as the alcohol use disorders identification test, severity of alcohol dependence questionnaire and the treatment outcomes profile to assess severity and measure progress in key areas of patients' lives. They reported outcomes to the National Drug Treatment Monitoring Service. Data provided by the trust showed that successful completions of treatment in the reporting period to 31 December 2016 were 6% at Ambition Sefton, 6% at Brook Place, 38% at Liverpool Community Alcohol Service and 65% at the Windsor Clinic, compared with the national average of 50%.

The service used the data to work in partnership with commissioners, service users and other substance misuse providers to outline a new model of care that provided quality and which could be delivered safely and effectively within a city wide treatment pathway. We saw a copy of the service transformation delivery plan that set out how this was to be achieved. At Ambition Sefton, staff told us that since the new provider had taken over the service level agreement on 01 October 2016, the model of care was much more recovery centred, with a strong focus on clinical support. In that time, the service had established working practices planned to support patients to live independently in the community. At Brook Place, the team had been developing a new model of care in response to local need. This was due to become operational in June 2017.

The Windsor Clinic had taken part in three clinical audits in the last 12 months. This included an audit of malnutrition

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universal screening tool to measure the rate of screenings for malnutrition on admission, the use of the malnutrition universal screening tool and use of care plans and referral rates to dieticians.

In February 2017, the clinical lead and ward manager at the Windsor Clinic had carried out audits of modified early warning scores andclinical institute withdrawal assessments during the 12 months before this inspection, with the aim of measuring accurate use of the tools.

The modified early warning scores audit identified that staff were not always following the trust's modified early warning scores action protocol and procedure. Issues highlighted included incomplete baseline recordings and missing signatures.

The clinical institute withdrawal assessments audit identified that assessments were completed regularly and appropriately to inform monitoring, administration and prescribing. However, staff did not always transfer them to the electronic record.

Action plans had been created that included dates for completion and the responsible person. For the modified early warning scores audit, we saw from team meeting minutes that some actions had been completed. However, it was not possible to ascertain whether all actions had been completed as the timelines had not passed.

Ambition Sefton and the Windsor Clinic had undergone a pharmacy audit in January 2017. The audit included medication storage and management of forms used for prescribing medicines. Southport had scored 100% and Bootle 93%. Windsor Clinic had scored 81%. We saw an action plan that showed that some actions had been completed and the remainder were in progress.

Skilled staff to deliver care

Patients had access to a range of mental health disciplines to aid their recovery. There was an effective multidisciplinary structure that included input from dietitians, nurses qualified in mental health and physical health, occupational therapists, psychiatrists, psychologists, recovery and assessment staff, social workers and specialty doctors.

Managers supported staff to deliver effective care by means of supervision and appraisal of their work performance. They used the supervision and appraisal process to identify additional training requirements and manage performance. The trust's values were linked to appraisal. Staff had an annual appraisal that included setting objectives for personal development. As at 31 March 2017, 62% of non-medical staff at Brook Place and the Windsor Clinic had had an appraisal in the last 12 months and 70% at the Liverpool Community Alcohol Service. Accurate data was not available for Ambition Sefton as the trust had taken over the service level agreement in October 2016, which was outside the regular window for appraisal in 2016 to 2017.

All medical staff revalidations were up to date.

Staff told us they received clinical and managerial supervision every six to eight weeks or more often if necessary. Supervision records included discussion of staff wellbeing, National Institute for Health and Care Excellence guidelines, performance, training needs and patient engagement. Managers also reviewed a selection of case files. Staff said they found supervision helpful and valuable.

The trust had recently introduced a new electronic system for recording supervision. We could not establish from these records that staff had received supervision before December 2016. At the Windsor Clinic and Brook Place, 81% of eligible staff had received supervision. At Ambition Sefton, 76% of staff had received supervision and 73% at the Liverpool Community Alcohol Service. This was against the trust target of 90%. A red, amber, green system flagged up when supervision was due so that managers had oversight. We were assured by our observations and from speaking with patients and staff, that staff were skilled and competent and that they understood their roles. Staff also felt valued and supported.

Staff had received additional training to enable them to carry out their roles. This included training on veterans, post-traumatic stress disorder, questioning addiction and recovery, being an alcohol champion, motivational interviewing, clinical examination skills, physical health assessment, root cause analysis and advanced supervision. At Ambition Sefton, staff had arranged and led monthly lunchtime education sessions, such as smoking advice and methadone and buprenorphine prescribing. Senior managers had commissioned an external provider to deliver training tailored to enable staff to better meet patients' needs, including needle exchange, safer injecting and harm reduction. Senior staff had access to human resource clinics and to leadership training specific to their role.

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The service transformation delivery plan included a work stream that was looking specifically at the skills recovery workers should have.

Staff and managers discussed performance in one-to-one supervision sessions. We saw evidence of this in the records we looked at. Managers explained the process they followed and told us they felt well supported in dealing with performance matters.

Team meetings took place every month. There was also a monthly unit management group meeting that all managers attended to discuss service wide issues, such as the introduction of further satellite clinics and review of the clinical model.

Multi-disciplinary and inter-agency team work

Staff recognised the benefit of close working with allied professionals and care from a range of different disciplines was coordinated. The multidisciplinary team was well integrated and collaborative working was embedded. All relevant staff, teams and services were involved in assessing, planning and delivering patients' care and treatment. Staff worked together to understand and meet the range and complexity of patients' needs. They provided a range of therapeutic interventions to support patients' recovery in line with best practice guidance.

The ward at the Windsor Clinic held twice-weekly multidisciplinary team meetings to review patients' clinical needs.

There were handover meetings twice daily on the ward, at every shift change. We attended one of these meetings and found it to be well structured, informative and productive.

The community teams held weekly multidisciplinary meetings, which gave staff the opportunity to discuss complex issues.

We observed one multidisciplinary team meeting at Brook Place. The multidisciplinary team discussed clinical and process issues. They worked closely to plan patients' care and treatment in a holistic way. Staff liaised with the patients' GP and a local drug and alcohol charity. Discussion was factual, sensitive and patient focused. Physical health care was also discussed.

All the teams had established positive working relationships with other service providers such as GPs, the local acute NHS trust, local authority services, the probation service, addiction charities, mutual aid groups and other third sector organisations. Staff from referring services were invited to multidisciplinary team meetings and so were kept informed of patients' progress whilst in hospital.

The community teams operated a shared care model with patients' GPs. Liverpool Community Alcohol Service had produced a training package to inform GPs and equip them with the knowledge and skills to feel confident about discussing with patients' alcohol use with them.

The teams also worked with a local addictions charity. They met with the charity every month to discuss issues and processes. The teams worked with patients whose lifestyles were most chaotic, to stabilise them, then transferred their care to the charity for the second stage in their recovery.

Brook Place also ran fortnightly clinics for pregnant women, with local acute hospital trust. The other teams linked into this service.

Good practice in applying the MCA

Across the service, 61% of eligible staff had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The trust had a policy that staff could refer to for guidance.

The policy set out the process for assessment following concerns that a patient may lack capacity and for determining best interests.

Staff we spoke with understood the statutory principles of the Act. They explained how they would adapt communication to support patients who might have impaired capacity to make a decision. Staff discussed the process of referral to an independent mental capacity advocate during their team meetings. There was a clear protocol for patients who attended appointments when they were intoxicated. Staff would only give prescriptions to patients whose breath alcohol level was below a certain level. This was because intoxication could affect the patient's capacity.

Equality and human rights

There was an equality and diversity policy that covered protected characteristics under the Equality Act 2010 and definitions of discrimination and positive action. It also

Are services effective?

Good

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promoted commitment to equality issues that related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, such as respect for personal preferences and lifestyle choices.

We looked at staff training records. Ninety per cent of staff had completed equality and diversity training. Equality and diversity training was part of the mandatory training programme. Managers used an electronic training matrix to monitor compliance and record renewal dates.

One patient we spoke with told us they had specific diverse needs and they were clear that staff respected their needs. Another did not have specific needs but they felt that staff would respect and respond to patients that did.

The ward at Windsor Clinic had some blanket restrictions. There was a blanket restriction on the use of drugs or alcohol. There was also a blanket restriction on visits by individuals in active addiction and patients who were acutely unwell were not allowed to have visitors. The ward was kept locked and access to outside space was only allowed with an escort. Staff explained how they would incorporate these restrictions into patients' care plans.

These restrictions were appropriate due to the nature of the service. They were intended to ensure clients focused on their treatment.

In the community teams, we saw evidence of interagency work that ensured patients with protected characteristics were able to access the service. For example, staff provided clinics in local hostels and a clinic for pregnant women. There was a drop-in session in a local shopping centre. They also liaised with other organisations, such as those that worked with sex workers.

Management of transition arrangements, referral and discharge

There were agreed pathways for transfers into the community services, and from the services to local primary care providers.

The community teams accepted referrals from individuals and any other organisation, for example, NHS and third sector substance misuse services, GPs, local health and support agencies. Staff carried out an assessment and liaised to ensure the referrals were appropriate.

The ward accepted referrals from the community teams or through social services single point of access.

There was a clear process for discharge from the ward. Patients admitted to the Windsor Clinic for detoxification were expected to have made an aftercare plan before admission. Ward rounds took place twice weekly and patients were discharged according to their aftercare plan once they had completed detoxification. If a patient decided they wished to leave, staff would try to persuade them to stay and complete their treatment. They would explain the risks of overdose due to reduced tolerance, discuss harm minimisation and what to do if their health deteriorated. They would ask the patient to sign a discharge form and arrange for them to see a community based recovery team.

Records we reviewed showed that all the teams worked with other agencies to facilitate access and discharge.

Only three of the care records we reviewed included any individual plans for unexpected exit from treatment that, for example, set out the increased risk of overdose when misusing some substances after a period of abstinence. Four had assessed unexpected exit as no risk. This meant that some patients could have an increased risk of overdose if they left the service unexpectedly.

Staff explained the generic process for managing unplanned exits from treatment. If patients did not attend appointments, staff tried to contact them by telephone or through other support agencies to encourage them to engage. They discharged patients who did not attend three consecutive appointments.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

There was a visible person centred culture. We observed a number of groups and sessions between staff and patients. There was good engagement between staff and patients. Staff were warm and friendly. They treated patients with dignity, respect and kindness during their interactions and the relationships between them were positive. Staff recognised and respected patients' needs. Patients told us they felt supported and said staff cared about them. They described staff as friendly, approachable and helpful.

Staff were motivated to offer care that was kind and promoted patients' dignity. Relationships between patients, the people close to them and staff were caring and supportive.

Feedback from patients and the people close to them was positive about the way staff treated them. Patients and those close to them told us that the care they received was good and they felt supported.

A patient said, 'Reception staff are brilliant – I'm always greeted with a smile.' Another told us 'You are treated like a person here.'

The staff ensured patients' dignity, privacy and confidentiality was always respected. For example, in all the services, interventions such as drug testing were carried out in a private room to maintain the dignity and confidentiality of service users.

The involvement of people in the care they receive

At Liverpool Community Alcohol Service and Ambition Bootle, only one record at each service contained clear evidence of the patient's own views.

Based on these records, we were unable to make a judgment on whether patients were fully involved in care planning. However, all but one of the patients we spoke with said they had been fully involved in all their care planning. Two said specifically that although staff were supportive and made suggestions, the final decision was theirs.

At the Windsor Clinic, detoxification followed a medical model that staff agreed with patients before admission. Clinical interventions during admission were based on this model. Before admission, staff and patients also agreed plans for aftercare as part of the recovery pathway.

At Ambition Southport, the care records were of good quality. They contained comprehensive assessments of each patient's needs, assessment of substance misuse and associated risks, and assessment of the patient's motivation to make changes, incorporating the patient's own views. Staff and patients had formulated these into care plans that were recovery focused, individual and holistic. They contained evidence of the rationale for treatment and staff had provided harm reduction advice.

We reviewed five care plans at Brook Place. There was no evidence from the records that patients had been actively involved in their own care planning, for example, by setting their own goals. The care records did not identify whether patients had been offered a copy of their care plan. However, in the one to one sessions we observed, staff took time to highlight patients' strengths and took a collaborative approach to care planning. Patients were actively involved in care planning and staff offered them copies of their care plan.

Staff at the Ambition Bootle service told us how they encouraged patients to maintain their independence. For example, staff had reduced the number of groups they facilitated, such as a breakfast club, and instead they supported patients to become involved with community groups, such as courses and an employment hub at the Life Rooms to help patients get back to work, through volunteering opportunities and further education.

The Windsor Clinic held weekly community meetings. These meetings engaged patients and improved communication. We saw minutes of some of these meetings that documented discussion and feedback about issues patients raised. There were suggestions boxes and a 'you said, we did' board on the ward. There was also a group called 'R-Space' that a former patient had set up for patients in recovery.

There was a trust-wide veterans' advisory group of staff and service user veterans contributed to service developments, training, and information.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Patients helped to recruit staff by sitting on interview panels. Patients at Windsor Clinic had been involved in the refurbishments at the Kevin White unit.

At Windsor Clinic, the patient advice and liaison service visited the ward twice each week to ensure that patients were aware of the support that they could provide. Community based advocacy services were well advertised.

Staff asked patients to complete patient experience questionnaires to give their views about the service. The questionnaire was based on National Institute for Health and Care Excellence guidance CG136 service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, and included questions relating to involvement in care and treatment, for example:

- Do you feel involved in decisions about your care and treatment?
- Do you feel supported in your recovery and self-management?
- Did you feel involved in decisions about your medication?
- Have you been involved in the development of your care plan?
- Do you feel listened to by staff?

The teams carried out this questionnaire every month. Outcomes were reported through the governance processes. Between 1 January 2017 and 1 April 2017, the overall score for all of the substance misuse services was 92%.

Some former patients had gone on to become volunteers, for example, they ran 'R-Space' groups and some worked with mutual aid groups.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

Over a 12-month period, between 1 January 2016 and 31 December 2016, average bed occupancy was 81%. Windsor Clinic had the shortest average length of stay of discharged patients with nine days. The Kevin White Unit had the longest average length of stay for discharged patients at 13 days before the two units merged in August 2016.

There were no out of area placements between 1 January 2016 and 31 December 2016 and only one ward move for three separate patients after admission at the Kevin White Unit which accounted for just two per cent. No patients had moved wards after 10pm in the same reporting period. There were five readmissions within 28 days at Windsor Clinic, the fastest being just seven days after discharge in January 2016.

During the same period there were a total of 688 discharges, of which only one was delayed. This delayed discharge happened at the Kevin White Unit in March 2016.

The trust was unable to report on the accurate mean number of days for referral to assessment and treatment times due to an internal issue. Based on the information provided, in the community services, referral to initial assessment was normally within two working days, and at Windsor Clinic for alcohol services, the trust was operating within the national target for urgent cases at two working days.

The Windsor Clinic acted as a gatekeeper for new referrals, which mainly came from the community teams. Every week, the multidisciplinary team discussed all new referrals. If accepted, they would be offered a bed within three weeks. This had been agreed with commissioners. All patients waiting for admission were supported by the community services and their GP until a bed was available. There were no exclusion criteria but staff expected that patients would have worked with their community worker to make changes to their lifestyle before referral, and would have agreed a robust recovery plan before admission.

The community-based services did not have waiting lists; new referrals would be allocated to a member of staff straight away. There was always one member of staff on duty each day. The duty member of staff answered urgent telephone calls and screened new referrals. We saw in the one to one sessions that staff informed patients that they could contact the duty worker if their key worker was not available.

Appointment times were flexible and rarely cancelled. Staff also ran 'drop-in' clinics at local venues. This meant that patients did not have to attend appointments at the team base to be able to access the service.

If patients did not attend appointments, staff tried to contact them by telephone or through other support agencies to encourage them to engage. The service discharged patients who did not attend three consecutive appointments.

The facilities promote recovery, comfort, dignity and confidentiality

The facilities and premises were suitable to promote recovery and support care and treatment. Each team had a fully equipped clinic room where staff could examine patients. The clinic rooms contained an electrocardiograph machine, equipment to measure height, weight and blood pressure, and a couch. There was a separate urine testing room with toilets, stainless steel counters and all of the equipment required for testing.

There were group rooms and smaller consultation rooms available for one to one sessions. There was adequate soundproofing, which meant that conversations in adjoining rooms could not be overheard.

Local information and information such as keeping safe, how to complain, patients' rights and advocacy services was displayed on noticeboards in the consultation rooms and waiting area.

On the ward at Windsor Clinic there was a main lounge and a female only lounge. There were rooms where patients could relax or engage in therapeutic activities. These included a low stimulation relaxation room, quiet areas, activity rooms and meeting rooms. There was a separate family room where patients could meet their visitors away from the ward area. Patients had access to the internet via a computer on the ward. Staff encouraged patients to personalise their bedrooms. We saw bedrooms that contained pictures, books and personal effects.

There were several initiatives to improve physical health and encourage healthy lifestyles.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Drinks and snacks included sugar free and low fat wherever possible. Patients at the Windsor Clinic took part in walking groups. Patients attending the community services could take part in exercise groups, such as 'recovery in the park' at Ambition Southport. Some had completed the 'couch to 5 k' programme, which the NHS recognises. They then took part in the Greater Manchester 10k run and went on to join a local running group.

Meeting the needs of all people who use the service

The community buildings were fully accessible for wheelchair users and people with limited mobility. Staff could request interpreters and written translations for patients whose first language was not English. Staff did not routinely request or provide accessible information for patients with a learning disability. Staff explained that they would seek to gain these patients' consent for involvement of carers or support workers who could help patients understand information.

At the Windsor Clinic, the ward environment was accessible and there was a stair lift to the upper level. Staff took a proactive approach to understanding the needs of different groups of patients, and to deliver care in ways that met their needs and promoted equality. This included patients in vulnerable circumstances or those with complex needs.

The needs of different patients were taken into account when planning and delivering services. There was a dedicated service for veterans and a veteran lead who championed veteran issues across the trust.

Meal choices on the ward included options for vegan and halal diets and for patients with allergies or medical conditions such as diabetes. Patients' cultural and religious needs were met and they had access to spiritual support.

Listening to and learning from concerns and complaints

Staff knew how to handle complaints appropriately. Feedback from complaints was a standing agenda item at team meetings. We saw evidence that staff discussed learning from complaints.

Patients we spoke with told us they knew how to make a complaint.

In the 12 month period from 1 January 2016 to 31 December 2016, the substance misuse services received a total of 17 complaints. None were upheld or referred to the ombudsman. The most complaints made were regarding the Brook Place team at 10, with nine out of 10 regarding concerns about the clinic moving premises. Five complaints were received by Windsor Clinic, of which three were in relation to the introduction of a smoking ban. Liverpool Community Alcohol Service and the Kevin White unit had received one each.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

Staff understood the vision and direction of the service they worked in and about how their work linked into the trust's vision of delivering 'perfect care'. They described an ethos that promoted recovery. The vision and values were integrated into everyday business via, for example, 'you said, we did', lessons learned and handover meetings. Our discussions with staff and our observations of care being delivered assured us that the concept of 'perfect care' was embedded in the service and in individual practice.

Staff commented that managers were extremely approachable and operated an 'open door' policy for staff to raise any issues or concerns. They knew who the senior managers were and throughout our inspection we saw them acknowledging and speaking with each other. Staff told us that throughout the service transformation programme, the senior managers regularly visited to support staff. The patients we spoke with told us that staff were approachable and caring.

Good governance

Staff told us they had regular contact with the senior management team. They explained the leadership and management structures in their service and they knew who the senior managers were.

We found all the teams were well managed locally. Managers had the experience, capacity and capability to ensure that the vision and values could be delivered. Staff were clear about their roles and they understood the management structure. They received appropriate training and were appraised and supervised, complaints were investigated, incidents were reported and investigated, changes were made where needed and safeguarding procedures were followed.

In all the teams, staff completed regular audits. Assessments, care plans and risk management plans were audited to ensure they were completed and reviewed regularly. This was done via a monthly quality review visit carried out by staff independent of the service. A quality review visit at Ambition Bootle in January 2017 had identified that care plans, risk assessments and risk management plans were not compliant with the trust's recording processes. There was an action plan on the trust's tracker system to ensure these were completed.

There was also evidence of case file audit in supervision, but some of the records we reviewed were incomplete, which meant we could not be assured of the effectiveness of the review.

There were environmental audits that included ligature risk audits, and audits of infection control systems, equipment and medicines. With the exception of the environmental suicide risk assessment and the fire risk assessment at the Windsor Clinic, we saw evidence that these audits were effective and findings were addressed quickly.

Staff used a number of quality tools and assessments to measure patient safety. Examples included infection control audits, Oxford model events and the quality practice alerts. The service had developed a framework for analytical review of alcohol related deaths that set out key lines of inquiry and areas of investigation, designed to provide direction and manage the scope of the review.

Across the teams, staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Performance information was used to hold management and staff to account. Staff supervision was carried out at least every six to eight weeks. Staff told us they had been supervised and appraised by their line managers and that they were supported by them as well as by their peers. We saw that supervision records were mainly up to date. However, due to the new system being implemented, we could not establish that staff had received supervision before December 2016.

Staff were responsible for ensuring their training was up to date but their managers also monitored compliance. Staff compliance with mandatory training requirements on the days we inspected was 92% to 100%. These figures were higher than those provided by the trust, which showed that, at 17 March 2017, compliance with mandatory training across all the services ranged from 43% to 98%. Throughout our inspection we discussed various issues with staff, such as safeguarding, mental capacity and

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strategies for recovery, and we reviewed care records and supervision notes. We were assured that staff were competent and had the skills necessary for them to carry out their roles.

There was a good governance structure to oversee the operation of the service. There was a handover meeting every morning. All the teams held monthly business meetings where issues such as performance, incidents, complaints and new referrals were discussed. Discussions included information from patient community meetings. We saw minutes of several meetings of all the teams and found them to be well structured, informative and productive, addressing quality issues clearly.

Staff used performance systems and information to manage current and future performance. They used the data to identify opportunities to drive improvements in care. Managers were developing improvements and efficiency changes, with input from clinicians to understand their impact on the quality of care. Staff reported and reviewed information on patients' experiences alongside other performance data.

The managers told us they had sufficient autonomy to carry out their role and they felt supported by the senior managers. Service deficits were recognised and there was a service transformation delivery plan to resolve the issues.

There was a monthly unit management group meeting that all managers attended to discuss service wide issues. Staff were able to escalate issues to the risk register via this meeting.

The trust had identified one financial risk in relation to vision, values and strategy for substance misuse services. As a result of commissioners having confirmed they are unable to support previously agreed costs for the addiction services, there was a risk of £1.9m of addiction services being decommissioned. This would have a significant impact on the stability of addiction services. It may result in a reduction of services for addictions and have a negative impact on other services.

We saw that the service transformation delivery plan included cost effectiveness, reducing variation, waste and harm, and ensuring links and reducing duplication with other pieces of work and other services were taken into account in its overarching themes.

Leadership, morale and staff engagement

Since 13 February 2016, no staff had been suspended or placed in supervised practice within substance misuse services.

Staff told us that they had opportunities to give feedback through the annual staff survey.

The average sickness rate for substance misuse services in the 12 month period to 31 December 2016 was 6%.

Managers encouraged staff to be open and honest when things went wrong. They championed a culture of no blame. Staff we spoke with understood what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Staff were aware of the whistleblowing policy and the trust's 'freedom to speak up' guardian. They understood the whistleblowing process and said they would use it to escalate concerns. They told us they felt able to raise concerns without fear of victimisation, to promote service development and improvement.

Staff told us they felt well supported by their local managers, peers and more senior management. They were positive about leaders within the service and in the wider trust. They told us that demands on them were high due to the level of patient need and the number of vacancies in the teams. Despite this, morale was good. Staff were proud of the service as a place to work and they spoke highly of the culture. They felt respected, valued and supported, and were positive about their jobs. Staff were committed to their roles and enjoyed working with the patient group. Staff described a strong and supportive team. They felt able to ask the team manager for help if they were struggling to manage their workload.

Staff had opportunities for career progression. Some staff were completing the trust leadership course. The Brook Place team manager had arranged with the trust organisational effectiveness and learning team for all Brook Place staff to attend training in change management and resilience in June 2017.

We saw examples of good local leadership from the managers, such as implementing initiatives to meet the diverse needs of patients and ensuring the vision and values were embedded into individual practice and service delivery.

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Leaders encouraged cooperative and supportive relationships among staff. They reported good multidisciplinary team working. We observed staff interacting as a cohesive team, with a clear understanding of each other's roles. They told us they enjoyed their work and were proud of the culture of care. They showed a clear commitment to providing the quality care that patients needed. There was strong collaboration and support across the teams and a common focus on improving patients' experiences.

Staff were encouraged to discuss issues and ideas for service development within supervision, team meetings and with senior managers. Records we reviewed confirmed this.

The team at Brook Place had been developing a new model of care in response to local demand and reduction in service funding. This was being discussed with commissioners and due to become operational in June 2017.

We saw that staff had been consulted about developing the service and suggestions they had made had been implemented, such as red, amber and green risk ratings for each patient.

One member of staff had won the trust's positive achievement award in the category of 'improving the service user experience'. This achievement included developing and delivering an outreach clinic to improve access to addiction services, delivering an outreach pregnancy clinic and working alongside a drug and alcohol charity to set up an addictions clinic.

Commitment to quality improvement and innovation

The substance misuse services had not registered for any accreditation schemes in the last 12 months.

Senior managers had participated in an exchange visit with a Vancouver clinic to compare practice and ideas for improving harm reduction. As a result, they had commissioned an external provider to deliver training tailored to enable staff to meet patients' needs better, including assessment, what questions to ask, what equipment to provide and safe disposal. They had developed a harm reduction programme that included needle exchange, safer injecting, advice and support, and an information DVD for patients.

In partnership with two other local agencies, the service had formed the National Veterans Community Recovery project, to provide support for veterans and reservists seeking military-specific addiction treatment by delivering seamless access to detoxification, rehabilitation and reintegration to veterans from across the UK.

The Liverpool Community Alcohol Service had conducted a clinical study to evaluate care pathways for managing dependent drinkers, a comparison of acute, short term inpatient detoxification, traditional elective inpatient detoxification and community based (ambulatory) detoxification following referral from the emergency department. Demographically, patients were similar across all three pathways. The study found that recruitment was more rapid for the community based pathway and this was an effective model as well as the acute and elective models. It concluded that more rigorous and robust research was needed to look at the effectiveness of the ambulatory clinical model.

The Liverpool Community Alcohol Service had also developed an assessment tool and a pathway for community based ambulatory detoxification. This meant that eligible patients could undergo detoxification in their own homes, without needing to be admitted to hospital.

In partnership with a local acute trust and health centre, staff at Brook Place had conducted a hepatitis C antibody mouth swab study that led to setting up community blood borne virus clinics. The clinics offered blood borne virus screening, genotype testing, referral to secondary care and fibroscanning to detect fibrosis and cirrhosis.

The team had also conducted a hepatitis C screening pilot. They developed a care pathway and the pilot achieved a treatment outcome of approximately 12%, with another 11% having been assessed and awaiting treatment. This is higher than the national average of 3%.

Another member of staff at Brook Place had won the trust's positive achievement award in the category of 'improving the service user experience' for trying to better patients' experiences by enhancing services and demonstrating partnership working with other NHS trusts and partners in the charity sector.