Addaction North East Lincolnshire

Quality Report

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

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.

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.

Summary of findings

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 North East Lincolnshire as good because:

- The service had enough staff to ensure the caseload of the team, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. They followed good practice with respect to medicines management, safeguarding and appropriately investigated incidents to ensure lessons were learnt and shared.
- Staff provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. They engaged in audits and benchmarking to evaluate the quality of the care they provided.
- The team included all specialists required to meet the needs of clients under their care. Managers ensured these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness. They understood the individual needs of clients and actively involved them in their care.
- The service was easy for clients to enter treatment. Staff planned and managed transfers and discharges well and encouraged clients to engage with the wider community. They met the needs of clients with complex needs and in vulnerable circumstances who often found engagement with services difficult. They listened to, investigated and learnt from concerns and complaints.
- The service was well led and the governance processes ensured that its procedures ran smoothly.

However:

- The premises did not enable staff to provide safe care on all occasions. The service did not have a working lift which meant clients who attended unexpectedly, and with mobility limitations, were very occasionally seen in a room which was unsuitable for both clients and staff.
- Staff did not ensure they recorded all current risks and interventions clearly on the risk assessment and management plans in a timely manner.
- Recovery plans and electronic case notes were not reflective of the holistic conversations which had taken place. They did not contain goals which were specific, measurable or timely. The service did not have a formal process in place to ensure a client's physical health was regularly reviewed.
- Staff were unable to locate the information sharing agreements for some client's; this meant they could not be assured that information was being shared with the client's consent.

Summary of findings

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Good

Addaction North East Lincolnshire

Services we looked at

Community-based substance misuse services

Summary of this inspection

Background to Addaction North East Lincolnshire

Addaction North East Lincolnshire is a community substance misuse service located in Grimsby. It is provided by the national drug, alcohol and mental health charity Addaction. The service is commissioned by the local authority to provide community services for adults and young people experiencing problems with substance and alcohol use. The service delivers both pharmacological and psychosocial interventions to address harm reduction through to recovery and rehabilitation. At the time of our inspection, they were working with approximately 700 clients.

The service has been registered with the Care Quality Commission since October 2018 to provide the following regulated activity:

- Treatment of disease, disorder or injury.

This service has not been previously inspected.

The service has a registered manager.

Our inspection team

The team that inspected the service comprised two CQC inspectors and one specialists advisor with a substance misuse background.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with eight clients who were using the service;
- spoke with the registered manager for the service;
- spoke with 13 other staff members including the clinical lead, non-medical prescribers, recovery workers, agency staff and volunteers;
- attended and observed one client review;
- attended and observed one staff meeting;
- attended and observed two client groupwork sessions;
- looked at the care and treatment records of 10 clients:
- looked at the prescribing records for seven clients;
- carried out a specific check of the medication management and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with eight clients who were using the service during our inspection and looked at the client satisfaction survey. Clients were positive about the care and treatment they received.

They told us they felt safe at the service and the premises were mostly clean and well maintained. They had good relationships with their recovery workers and felt they could talk about anything openly and honestly and were supported with all their needs.

Clients felt fully involved in their treatment and setting goals in their recovery plans.

However, clients were not happy that the lift did not work.

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 who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the team, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.
- Staff considered clients' risks. They responded promptly to sudden deterioration in client's physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's physical health.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Trained staff investigated incidents and shared lessons learned with the whole team.

However:

- Not all areas where clients received care were safe, well equipped, well maintained or fit for purpose.
- Staff had not ensured all risk assessments were fully up to date and reflecting all current risks.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments with clients on accessing the service in a timely manner. They considered the client's holistic needs in the assessment and in discussions with clients whilst in treatment.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They used recognised rating scales to assess and record severity and outcomes. They also participated in audits and benchmarking to improve quality.

Summary of this inspection

- The team included the full range of specialists required to meet the needs of the client group. Managers made sure that staff had the range of skills to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team had effective working relationships with other relevant teams outside the organisation.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity might be impaired.

However:

- Recovery plans and electronic case notes did not reflect the holistic conversations which took place between clients and staff in their appointments. The goals which were detailed in the recovery plans were mainly focussed on drug and alcohol use and were not specific, measurable, attainable or timely.
- The service did not have a system in place to ensure physical health checks were completed and regularly reviewed.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with compassion and kindness. They understood the individual needs of the clients and supported them to understand and manage their care and treatment.
- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

However:

- Staff were unable to locate the information sharing agreements for some client's; this meant they could not be assured that information was being shared with the client's consent.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- The service was easy to access. Staff ensured transfers into the service were managed so clients received continuity in their care. They planned and managed discharge well. They took appropriate steps to engage clients who had missed appointments or dropped out of treatment.
- The design and layout of the premises met the needs of the service. There were enough rooms to see clients for groups, one to one appointments and clinical reviews. Staff offered a range of groups to meet the individual client's needs.
- The service met the needs of clients including those with a protective characteristic or in vulnerable circumstances.
- The service treated concerns and complaints seriously. They investigated them and learnt lessons from the results which were shared with the whole team.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the service they managed, and were visible and approachable for clients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They worked well as a team to maximise the client's outcomes. The organisation promoted equality and diversity in its day to day work and provided staff with support to upheld positive wellbeing. Staff felt able to raise concerns without fear of victimisation.
- Our findings from other key questions demonstrated that governance processes operated effectively, and that performance and risk were well managed.
- The team had access to the information they needed to provide safe and effective care and used that information to good effect.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The organisation had a policy on the Mental Capacity Act which staff were aware of and could refer to. They also had a good relationship with the local mental health provider who they could contact for advice.

Staff supported clients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes and history.

Staff ensured clients consented to their care and treatment during their comprehensive assessment. Capacity was assessed and clearly recorded at each appointment.

Staff working with young people used The Gillick competence framework to determine a young person's ability to make decisions.

Mental Capacity was a mandatory training unit. The service was 100% compliant in completion of the unit. Staff we spoke to demonstrated a good knowledge of the act and their responsibilities under it.

Good

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Good

Safe and clean environment

The premises where clients received care and treatment were mostly safe, clean, well equipped, well furnished, well maintained and fit for purpose.

The service had the required health and safety assessments and staff carried out appropriate inspections of the premises. Cleaning records demonstrated that domestic staff cleaned the premises regularly. Staff discussed environmental risks at a daily morning meeting. There were alarms in all client rooms. Staff were required to check these on a weekly basis, However, there were gaps in the weekly checks in November and December 2019.

The service had a clinic room which was clean, tidy, well ordered and appropriately equipped. Staff maintained the equipment well and staff adhered to infection control principles.

There was one area where staff occasionally saw some clients which was not suitable for both staff and service users. The service was located on the second floor. Since moving into the building in 2018 the lift had been out of action. Managers had been in negotiations with the landlord throughout this time without a resolution. Service users with mobility problems were offered appointments at alternative locations. However, in order to be responsive, the manager and staff told us that on occasions, they used a room at ground floor level to see those service users who attended the service in an unplanned manner and were unable to use the stairs. To use this room, staff needed to go to the ground floor of the building, exit onto the street and then enter a second external door. We observed staff having trouble opening this door and then using a further external door where the entrance was isolated. Both buildings were vacant other than for Addaction's use. The room itself was then accessible by entering two further doors. The room was a dirty unkempt space which was not subject to cleaning or environmental checks. There was an unsecured fire extinguisher in the room which had not been maintained and could be used as a weapon. There was also a hole in the wall.

The manager provided a risk assessment for the room. The risk assessment described control measures such as taking a mobile phone, panic alarm and working in pairs. The room was totally isolated from the main building where a panic alarm would not be heard. This meant the room was unsuitable for both staff and service user use as it was not safe, secure or well maintained. However, the service had sourced alternative premises and were due to relocate around April 2020. We were also assured by the manager that this room will not be used following the inspection.

Safe staffing

The service had enough staff who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the team, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.

Managers agreed staffing numbers with commissioners at the commencement of their contract and were able to negotiate additional staff if required on a need's basis. The service had 32 full time equivalent staff which included non-medical prescribers and recovery workers. They had a

vacancy rate of 13.6% and 7% sickness. To ensure client needs were met, the service employed four agency recovery workers and one agency non-medical prescriber. At the time of the inspection, they were recruiting into the vacant posts. The service also used volunteers and community recovery champions. A community recovery champion is a person already in recovery who is able to mentor and support clients into their own personal recovery journey. Staff used a morning briefing meeting to allocate roles, adjust appointments to cover unplanned absence and to ensure lone working protocols were followed.

There was a clinical lead who covered this service and a neighbouring Addaction provision.

The service ensured staff, including volunteers, received the necessary training to keep clients safe. This included a suite of mandatory training units which included safeguarding, mental capacity, equality and diversity, infection control and keeping information safe. Staff were 78% compliant with infection control and 85% compliant in mental capacity training; they were 100% compliant with all other mandatory units.

Assessing and managing risk to clients and staff

Staff undertook a risk assessment of clients at the start of treatment. They updated them at least every three months or earlier to respond to changes in circumstances and reviewed risks at every client contact. We looked at the treatment records for 10 clients, all had risk assessments in place. Staff completed seven of these within the 12 weeks required. Three of the risk assessments were out of date. These were between three and six months old. Although these clients had disengaged from the service, the risks were not updated to reflect this. We observed two risk assessments which did not detail risks of children in the house or a chaotic client at risk of self-harm. Case notes did evidence interventions staff had taken to consider these risks. They were, however, not clearly recorded on the actual risk assessment or management tools which gave staff an instant summary without the need to read through all the case notes.

Staff developed contingency plans with clients at the start of their treatment to agree actions which would help them to return if they fail to attend their appointments.

Staff recorded actions to mitigate or reduce risks in all the records we reviewed. These actions included evidence of harm minimisation advice, liaison with and referrals to other professionals and dual working. Staff used the morning daily meeting to discuss those clients with new risks and to agree immediate actions. This included those who had missed collections of their prescriptions for three days leading them to be out of treatment and, information about clients due to attend who may pose a risk to others. The electronic record system recorded high risk alerts for all staff to see and respond to, for example when two staff were needed to see someone. All clients agreed to a behaviour contract at the start of their treatment. For young people this was adapted to expectations from both parties.

The service issued out naloxone kits for clients and others they may know with a high risk of overdose from opiates. Naloxone is an injectable medicine that reverses the effects of an opiate induced overdose. All staff were trained on how to administer naloxone and also how to provide training to the client and their relatives for all kits offered.

Staff discussed harm minimisation during one to one meetings. It was also discussed in a welcome meeting which most clients attended at the start of their treatment.

The organisation disseminated national drug alerts for staff to share with clients about drug trends and unusual reactions to substances. They participated in local clinical networks to share and receive specific issues for their locality. Nurse practitioners liaised regularly with the client's GP to share information and safeguard against duplicate prescribing.

Safeguarding

Staff were trained in safeguarding and knew how to make a safeguarding referral. It was mandatory for all staff to attend training at appropriate levels in safeguarding adults and children. Compliance for this training was 100%. Staff were able to describe what constituted a safeguarding concern and how they would escalate this. Managers and team leaders discussed safeguarding with staff in supervisions. Staff participated in safeguarding audits as part of a peer audit process. Safeguarding was included in the staff's morning meeting and as part of the agendas throughout the organisation's governance structure. Staff attended regular internal and external multi-disciplinary team safeguarding meetings. The service had a good relationship with the local safeguarding authority and staff

were able to contact them for advice when considering a referral. Staff discussed the safe storage with clients who had children in the house and the client was on a take home medication prescription.

Staff access to essential information

All information needed to deliver care was stored securely on an electronic system and available to staff when needed and in an accessible form.

Medicines management

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

The service stored blood borne virus vaccinations and naloxone kits. There were no controlled drugs stored or dispensed from the service location; these were dispensed by community pharmacies. The service stored and managed prescription paperwork on the premises and for this purpose implemented the organisation's Controlled Drug Policy Standard Operating Procedures and completed an annual medicines management audit. The service used effective templates and processes to ensure a safe system and that a client's physical health was assessed at regular appointments with the non-medical prescribers.

Track record on safety

There were no serious incidents requiring investigation that occurred 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

The service effectively reported incidents, investigated appropriately, learnt lessons from their findings which they shared and supported those affected.

Staff knew what constituted an incident and how to report it. They told us the reporting system was easy to use.

The organisation had trained root cause analysis staff to investigate incidents meeting a set criteria. There was a clear governance structure to escalate incidents from service level up to board level depending on analysis of the risk. This included a monthly incident review group which reviewed all incidents and a clinical governance meeting at regional level.

Staff received debriefs, reflective practice and lessons learned sessions as well as incidents and lessons learnt being discussed in monthly team meetings and supervisions.

The manager and most staff had an understanding around their duty of candour.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on accessing the service. The assessment looked at a client's drug and alcohol use, physical health, mental health, social factors, criminal involvement, previous treatment experiences, children and families. Staff and clients used the information gathered in the assessment to develop a recovery plan. The organisation expected the recovery plans to be updated at least every 12 weeks. We looked at 10 treatment records. All clients had a comprehensive assessment. Seven clients had up to date recovery plans. Two clients had recovery plans which were seven months old and one client did not have a recovery plan. The recovery plans we observed were personalised. However, the goals set were not holistic and focused mainly on drug and alcohol use, accommodation and some health considerations. We did not see any goals around social circumstances such as family engagement, recreational activities or reducing offending. Goals which were set were mostly not specific, measurable, attainable or timely. The manager of the service, who had been in post for six months, had identified this and was delivering training around effective recovery plans to staff. The newer recovery plans showed improvements. We did observe an holistic approach in client appointments, case notes and in communication to other professionals, however, this was not reflected in the goals set in the clients' recovery plans.

Assessments and recovery plans for young people using the service were adapted to be more suitable for the younger age group. They included greater emphasis on themes such as structure and education, safety and security, family and friend relationships and citizenship.

Good

Community-based substance misuse services

Best practice in treatment and care

Staff provided a range of treatment interventions suitable for the patient group. They provided the right interventions at the right time. The organisation's clinical governance directorate oversaw effectiveness and ensured interventions were those recommended by, and were delivered in line with guidance from the National Institute for Health and Care Excellence and from the Department of Health's publication Drug misuse and dependence UK guidelines on clinical management.

The service was working towards optimised dosage. This is where clinical research has shown that whilst a lower dose may extinguish withdrawal symptoms, a higher dose may be needed to minimise episodes of craving. Non-medical prescribers were also reducing the number of clients with daily supervised consumption regimes which had been instigated from the previous provider. This is following Medications in Recovery 2012 (National Treatment Agency 2012) guidance that cites that the relaxation of supervised consumption regimes provides positive reinforcement for clients regarding their progress in treatment and is a form of contingency management. This was evidenced in the seven client prescribing records we looked at whilst staff also considered individual risks.

The Department of Health's guidance states that treatment for drug misuse should always involve a psychosocial component. Staff provided groups and key work sessions underpinned by recommended interventions including cognitive behavioural therapy, motivational interviewing and solution-focused brief therapy. However, case notes tended to be more factual and did not reflect the holistic conversations which had taken place.

The service considered healthcare needs including testing, vaccinating and treatment for blood borne viruses. Staff routinely tested clients for their blood borne virus status and vaccinated as needed. All staff were trained to obtain tests using dry spot blood testing and kits were in all client rooms to maximise opportunities to test.

The service considered a client's physical health needs at all medical reviews and as part of a client's one to one appointments. However, there was no formal process in place to reflect this or to ensure reviews had taken place.

Staff used recognised measures and approaches to measure severity and outcomes. These included periodic treatment outcome profiles for the clients. This information reports into the National Drug Treatment Monitoring Service. The National Drug Treatment Monitoring Service collects, collates and analyses information from, and for those involved in the drug treatment sector. Public Health England manages the National Drug Treatment Monitoring Service; producing activity reports for providers to give a full picture of activity nationally. Addaction had expanded the treatment outcome profile tools for their services to also monitor interventions being used and friends and family's tests.

The service used technology to support clients effectively. Clients who are prescribed high levels of substitute prescribing require regular ECG tests. The service used phone technology to monitor a client's electrocardiogram without the need for additional appointments with their GP.

Staff participated in audits to improve quality. This included regular infection control audits, medicine management audits and case management audits. The organisation had a team of internal auditors who visited their services to look at overall quality.

Skilled staff to deliver care

The teams included or had access to the full range of specialists to meet the needs of clients under their care. This included a clinical lead, service manager, non-medical prescribers, recovery workers, engagement workers, health care assistance, administration staff, volunteers and recovery champions who had their own experience of substance misuse.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of the patient group. They had opportunities to develop their skills and knowledge in training beyond the organisation's mandatory requirements. Additional training included group work skills, domestic abuse, psychosocial interventions, responding to suicide and basic life support.

New staff and volunteers all received an induction period which included completion of the mandatory training units. Volunteers were also able to access the additional training provided by the organisation.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance.

Good

Community-based substance misuse services

The service and staff reported that they were 100% compliant in receiving regular supervision. Non-medical prescribers also attended group supervision and managers attended reflective practice meetings for support.

The young person's recovery worker was supervised by the manager of one of the organisation's young person's services. They attended reflective practice sessions at their location with colleagues working solely with young people.

The appraisal rate was 72%, this was lower due to some staff not requiring appraisals as recently employed with the organisation and still in their probationary periods.

Staff attended monthly team meetings. The agenda included discussions relating to roles, recruitment, safeguarding, incidents, community engagement, performance, training and organisational updates.

Multi-disciplinary and inter-agency team work

Staff worked together as a team to benefit clients. Clients attending appointments with their non-medical prescribers were also supported to the meeting by their recovery worker. This promoted a three-way co-ordinated approach when planning their care and treatment and ensured all information was shared. The service used internet based video and voice calls for appointments where all parties could not attend in person.

All staff attended a daily briefing meeting each morning to share relevant information pertinent to the day. This included risks and activities. They held fortnightly case review meetings where staff could present a client's case which would benefit from a wider team discussion.

The team had effective working relationships with other services outside the organisation. A recovery worker worked full time from the local homeless service, staff made weekly visits to the YMCA and job centre. Staff from the job centre also attended the service to support clients. Staff from Addaction attended the community's mental health hospital weekly and staff from the mental health service attended Addaction also to see clients.

Staff had good relationships with the probation service and the integrated offender management team to ensure the care of those in the criminal justice system was co-ordinated effectively.

Client's key workers attended external multi-disciplinary meetings with social services and the hospital to provide support as needed. Managers engaged with the local area's strategy groups to ensure substance misuse was appropriately incorporated into decisions.

Good practice in applying the MCA

The organisation had a policy on the Mental Capacity Act which staff were aware of and could refer to. They also had a good relationship with the local mental health provider who they could contact for advice.

Staff supported clients to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes and history.

Staff ensured clients consented to their care and treatment during their comprehensive assessment. Capacity was assessed and clearly recorded at each appointment.

Staff working with young people used The Gillick competence framework to determine a young person's ability to make decisions.

Mental Capacity was a mandatory training unit. The service was 100% compliant in completion of the unit. Staff we spoke to demonstrated a good knowledge of the act and their responsibilities under it.

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They understood their individual needs and supported them to understand and manage their care and treatment. We observed staff attitudes and behaviours when interacting with clients which showed discretion and empathy. Clients were positive about their recovery worker and the support offered and said they were able to be open and honest.

The service could not be assured that a patient's confidentiality was maintained. Clients completed information sharing agreements during their initial assessment; this was to be informed and to agree where

their information could be shared. Some clients had no information sharing agreements stored on the electronic records system. We looked at the electronic records for 10 clients. We saw signed information sharing agreements in eight of these records. However, staff were unable to locate the agreements for two clients. It was unclear whether these agreements had either not been uploaded to the service's system or not completed at assessment. The service submitted individual client information to the National Drug Treatment Monitoring Service monthly. This meant that the service may be sharing client information for those clients without an information sharing agreement and therefore without the client's consent. This also meant that potentially staff may breach a client's confidentiality where they may have liaised with external agencies or significant others.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured clients had easy access to additional support. Clients received a welcome booklet when they first entered treatment describing what to expect and what recovery could look like. This included information on treatment options. Clients told us they felt involved in their treatment and were given options relating to groups and prescribing choices. We observed a client's appointment with a non-medical prescriber who described to the client how the medications worked. The previous year's client survey showed that out of 20 responses, 17 felt fully involved in their treatment and three clients felt partially involved. However, there was a lack of evidence to support their involvement in an individual recovery plan.

Client's family members were able to attend their appointments where this was agreed and beneficial to the client's recovery capital. The service signposted family members to community support services as needed. Staff also used a local advocacy service to refer clients to if required.

Staff enabled clients to give feedback on the service they used. This was done either through their annual client survey, suggestion boxes or by using the organisation's webchat facility on their website. The service had listened to client feedback when developing their activity programme.

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

Good

Access and discharge

The service was easy to access. Clients either self-referred or were referred through external agencies such as the criminal courts and probation, youth services and social services. The service offered welcome meetings for adults where potential clients could find out what treatment involved and the expectations from the service and what the service expects from them. Prior to the meetings being offered, staff gathered essential information to ensure immediate risks were considered and urgent one to one appointments could be offered if needed. Welcome meetings were offered several times a week. Most clients were then seen within five days for their full comprehensive assessment.

Staff took a proactive approach when clients missed appointments or unexpectedly dropped out of treatment. They took actions agreed in client contingency plans and followed an engagement pathway. This included actions such as liaising with pharmacies and other agencies, using text services and letters, outreach, and if deemed safe, the holding of prescriptions with the aim of re-engagement. We observed staff discussing a disengaged client in their morning meeting and arranging a safe and well check at the client's home. We also observed how the staff responded immediately to an unplanned attendance from a disengaged client to ensure they were seen.

Staff discussed planned prison releases and hospital discharges in their morning meeting to ensure the client did not experience any gaps in their treatment.

Staff planned for a client's discharge ensuring they had support mechanisms in place with other support services and informing the client that they could return if they relapsed.

The facilities promote recovery, comfort, dignity and confidentiality

The design and layout of the main premises met the needs of the service. There were enough rooms to see clients for

groups, one to one appointments and clinical reviews. The rooms were clean, quiet and private. However, they were dated with worn carpets. Clients could access water from a drink's dispenser in the waiting area and hot drinks were offered in group sessions.

Staff delivered a range of groups for clients. These varied depending on the stage of a client's treatment and depending on the client's substance of misuse.

Clients' engagement with the wider community

Staff encouraged clients to develop links with the local community. The service had a community engagement worker who had an agenda slot in team meetings. They worked with the local college's art department to help clients use artwork to interpret their stories. Some clients participated in a Duke of Edinburgh activity around bush craft and others attended taster sessions for paddle boarding. Staff took 10 clients to a regional recovery games to participate in sporting activities and some visited a local museum. Recovery champions attended a wellbeing week at a large commercial company to explain recovery and treatment. Clients were also signposted to the area's mutual aid recovery hubs.

Meeting the needs of all people who use the service

The service met the needs of clients. They opened late one night a week to allow those working or with other restrictions to attend outside normal day hours. They worked in partnership with the police and the Crime Commissioner to focus on those with complex needs who where either at risk of becoming involved with the criminal justice service or already involved.

The service had a recovery worker seconded to the homeless team. They worked from the homeless shelter as well as walking the streets to build relationships with people who were usually hard to engage. Staff attended satellite sites to ensure those living on the outskirts of the town could access treatment. They held regular clinics at the job centre, YMCA and mental health service to make accessing treatment easier for those individuals who may otherwise not attend the service.

They supported clients with a protected characteristic or with communication support needs. Clients with mobility problems had arranged appointments at an alternative site to the main service to allow accessibility. Staff could use interpreters where necessary and leaflets in other languages could be obtained through the organisation.

The service had lead workers for veterans, the LGBT+ community, sex workers and those experiencing domestic abuse.

Staff saw young people at venues such as schools, colleges or any suitable location that met the needs of the young person and was safe. They used an electronic approach and phone applications in the treatment interventions.

Listening to and learning from concerns and complaints

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

During the reporting period 1 October 2018 to 30 September 2019, Addaction North East Lincolnshire received nine complaints. Of these, three were upheld; no complaints had been referred to the Ombudsman.

Clients told us they knew how to complain if needed and felt their complaints would be listened to. The service had a suggestion box and feedback forms in the reception area. Clients were informed how they could complain in their welcome meeting.

Staff generally tried to resolve complaints informally in the first instance. All formal complaints were investigated and reviewed from locality level to the executive director of operations. They were thematically monitored by the clinical governance directorate with minutes circulated to board level. The organisation had recently incorporated a complaints module to their incident reporting system to make it easier for complaints to be reported and monitored. The system also captured compliments and informal complaints which were resolved at the time.

Staff received feedback through team meetings and supervisions and lessons learnt were shared with the whole team.

Are community-based substance misuse services well-led?

Good

Community-based substance misuse services

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the service they managed, and were visible and approachable for clients and staff. The manager had enough administrative support and authority to carry out the role as needed.

The organisation's training department were developing a talent programme for staff which would lead to development opportunities.

Vision and strategy

Staff knew and understood the organisation's vision and values. Addaction had a set of guiding principles and core values which underpinned all elements of staff recruitment, induction, supervision, performance management and personal development. Their guiding principles were collaborative, ethical, resilient, self-Challenging and inspiring. The values were to be compassionate, determined and professional.

Culture

Staff felt respected, supported and valued. They told us staff morale had improved in the months prior to our inspection due to changes in management and reported a happy staff team. They felt proud to work for the provider and we observed different staff groups working well together.

The organisation promoted equality and diversity with a group of policies which were implemented into the service and mandatory training for staff.

Staff were supported in positive wellbeing with access to an employee assistance programme to support them and their families.

All staff felt supported by their peers and the managers and felt they could raise concerns if needed without fear of victimisation. They demonstrated dedication and passion in providing support to the client group.

Governance

Addaction had systems and processes in place to monitor and manage their objectives, drive improvements and meet the required standards. The governance structure for the organisation was incorporated into a national framework which aimed to ensure the organisation met regulations, best practice, continually improved and safeguarded those using their services. The structure was underpinned by an audit schedule supported by internal auditors, risk management and training with a programme of meetings from board to local service level.

Staff at Addaction North East Lincolnshire attended regular meetings to enable information from local level and from board level to be disseminated.

Managers from the service attended regional internal governance meetings and periodic meetings with their commissioners to monitor progress against their key performance indicators.

Management of risk, issues and performance

There was a clear quality assurance management and performance framework in place that was integrated across all organisational policies and procedures.

The service had a risk register which was kept up to date. The identified risks for Addaction North East Lincolnshire included the premises lift not working and the recruitment of non-medical prescribers. Staff could raise risks or concerns in team meetings for consideration and the manager could escalate as needed.

The service had contingency plans for emergencies, such as adverse weather or temporary loss of access to the service building. This ensured the service could continue to be provided to high risk clients.

Information management

Staff had access to the information and equipment required to complete their roles and to provide client care. They used electronic systems to maintain client records. Staff felt confident in using the systems and were able to demonstrate an awareness of information governance.

The organisation used a performance monitoring framework to monitor the health of the organisation and performance. This was used to benchmark against external data and included contracted key performance indicators, financial summaries, staff reports and internal and external audit results.

Good

Community-based substance misuse services

The service used a case management tool to assist staff to effectively manage their caseloads. The tool imported data from the electronic client reporting system. This allowed staff and their managers to monitor the workers overall compliance. The non-medical prescribers used a system to scrutinise prescribing regimes to address themes and review their practice if required.

The service made notifications to external bodies as needed and had developed good working relationships and arrangements with other services where appropriate to do so.

Engagement

Managers at Addaction North East Lincolnshire used the monthly staff meetings to engage and inform staff about the service. They aimed to keep clients informed and engaged in service developments through client appointments, the organisation's internet site and social media.

Staff had access to the Addaction's intranet system which enabled them to access key documents, policies and information.

Everyone had opportunities to give feedback about the service. This could be through staff meetings, supervisions, client groups or within key work sessions for clients.

Learning, continuous improvement and innovation

Staff could contribute ideas to drive improvements in the service. They told us that they could do this through their team meetings and supervisions.

The service submitted data to Public Health England. This meant that they received national information and data for comparisons and analysis which they could use for future planning and direction.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure they use only the rooms of the main premises and the agreed sataliette locations and not the room offsite which does not have the necessary safeguards in place.
- The provider should ensure clients' records, such as risk assessments, care plans and case notes, reflect the holistic conversations and meetings which have taken place and that goals are clearly defined in a specific way.
- The provider should ensure there are formal systems in place to regularly assess a patients health needs.
- The provider should ensure they share information appropriately and with the client's agreement.