Addaction Recovery Centre - Croxteth Liverpool

Quality Report

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Date of inspection visit: 21 and 22 January 2019
Date of publication: 02/04/2019

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

Ratings

Overall rating for this location	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 and Deprivation of Liberty Safeguards

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

Summary of findings

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

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

Overall summary

We rated Addaction Recovery Centre – Croxteth **Good** because:

- Staffing levels and skill mix were planned, implemented and reviewed to keep clients safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handover, risk management and multidisciplinary team meetings held to ensure staff could manage risks to clients.
- Clients' care and treatment was planned and delivered in line with current evidence-based guidance and outcome measures were in place to check consistency of practice. Clients' individual needs and preferences were central to the planning and delivery of tailored services. Clients had comprehensive assessments of their care needs which considered physical, mental and emotional health.
- There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. There were defined and embedded systems, processes and standard operating procedures in place to keep clients safe and safeguarded from abuse.
- The services were flexible, gave choice and ensured continuity of care. There was a proactive approach to understanding the needs of diverse groups of clients and to deliver care in a way that met their needs and promoted equality.
- There was a clear statement of vision and values, driven by quality and safety. Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. There was a focus on continuous learning and improvement. Leaders were visible within the service and valued by the team.
- However, the provider should ensure:
- Risk assessments and risk management plans are started at the point of assessment.
- Care records hold all necessary essential information for providing care and treatment, including recovery goals and audit of alcohol consumption.
- Missed appointments are recorded without delay.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	

Summary of findings

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Summary of this inspection

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Good

Addaction Recovery Centre - Croxteth Liverpool

Services we looked at
Substance misuse services

Summary of this inspection

Background to Addaction Recovery Centre - Croxteth Liverpool

Addaction Recovery Centre - Croxteth in Liverpool, is an adult community substance misuse service provided by Addaction. The service operates from a building in Croxteth and is managed by the charitable organisation Addaction. In addition, there is a satellite service in Garston, Liverpool also registered under this location.

Addaction Recovery Centre - Croxteth was registered with the Care Quality Commission on 9 August 2012 and is registered for the regulated activity treatment of disease, disorder or injury. The service had a new manager who had applied to CQC to be a registered manager.

CQC last inspected the service on 7 September 2016.

Our inspection team

The team that inspected the service included two CQC inspectors and a specialist advisor with experience of working in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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?

Before the inspection visit, we reviewed information that we held about the location including the provider information return that the registered manager had submitted. We also contacted Liverpool City Council that commissioned services from Addaction.

During the inspection visit, the inspection team:

- received a presentation from the service manager
- toured the service's two locations at Croxteth and Garston and looked at the quality of the care environments
- spoke with six clients (two of whom were recovery champions) a recovery champion is a former or recovering client volunteering to provide a positive and visible role model. Recovery Champions support other clients, through visible recovery, to engage and re-engage in treatment and to promote and support others through their recovery.
- spoke with the registered manager, the contracts manager, the director of operations, two nurse prescribers, eight project workers, two administrators and one volunteer (who was a former client) attended and observed one daily 'flash' meeting and one risk and debrief meeting
- looked at nine clients' care and treatment records
- checked the medication management and infection control procedures
- looked at policies, procedures and other documents relating to running the service and
- collected feedback from 16 patients using comment cards.

Summary of this inspection

Information about Addaction Recovery Centre - Croxteth Liverpool

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What people who use the service say

We spoke with six clients and received comment cards from a further 16. Clients said they felt supported and safe visiting the location. They felt inspired, supported and motivated to recover and had progressed through their treatment. Clients described the service as life-changing. They said the therapeutic and drop-in activities offered by the service offered clients who needed a hot meal and others support to develop life skills. This included help with managing money, cooking, information technology, education and paid or voluntary work. Clients said attending the service helped reduce social isolation.

However, clients said their recovery did not benefit from having several different key workers and needing to repeat their substance misuse history and trauma.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

• The service had enough staff to meet clients' needs. Where there were vacancies these were covered by team leaders and managers or by moving staff around bases to ensure there was no impact to client care.

• Both locations had well-equipped clinic rooms. The clinic rooms were clean, tidy and had all necessary equipment available.

There were emergency medicines in stock at the service. These were all stored securely and safely and were in date. Staff had received training on how to administer emergency medicines.

• Managers encouraged openness and transparency about safety. Staff understood and fulfilled their responsibilities to raise concerns and report incidents.

• There were defined and embedded systems, processes and standard operating procedures to keep clients safe and safeguarded from abuse.

• Risk assessments, risk management plans and recovery plans were mostly up to date and regularly reviewed.

• Staff recognised and responded appropriately to changes in risks to clients.

However:

• One of the nine care records that we reviewed did not have an up-to-date risk assessment.

Are services effective?

Good

We rated effective as **good** because:

- The records we reviewed all had comprehensive assessments and detailed care plans that identified and met clients' needs.
- Staff collected and checked information about clients' care, treatment, and outcomes.
- Staff were skilled and experienced and offered a range of psychosocial interventions.
- Blood borne virus testing was routinely offered to all clients through a one stop shop for testing and vaccine from local NHS Trusts.

Summary of this inspection

- The service had effective protocols in place for the shared care of clients.
- There was a robust discharge policy in place. Staff planned discharges well. They offered each client a recovery care package.

However:

- Four of the nine care records that we reviewed did not include information that was essential to client care.

Are services caring?

Good

We rated caring as **good** because:

- Feedback from clients was positive about the way they were treated. Clients told us they were treated with dignity, respect and kindness during all interactions with staff.
- There was a positive emphasis on client inclusion. Clients told us they were encouraged to be partners in their care and in making decisions. They said that they received the support they needed and information in a way they understood.
- Staff recognised and respected clients' needs. They always took personal, cultural, social and religious needs into account.
- Staff actively engaged clients, families and carers in planning care and treatment. Clients were active partners in their care. Staff were fully committed to working in partnership with clients.
- Clients emotional and social needs were valued by staff and were embedded in their care and treatment.

Are services responsive?

Good

We rated responsive as **good** because:

- Clients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
- The involvement of other organisations and the community was integral to services planning and ensured clients' needs were met. There were innovative approaches to providing integrated care pathways that involved service providers, particularly with multiple and complex needs.
- There was a proactive approach to understand the needs of diverse groups of people and to deliver care in a way that met those needs and promoted equality. This included people who were vulnerable and/or had complex needs.

Summary of this inspection

- There was an active review of complaints and how they were managed and responded to. Improvements were made as a result across the service.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff knew and understood the vision, values and goals of the service.
- The service had an effective governance structure. Governance policies, procedures and protocols were regularly reviewed, improved and were all up to date.
- Managers were experienced, well respected and visible. All staff we spoke with felt supported by the leadership team.
- Information and analysis were used proactively to identify opportunities to drive improvements in care.
- There was a strong focus on continuous learning and development at all levels within the service.
- Staff morale was good across the service. Staff felt listened to and respected.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act which staff were aware of and could refer to.

Mental Capacity Act training was included in the mandatory training package. The completion for training was 93% within the service. Staff ensured clients consented to care and treatment and this was assessed, recorded and reviewed on time. This was seen in all care records we reviewed on inspection.

Clients were supported to make decisions where appropriate and staff knew how to access further support if they had concerns around capacity.

Overview of ratings

Our ratings for this location are:

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

Good

Substance misuse services

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

Are substance misuse services safe?

Good

Safe and clean environment

Safety of the facility layout

The service had CCTV and an entry control system in place. Clients were informed CCTV was used by signage displayed. CCTV monitoring included the entrance and waiting area so administration staff observed client's safety.

There was disabled access to the building and accessible rooms and toilet facilities on the ground floor. There was no lift or disabled access to the first floor. The waiting room was well-lit and equipped with well-maintained furniture. All areas, including the waiting room, were visibly clean and tidy. Access to the first floor was granted through staff using a security pass linked to the security system. If clients needed access to the first floor a staff member escorted them.

There were enough rooms available to hold one to one appointments and group sessions.

Staff adhered to infection control policies, including hand-washing and the disposal of clinical waste. An external contractor collected clinical waste through an agreed contract.

The service kept records of all general areas, including, cleaning, kitchen, toilet, needle exchange, hazards, waste and fire safety. Cleaning materials and equipment were stored separately from other equipment.

The service had an up to date health and safety and fire risk assessment in place. There was an up to date fire escape and evacuation plan displayed on notice boards throughout the ground and first floor, which showed who were nominated fire wardens. There was evidence of weekly fire alarms testing, and full evacuation of the building completed monthly for November and December 2018. There were safety certificates to cover the maintenance and operation of the building including a business management continuity plan.

Personal alarms were available in rooms used for one to one appointments and outreach staff had access to personal alarms.

The services had a well-equipped clinic room, which was clean, tidy and had all necessary equipment available. The service replaced the clinic room floor with a washable surface which met infection control standards, since the last inspection. Staff carried out temperature checks of the fridge used to store medication and these checks were audited. Records seen on inspection were completed and up to date.

There were emergency medicines in stock, stored securely and safely. All were in date.

Needle exchange facilities were fully equipped, and staff had access to a robust policy.

Clients we spoke with on inspection told us they felt safe when attending the service.

Safe staffing

Staffing levels and mix

The provider submitted whole-time equivalent (WTE) staffing numbers, with 48 WTE staff employed at the registered location and satellite service. The service had enough staff to meet the needs of the clients. At the time of

inspection there was one vacancy. The service had recently recruited a new staff member as well as having an experienced staff member transferred to it. There were staff on long term sick and arrangements to cover sickness were in place. The service also recruited a second nurse as a non-medical prescriber. In the last 12 months the service had not used any agency or bank staff.

The service had a daily flash and risk and debrief meeting. In the meetings staff discussed risk management, client assessment and solutions to cover gaps in service delivery. For example, looking at available capacity within the staff on duty to cover additional service demand.

Staff told us that increased demand within the service meant they prioritised clients' care and treatment. To support staff to prioritise their workload the provider introduced a case management system; the manager was supporting staff to use this.

The management team proactively assessed current staffing levels and absence to predict potential shortfalls.

Staff completed mandatory training in Infection control, safeguarding (adults), safeguarding (children and young people), safeguarding information, equality and diversity, health and safety, safeguarding levels 3 and 4, alcohol awareness, CQC and Mental Capacity Act. At the time of inspection mandatory training figures were below the provider's target as the provider set a target of 100% compliance. The average compliance rate for mandatory training was 86%. The reason the service did not meet 100% training targets was due to new staff starting at the service.

The service ensured that robust recruitment processes were followed and all staff had a job description in place. The service provided evidence prior to the inspection that all staff and volunteers had a completed disclosure and barring service check.

Personal safety protocols for staff, including lone working, was in place. The outreach and lone working policy was reviewed in December 2018 and staff described the arrangements for adherence to the policy, which was discussed in daily flash meetings, team meetings and supervision.

Assessing and managing risk to patients and staff

We reviewed nine sets of care records. All but one had an up to date risk assessment that was started at the point of assessment with the client. One risk assessment was only partially completed, and a blank risk management plan for the unexplained exit from treatment. This meant we could not clarify if the client presented with any risks. All nine records held a completed physical health check. On referral to the service GPs provided a history of physical and mental health and these notes were and scanned onto the service's electronic notes system. Recovery workers could access both the GP and Addaction electronic patient system and were able to transfer information from the GP system into Addaction's. There was evidence that the service recognised and responded to deterioration in the client's health including referrals to external agencies.

Staff gave clients information about the risks of continued substance misuse and harm minimisation. Safety planning was an integral part of the care received within the service. All staff were trained in the use of naloxone. The early use of naloxone a non-addictive, life-saving drug, can reverse the effects of an opioid overdose.

Individual client risks were discussed in the daily flash meetings and if needed necessary arrangements were made to see clients at home, on site or at the GP clinic together with a colleague as per the lone working policy.

Staff adhered to best practice in implementing a smoke-free policy and during the inspection we saw staff enforcing this. The provider's smoking at work policy and standard operating procedure 2017 identified the building is a smoking free site. This included E-cigarettes and vaping. The service offered staff and clients smoking cessation education.

Management of risk included unexpected exit from treatment as well as protocols for dealing with this issue. Risk management plans detailed the risk of unexpected exit from treatment.

The service had processes in place for what to do when there were suspicions or evidence that clients had passed on their medication to a third-party for illicit purposes (an act known as diversion). The onsite clinician reviewed decisions about continued treatment. The provider also had an exclusion policy reviewed in 2017, which said exclusion from the service would be the last resort.

Safeguarding

Staff received training in safeguarding adults and children and the staff we spoke to were knowledgeable about

recognising signs of abuse and knowing when and how to refer to social care services. There was evidence in care records of staff working closely with other agencies to promote safety and good evidence of information sharing where appropriate.

Staff knew how to identify adults and children at risk of, or experiencing significant harm. This included working in partnership with other agencies. For example, local authorities, probation services and the Multi-Agency Risk Assessment Conference (MARAC); a meeting where agencies talk about the risk of future harm to people experiencing domestic abuse, and draw up an action plan to help manage that risk.

There was a designated safeguarding lead for the service who acted as a point of contact for advice. Safeguarding was included in supervision for staff and all management. Addaction's Director of Nursing led on safeguarding.

Staff assessed the home environments of clients with children and gave clients advice on safe storage of mediation and medication boxes if prescribed a controlled medicine. In addition, the service could give clients sharps boxes from the needle exchange service.

There was a robust policy in place for safeguarding and local pathways were available for staff and volunteers to help them in making appropriate referrals. Staff attended safeguarding meetings with external agencies. The service had reported only one safeguarding incident to the local authority and CQC in the last 12 months.

Staff access to essential information

Staff had access to an electronic system for client records as the service was paper light, which provided them with prompt access to care records that were correct and up to date. Staff working in GP services had access to the GP electronic patient record system.

Medicines management

Staff had effective policies, procedures and training related to medicines management including prescribing, detoxification, assessing people's tolerance to medication and take-home emergency medication such as naloxone.

Staff followed good practice in medicines management and did this in line with national guidance. Only emergency drugs were kept on site and these were stored securely and in date. The service stored prescriptions securely and sent prescriptions for medicines to local pharmacies for dispensing to clients.

A community practitioner followed a robust policy, used an assessment tool and visited clients at home to judge their suitability to collect prescriptions and keep them at home. The service offered guidance on family focused prescribing.

Track record on safety

There were no serious incidents reported to the Care Quality Commission in the 12 months between October 2017 to September 2018.

The service reported deaths to the Care Quality Commission and provided thorough internal investigations when requested. Managers fed back information from death reviews including lessons learnt to staff through team meeting.

Reporting incidents and learning from when things go wrong

All staff read the incident policy as part of their induction. Staff had a good knowledge and understanding of when and how to report an incident.. Managers received training in reporting and investigating of incidents and root cause analysis investigation.

Staff reported incidents via an electronic system that would send an alert to the relevant service manager. Managers shared the outcome of any investigation including patterns and themes with staff in team meetings.

A duty of candour policy was in place which reflected the provider's duty to the regulation. The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to clients if there have been mistakes made in their care that have or could have potentially led to significant harm. Staff had access to the duty of candour policy, which is not part of the provider's mandatory training requirement. Staff we spoke with were aware of how to report incidents, including being open and honest with clients when things go wrong. Staff said they understood the provider had to investigate all incidents and apologise to clients if the provider was at fault.

Are substance misuse services effective?

Good

Substance misuse services

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed nine sets of care records. The records we reviewed all contained assessments following a referral into the service and care plans. Care plans were holistic, person centred and personalised.

Care records including recovery plans were generally up to date and reviewed. However, three of the nine client records we reviewed did not include all essential information. One did not have an audit of alcohol consumption completed. In a second record a recovery plan goal was 'remain drug free' and lacked the detail as to how this goal was to be achieved. And in a third a client did not attend an appointment and this information was only added into case notes two months later.

However, staff recorded how they had tried to contact clients and other agencies involved in their care when clients had an unexplained exit from treatment. They phoned the client, or family member or carer if the client had agreed to information being shared. If no one answered, they left a message asking the client to contact the service and if the client did not get in touch staff visited them at home.

Staff also contacted GPs, probation, mental health services, police or social services to ensure agencies involved in the clients' care were aware. The service would write to the client advising them to contact the service and offering an appointment. There was good evidence of multi-agency working seen throughout all documentation.

Clients could refer themselves into the service and referrals were received from many other sources including housing, GPs, social care and mental health teams. Staff assessed clients using a national tool that recorded the client journey and client integrated risk and recovery plan.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). For example, withdrawing from opiates, alcohol secondary to opiate withdrawal, counselling and psychosocial interventions, low dose or longer-term detoxification.

Most staff had received motivational interviewing training. Other interventions offered included strength-based personalised assessments, extended brief interventions, psychosocial interventions offered through one to one appointments, group sessions, drop in clinics and a counselling service.

Staff undertook health and well-being assessments along with medically assisted treatment and community detoxification. Non-medical prescribers referred to the 'orange book' (guidelines on clinical management of drug misuse and dependence) as being key to their practice. Staff used the treatment outcome profile (TOPS) a validated tool for checking the changes that occur during treatment for clients so that their needs were identified and addressed in the care plan.

The service routinely offered blood borne virus testing and referred clients to the hepatitis services provided by the local NHS acute trust. The trust offered a one stop shop for testing and vaccine to increase accessibility to treatment and promote engagement.

Staff supported clients to live healthier lives for example in smoking cessation schemes, healthy eating advice and dealing with issues relating to substance misuse. Staff supported clients by ensuring they were following the correct care pathway for example for chronic obstructive pulmonary disease (COPD) or Hepatitis C.

The service offered clients exercise on prescription through local community and leisure centres and clients we spoke with told us this was excellent.

Staff used technology to support patients effectively, for example, advice on medicines and self-help tools. The service offered virtual appointments as an alternative to face to face appointments on site and at GP clinics. Staff offered a range of services from triage and assessment, advice/information, key worker appointments, welfare checks, recovery plan reviews and clinical appointments/ reviews via mobile messaging.

In addition, the service had a suite of computers and was running sessions on information technology to support

clients to access paid or voluntary employment, with support from the local community centre. This provided clients with advice on applications for employment and preparing for interviews.

In October 2018 the service introduced a new care plan format following feedback from clients and staff. Clients told us this has meant more regular reviews via utilisation of information technology and a more collaborative approach to treatment outcomes. For example, better access to reviewing progress and recovery goals.

Skilled staff to deliver care

The service provided all staff with a comprehensive induction.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. For example, registered nurses developing their role as non-medical prescribers, key or project workers specialising in mindfulness or cocaine addiction.

Staff completed individual performance and development plans that identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers held monthly supervision and completed annual appraisals with staff. Supervision and appraisal formed part of the individual performance and development plans. The service provided evidence prior to the inspection that 100% of staff had a completed appraisal.

There were staff members under performance management during the inspection period. Managers had access to a policy and the Addaction human resources team to support this if needed.

The service recruited volunteers who went through the same robust recruitment process as permanent members of staff. Volunteers received the same induction programme, completed the same mandatory training and had access to the same support available to all staff. Three volunteers told us about the support they received and the transition from client to volunteer. Volunteers complete a two-stage programme as an initial peer supporter and then peer lead. This is in line with best practice and the recommendations of the Strang report 2012.

Multi-disciplinary and inter-agency team work

The service ensured multi-agency input into clients' comprehensive assessments from mental health teams, GPs, children and family services, social workers and criminal justice services.

Staff held bespoke clinics in GP surgeries to deliver services to those clients that preferred to be seen in a GP setting, including ones by virtual clinic. There were four days per week when a clinician was at the location to assess and review clients.

Senior management meetings were held monthly with local team meetings held immediately after to ensure information was fed down to the teams. Multidisciplinary flash and debrief meetings were held each morning and evening respectively.

The service had effective protocols in place for the shared care of clients which was evident on inspection when we spoke with staff and reviewed care records. GPs could attend multi-disciplinary team meetings via virtual clinics. Recovery workers told us team leaders also acted as points of contact for shared care services, for examples health and justice, probation, social services and mental health.

Recovery plans included clear care pathways to other supporting services. The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care to meet the diverse needs of client groups. For example, there were clear pathways for chronic obstructive pulmonary disease, hepatitis C and blood borne viruses.

Good practice in applying the MCA

The service had a policy on the Mental Capacity Act which staff were aware of and could refer to.

Mental Capacity Act training was included in the mandatory training package and 93% of staff had completed training on the Mental Capacity Act.

Clients were supported to make decisions where appropriate and staff knew how to access further support if they had concerns around capacity. The service did not use an assessment tool for capacity and if staff were concerned about a client's capacity to consent to care and treatment they referred them back to their GP or to mental health services for a capacity assessment.

Good

Substance misuse services

Staff ensured clients consented to care and treatment and that this was assessed, recorded and reviewed promptly. This was seen in all care records we reviewed on inspection.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

During our inspection we saw interactions between clients and staff. These were consistently positive, with staff always being polite and respectful.

Feedback from clients was consistently positive about the way staff treated them. Clients told us their care was excellent.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to clients and staff without fear of consequences.

Staff supported clients to understand and manage their care and treatment. Clients told us they were always given options about their treatment and that all aspects of their care were explained. Clients told us staff directed them to use self-help groups and notes from counselling sessions were provided for clients to reflect on. Clients said they could also access other support services such as other agencies supporting addictions to drugs, alcohol, gambling and local counselling services.

Key workers co-produced recovery plans with clients. This was clear when we reviewed care records and spoke with clients and staff. Documentation included a risk and recovery assessment that considered client preferences and goals. Staff offered clients a copy of their recovery plan.

There was a positive approach to clients that was kind and promoted clients' dignity. Relationships between clients were strong, caring and supportive. The relationships were valued by staff and promoted by leaders within the service.

Staff recognised and respected the totality of clients' needs. They always took personal, cultural, social and religious needs into account.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients.

Consent forms were seen in all care records we reviewed, and clients told us they were asked to consent to care and treatment. As part of the assessment process staff sought consent from clients as to who they could contact or share information with about their care and treatment.

Involvement in care

Staff communicated with clients so that they understood their care and treatment. They found effective ways to communicate with clients with communication difficulties. For example, providing information in accessible formats, access to an interpreter service and allowed longer appointment times for people with learning difficulties or disabilities.

We reviewed nine sets of care records. There was evidence that clients had been involved in developing these. Five of the of the six clients we spoke with told us they were involved in reviews of care and could contribute toward their care and treatment plans.

Staff actively engaged clients, families and carers in planning care and treatment. People who used the service were active partners in their care. Staff worked in partnership with clients. Staff always empowered clients to have a voice and to realise their potential. Clients' individual preferences and needs were reflected in how care was delivered.

The service empowered and supported access to appropriate advocacy for people who used the service and their families and carers. Clients were aware of the advocacy service, they were signposted to use.

Clients told us that they were asked what they wanted to achieve through treatment. Clients told us they were asked how best to be contacted and told us they felt their care was centred around them as a person and based on their own needs.

Staff enabled families and carers to give feedback on the service they received, via email, comment cards, client forum monthly meetings and on a one to one basis. Clients were involved in the recruitment process of new staff and attended appropriate staff team meetings.

Good

Substance misuse services

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

Good

Access and discharge

The service had a clearly documented admission criterion. Referrals into the service were received from clients as a self-referral, client relatives, GPs, other health professionals and other external agencies including criminal justice, housing and social care services.

Clients were seen within the locally agreed response time set with commissioners. The maximum waiting time between initial assessment and a comprehensive assessment for structured treatment was one week. If an initial assessment indicated a need for a clinical assessment, the maximum waiting time for a clinical assessment was two working days. The service could see urgent referrals on the same day for priority groups or those who may present as being at immediate risk of harm. The service checked these timescales monthly and reported the results to the commissioners.

The service had robust alternative care pathways and referral systems in place for people whose needs could not be met by the service. For example, residential detoxification services and bereavement counselling.

The location was open Monday to Friday 9am to 5pm and offered two late night openings per week. Clinics with set appointments were available as were direct access clinics to meet the needs of clients who would prefer to drop into the service.

The involvement of other organisations and the community were integral to how services were planned and ensured that clients' needs were met, particularly with multiple and complex needs.

Recovery and risk management plans reflected the diverse/complex needs of clients including clear pathways to other supporting services. For example, probation, housing or mental health services.

The service discharged clients when specialist care was no longer necessary and worked with relevant supporting services to ensure prompt transfer of information.

The facilities promote recovery, comfort, dignity and privacy

Clients at the Garston site had been involved in the redesign of the building so clients accessing the service could not be directly seen by members of the public.

Services had enough rooms to see clients to support care and treatment and rooms large enough to facilitate group sessions.

The needle exchange provided privacy and dignity to those who used this service.

The service kept confidential information safe and clients signed consent forms to confirm who could be contacted about their care and treatment.

There was a variety of leaflets and information provided at all locations visited. These were accessible in other languages.

Patients' engagement with the wider community

Staff encouraged clients to develop and keep relationships with people that mattered to them, both within the service and the wider community.

There were leaflets and posters encouraging clients to attend community activities displayed throughout the service. These included local leisure centres to promote good health and community centres for adult education.

The service offered clients access to education and work opportunities. For example, the service was offering an IT literacy course so clients could access and apply for tax credit on line. There was also an education training and employment team to support clients to access these and help them find funding and grants for particular things.

Meeting the needs of all people who use the service

There was a proactive approach to understand the needs of diverse groups of people and to deliver care in a way that met those needs and promoted equality. This included people who were vulnerable and/or had complex needs.

Good

Substance misuse services

Clients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.

People with mobility difficulties could access the service and for people who struggled to get to the service there were other innovative ways to meet their needs by offering treatment such as home visits and medical assessments via Skype. The key worker would attend the client home, or GP and the link would be set up with the doctor at a service location.

The provider showed an understanding of the potential issues facing vulnerable groups, for example, older people, people experiencing domestic abuse and sex workers and were offered appropriate support. The provider also supported people who were homeless, begging and rough sleepers. A bespoke support team, the Chemsex Open Access Support Team (COAST), provided support to men who have sex with men and take part in 'chemsex'. Chemsex is the use of drugs prior to or during planned sexual activity. The service worked to reduce the harms of Chemsex whilst decreasing transmission rate of HIV and other blood borne viruses by providing a collaborative approach to education, prevention and harm reduction.

The Street Lifestyle project was a collaboration between all the Addaction Liverpool services, local council and local police in supporting clients involved in rough sleeping, street begging and street drinking. Addaction delivered harm reduction advice and information, a needle syringe provision and safer injecting advice for the prevention of blood borne viruses (BBV). The project supported clients into a variety of services including substance misuse and alcohol treatment, housing, health, blood borne virus treatment and wound care. Addaction arranged the safe disposal of sharps and other substance misuse paraphernalia with the city council.

Clients told us that appointments were rarely cancelled.

The provider monitored people on waiting lists to detect increases in level of risk. For example, they monitored the frequency when initial client contact and comprehensive assessment was more than five working days for non-prescribed clients, and more than two working days for prescribed clients.

The provider also checked the percentage of clients waiting three weeks or more between referral date and date first appointment offered for psychosocial and pharmacological intervention. They monitored the number of clients that did not attend the first appointment offered within five working days.

Listening to and learning from concerns and complaints

Complaints were handled in line with Addaction complaints policy. There was an active review of complaints and how they were managed and responded to. Improvements were made as a result within the service.

The service gave information to clients on how to complain as part of their assessment into the service. Information leaflets and posters were visible throughout the service informing clients on how to complain.

During the reporting period of October 2017 to September 2018 there were six complaints received at the service. There were no complaints received by CQC in this period.

Managers gave feedback from complaints to staff to ensure continuous learning and improvement.

The service provided us with an example of a client who had made a complaint to the service. We saw following the outcome of the investigation into the complaint, the client was informed of the actions taken. The service took a proactive approach to resolving complaints locally. We did not see any themes emerging from the complaints the service received.

The service also received 12 compliments from clients and their families, which complimented the service offered, the support and professionalism of staff and volunteers and the caring, respectful relationships experienced.

Are substance misuse services well-led?

Good

Leadership

Leaders within the service had the skills, knowledge and experience to perform their roles. A new manager was appointed in September 2018, supported by the contracts manager. The service had put in place a robust management structure to give effective leadership. Staff

told us the managers had improved the service and would cover duties if service demand increased. We saw at flash meetings the managers offering to cover clinics and be the first responder should staff need help.

Leaders had a good understanding of the services they managed. They could explain how the teams were working to give high quality care.

Leaders within the service were visible and approachable for clients and staff. On inspection we saw leaders welcoming clients on first name terms. Staff told us on inspection that senior leaders were occasionally on site and were approachable and respectful.

Vision and strategy

The organisations values were 'compassionate', 'determined' and 'professional'. The staff we spoke to were familiar with these and could give us examples of how they were embedded in their day to day work.

All staff had a job description including volunteers in the service.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff contributed to improvement for the service through team meetings and service delivery projects. For example, how did staff see the service evolving, finding gaps in provision and how the changes could be made.

Culture

Staff felt respected and valued. Staff we spoke with felt supported by the service and contracts manager in their roles and felt they worked within a very caring and supportive staff group.

The service had a staff group that felt positive, though experienced elevated levels of stress. This was recognised as a long-standing problem by the new management team, who were engaging with and listening to staff to discuss this. Staff told us that communication within the service was good.

The provider recognised staff success within the service. There was an employee and team of the month award given in the joint Addaction Liverpool services.

Staff felt positive and proud about working for the service and their team. They spoke highly of services provided and felt their contributions made teamwork effective.

Staff appraisals included conversations about career development and how it could be supported.

There were no reported cases of bullying or harassment in this service and staff were confident about speaking out if there had been any concerns.

Staff had access to support for their own physical and emotional health through an employee assistance programme with access to an occupational health department.

The service had worked hard to improve awareness and provide information to staff around disability issues. Staff had access to training about disabilities, health conditions and working with clients who have them.

The provider promoted equality and diversity in its work; via associated policies, training and information. Staff had access to specific policies on equality and diversity.

Governance

The service had an effective governance structure. Governance policies, procedures and protocols were regularly reviewed and improved and were all up to date. The service had introduced the provider case management toolkit, to check performance and compliance with the assessment, planning and evaluation of clients care and treatment. However, this was not completely embedded into the governance system of the service. For example, in the effective domain we highlighted concerns about the completion of documents related to the assessment of need and planning of care. Four of the nine clients record we reviewed lacked essential information, which was not picked up through the case management system.

There was a clear framework of what had to be discussed at team and management level team meetings that ensured essential information such as learning from incidents and complaints was shared and discussed.

The provider introduced a case management tool with key performance indicators (KPIs) linked to this for completion of care and treatment records and to monitor risk. We saw evidence in management and staff meetings that KPIs were being checked.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at service level.

Staff took part in local clinical audits. The audits were enough to provide assurance and staff acted on the results when needed.

Data and notifications were given to external bodies and internal departments as required including notifications to the CQC. For example, Addaction provided commissioners with their internal reporting process document and any incidents were notified to commissioners and discussed in monthly contract meetings. Addaction also took part in the Liverpool quarterly drug related deaths panel, involving a University, commissioners and clinicians. Learning from drug related deaths and other lessons learnt were shared through management and team meetings.

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

The service had a whistle blowing policy in place and staff felt confident to use this if needed and felt any concerns would be actioned.

Management of risk, issues and performance

The provider's national clinical governance directorate oversaw the care and treatment delivered to clients. The directorate consisted of many clinical leads who gave clinical supervision and leadership across many work streams and professional groups, including clinical, psychosocial and pharmacy services. There was a team of internal auditors and an improvement team with oversight of organisational learning. They also provided required improvement support to services following internal or external audit. This team audited the service over two days in November 2018 but at the time of the inspection the service had not received the audit report. The service had completed its own pharmacy audit and the actions identified in this were completed in December 2018.

The senior management team met monthly to review clinical activity, risks, service improvement and good practice.

The service had access to the provider risk register and recorded any local risks on this. The risk register was discussed in team meetings and staff at all levels could escalate concerns when needed and have items added to the risk register.

The service had plans for emergencies. There was an evacuation plan in place that was up to date and displayed within the service.

The service assessed quality and sustainability impact of changes including financial. The service manager reviewed financial reports monthly to check and forecast spending. Monthly formal contract monitoring meetings were held with commissioners to review service performance, risks, information sharing and incidents.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped improve the quality of care.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care.

Information was in an accessible format, and was prompt, accurate and identified areas for improvement.

All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it.

The service had developed information sharing processes and joint working arrangements with other services where appropriate to do so.

The service ensured confidentiality agreements were explained including in relation to sharing of information and data. The provider was rolling out the Accessible Information Standard across all Addaction services so the provider could consistently capture useful information about the needs of clients.

Engagement

Staff, clients and carers had access to up to date information about the work of the service though the internet, notice boards, leaflets and social media platforms.

Good

Substance misuse services

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Client, staff and stakeholder consultation was completed as well as joint events held when the service model was changed.

Clients and staff could meet with members of the senior leadership team to give feedback through the service user forum held monthly.

Learning, continuous improvement and innovation

The service encouraged creativity and innovation to ensure up to date evidence-based practice was implemented and embedded.

The provider recognised the value of research and was involved in a project with a local University in Liverpool looking at chronic pulmonary obstruction disease. This 7 month research project aimed to improve testing, diagnosis and access to treatment for chronic obstructive pulmonary disease (COPD) within the drug using population. This cohort is a recognised 'hard-to-reach' group with a high level of incidence of COPD. Through providing lung function tests (spirometry) alongside routine care and treatment for substance misuse within a shared care practice setting, good uptake and COPD treatment engagement was attained. Thus improving treatment uptake with real benefits to improving the overall health and wellbeing of Addaction clients. Close working relationships with NHS specialist providers were also established and continue to be maintained.

Outstanding practice and areas for improvement

Outstanding practice

The involvement of other organisations and the community were integral to how services were planned and ensured that clients' needs were met. There were innovative approaches to providing integrated person-centred pathways of care that involve service providers, particularly with multiple and complex needs. Examples of this were:

A bespoke support team the Chemsex Open Access Support Team (COAST) provided support to men who have sex with men and take part in 'chemsex'. Chemsex is the use of drugs prior to or during planned sexual activity. The service worked to reduce the harms of Chemsex whilst decreasing transmission rate of HIV and other blood borne viruses by providing a collaborative approach to education, prevention and harm reduction.

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Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that risk assessments and risk management plans are started at the point of assessment.
- The provider should ensure that care records hold all necessary essential information for providing care and treatment, including recovery goals and audit of alcohol consumption.
- The provider should ensure that missed appointments are recorded without delay.